REPORTS OF THE COUNCIL ON MEDICAL EDUCATION

The following reports were presented by Liana Puscas, MD, MHS, Chair:

1. COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2011 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association policies to ensure that our AMA's policy database is current, coherent, and relevant. This policy reads as follows, laying out the parameters for review and specifying the needed procedures:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

The Council on Medical Education recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

Policy Number	Title	Texts	Recommendation
H-210.986	Physicians and Family Caregivers - A Model for Partnership	Our AMA (1) encourages residency review committees and residency program directors to consider physician needs for training in evaluation of caregivers. Emphasis at both the undergraduate and graduate level is needed on the development of the physician's interpersonal skills to better facilitate assessment and management of	Rescind; duplicative of H-210.980, "Physicians and Family Caregivers: Shared Responsibility," which reads: "Our AMA: (1) specifically encourages

		caregiver stress and burden; (2) supports health policies that facilitate and encourage home health care. Current regulatory and financing mechanisms favor institutionalization, often penalizing families attempting to provide lower cost, higher quality-of-life care; (3) reaffirms support for reimbursement for physician time spent in education and counseling of caregivers and/or home care personnel involved in patient care; and (4) supports research that identifies the types of education and support services that most effectively enhance the activities and reduce the burdens of caregivers. Further research is also needed on the role of physicians and others in supporting the family caregiver. Citation: (CSA Rep. I, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden; (2) continues to support health policies that facilitate and encourage health care in the home; (3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care; (4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and (5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers; and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients.”
D-295.322	Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools	Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity. (Res. 313, A-09; Modified: CME Rep. 6, A-11)	Retain; remains relevant, especially due to increased attention to the need for diversity in medical education and practice.
H-295.888	Progress in Medical Education: the Medical School Admission Process	1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges. 2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved	Retain; remains relevant, as the AMA’s Accelerating Change in Medical Education initiative and other activities seek to improve the selection process for medical students (and change the composition and diversity of the future physician workforce).

		assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school. (CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11)	
H-305.962	Taxation of Federal Student Aid	Our AMA opposes legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA). (Res. 210, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
H-305.997	Income Tax Exemption for Medical Student Loans and Scholarships	The AMA supports continued efforts to obtain exemption from income tax on amounts received under medical scholarship or loan programs. (Res. 65, I-76; Reaffirmed: Sunset Report, I-98; Reaffirmation A-01; Reaffirmed: CME Rep. 2, A-11)	Rescind; superseded by H-305.962, "Taxation of Federal Student Aid," which reads: "Our AMA opposes legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA)."
H-40.994	Military Physicians in Graduate Medical Education Programs	Our AMA opposes any arbitrary attempt to limit the percentage of resident physicians in military graduate education or training programs. (Res. 71, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-11)	Rescind; superseded by H-40.995, "Graduate Medical Education in the Military," which reads, in part: "Our AMA: (1) strongly supports and endorses the graduate medical education programs of the military services and recognizes the potential benefit to the military services of recruitment, retention and readiness programs; (2) is gravely concerned that closures of military medical centers and subsequent reduction of graduate medical education programs conducted therein will not only impede the health care mission of the Department of Defense, but also harm the health care of the nation by increasing the drain on trained specialists available to the civilian sector; … 5) oppose any reductions to military GME

			residency or fellowship positions without dedicated congressional funding for an equal number of civilian residency positions in addition to any other planned increases to civilian GME to avoid further exacerbating the United States' physician shortage."
D-180.995	Physician Privileges Application -Timely Review by Managed Care	Our AMA will work with the American Association of Health Plans (AAHP), the American Hospital Association (AHA), the National Committee on Quality Assurance (NCQA), and other appropriate organizations to allow residents who are within six months of completion of their training to apply for hospital privileges and acceptance by health plans. (Res. 708, A-01; Reaffirmed: CME Rep. 2, A-11)	Retain; still relevant.
D-255.982	Oppose Discrimination in Residency Selection Based on International Medical Graduate Status	Our AMA: 1. Will request that the Accreditation Council for Graduate Medical Education include in the Institutional Requirements a requirement that will prohibit a program or an institution from having a blanket policy to not interview, rank or accept international medical graduate applicants. 2. Recognizes that the assessment of the individual international medical graduate residency and fellowship applicant should be based on his/her education and experience. 3. Will disseminate this new policy on opposition to discrimination in residency selection based on international medical graduate status to the graduate medical education community through AMA mechanisms. (Sub. Res. 305, A-08; Reaffirmation I-11)	Rescind. Clause 1 is reflected in ACGME Institutional Requirement IV.1.5, "Discrimination: The Sponsoring Institution must have policies and procedures, not necessarily GME-specific, prohibiting discrimination in employment and in the learning and working environment, consistent with all applicable laws and regulations. (Core)" Clause 2 is superseded by H-255.988 (11), "AMA Principles on International Medical Graduates," which reads, "That 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." Also reflected in H-255.983, "Graduates of Non-United States Medical Schools," which reads, "The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical

			education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character." Clause 3 was accomplished at the time of adoption of the resolution.
D-275.993	Reporting of Resident Physicians	Our AMA will: (1) work with appropriate groups, including the Federation of State Medical Boards, to attempt to increase the standardization of information about resident physicians that is reported to state medical licensing boards to obtain or renew the limited educational permit, consistent with existing AMA Policy H-265.934 (#4); (2) encourage state medical societies to act as a link between state medical licensing boards and medical schools/residency programs to ensure that educational programs are familiar with and have the opportunity to comment on proposed changes in reporting requirements for resident physicians; and (3) make relevant groups-- for example, medical schools, state medical societies, resident physicians--aware of what types of information must be supplied in order for resident physicians to obtain and renew a limited educational permit. (CME Rep. 4-I-01; Reaffirmed CME Rep. 2-A-11)	Retain in part. Policy H-265.934 is no longer AMA policy, hence the deletion in clause 1.
D-305.992	Accounting for GME Funding	Our AMA will encourage: (1) department chairs and residency program directors to learn effective use of the information that is currently available on Medicare funding accounting of GME at the level of individual hospitals to assure appropriate support for their training programs, and publicize sources for this information, including placing links on our AMA web site; and (2) hospital administrators to share with residency program directors and department chairs, accounting and budgeting information on the disbursement of Medicare education funding within the hospital to ensure the appropriate use of those funds for Graduate Medical Education. (Sub. Res. 302, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmation A-11)	Retain; remains relevant. See also H-305.929, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs": "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."
H-310.911	ACGME Allotted Time Off for Health Care Advocacy and Health Policy Activities	Our AMA: 1) urges the Accreditation Council for Graduate Medical Education (ACGME) to acknowledge that "activities in organized medicine" facilitate competency in professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice; 2) encourages residency and fellowship programs to support their	Retain; remains relevant. See also H-310.905, "Scholarly Activity by Resident and Fellow Physicians."

		residents and fellows in their involvement in and pursuit of leadership in organized medicine; and 3) encourages the ACGME and other regulatory bodies to adopt policy that resident and fellow physicians be allotted additional time, beyond scheduled vacation, for scholarly activity time and activities of organized medicine, including but not limited to, health care advocacy and health policy. (Res. 317, A-11)	
H-310.959	In-Service Training Examinations - Final Report	It is the policy of the AMA (1) to encourage entities responsible for in-service examinations and the ACGME to recognize that in-service training examinations should not be used in decisions concerning acceptance, denial, advancement, or retention in residency or fellowship training positions; should not be used by outside regulatory agencies for the purpose of assessing resident knowledge or the quality of training programs; and should not be used as a pretest to sit for specialty boards; (2) to encourage residency program directors to use the results of in-training examinations to counsel residents and as the basis for developing appropriate programs of remediation and also for the purpose of educational program evaluation; and (3) to urge that evaluation of residents for promotion or retention be based on valid and reliable measures of knowledge, skills, and behaviors, applied sequentially over time. In-training examinations should be administered under appropriate testing conditions. Residents should be relieved of on-call duty the night prior to and during the administration of the examination. The results, if used at all, should not be the sole factor in evaluation of residents. (CME Rep. A, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain in part. Clause 1 is still relevant. For clauses 2 and 3, the Accreditation Council for Graduate Medical Education is using Milestones and multiple measures of evaluation. Relying on one metric is frowned upon. (see Sections V.A.1 Resident Feedback and Evaluation and V.A.2 Resident Final Evaluation.)
H-310.960	Resident Education in Laboratory Utilization	Our AMA 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)	Retain; remains relevant.
H-310.996	Residency Review Committee Representation	Our AMA: (1) supports resident membership on Residency Review Committees; (2) requests that the resident representatives to the Residency Review Committees (RRCs) of the Accreditation Council for Graduate Medical Education (ACGME) serve for at least a one-year term as a full and voting participant at all RRC meetings; (3) requests that the resident members of the RRCs be peer-selected; and (4) will advocate for diversity of appointees to RRCs. (Res. 67, I-82; Reaffirmed: Sub. Res. 186, A-87; Reaffirmed: CLRPD Rep. A, I-92; Appended: Res. 306, I-98; Reaffirmed: CME Rep. 2, A-08; Appended: Res. 304, A-11)	Rescind; is now reflected in ACGME documents, including ACGME Policies and Procedures, Subject: 9.00 Review Committees and Recognition Committee: "(8) Member Appointment – Nominating organizations should submit to the ACGME administration the names of two candidates for each vacancy at least 12 months before the date of the appointment. Nominating organizations should consider professional qualifications, geographic distribution, and diversity in nominating their candidates." Also reflected in Committees and Members Selection Process: "Review Committees have physician members, at least one of whom is a resident at the

			time of appointment, and a public member. "Appointment of Resident Members to Review Committees "The process takes approximately 12 months from the call for nominations until the member's term begins. The Review Committee Executive Director requests nominations through the ACGME e-Communication and/or via letter to the specialty-specific professional organizations that have resident groups."
H-410.986	Resident Involvement in Practice Parameters	Our AMA urges national medical specialty societies to work with resident physicians within their specialty in developing practice parameters. (Res. 52, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Rescind. The intent of this policy is being met, as many specialty societies include residents/fellows on committees on development of guidelines for physician practice.
D-140.981	Ethical Guidelines on Gifts to Physicians from Industry	Our AMA shall: (1) communicate to all medical school deans and residency program directors the importance of including education on ethical guidelines regarding gifts to physicians from industry within the ethics curriculum of their medical student and housestaff education programs; (2) communicate to all medical school deans and residency program directors the content of CEJA Opinion E-8.061 and shall recommend that it or another nationally-recognized ethical guideline be used as the basis for educational content on this issue; (3) recommend to all medical school deans and residency program directors that appropriate policies be developed for medical students, housestaff and faculty in their respective institutions regarding the issue of gifts to physicians from industry; (4) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to encourage the Liaison Committee on Medical Education and the American Osteopathic Association Commission on Osteopathic College Accreditation to require all medical schools to make known to students the existence of the physician-industry financial disclosure databases that exist or will be created by 2013 as required by the Patient Protection and Affordable Care Act; and (5) work with AAMC and AACOM to encourage all medical school faculty to model professional behavior to students by disclosing the existence of financial ties with industry, in accordance with existing disclosure policies at each respective medical school. (Res. 13, A-02; Reaffirmed: Res. 303, A-05; Appended: Res. 308, A-11)	Rescind. This directive has been accomplished.
H-275.993	Examinations for Medical Licensure	Our AMA affirms its recommendation that medical school faculties continue to exercise the responsibilities inherent in their positions for the evaluation of students and residents, respectively. (CME Rep. B, I-81; Reaffirmed: CLRPD Rep. F, I-91; Modified: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Rescind. This is in essence the role of medical school faculties, and the essence of medical school accreditation.

H-295.868	Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training	1. Our AMA recommends that formal education and training in disaster medicine and public health preparedness be incorporated into the curriculum at all medical schools and residency programs. 2. Our AMA encourages medical schools and residency programs to utilize multiple methods, including simulation, disaster drills, interprofessional team-based learning, and other interactive formats for teaching disaster medicine and public health preparedness. 3. Our AMA encourages public and private funders to support the development and implementation of education and training opportunities in disaster medicine and public health preparedness for medical students and resident physicians. 4. Our AMA supports the National Disaster Life Support (NDLS) Program Office's work to revise and enhance the NDLS courses and supporting course materials, in both didactic and electronic formats, for use in medical schools and residency programs. 5. Our AMA encourages involvement of the National Disaster Life Support Education Consortium's adoption of training and education standards and guidelines established by the newly created Federal Education and Training Interagency Group (FETIG). 6. Our AMA will continue to work with other specialties and stakeholders to coordinate and encourage provision of disaster preparedness education and training in medical schools and in graduate and continuing medical education. 7. Our AMA encourages all medical specialties, in collaboration with the National Disaster Life Support Educational Consortium (NDLSEC), to develop interdisciplinary and inter-professional training venues and curricula, including essential elements for national disaster preparedness for use by medical schools and residency programs to prepare physicians and other health professionals to respond in coordinated teams using the tools available to effectively manage disasters and public health emergencies. 48. Our AMA encourages medical schools and residency programs to use community-based disaster training and drills as appropriate to the region and community they serve as opportunities for medical students and residents to develop team skills outside the usual venues of teaching hospitals, ambulatory clinics, and physician offices. 59. Our AMA will make medical students and residents aware of the context (including relevant legal issues) in which they could serve with appropriate training, credentialing, and supervision during a national disaster or emergency, e.g., non-governmental organizations, American Red Cross, Medical Reserve Corps, and other entities that could provide requisite supervision. 610. Our AMA will work with the Federation of State Medical Boards to encourage state licensing authorities to include medical students and residents who are properly trained and credentialed to be able to participate under appropriate supervision in a national disaster or emergency. 711. Our AMA encourages physicians, residents, and medical students to participate in disaster response activities through organized groups, such as the Medical	Retain in part. Still timely, with deletion of clauses 4-7, as these are no longer relevant.

		Response Corps and American Red Cross, and not as spontaneous volunteers. 8. Our AMA encourages teaching hospitals to develop and maintain a relocation plan to ensure that educational activities for faculty, medical students, and residents can be continued in times of national disaster and emergency. (CME Rep. 15, A-09; Reaffirmed: CME Rep. 7, A-10; Appended: CME Rep. 7, A-10; Reaffirmed and Appended: CME Rep. 1, I-11)	
H-310.970	Mandatory Helicopter Flight for Emergency Medical Residents in Training	Our AMA urges residency training programs that require helicopter transport as a mandatory part of their residency to notify applicants of that policy prior to and during the interview process. (Res. 239, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 01, A-20)	Rescind; superseded by H-295.943, "Issues Regarding Patient and/or Donor Transports by Resident Physicians and Medical Students."
H-295.943	Issues Regarding Patient and/or Donor Transports by Resident Physicians and Medical Students	Our AMA (1) urges medical schools not to require medical students to participate in the air or ground transport of patients or organs during required clinical rotations; and (2) encourages all teaching institutions where medical students or resident physicians participate (compulsorily or voluntarily) in the air or ground transport of patients or organs (a) to notify prospective students and residents of all program requirements related to transports; (b) to include accident, disability, and life insurance as part of an available package for participating medical students and resident physicians, and to provide such insurance where participation is mandatory; (c) to include in the educational curriculum formal training on general and safety issues pertaining to emergency transport before students or residents participate in such activity; and (d) to adhere to the Association of Air Medical Services (AAMS) Minimum Quality Standards and Safety Guidelines for transport. (CME Rep. E, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant. See also H-310.970, "Mandatory Helicopter Flight for Emergency Medical Residents in Training," which is being rescinded through this report, as it is superseded by H-295.943.
D-305.990	Impact of Health System Changes on Medical Education	Our AMA wil continue to monitor the financial status of academic medical centers and the availability of faculty and patients to support the clinical education of medical students and resident physicians. This should both include collecting information and synthesizing information from other sources on these issues. (CME Rep. 4, A-01; Reaffirmed: CME Rep. 2, A-11)	Rescind; remains relevant, but superseded by H-305.942, "The Ecology of Medical Education: The Infrastructure for Clinical Education," which reads: "The AMA recommends the following to ensure that access to appropriate clinical facilities and faculty to carry out clinical education is maintained: (1) That each medical school and residency program identify the specific resources needed to support the clinical education of trainees, and should develop an explicit plan to obtain and maintain these resources. This planning should include identification of the types of clinical facilities and the number and specialty distribution of full-time and volunteer clinical faculty members needed. (2) That affiliated health care institutions and volunteer

			faculty members be included in medical school and residency program resource planning for clinical education when appropriate. (3) That medical school planning for clinical network development include consideration of the impact on the education program for medical students and resident physicians. (4) That accrediting bodies for undergraduate and graduate medical education be encouraged to adopt accreditation standards that require notification of changes in clinical affiliations, in order to ensure that changes in the affiliation status of hospitals or other clinical sites do not adversely affect the education of medical students and resident physicians."
D-405.987	Debilitating Accidents and Accidental Deaths of Physicians in Training	Our AMA: 1) requests modification in the annual survey distributed to medical schools in order to assess the topic of serious accidents and accidental deaths; 2) requests modification of other annual surveys of medical schools, residency directors, and other medical educators in order to assess the topic of serious accidents and accidental deaths among physicians in training. (Res. 323, A-11)	Rescind; this directive was accomplished.
H-435.997	Medical School Malpractice Risk Prevention Curriculum	Our AMA (1) acknowledges the continuing and growing severity of the problem of physician professional liability insurance nationwide and (2) urges medical schools and directors of residency programs to assist students and residents to understand and apply the determinants of sound risk management to clinical practice. (Sub. Res. 48, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind; superseded by H-295.924, "Future Directions for Socioeconomic Education," which reads: "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."
G-615.060	CME Activities	Our AMA supports intensified efforts of the Council on Medical Education and other bodies within our AMA to initiate meetings and encourage continuing dialogue with medical students, interns, and residents. (Sub. Res. 22, I-69; CME Rep. I, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CC&B Rep. 2, A-11)	Rescind; this work is already reflected in multiple AMA activities and initiatives, including the Medical Student Section and Resident and Fellow Section (neither of which were in existence in 1969, when this policy was adopted).
H-300.946	Inappropriate Use of Social Security Numbers in CME Accreditation	Our AMA opposes the use of Social Security numbers as: (1) a requirement to obtain continuing medical education credit and strongly encourage the use of the AMA Medical Education number for such educational activities; and (2) file identifiers by providers of continuing medical education, certification boards and similar entities, suggesting instead the use of the AMA Medical Education number where such a unique identifier is required and applicable. (Res. 306, A-00; Appended Res. 301, A-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant. See also H-190.963, "Identity Fraud," which reads: "Our AMA policy is to discourage the use of Social Security numbers to identify insureds, patients, and physicians, except in those situations where the use of these numbers is required by law and/or regulation."
D-300.980	Opposition to Increased CME Provider Fees	1. Our AMA will (a) communicate its appreciation to the Accreditation Council for Continuing Medical Education (ACCME) Board of Directors for their responsiveness to AMA's requests this past year; (ab) 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, and (iv) encourage the ACCME to show that the updated accreditation criteria improve patient care; and (bc) continue to work with the ACCME to (i) mandate meaningful involvement of state medical societies in the policies that affect recognition and (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." 3. Our AMA, in collaboration with the ACCME, will do a comprehensive review of the CME process on a national level, with the goal of decreasing costs and simplifying the process of providing CME. (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)	Retain in part. Delete 1.(a) and 3, which have been accomplished, and delete "updated" in 1.(b)(iv), in that these criteria were revised in the past. As stated in Council on Medical Education Report 7-A-12, the Council monitored results of the recommendations from Policy D-300.980 for the prior three years, and the Accreditation Council for Continuing Medical Education has been amenable to discussing AMA concerns. In December 2009, the ACCME created a task force to explore strategies for clarifying the requirements, eliminating redundancies, and reducing the documentation requirements for providers. This Task Force reported back to the ACCME Board in November 2010. The ACCME reports that it

			continues to be actively engaged in ongoing discussions and that some of the "simplification" changes associated with the Task Force's work have already been implemented. For the past three years, the AMA has advocated for reduced fees and changes to the existing ACCME accreditation system. The Council on Medical Education will continue to monitor the activities and fees of the ACCME.
H-300.973	Promoting Quality Assurance, Peer Review, and Continuing Medical Education	Our AMA: (1) reaffirms that it is the professional responsibility of every physician to participate in voluntary quality assurance, peer review, and continuing medical education activities; (2) to encourage hospitals and other organizations in which quality assurance, peer review, and continuing medical education activities are conducted to provide recognition to physicians who participate voluntarily; (3) to increase its efforts to make physicians aware that participation in the voluntary quality assurance and peer review functions of their hospital medical staffs and other organizations provides credit toward the AMA's Physicians' Recognition Award; and (4) to continue to study additional incentives for physicians to participate in voluntary quality assurance, peer review, and continuing medical education activities. (BOT Rep. SS, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
H-300.974	Unification of Continuing Education Credits	Our AMA accepts American Academy of Family Physicians prescribed credit hours and American College of Obstetricians and Gynecologists cognate credit hours for formal learning, as equivalent to *AMA PRA Category 1 Credit*™. (CME Rep. C, I-91; Reaffirmed: Sunset Report, I-01; Modified: CME Rep. 2, A-11)	Retain; remains relevant.
H-300.975	Fraudulent/ Legitimate Continuing Medical Education Activities	Our AMA supports the development and publication of guidelines to assist physicians in identifying continuing medical education of high quality, responsive to their needs, and supports the promulgation of ethical principles regarding the responsibilities of physicians to participate in continuing medical education programs which they claim for continuing medical education recognition, credit or other purposes. (Sub. Res. 64, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
D-300.979	Suggested Revision in ACCME Evaluations	1. Our AMA will: (1) strongly encourage the Accreditation Council for Continuing Medical Education to recognize the value of gaining knowledge outside a physician's specialty and change the activity evaluation to reflect this; and (2) 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)	Retain in part with the deletion of (1) and editorial change to (2), along with the number 1., which is unneeded. Both (1) and (2) have been accomplished, but (2) is still relevant.
H-300.992	National Accreditation of AMA as Provider of	Our AMA assigns to the CME Council on Medical Education the responsibility to be the unit of the AMA to become accredited for continuing medical education.	Retain; remains relevant, with editorial change to specify the "Council on Medical Education," to

	Continuing Medical Education	(BOT Rep. NN, A-81; CLRPD Rep. F, I-91; Modified: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	avoid confusion with "continuing medical education."
D-300.995	Reducing Burdens of CME Accreditation and Documentation	Our AMA will work with the Accreditation Council for Continuing Medical Education to simplify the requirements for documentation and administration of accredited CME programs. (Res. 304, I-01; Reaffirmed: CME Rep. 2, A-11)	Rescind; accomplished. In 2017, the AMA and ACCME completed a multi-year process of simplification and alignment of the credit and accreditation systems. The process included multiple avenues of input from the CME community, culminating in a call for comment regarding proposed changes. The recommendations of the AMA/ACCME bridge committee were approved by the AMA Council on Medical Education and the ACCME Board of Directors.
D-300.998	Attendance of Non-Physicians at Courses Teaching Complex Diagnostic, Therapeutic or Surgical Procedures	Our AMA will encourage the Accreditation Council for Continuing Medical Education, the American Academy of Family Physicians, and other groups that accredit providers of continuing medical education to adopt the principle that continuing medical education should be focused on physicians (MDs/DOs). Courses teaching complex diagnostic, therapeutic or surgical procedures should be open only to those practitioners and/or sponsored members of the practitioner's care team who have the appropriate medical education background and preparation to ensure patient safety. This should not be construed to limit access to or apply to programs leading to life support certification, e.g. ATLS, ACLS (CME Rep. 2, A-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
H-250.996	Enhancing Young Physicians' Effectiveness in International Health	It is the policy of the AMA to work with national medical specialty societies and other organizations in preparing materials which guide young physicians in the development of skills necessary for effectively promoting the health of poor populations both in the United States and abroad. (Res. 407, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain; remains relevant.
H-260.978	Salary Equity for Laboratory Personnel	It is the policy of the AMA to promote adequate compensation for medical technologists, cytotechnologists and other medical laboratory personnel and to promote increased funding for their educational programs. (Sub. Res. 39, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Rescind; outside the scope of the AMA.
D-275.964	Principles of Due Process for Medical License Complaints	1. Our AMA will explore ways to establish principles of due process that must be used by a state licensing board prior to the restriction or revocation of a physician's medical license, including strong protections for physicians'? rights. 2. Our AMA takes the position that: A) when a state medical board conducts an investigation or inquiry of a licensee applicant's quality of care, that the standard of care be determined by physician(s) from the same specialty as the licensee applicant, and B) when a state medical board conducts an investigation or inquiry regarding quality of care by a medical licensee or licensee applicant, that the physician be given: (i) a minimum of 30 days to respond to inquiries or requests	Retain; still relevant. Note editorial change to clause 1 to fix error.

		from a state medical board, (ii) prompt board decisions on all pending matters, (iii) sworn expert review by a physician of the same specialty, (iv) a list of witnesses providing expert review, and (v) exculpatory expert reports, should they exist. (Res. 238, A-08; Appended: Res. 301, A-11)	
D-275.989	Credentialing Issues	1. Our AMA shall: (A) continue to encourage the Federation of State Medical Boards (FSMB) and its licensing jurisdictions to widely disseminate information about the Federation Credentials Verification Service; and (B) encourage the FSMB and the Educational Commission for Foreign Medical Graduates to work together to develop a system for the prompt and reliable verification of the medical education credentials of international medical graduates and to serve as a repository and a body for primary source verification of credentials. 2. Our AMA encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept the Educational Commission for Foreign Medical Graduates certification as proof of primary source verification of an IMG's international medical education credentials. (CME Rep. 3, A-02; Appended: CME Rep. 10, A-11)	Rescind in part. Clause 1 has been accomplished through work by the FSMB and ECFMG to replace paper-based processes with an electronic portal for medical school transmission of diplomas and transcripts for IMGs. These technological advances have reduced turnaround time for credentials verification for the majority of applicants. Clause 2 should be retained, in that states should be encouraged to accept the ECMG certification as proof of primary source verification of an IMG's international medical education credentials, to ensure efficiency and reduced processing time for IMGs seeking licensure while protecting the public.

2. LICENSURE FOR INTERNATIONAL MEDICAL GRADUATES PRACTICING IN U.S. INSTITUTIONS WITH RESTRICTED MEDICAL LICENSES (RESOLUTION 311-A-19)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 311-A-19 REMAINDER OF REPORT FILED
See Policies H-160.949, H-255.988, H-275.934, H-275.978 and D-255.977

INTRODUCTION

Resolution 311-A-19, "Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses," introduced by the International Medical Graduates Section (IMGS), and referred by the House of Delegates, asked that our American Medical Association (AMA) work with the Federation of State Medical Boards (FSMB), the Organized Medical Staff Section, and other stakeholders to advocate for state medical boards to support the licensure to practice medicine by physicians who have demonstrated they possess the educational background and technical skills and who are practicing in the U.S. health care system.

Testimony on this item during the 2019 Annual Meeting from an international medical graduate (IMG) academic physician who has trained many residents and fellows in the United States, but who is ineligible to obtain a medical license, reflected the impetus for this item. A physician from Florida testified how that state continues to grapple with the issue of physician immigrants from Cuba and other countries who do not meet state licensure requirements yet

seek to find a way in which to put their (often considerable) skills to work in their new country in service to patients and society.

BACKGROUND

All state medical boards require physicians to have completed at least one year of graduate medical education (GME) in a residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) to be eligible for a full, unrestricted medical license.[1] Some states do issue limited, restricted licenses that allow a physician to practice, under supervision, in specific institutions. Some of these physicians are IMGs who not only received their medical education outside the U.S. but also trained in a specialty and practiced abroad. After immigrating to the U.S., these physicians have been able to establish themselves in an institution utilizing one of these limited, restricted licenses, despite being ineligible for full licensure. Some institutions, however, have instituted changes to require that all physicians employed by the institution be board certified or board eligible. This has excluded physicians with restricted, limited licenses who may have been serving their community for years while contributing to patient care and the medical education of students and residents.

RESTRICTED LICENSES

Medical boards issue a variety of licenses other than full, unrestricted licenses. Of relevance, 40 medical boards issue "faculty/educational" licenses; 44 issue "limited/special purpose" licenses, and 19 issue "institutional practice" licenses.[1] Medical boards may determine the limitations or conditions of practice under these licenses differently, as well as the educational and/or training requirements. In addition, the boards use different names for possibly similar types of licenses, making it challenging to quantify less common license types at the national level. For example, according to a requested analysis provided by the FSMB, 163 physicians nationwide possess a license categorized as "teaching." These licenses are labeled variously, such as "Foreign Teaching Physicians" or "Distinguished Faculty." This count could be low considering the variability in how medical boards categorize and share data for these less common license types.

For example, in Washington state, the Washington Medical Commission may "issue a limited license to a physician applicant invited to serve as a teaching-research member of the institution's instructional staff if the sponsoring institution and the applicant give evidence that he or she has graduated from a recognized medical school and has been licensed or otherwise privileged to practice medicine at his or her location of origin. Such license shall permit the recipient to practice medicine only within the confines of the instructional program specified in the application."[2]

Texas offers a faculty temporary license, with similar requirements as Washington, with specific restrictions concerning the institution that can hire the physician (i.e., certain medical centers, Texas medical schools, or GME sponsors).[3] The District of Columbia specifically offers licenses "for foreign doctors of eminence and authority."[4] New York offers a limited permit that can allow an IMG without U.S. GME to practice in a nursing home; state-operated psychiatric, developmental or alcohol treatment center; or incorporated, nonprofit institution for the treatment of the chronically ill, but only for up to four years.[5]

Florida offers a "house physician" license and provides a detailed description of the work that can be done, all under the supervision of a physician with an active, unrestricted Florida license. The license for house physicians does not require U.S. GME and seems to have relatively few requirements, i.e., types of institutions are not specified, nor time limits.[6]

BOARD CERTIFICATION REQUIREMENTS

The American Board of Medical Specialties (ABMS) acknowledges that there may be acceptable alternative pathways to initial certification for candidates who have not completed U.S. GME. Some ABMS member boards recognize alternative pathways, but others do not, due to the challenges associated with assessing equivalency of training for these medical specialties.[7]

The ABMS Position Statement on Alternative Pathways to initial certification defines the guiding principles for acceptable alternative pathways that do not meet the standard pathway (i.e., ACGME-accredited or Canadian-accredited GME). An ABMS workgroup is currently reviewing the ABMS Position Statement to determine if additional changes are required to ensure continued clarity.[7]

The ABMS stipulates that alternative pathway policies and procedures for initial certification should:

1. Be transparent, objective, equitable, and readily available to interested candidates and stakeholders;
2. Not be arbitrary or capricious to interested candidates and stakeholders;
3. Include the assessment of all six of the ABMS/ACGME core competencies;
4. Include the assessment of professional standing in adherence with the ABMS Professional Standing Policy; and
5. Adhere to Member Boards' existing Board Eligibility policies for both specialties and subspecialties, provided those policies adhere to the ABMS Board Eligibility Policies.

Sixteen boards offer pathways for internationally trained physicians; in particular, ten boards offer pathways for physicians practicing in the United States at an ACGME-accredited institution who are faculty at an ACGME-accredited program and may have achieved a specified academic rank (from associate to full professor); two boards will accept international training as meeting all of the training requirements on a case-by-case basis; and four boards will accept international training as meeting some of the training requirements on a case-by-case basis. Two boards have established that training in Australia and New Zealand is equivalent to ACGME-accredited training; these boards will accept candidates who trained in those countries.

Twenty-two member boards accept all of a candidate's training in Canada (either accredited by the Royal College of Physicians and Surgeons of Canada [RCPSC], or by another body acceptable to the board). Of these, eleven further require that a candidate be certified by the RCPSC or other Canadian certifying body. Three boards will accept some of a candidate's training in Canada (either accredited by the RCPSC or by another body acceptable to the board).

Regardless of a member board's position on alternative pathways, it is the policy of the ABMS that, to be eligible for certification in any specialty or subspecialty and to maintain certification, a physician must have a full and unrestricted license to practice medicine in at least one jurisdiction in the United States, its territories, or Canada.

EXPLORATION OF ALTERNATIVE PATHWAYS IN MINNESOTA

Minnesota's International Medical Graduate Assistance Program, operational since 2016, helps IMGs in the state obtain residency positions. One aspect of the program includes study of possible licensure changes that would allow qualified IMGs to practice in Minnesota. The Minnesota Department of Health, working with the Minnesota Board of Medical Practice and other stakeholders, proposed two possible strategies in 2018: the creation of an IMG Primary Care Integration license and an amendment to the medical practice act to include an exemption for practice in primary care in a rural or underserved area. Objectively qualified IMGs would be able to practice in areas experiencing primary care shortages without entering U.S. GME. The process includes passage of all licensure exams, demonstrating at least seven years of medical practice, participation in a six-month clinical experience, and an assessment that would culminate in a certificate that would allow work under supervision.

The program would require the commitment of an accredited assessor. Another concern is that these physicians would not be eligible for board certification and may encounter employment restrictions. Two major stakeholders—the Minnesota Academy of Physician Assistants and the Minnesota Medical Association—have raised objections, citing concerns over professional role confusion and a tiered licensure system. The Minnesota Department of Health continues to research possible licensure changes.[8,9]

CURRENT AMA POLICY

As shown in the appendix, the AMA has substantial policy that supports full licensure for practicing physicians, whether U.S. medical school graduates or IMGs, only after completion of at least one year of GME in the U.S. (see H-255.988 [12] and H-275.934 [2]).

Policy H-160.949 (6) specifies as well that the AMA "opposes special licensing pathways for physicians who are not currently enrolled in an [accredited]...training program." This policy was adopted at the 2014 Annual Meeting in response to development in Missouri of a special licensure pathway for practice by "assistant physicians" who have not had any GME in the U.S. (see https://www.aapa.org/news-central/2014/06/american-medical-association-house-of-delegates-rejects-assistant-physician-concept/). Meanwhile, Policy H-275.978 (5) states that the AMA "urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is

recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public." It would seem that these two policies are contradictory; accordingly, they are proposed for modification in the recommendations below.

In addition, the AMA both recognizes the value of board certification but advocates against discrimination against physicians based on a lack of board certification. Policy H-220.960 asks The Joint Commission to "support retention of important medical staff structural standards in its hospital accreditation programs, including, but not limited to, standards...that board certification is an excellent benchmark for the delineation of clinical privileges." At the same time, H-275.926 states that the AMA "(4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination."

SUMMARY AND RECOMMENDATIONS

Existing AMA policy is of two minds in terms of the requirements for full licensure and board certification. Indeed, the need for an expanded workforce, to meet the growing needs of patients for access to health care services, must be balanced with requisite caution in awarding licensure for practice, given the need to protect the public and ensure the quality of the medical workforce. Given, however, that physicians who have been serving their communities for years may have their careers jeopardized as a result of employers adopting new employment standards, the Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 311-A-19 and the remainder of this report be filed:

1. That our American Medical Association (AMA) advocate that qualified international medical graduates have a pathway for licensure by encouraging state medical licensing boards and the member boards of the American Board of Medical Specialties to develop criteria that allow 1) completion of medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and 3) evidence of good standing within the local medical community to serve as a substitute for U.S. graduate medical education requirement for physicians seeking full unrestricted licensure and board certification.

2. That our AMA amend Policy H-255.988 (12), "AMA Principles on International Medical Graduates," by addition to read as follows:

   Our AMA supports …12. 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: 1) completion of medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and 3) evidence of good standing within the local medical community.

3. That our AMA amend Policy H-275.934 (2), "Alternatives to the Federation of State Medical Boards Recommendations on Licensure," by addition to read as follows:

   2. All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all state-required licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement for completing one year of accredited GME in the U.S.: 1) completion of medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and 3) evidence of good standing within the local medical community.

4. That our AMA amend Policy H-160.949 (6), "Practicing Medicine by Non-Physicians," by addition and deletion to read as follows:

Our AMA … (6) opposes special licensing pathways for "assistant physicians" (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education ~~of American Osteopathic Association~~ training program, or have not completed at least one year of accredited ~~post-~~graduate ~~US~~ medical education in the U.S).

5. That our AMA amend Policy H-275.978 (5), "Medical Licensure," by addition to read as follows:

Our AMA … (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses, with the exception of special licensing pathways for "assistant physicians." It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;

REFERENCES

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3. Texas Medical Board. Faculty Temporary License. www.tmb.state.tx.us/page/licensing-faculty-temporary-licenses. Accessed September 16, 2019.
4. Code of the District of Columbia, § 3–1205.09a. Licenses for foreign doctors of eminence and authority. https://code.dccouncil.us/dc/council/code/sections/3-1205.09a.html. Accessed September 16, 2019.
5. New York State Education Department. License Requirements. Physician. Limited Permits. www.op.nysed.gov/prof/med/medlic.htm. Accessed September 16, 2019.
6. Florida Board of Medicine. Resident Physicians, Interns, Fellows, and House Physicians. https://flboardofmedicine.gov/licensing/resident-physicians-interns-fellows-and-house-physicians/. Accessed September 16, 2019.
7. American Board of Medical Specialties Committee on Certification (COCERT). December 2020.
8. Minnesota Department of Health. International Medical Graduate (IMG) Program. https://www.health.state.mn.us/facilities/ruralhealth/img/index.html. Accessed September 16, 2019.
9. Hirsi I. Could the state-funded International Medical Graduate Assistance Program do more for immigrant doctors — and help address Minnesota's looming doctor shortage? MinnPost. May 11, 2018. https://www.minnpost.com/new-americans/2018/05/could-state-funded-international-medical-graduate-assistance-program-do-more-i/. Accessed December 30, 2019.

APPENDIX

H-160.949, "Practicing Medicine by Non-Physicians"
Our AMA . . . (6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.

H-220.960, "The Joint Commission Hospital Accreditation Program Standards"
Our AMA requests its trustees who serve as Commissioners to The Joint Commission to support retention of important medical staff structural standards in its hospital accreditation programs, including, but not limited to, standards requiring that medical staff operate as a self-governing entity - as defined in medical staff bylaws; that physician directors of hospital departments be board certified or possess equivalent qualifications; and that board certification is an excellent benchmark for the delineation of clinical privileges….

H-255.966, "Abolish Discrimination in Licensure of IMGs"
1. Our AMA 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 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 Federation of State Medical Boards 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.

H-255.970, "Employment of Non-Certified IMGs"
Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure.

H-255.988, "AMA Principles on International Medical Graduates"
Our AMA supports:
6. 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, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
12. 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.

H-275.926, "Medical Specialty Board Certification Standards"
Our AMA: (4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.

H-275.934, "Alternatives to the Federation of State Medical Boards Recommendations on Licensure"
Our AMA adopts the following principles: (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine.

H-275.936, "Mechanisms to Measure Physician Competency"
Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience….

H-275.978, "Medical Licensure"
Our AMA: (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;

3. OPTIMIZING MATCH OUTCOMES (RESOLUTION 304-I-19)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 304-I-19 REMAINDER OF REPORT FILED
See Policies H-200.954, D-305.967 and D-310.977

INTRODUCTION

Resolution 304-I-19, "Issues with the Match, the National Residency Matching Program (NRMP)," introduced by the Indiana Delegation, asked the AMA to:

1. continue working to promote an increase in residency program positions in the U.S.
2. study how residency programs can expand in novel ways;
3. determine what strategies can increase an applicant's ability to match into a residency program;
4. support the option of permitting those who failed to obtain a position during the Supplemental Offer and Acceptance Program® (SOAP®) in 2019 to participate in a future matching opportunity at no cost; and
5. encourage the National Resident Matching Program (NRMP) and the Electronic Residency Application Service (ERAS) to conduct an audit to identify opportunities for lowering the financial burden on applicants and to promote and disseminate strategies to mitigate issues that interfere with successfully matching. The full resolution is in the Appendix.

Online and in-person testimony during the 2019 Interim Meeting suggested that this resolution, which calls for a broad investigation into several different aspects of the resident match, has already been addressed in the recent past by the Council on Medical Education (CME Report 3-A-16, "Addressing the Increasing Number of Unmatched Medical Students"). It was noted that the AMA has extensive policy on expanding graduate medical education (see for example D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education"). Testimony also noted that the NRMP and the Association of American Medical Colleges (AAMC) release yearly authoritative reports on match outcomes with granular data for medical students to aid in their decision making. Others, however, expressed concern that current efforts to address this issue have been insufficient. The reference committee initially considered reaffirmation of existing policy in lieu of Resolves 1 and 2, and deletion of Resolve 3, but ultimately recommended referral of the entire resolution. The House of Delegates (HOD) subsequently agreed; this report is in response to that referral.

BACKGROUND

For many years there have been concerns that the system for entry into U.S. residency training programs has barriers that stymie the efforts of qualified applicants to achieve their goal of practicing medicine in the U.S., often at great personal financial cost. These concerns have led to many resolutions presented to the AMA HOD and subsequent reports and policies generated to address those concerns. This report: a) summarizes the AMA's recent efforts to increase residency training positions and assist applicants in applying to residency programs; b) describes the technological problems of SOAP in 2019 and what has been done to prevent future problems; and c) describes resources for applicants on effective program application and matching.

AMA REPORTS, POLICY, AND ADVOCACY

The AMA Council on Medical Education (CME) has prepared several reports for the HOD addressing the process of matching into residency programs, as well as the need to increase funding for graduate medical education (GME). For example, CME Report 3-A-18, "Expanding UME Without Concurrent GME Expansion," included three recommendations that were adopted as policy and recorded in D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education:"

> (32) Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans;

(b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

CME Report 5-A-17, "Options for Unmatched Medical Students," outlined a number of key points related to unmatched medical students, including the long-term stability of match rates, common reasons for an unsuccessful match, options for students who do not match, and tools/initiatives from medical schools and medical organizations (including the AMA) to ensure an effective, efficient, and equitable match process that balances the interests of applicants and programs and promotes rational, strategic decision making by all parties. This report also highlighted AMA resources, including the AMA's Career Planning Resource, which includes guidance on applying for residency, choosing a specialty, interviewing for residency, writing a C.V., and finding residency programs through FREIDA™. Another tool described in this report is the AAMC's Careers in Medicine (CiM) online guide, which helps students make strategic decisions about residency training and beyond and provides self-assessment tools and specialty-specific data to inform those decisions.

CME Report 3-A-16, "Addressing the Increasing Number of Unmatched Medical Students," recommended reaffirming existing policy, namely D-305.967 (4) and (22), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education;" H-200.954 (4) (5) (6) and (7), "US Physician Shortage," and D-310.977 (11), "National Resident Matching Program Reform." These various policies direct the AMA to advocate for increasing GME positions; encourage research and data that support the value of GME; and encourage medical schools and residency programs to consider policies to attract physicians to practice in and care for patients in underserved and rural areas. Other policy encourages the AMA to work with other major stakeholders in medical education to evaluate data and propose new research that would describe how many students graduating from U.S. medical schools each year do not enter into a U.S. residency program; how many never enter into a U.S. residency program; whether there is disproportionate impact on individuals of minoritized racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs.

The AMA has long advocated for advancing GME, including increasing funding for residency positions, developing innovative funding models, and creating residency positions that reflect patient and societal needs. The AMA launched the Reimagining Residency Initiative in 2019 with $15 million in grants to projects promoting systemic change in GME. Recently the AMA offered technical assistance in the drafting of the Health Heroes 2020 Act (H.R. 6650), which proposes to bolster the National Health Service Corps (NHSC) by providing an additional $25 billion for both the loan repayment and scholarship programs to increase the number of medical professionals in underserved communities. The Act would also increase the mandatory NHSC funding level from $310M to $690M for fiscal years 2021-2026 to increase scholarship and loan forgiveness awards. The AMA offered assistance in the drafting of the Rural America Health Corps Act (S.2406) which builds upon the existing NHSC model by proposing up to five years of loan forgiveness (versus two) to help pay down medical school debt and increase the number of individuals that can enter the NHSC.

The AMA continues to voice its support for federal bills to increase residency positions, including the Resident Physician Shortage Reduction Act of 2021 (S. 834), which would expand Medicare funding for 15,000 additional residency positions. Earlier legislative proposals from 2019 that garnered AMA support and advocacy would close a loophole in GME cap-setting criteria affecting hospitals that temporarily host small numbers of residents (H.R. 1358), and provide 1,000 additional Medicare-supported GME positions over five years in hospitals that have, or are establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain management (H.R. 2439).

Most recently, there were multiple provisions in the new Appropriations Act that provide benefits for GME, variations of which AMA has advocated for, including:

- Increased funding ($310 million) from 2021-2023 for the National Health Service Corps, and extended funding through 2023 for teaching health centers that operate GME programs. (Sec. 301)

- Hospitals will be allowed to host a limited number of residents for short-term rotations without being negatively impacted by a set permanent full time equivalent (FTE) resident cap or a per resident amount (PRA). A hospital must report full-time equivalent residents on its cost report for a cost reporting period if the hospital trains at least 1.0 full-time-equivalent residents in an approved medical residency training program or programs in such period. (Sec. 131)
- A thousand additional Medicare-funded GME residency positions (200 per year for 5 years), to be distributed to rural hospitals, hospitals that are already above their Medicare cap for residency positions, hospitals in states with new medical schools or new locations and branch campuses, and hospitals that serve Health Professional Shortage Areas. However, a hospital may not receive more than 25 additional full-time equivalent residency positions. (Sec. 126)

TECHNOLOGICAL PROBLEMS FOR SOAP

SOAP is a joint service of the NRMP and ERAS. Through SOAP, qualified applicants who do not obtain a position through the NRMP Match are privy to a list of participating programs that did not fill all their positions through the Match. Applicants submit applications to programs of interest. Programs review the applications and select candidates to interview (via phone, video, or in-person if local), and positions are then offered to successful applicants. This occurs over a compressed timeframe, with three rounds over two days.

In 2019 the ERAS system experienced technical issues during the SOAP process, which affected applicants and program directors. The system was taken offline to correct the problem, resulting in a shortened time frame to complete the process; therefore, the NRMP reduced the number of rounds from three to two. The AAMC conducted an internal root-cause analysis and had an external review completed by an industry expert to evaluate technology and processes. Those reviews identified immediate and long-term steps that were implemented to mitigate future risk and to improve systems and operations.[1] Similar technical issues also occurred during the first day of the SOAP process in 2021. The cause of these issues was not known at the time this report was prepared, but the AAMC has apologized for the situation and promised another thorough investigation to understand the poor performance and identify and implement solutions to improve the process. The Council on Medical Education will continue to monitor the situation.

Typically, around 600 U.S. MD seniors are without a position at the conclusion of SOAP. In 2019, there were 623 without a position versus 620 in 2018. In 2020, there were 522. Overall, all applicants accepted offers with roughly the same frequency: the percent of offers accepted was 64.1 in 2018, 62.5 in 2019, and 61.8 in 2020.[2,3,4] Data from the 2021 Match were not available at the time this report was prepared. Although the compressed schedule caused additional anxiety during a period that is normally stressful, the resulting proportions of applicants with positions are much the same. However, the NRMP has become concerned that in the past few years there has been a decrease in the number of SOAP-eligible applicants at the conclusion of the Match, compared to an increasing number of unfilled positions placed in SOAP, and an increasing number of unfilled positions at the end of SOAP. Coupled with the uncertainty surrounding the upcoming application and match season due to the COVID-19 pandemic, the NRMP has decided to add an additional, fourth offer round to the SOAP process.[5]

EFFECTIVE STRATEGIES FOR APPLYING AND MATCHING

The AAMC has numerous tools and informational guides developed to help students select a specialty and then apply to, interview with, and rank programs, all through the CiM website (https://www.aamc.org/cim/). Users of most CiM material need a subscription. Students of U.S. MD-granting schools have a subscription through their schools as a result of their school's membership in the AAMC. Students of DO-granting schools and international medical students may have subscriptions through their schools or may need to purchase an individual subscription for $75. Medical school advisers also have access to CiM material.

The AAMC launched the Apply Smart website in 2016 to assist students in determining the optimal number of residency programs to which they should apply. The website provides information on the relationship between the number of applications submitted and the likelihood of entry into a residency program, highlighting the point at which the likelihood does not increase as the number of applications increase. Apply Smart also provides ranges of United States Medical Licensing Examination® (USMLE®) Step 1 scores as a comparison metric and suggests that students should consider limiting their applications at the point of diminishing returns.[6] Although relatively easy to use and understand, there are some caveats to the tool's utility. The tool relies on USMLE 3-digit Step 1 scores, so students who do not have a Step 1 score, e.g., some students at DO-granting medical schools, will not find the tool useful.

Future use of the tool when Step 1 results are reported as pass/fail (proposed to occur in January 2022) will also be in doubt, unless another valid metric is provided. Further, the tool's methodology has been questioned, in that the data uses the number of applications submitted through ERAS, which does not distinguish between preferred specialties and backup specialties. Therefore, for example, a student may submit 10 applications to a specialty that is not the preferred one and ultimately choose not to enter it. This datapoint will contribute to a low likelihood of entering that specialty with only 10 applications.[7] One suggestion is to pair ERAS applications data with interviews offered data, which, with the support of residency programs, is available through ERAS, thus creating a probability that a given number of applications results in an interview offer. Also suggested is pairing ERAS application data with NRMP data, to filter preferred specialties from backup specialties.[7]

The AAMC has also developed the Residency Explorer tool, which uses Step 1 scores as well as Step 2CK and COMLEX-USA Level 1 and Level 2-CE scores. Offered free to U.S. medical and international students, Residency Explorer has benefited by creating a consortium of data providers. Users create a profile based on their test scores and academic achievements, and Residency Explorer will provide a list of programs in a chosen specialty with statistics on current and recent residents. Users can then compare where they stand in relation to matched residents at a given program. In addition, other characteristics about the program are provided for students to consider. Programs that have few residents or have been accredited for only a few years will not have test score information available and may also have few program characteristics to report. As with the Apply Smart tool, Step 1 three-digit scores will not be available once score reporting transitions to pass/fail; therefore, students of MD-granting schools will have one less metric.

The NRMP produces several reports that can be helpful in guiding applicants' decision-making. The "Results from the Program Director Survey" describes what factors are considered by program directors, as well as their importance, when deciding which applicants to interview, and then the same for deciding how to rank applicants. The report is broken down by specialty. Unfortunately, the response rate by program directors to this survey is low, averaging 18 percent in 2019.[8] Similarly, the NRMP surveys applicants and asks about the program characteristics that influenced both application and ranking choices as well as the relative importance of those characteristics. In the "Results of the 2019 NRMP Applicant Survey by Preferred Specialty and Applicant Type" report, applying, interviewing, and ranking behavior is available by whether the applicant successfully matched or not. These data are also available by specialty. This report has a response rate of 42.3 percent, and specialties with fewer than 50 respondents are excluded.[9]

More data on applicant characteristics and applying, interviewing, ranking, and matching success are available in the Charting Outcomes in the Match reports, available for U.S. MD seniors,[10] U.S. DO seniors,[11] and graduates of international medical schools (IMGs).[12] All data are self-reported, with the exception of match data. These reports are also segmented into specialties. In addition, the NRMP used 2018 match data to create an interactive tool, the Interactive Charting Outcomes in the Match, which allows users to enter their own values, such as number of publications, and assess the percentage of applicants who matched or did not match, by Step 1 or Level 1 score range.[13] Given the similarity to Residency Explorer, the NRMP has not further developed the interactive charts and collaborates with the AAMC on Residency Explorer.

The AMA provides general guidance offered by experts in the field on choosing a specialty and effective applying and matching strategies, most of which can be found on the AMA website ("The Match journey made simple," at https://www.ama-assn.org/residents-students/match/match-journey-made-simple). The AMA has also developed a new residency calculator tool to help students estimate the costs of applying to programs (https://freidaresidencycalculator.com/).

Aside from the AAMC and the AMA, other websites provide advice on residency program applications and interviews. Many of these are geared in particular to IMGs, but not always, and may charge a fee for assistance. Specialty societies also present information on program locations and characteristics and advice on how to apply to programs in the specialty, such as family medicine (https://www.aafp.org/medical-school-residency/residency/process.html).

Finally, U.S. medical schools have dedicated staff that are eager to help students successfully match into residency programs, providing accessible online advice as well as personal counseling. The most commonly reported reason why a student does not successfully match is that the student's academic performance (e.g., clinical grades) and/or USMLE scores are below the norm for the desired specialty. Other commonly cited reasons are 1) applications in a single specialty, 2) lack of a backup plan, and 3) application to too few programs. These issues could be mitigated with advice, but some advisers report that some students do not make themselves available for career counseling.[14]

Pilots for 2021

The Otolaryngology Program Directors Organization, the Society of University Otolaryngologists, and the Association of Academic Departments in Otolaryngology created a voluntary signal preference program in advance of the 2021 match, modeled after the preference signaling program developed by the American Economic Association (AEA) to facilitate interview offers for economics graduate students. In the AEA model, students can send signals to up to two employers to indicate their interest in receiving an interview. Signals were found to increase probability of interviews, especially for niche scenarios (e.g., an applicant whose academic and personal background is limited to a single state or region may be viewed as unlikely to move to a different geographic region and therefore an interview may not be offered despite excellent qualifications of the applicant. A signal in this scenario changes the program's erroneous perception of applicant disinterest). The otolaryngology pilot allows applicants to signal up to 5 programs. The signals will be sent to participating programs around the time programs download applications from ERAS. Participating programs are advised to consider signals of interest as one factor in a holistic review of all applications and should not rely on signals to screen applications. In addition, programs should expect many non-signaled applications from interested and highly qualified applicants. Applicants were instructed not to signal their home institution or any programs at which they have completed a clinical subinternship in the current calendar year, and programs were advised not to expect to receive a signal from applicants in these scenarios.[15] Examining ERAS data does not suggest a reduction in the number of applications per applicant to otolaryngology programs compared to previous years.[16] It is not known publicly at this time how many programs and applicants participated in the pilot.

The Association of Professors of Gynecology and Obstetrics and the Council on Resident Education in Obstetrics and Gynecology have created the "Right Resident, Right Program, Ready Day One" pilot program for the obstetrics and gynecology specialty. The program received a $1.75M grant from the AMA's Reimagining Residency Initiative. Aspects of the program include a uniform application deadline date across all programs, limiting interview invitations to the number of interview slots available, allowing a minimum of 72 hours for applicants to respond to an interview invitation, and providing interview status (invited, waitlisted, or rejected) to all applicants by November 22, 2020.[17] In addition, the pilot program will develop an applicant compatibility index mobile device application that facilitates alignment between applicants' profiles and residency program offerings, and develop additional application review metrics for programs to use in screening. The goal is to increase transparency and efficiency in the process to reduce costs and anxiety and ultimately to increase individuals' success in training.[18]

CURRENT AMA POLICY

AMA policies related to this topic are listed in the Appendix.

SUMMARY AND RECOMMENDATIONS

Resolution 304-I-19 contained a wide variety of requests for action, including some in which the AMA is currently engaged. The AMA continues to advocate for an increase in GME positions, innovative models of GME training, and greater accountability overall in the funding for and outcomes of GME. The AMA has studied the causes of failures to match into a residency program—as have many medical education stakeholders—and has made resources available to students that can reduce the risk of failure (again, as have many medical education stakeholders). Other actions requested in the resolution are already reflected in material and tools prepared by the AAMC and NRMP. This information, however, is not all in one location. Furthermore, availability and ease of access to known successful strategies will not help applicants who do not avail themselves of advice that runs counter to their own sense of identity as a practitioner of a particular specialty.

Current proposals in the literature to improve the process of applying to, interviewing with, and matching to residency programs include, among many, signaling program preference in the application,[19] multi-phase matches,[20,21] and capping the number of applications so that each applicant can be considered more holistically.[22] The recent decisions of the Federation of State Medical Boards and the National Board of Medical Examiners, and the National Board of Osteopathic Medical Examiners, to report results of the USMLE Step 1 and the COMLEX-USA Level 1 examinations, respectively, as pass/fail rather than a three-digit score will remove metrics relied on by many individual program directors and application tools as a measure easily obtained and understood, although questionable in its ability to predict clinical performance. The application and interview season for the 2021 Match presented its own challenges, as programs were encouraged to interview applicants through video to reduce exposure to COVID-19. Few programs are experienced using virtual interviews, and most that have, have used them as adjunct to in-person interviews.[23]

Programs were also encouraged to provide more information on the type of resident they are looking for, beyond academic statistics and overused adjectives. This is essential insight for students, who need to know when making their decisions to apply as to how well they would fit a given program.

Movement is afoot to revise the current system for program application, interviewing, and matching. In the interim, key stakeholder organizations, like the NRMP and AAMC, can consolidate information that can assist students and their advisers to create effective application strategies. Those applicants without an adviser should also have easy access to such information. All applicants, however, will need to use this information rationally if the desire is to successfully match to a program without unnecessary financial cost.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 304-I-19 and the remainder of this report be filed:

1. That our AMA reaffirm Policies D-310.977, "National Resident Matching Program Reform," H-200.954, "US Physician Shortage," and D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education."

2. That our AMA encourage the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, National Resident Matching Program, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency.

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APPENDIX - RELEVANT AMA POLICY

D-310.977, “National Resident Matching Program Reform”
Our AMA:
(1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process;
(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises;
(5) will work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant;
(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
(10) will work with the National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical Education (ACGME) to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies; and

(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.

H-200.954, "US Physician Shortage"
Our AMA:
(1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
(6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
(8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education"
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key

stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and

osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

4. EXPEDITING ENTRY OF QUALIFIED IMG PHYSICIANS TO U.S. MEDICAL PRACTICE (RESOLUTION 308-I-19)

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 308-I-19
REMAINDER OF REPORT FILED
See Policies H-255.966 and D-255.980

American Medical Association (AMA) House of Delegates (HOD) Policy D-255.978, "Study Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice," asks that our AMA "study and make recommendations for the best means for evaluating, credentialing, and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA." This report is in response to that policy.

INTRODUCTION

There is a projected shortage of physicians in the United States, given the aging of the present physician and general civilian populations, as well as potential and ongoing crisis situations, such as the COVID-19 pandemic, which has spiked the need for patient care and hospital beds across the country.[1] Compared with U.S. medical school graduates, IMGs provide care to a disproportionate number of socioeconomically disadvantaged patients, and certain states and specialties disproportionately depend on these physicians. IMGs represent nearly one-quarter of the U.S. physician workforce. They often practice at institutions that are on the front line of the COVID-19 pandemic, and these physicians play a critical role in providing health care in areas of the country with higher rates of poverty and chronic disease. Appendix A displays the U.S. map indicating medically underserved areas/populations (MAU/P) and practicing IMGs by state.

The continued steady influx of immigrants from strife-torn regions of the world to the U.S. includes highly trained physicians fleeing their country because of political or religious persecution. These immigrant physicians may have beneficial skills, such as professional experience and language proficiency. However, IMGs often face licensing barriers beyond those of physicians who graduated from a U.S. medical school. IMGs often are required to repeat complete cycles of training, including medical school, residency, and subspecialty training. This report provides information on state legislatures that have begun to implement strategies to assist IMGs with credentialing, licensure, and certification requirements in order to increase access to primary care in rural and underserved areas.

This report also provides information on AMA efforts to assist non-U.S. citizen IMGs, who are severely restricted as to where they can practice under the terms of their visas. This includes some physicians who could not work as a result of being furloughed when the facilities at which they were working closed.

CREDENTIALING REQUIREMENTS

Certification by the Educational Commission for Foreign Medical Graduates (ECFMG) is the standard for evaluating the qualifications of IMGs before they enter U.S. residency and fellowship programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). ECFMG requirements include examinations in the medical sciences, evaluation of English language proficiency, and documentation of medical education credentials.[2]

Non-U.S. citizen IMGs who seek entry into U.S. graduate medical education (GME) programs must obtain a visa permitting clinical training to provide medical services. The ECFMG / Foundation for Advancement of International Medical Education and Research Exchange Visitor Sponsorship Program (EVSP) serves as the visa sponsor for approximately 12,000 IMGs at teaching hospitals in the U.S.[3-4] All non-U.S. citizen IMGs enter the U.S. in one of two broad immigration categories—either under a temporary, nonimmigrant visa or as a permanent resident. The two most common temporary, nonimmigrant classifications for IMGs are the J-1 Exchange Visitor program and the H-1B temporary worker classification. Both classifications limit a physician's duration of residence in the U.S. and impose strict controls over the range of employment authorized. In contrast, permanent residence provides a foreign national with both an unlimited duration of residence in the U.S. and authorization of full, unrestricted employment. However, the lead time required to qualify for permanent residence status is usually substantially longer than the lead time required to obtain temporary worker status.[4] Additional information about visa options for IMGs is provided in Appendix B.

Certification from the ECFMG is a requirement for medical licensing, and it is a prerequisite for taking the United States Medical Licensing Examination (USMLE) Step 3. However, state licensure requirements vary from state to state.[5] All state licensing jurisdictions require IMGs to complete at least one year of accredited U.S. or Canadian GME before licensure. However, 21 states require two years, and 27 states require three years of accredited GME.[5]

Some states issue limited, restricted licenses that allow IMGs who have not entered U.S. GME to practice in the U.S. under supervision and in specific institutions. To qualify, IMGs must have been trained in a specialty and practiced medicine abroad. After immigrating to the U.S., these physicians have been able to establish themselves in an institution, despite being ineligible for full licensure. (Refer to CME Report 2, June 2021, "Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses," for more information about states that issue restricted licenses.)

Many institutions also require that physicians be board-certified or board eligible. However, it is the policy of the American Board of Medical Specialties (ABMS) that to be eligible for certification in any specialty or subspecialty and to maintain certification a physician must: 1) complete ACGME-accredited or Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited GME; and 2) hold a full and unrestricted license to practice medicine in at least one jurisdiction in the U.S., its territories, or Canada. Some of the ABMS member boards recognize alternative pathways that may meet eligibility requirements for initial board certification for candidates who have not completed U.S. or Canadian-accredited GME.

Recognized alternative pathways for international trainees that may meet eligibility requirements include Canadian and international training. Twenty ABMS member boards accept all of a candidate's training in Canada (either accredited by the RCPSC or by another body acceptable to the board) and of these, seven further require that a candidate be certified by the RCPSC or other Canadian certifying body. Three boards will accept some of a candidate's training in Canada (either accredited by the RCPSC or by another body acceptable to the board). Fifteen boards offer pathways for non-Canadian internationally trained physicians. Of these, nine boards offer pathways for physicians practicing in the U.S. at an ACGME-accredited institution who are faculty at an ACGME-accredited program and may have achieved a specified academic rank (from associate to full professor). Two boards will accept international training as meeting all training requirements on a case-by-case basis, and four boards will accept international training as meeting some of the training requirements on a case-by-case basis. (Refer to CME Report 2, June 2021, "Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses," for more information about board certification pathways.)

On January 26, 2021, the Federation of State Medical Boards (FSMB) and National Board of Medical Examiners (NBME), co-sponsors of the USMLE, announced the discontinuation of work to relaunch a modified Step 2 Clinical Skills examination (Step 2 CS) and henceforth the discontinuation of Step 2 CS, while continuing to seek innovative and sensible ways to assess medical licensing eligibility. ECFMG continues to oversee requirements for its certification of IMGs and announced an expansion of its pathways allowing qualified IMGs to meet the requirements for ECFMG Certification and continue to pursue U.S. graduate medical education.

AMA ADVOCACY ACTIVITIES DURING COVID-19 RELATED TO IMGS

The AMA has been especially active in its federal level advocacy efforts on behalf of IMG physicians during the COVID-19 pandemic. Some of the areas in which AMA advocacy has been most significant include visas, labor condition applications, work surrounding last year's presidential proclamations, and the HEROES Act.

Visa Processing, Allocation, and Extensions

On March 20, 2020, U.S. Citizenship and Immigration Services (USCIS) suspended premium processing for visas. As such, IMG physicians were concerned about being able to obtain visas in a timely manner. In response, on March 24, 2020, the AMA sent a letter to USCIS urging USCIS to reconsider the suspension and instead expand premium processing for H-1B visas. USCIS reopened its offices and resumed citizenship ceremonies in June 2020. Additionally, it restarted premium processing for certain visa petitions, including H-1B visas, in phases throughout June. Moreover, companies were allowed request accelerated processing for immigrant worker visas, and employers who had pending H-1B temporary worker visas could ask for their applications to be fast-tracked. Per the USCIS website, premium processing for H-1B visa holders is available.

As the severity of the COVID-19 pandemic increased, embassies and consulates around the world stopped processing visas, including J-1 physician visas. As such, J-1 physicians were concerned that they would not be able to obtain or maintain a valid visa. Additionally, due to visa restrictions, J-1 physicians were concerned about being able to continue their training during the pandemic. In response, the AMA sent a letter to the U.S. Department of State (DoS) and the U.S. Department of Homeland Security (DHS) requesting opening of visa processing at embassies and consulates for physicians joining U.S. residency programs on July 1, 2020. Additionally, the AMA requested that J-1 physicians be allowed to engage in extended training activities and asked for confirmation concerning J-1 physician redeployment to new rotations to respond to the pandemic. As a result of AMA advocacy, in concert with ECFMG, the DoS agreed to begin processing visa applications for foreign-born medical professionals and announced that J-1 physicians may consult with their program sponsor to extend their programs in the U.S. The AMA also confirmed that J-1 physicians can engage in revised clinical training rotations/assignments, in keeping with the ACGME's "Response to Pandemic Crisis."

IMG physicians were also concerned about alterations in work schedules and the visa consequences of being laid off due to the impact of the COVID-19 pandemic. To help ease these concerns, on April 14, 2020, the AMA sent a letter urging USCIS to recognize the COVID-19 pandemic as an extraordinary circumstance beyond the control of non-U.S. citizen IMG applicants or their employers. The AMA consequently asked to expedite approvals of extensions and changes of status for non-U.S. citizen IMGs practicing, or otherwise lawfully present, in the U.S. In addition, the AMA urged the Administration to extend the 60-day maximum grace period to a 180-day grace period to allow any non-U.S. citizen IMG who had been furloughed or laid off as a result of the pandemic to remain in the U.S. and find new employment. Moreover, the AMA asked USCIS to protect the spouses and dependent children of H-1B physicians by automatically granting a one-year extension of their H-4 visas. Due in part to the advocacy efforts of the AMA, USCIS announced that it is temporarily waiving certain immigration consequences for failing to meet the full-time work requirement due to quarantine, illness, travel restrictions, or other consequences of the pandemic.

Throughout the pandemic, the AMA has not lost sight of the need for long term policy change, especially change surrounding the need for an increase in visas for additional physicians. As such, on May 8, 2020, the AMA sent letters to the U.S. House of Representatives and the U.S. Senate supporting the "Healthcare Workforce Resilience Act" and urging the Congress to quickly pass the legislation so that the U.S. can recapture 15,000 unused employment-based physician immigrant visas from prior fiscal years. The bill was not enacted.

Labor Condition Applications

Labor Condition Application restrictions have made it difficult for IMGs to practice in areas where they are most needed during the pandemic. As such, on April 3, 2020, the AMA wrote a letter to then Vice President Pence and USCIS urging the Administration to permit non-citizen IMG physicians currently practicing in the U.S. with an active license and an approved immigrant petition to apply and quickly receive authorization to work at multiple locations and facilities, with a broader range of medical services, for the duration of the COVID-19 pandemic. The AMA also urged the Administration to expedite work permits and renewal applications for all IMG physicians who are beginning their residencies or fellowships or are currently in training. Due in part to the advocacy efforts of the AMA, USCIS

announced that IMGs can deliver telehealth services during the current public health emergency without having to apply for a new or amended Labor Condition Application. At the time of the writing of this report, the AMA is not planning additional follow up on the Labor Condition Application.

Presidential Proclamation

As a result of the April 22, 2020 Presidential Proclamation, Suspending Entry of Immigrants Who Present Risk to the U.S. Labor Market During the Economic Recovery Following the COVID-19 Outbreak, the AMA sent a letter to then-Vice President Pence urging the Administration to allow IMGs with J-1, H-1B, and O-1 (individuals with extraordinary ability or achievement) visas to be exempt from any future immigration bans or limitations, so that these physicians can maintain their lawful non-immigrant status while responding to the pandemic.

On June 22, 2020, President Trump issued a Proclamation, *Suspending Entry of Aliens Who Present a Risk to the U.S. Labor Market Following the Coronavirus Outbreak*. In response to the proclamation, the DoS issued a statement that "as resources allow, embassies and consulates may continue to provide emergency and mission-critical visa services. Mission-critical immigrant visa categories include applicants who may be eligible for an exception under these presidential proclamations, such as…certain medical professionals." As such, on June 26, 2020, the AMA sent a letter to the DHS and the DoS strongly urging the Administration to consider J-1 and H-1B IMGs and their families' entry into the U.S. to be in the national interest of the country, so that families could remain together and IMG physicians could immediately begin to provide health care services to U.S. patients. The AMA understands that every physician is mission-critical, especially at this time.

Moreover, on July 8, 2020, the AMA initiated a sign-on letter for medical specialty societies. The letter urges the DoS and DHS to issue clarifying guidance pertaining to the June 22, 2020, proclamation by directing Consular Affairs to advise embassies and consulates that H-1B physicians and their dependent family members' entry into the U.S. is in the national interest.

During his first day in office, President Biden issued a *Proclamation on Ending Discriminatory Bans on Entry to The United States* to revoke Executive Order 13780 of March 6, 2017 (Protecting the Nation From Foreign Terrorist Entry Into the United States), Proclamation 9645 of September 24, 2017 (Enhancing Vetting Capabilities and Processes for Detecting Attempted Entry Into the United States by Terrorists or Other Public-Safety Threats), Proclamation 9723 of April 10, 2018 (Maintaining Enhanced Vetting Capabilities and Processes for Detecting Attempted Entry Into the United States by Terrorists or Other Public-Safety Threats), and Proclamation 9983 of January 31, 2020 (Improving Enhanced Vetting Capabilities and Processes for Detecting Attempted Entry Into the United States by Terrorists or Other Public-Safety Threats).

On January 25, 2021, President Biden issued a *Proclamation on the Suspension of Entry as Immigrants and Non-Immigrants of Certain Additional Persons Who Pose a Risk of Transmitting Coronavirus Disease* to further examine certain current public health precautions for international travel and take additional appropriate regulatory action, to the extent feasible and consistent with Centers for Disease Control and Prevention guidelines and applicable law.

HEROES Act

H.R. 6800, the "Health and Economic Recovery Omnibus Emergency Solutions Act" (HEROES ACT), is the U.S. House of Representatives' next proposed coronavirus relief fund package and incorporates many of the IMG advocacy requests, including authorization of the Conrad 30 Program, expedited visa processing, and employment authorization cards for IMGs. For more information, see sections 191201 and 191204 of the HEROES Act or the AMA HEROES Act Summary. The AMA has worked with members of the U.S. House of Representatives to help ensure that favorable measures for IMGs are included in this proposed legislation. At the time of the writing of this Council report, the HEROES ACT had been passed in the House and was sent to the Senate. It was assigned to the Committee on Small Business and Entrepreneurship and hearings were held but no action was taken. The Continuing Appropriations Act (H.R. 8337) was passed; however, it had very little in it concerning IMGs. The most recent stimulus bill, the American Rescue Plan, does not include anything related to IMGs.

Additional Rule Changes

In the latter part of 2020, the AMA commented on related rule changes/proposed rule changes. Information regarding these rules and comments are located in Appendix C.

IMG Resource Guide

Due to the uncertainty that IMGs are experiencing during this time, the AMA has created an IMG resource guide, "FAQs: Guidance for international medical graduates during COVID-19." This guide answers some of the most pressing questions IMGs have surrounding their ability to practice and visas. It also lists available resources for assistance.

REVISIONS TO STATE LICENSURE REQUIREMENTS DURING COVID-19

In areas where physicians were acutely needed to address the needs of the patient surges during the pandemic, state agencies created stratification processes for those non-U.S. citizen IMG physicians most easily integrated into the system. These were IMGs working under direct supervision of licensed physicians and identified on the basis of education, training, certification as a medical specialist, English proficiency, and experience in direct patient care in countries other than the U.S. For example, in 2020 the New Jersey Division of Consumer Affairs had been authorized to issue temporary state medical licenses to IMGs who are licensed and in good standing in other countries, along with other workforce measures. In January 2021, it was announced they were no longer accepting new applications and pending applications were put on hold per review of the program.[6] In New York, a March 23, 2020 executive order from Governor Cuomo allows non-US citizen IMGs who are not licensed in the state but have completed at least one year of GME in the U.S., to provide patient care in hospitals, under the supervision of a New York State-licensed and registered physician, by way of a limited permit. This order was extended until May 6, 2021.[7-8]

PROGRAMS THAT SERVE AS MODELS FOR ACCELERATED TRAINING AND CREDENTIALING

Programs such as the National Health Service (NHS) of Scotland show it is possible to retrain immigrant physicians in 18 to 24 months, and that these physicians are able to demonstrate proficiency in language, medicine, and the culture of the host country. Immigrant physicians in Scotland who have been retrained on an accelerated path and who have demonstrated proficiency in language, medicine, and Scottish culture are obligated by the NHS of Scotland to practice in the NHS specific areas of need.[9]

Similarly, the following states are studying and developing pathways for qualified IMGs to expeditiously enter practice in the U.S.

Minnesota

The Minnesota Department of Health (MDH) has supported the integration of IMGs through the state's International Medical Graduate Assistance Program.[10] As the first program of its kind in the U.S., the Minnesota Legislature established this program in 2015 to address barriers to practice and facilitate pathways for immigrant IMGs to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state. It has achieved considerable success, including forming grant agreements with nonprofits to provide career support to IMGs and working with residency directors to carve out pathways for IMGs to demonstrate the clinical expertise required to enter into residency programs. The program requires that participants be legal residents who have lived in Minnesota for at least two years, graduated from an accredited medical school outside the U.S., and are willing to practice primary care in the state's underserved communities in rural and urban areas.

In its 2018 report, the MDH reported that the program has developed a database comprised of immigrant IMG physicians in Minnesota. The program also identified barriers to residency, and it is taking steps to address those barriers with the following interventions: funding dedicated residency positions for immigrant IMGs, supporting clinical readiness assessment and preparation programs, and providing career guidance and support. The MDH report includes data on IMGs who received career guidance and support as well as those who were selected by the University of Minnesota Medical School to participate in the clinical experience component, which began in September 2017.

The MDH met with the Minnesota Board of Medical Practice and other stakeholders to study possible changes to the Medical Practice Act. The group proposed two possible strategies: an IMG Primary Care Integration License and an amendment to the Medical Practice Act, which would include an exemption for practicing primary care in a rural or underserved area. As noted in the 2018 MDH report, the creation of this alternate license would be beneficial because it would allow objectively qualified IMGs into the system quickly to address issues of health disparities and primary care shortages. It would not require additional residency positions and thus would be cost-effective. The process would require that IMGs pass all licensure exams, demonstrate previous work of at least seven years in medical practice, participate in a six-month clinical experience, and undergo an assessment. This process would culminate in a certificate allowing work under supervision.

Implementation of this proposal raised several concerns. This effort is based on identifying and securing the commitment of an accredited assessor. In addition, these IMGs would not be eligible for board certification and may encounter employment restrictions. Key stakeholders, including the Minnesota Medical Association and Minnesota Academy of Physician Assistants, have raised objections, citing concerns over a tiered licensure system and professional role confusion. The MDH continues to research possible licensure changes.[11-13]

THE CONRAD 30 J-1 VISA WAIVER

IMGs who graduate from U.S. residency and fellowship programs may be in search of hospitals and practice groups that will support them in continuing their careers in the U.S. If these physicians held a J-1 Exchange Visitor visa during their GME in the U.S., they are required to return to their home countries for a two-year period before they can continue their careers in the U.S., but this provision can be waived in specific instances. One common way to do so is through the Conrad 30 Program, whereby a hospital or health center makes an application to a state department of health, requesting that the two-year home residency requirement be waived in exchange for the physician's three years of service in a medically underserved or health professional shortage area. The program currently allows for 30 waivers per state per year. However, the details of this annual program differ by state. States collectively recruit approximately 800 to 1,000 IMGs annually through the Conrad 30 program to practice in underserved communities.[17]

A study conducted by the Washington, Wyoming, Alaska, Montana, Idaho (WWAMI) Rural Health Research Center, University of Washington, showed that Conrad 30 program staff generally valued the J-1 visa waiver as one of several important tools for recruitment of physicians to rural and underserved communities.[17] Since at least 2013, there have been efforts to make the Conrad 30 J-1 visa waiver program for physicians permanent; as this has yet to occur, it has been necessary to reauthorize the program every year. In 2019, bill was introduced in Congress to improve and extend the program until 2021—*the Conrad State 30 and Physician Access Reauthorization Act*.[18] The bill was not enacted.

The AMA has been vocal in its support for the Conrad 30 program over the years. Recently, the AMA worked with U.S. Senator Amy Klobuchar and a bipartisan list of other U.S. Senators to show the impact of the Administration's immigration policy changes during the pandemic to IMGs, reiterating the value of the Conrad 30 program and the need for its reauthorization.

RELEVANT AMA POLICY

The AMA has extensive policy regarding the requirements to practice medicine in the United States. AMA Policy H-255.983 states that "the AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character." Policy H-275.934 (2) states, "All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine." Policy H-255.966 (1.D.) notes, "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." Policy H-255.985 (1) states, "Any United States or alien graduate of a foreign health professional education program must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States programs." Policy H-255.988 states that the AMA "continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs."

At the Special Meeting of the AMA House of Delegates in November 2020, Policy D-275.950 "Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association" was adopted. In part it asks that the AMA "in collaboration with the Educational Commission for Foreign Medical Graduates (ECFMG), advocate for an equivalent, equitable, and timely pathway for international medical graduates to demonstrate clinical skills competency." Other related policies are shown in Appendix D.

SUMMARY AND RECOMMENDATIONS

IMGs currently represent a quarter of the physician workforce and physicians-in-training. They have long been an integral part of the U.S. health care system, contributing substantially to primary care disciplines and providing care to underserved populations. The diversity of IMGs contributes to the many ethnicities and cultures represented in the health care workforce.[19] This is likely to be a factor enhancing health outcomes, considering the equally diverse nature of the U.S. patient population. In addition, IMGs are serving on the front lines of patient care during the COVID-19 pandemic.

IMGs are subject to the same rigorous credentialing standards as any other U.S. physician, but some licensing regulations may be more challenging for IMGs than for U.S.-educated physicians. There are, however, ways to improve and streamline licensing and credentialing policies and processes to ensure that IMGs can be recruited to federally designated health care shortage areas to address health care inequities and improve health care access. The AMA continues to assist IMGs through its International Medical Graduates Section and advocacy efforts. Proposed and enacted state models, such as those described in this report, may enable physicians to be quickly credentialed and licensed in an effort to address national or international pandemics or state/ regional medical emergencies. States remain best positioned to evaluate the relative success of these programs in addressing their needs; however successful efforts to reduce medical licensing barriers should be shared among state licensing boards as best practices.

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

1. That American Medical Association (AMA) Policy D-255.980 (1), "Impact of Immigration Barriers on the Nation's Health," that reads, "Our AMA 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" be reaffirmed.

2. That our AMA 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.

3. That our AMA encourage the Federation of State Medical Boards and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure—including successes, failures, and barriers to implementation.

4. That Policy D-255.978, "Study Expediting Entry of Qualified IMG Physicians to US Medical Practice," be rescinded, as having been fulfilled by this report.

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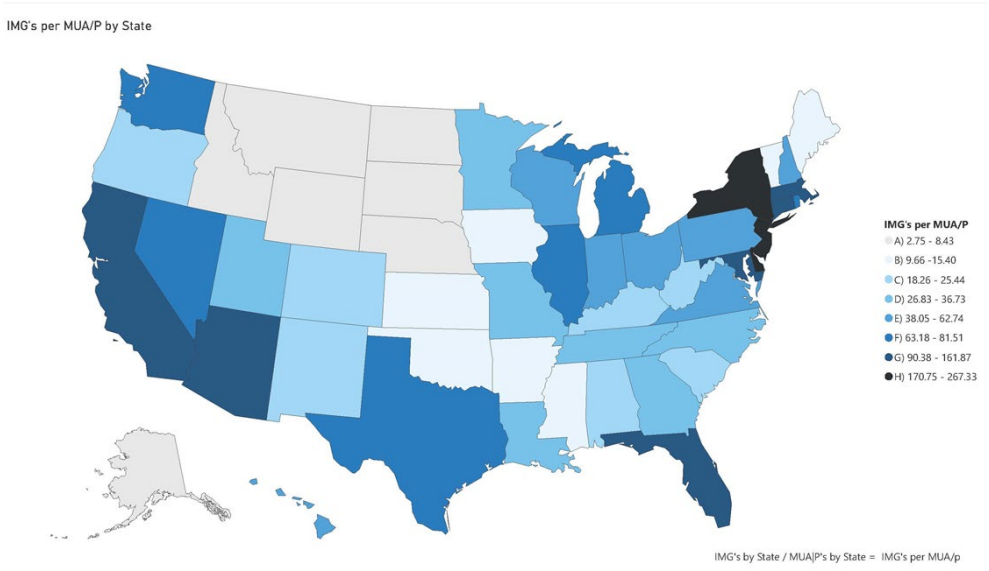
APPENDICES

APPENDIX A - U.S. map indicating medically underserved areas/populations (MAU/P) and practicing IMGs by state



Data sources;
Health Resources & Services Administration (HRSA), Medically Underserved Areas/Populations (MUA/P) data: 2021. Available at: https://data.hrsa.gov/maps/map-tool/. Accessed 1-14-21.

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Map created with Microsoft Power BI

APPENDIX B - Visa Options for Non-U.S. Citizen International Medical Graduate Physicians

Visa Option	Purpose	Requirements
J-1 Exchange Visitor program[1-2]	Intended to provide a broad range of foreign nationals with educational, employment, and training opportunities in the U.S. Allows International Medical Graduate (IMG) physicians to attend residency and fellowship programs in the U.S. *Physicians wishing to stay in the U.S. after completion of training (or applying for a Green Card), must first return to their home country for a period of two years.*	Educational Commission for Foreign Medical Graduates (ECFMG) Certification* including: 1. Passage of United States Medical Licensing Examination (USMLE) Steps 1 and 2 examinations or the Visa Qualifying Examination (VQE) prepared by the National Board of Medical Examiners, and administered by the ECFMG to establish medical competence 2. Passage of the ECFMG English language examination 3. Possession of an MD degree** from a foreign medical school listed in the International Medical Education Directory of the Foundation for Advancement of International Medical Education and Research (FAIMER®) A statement of need from the government of the country of the physician's nationality or last legal permanent residence to provide written assurance to the Secretary of Health and Human Services of the need in that country for persons with the skills the physician seeks to acquire and that the physician has filed a written assurance with the government of this country that he/she will return upon completion of the training An agreement or contract from a U.S. accredited medical school, an affiliated hospital, or a scientific institution to provide the accredited graduate medical education (GME), signed by the physician and the official responsible for the training *Upon entry to the U.S., an IMG is authorized to pursue GME training for a period of up to seven years. Each year, the training program in conjunction with the IMG must file an extension application with the ECFMG.*
J-1 Waiver[3]	Can be granted for the J-1 two-year requirement. *The most common waiver options are those granted by: 1) obtaining an official recommendation from an interested government agency in need of the physician's services, or 2) through the Conrad 30 Waiver Program offered by states in exchange for three years of service in a qualifying medically underserved area.*	Grounds under law to obtain a waiver of home residence obligation: • If the physician will suffer from persecution in his/her home country or country of last permanent residence • If fulfillment of the two-year home residence obligation will subject a U.S. citizen spouse or child to exceptional hardship • Based on a recommendation issued by a government agency interested in the physician's continued residence or employment in the U.S.
H-1B Temporary Worker classification[4]	Enables a foreign national to enter the U.S. to accept professional level employment for a period of up to six years. *IMG physicians must have an existing job offer for full-time employment with a U.S. employer. This can be a hospital, university, clinic, a doctor's office, or an assisted living community.*	A certified Labor Condition Application covering each location where the physician will perform services as required under Department of Labor regulations Completion of a medical degree from either a U.S. based school or an acceptable school in a foreign country

		Possession of a full, unrestricted state medical license or the "appropriate authorization" for the position Completion of the USMLE (Steps I, II, and III) or be eligible for the limited exceptions to this requirement English language competence as established through graduation from an accredited medical school or by passing the ECFMG English language examination
O-1 Visa: Individuals with Extraordinary Ability or Achievement[5]	Option for well-established doctors who are looking to come to the U.S. to practice. *Significant amount of documentation needed to qualify*	Must demonstrate (through awards, publications, or other evidence) extraordinary accomplishments in the medical field The position for which the physician is going to work must require someone with well-above average skills and experience Abilities must be corroborated with consultation letters (detailed letters of recommendation) from other respected experts in the applicant's specific field May be exempted from the USMLE examination requirement (some state medical boards may still require USMLE passage)

*All IMGs, regardless of country of citizenship, are required to complete ECFMG Certification to be eligible for J-1 visa sponsorship for clinical GME in the U.S. The location of the medical school, not the citizenship of the physician, determines whether the graduate is an IMG. U.S. and Canadian citizens who graduate from medical schools located outside the U.S. and Canada are considered IMGs and must be certified by ECFMG.[1]

**The ECFMG Reference Guide for Medical Education Credentials lists the exact name of the final medical diploma that these applicants must have earned (and must provide).

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APPENDIX C - Rule Changes/ Proposed Rule Changes

J-1s

- In October 2020, the U.S. Department of Homeland Security (DHS) released a proposed rule titled "Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media." The proposed administrative change to eliminate "duration of status" as an authorized period of stay would significantly disrupt the medical specialty and subspecialty training of thousands of foreign national physicians in the United States in J-1 visa status, which in turn will have severe implications for patient care.
- DHS is proposing to eliminate the duration of status in favor of only admitting J-1 physicians until the program end date noted in their Form I-20 or DS-2019, not to exceed four years, unless they are subject to a more limited two-year admission, plus a period of 30 days following their program end date. Individuals who need time beyond their period of admission would have to timely file a complete extension of stay (EOS) with U.S. Citizenship and Immigration Services (USCIS) before their prior admission expires. As such, under the proposed rule, J-1 physicians applying for EOS would need to file a Form I-539 with the required fee, provide biometrics, and possibly undergo an interview. While the rule provides an admission period of two to four years, this timeframe will not be applicable to J-1 physicians because they are required to undergo an annual application process.

- On October 23, 2020, the AMA commented on a DHS proposed rule concerning "Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media."
- The AMA urged DHS to withdraw the proposed rule as it relates to J-1 IMGs.
- The AMA signed onto two letters, one that was circulated around the Hill and one that was submitted as a formal comment that asked that IMGs be exempt from the proposed rule.
- The AMA spearheaded a letter that was sent by Representatives Brad Schneider (D-IL), Abby Finkenauer (D-IA), and David McKinley (R-WV) to the Department of Homeland Security (DHS) in opposition to the regulatory changes to duration of status for J-1 physicians. The letter also opposes the regulation because it will disrupt the Conrad 30 Program. The letter was co-signed by 36 bipartisan members of Congress and sent to DHS' Legislative Affairs Department.

H-1Bs

- The AMA drafted a letter in opposition to the interim final rule "Strengthening Wage Protections for the Temporary and Permanent Employment of Certain Aliens in the United States." In the letter the AMA strongly urged the U.S. Department of Labor (DOL) to rescind the Interim Final Rule (IFR), effective October 8, 2020. If rescission is not possible, we urged the DOL to exempt physicians from the IFR. Additionally, the AMA strongly urged the DOL to continue to approve, and DHS to annually accept, without reservation, the wage data from the Association of American Medical Colleges (AAMC) Survey of Resident/Fellow Stipends and Benefits Report for our foreign medical residents.
  - Currently, the Immigration and Nationality Act (INA) requires employers attempting to hire H-1B physicians to pay the greater of "the actual wage level paid by the employer to all other individuals with similar experience and qualifications for the specific employment in question," or "the prevailing wage level for the occupational classification in the area of employment." Without providing evidence-based reasoning, this rule increased wage levels. Specifically, the entry level wage (Level 1) was increased from representing the 17th wage percentile or higher than 17 percent of all wages for that specific position in that Metropolitan Statistical Area, to representing the 45th percentile. Subsequently, Level 2 (qualified) was increased from the 34th percentile to the 62nd percentile, Level 3 (experienced) from the 50th percentile to the 78th percentile, and Level 4 (fully competent) from the 67th percentile to the 95th percentile.
  - Recently ruled to be in violation of the Administrative Procedure Act by a District Court.
  - Implementation date has been delayed. Comment period has been reopened until April 21, 2021. Rescindment of rule also under consideration.
- The AMA commented on proposed rule "Modification of Registration Requirement for Petitioners Seeking To File Cap-Subject H-1B Petitions."
  - DHS proposed to amend its regulations governing the process by which U.S. Citizenship and Immigration Services (USCIS) selects H-1B registrations for filing of H-1B cap-subject petitions (or H-1B petitions for any year in which the registration requirement will be suspended), by generally first selecting registrations based on the highest Occupational Employment Statistics (OES) prevailing wage level that the proffered wage equals or exceeds for the relevant Standard Occupational Classification (SOC) code and area(s) of intended employment.
  - On December 2, 2020, the AMA submitted comments strongly opposing the DHS proposed rule "Modification of Registration Requirement for Petitioners Seeking To File Cap-Subject H-1B Petitions." This proposed rule seeks to abruptly and unnecessarily change the selection process for H-1B cap-subject petitions by prioritizing registrants based on the highest prevailing wage or highest proffered wage. In our comments, we acknowledge that it is false to assume that higher skilled workers are always paid a higher wage and thus, this conclusion made by DHS devalues physicians practicing in medically underserved areas. AMA strongly urged DHS to withdraw the proposed rule, but if withdrawal is not possible, DHS was urged to exempt physicians from this provision.
  - It was scheduled to go into effect March 9, 2021 but has been delayed until December 31, 2021
- The AMA commented on proposed rule "Strengthening the H-1B Nonimmigrant Visa Classification Program."
  - DHS is proposing to revise the regulatory definition of and standards for a "specialty occupation."
  - On December 4, 2020, the AMA submitted comments. The United States District Court of the Northern District of California ruled on December 1, 2020 that the IFR is in violation of the Administrative Procedures Act. For the reasons stated in the court's ruling, we agree. The AMA strongly urges DHS to rescind the IFR. If this, or a similar rule is implemented in the future, DHS was urged to exempt physicians.

APPENDIX D - Relevant Policy

D-255.978, Study Expediting Entry of Qualified IMG Physicians to US Medical Practice
Our AMA will study and make recommendations for the best means for evaluating, credentialing and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA.
(Res. 308, I-19)

H-255.983, Graduates of Non-United States Medical Schools
The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character.

(Sub. Res. 45, A-88 Reaffirmed by Res. 311, A-96 Reaffirmed: CMS Rep. 10, A-03 Reaffirmed: CME Rep. 1, I-03 Reaffirmed: CME Rep. 7, A-04 Reaffirmed: Sub. Res. 314, A-04 Reaffirmed: CME Rep. 11, A-10 Reaffirmed: BOT Rep. 25, A-15)

H-275.934, Alternatives to the Federation of State Medical Boards Recommendations on Licensure
Our AMA adopts the following principles:(1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills. (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.
(CME Rep. 8, A-99 Reaffirmed: CME Rep. 4, I-01 Reaffirmed: CME Rep. 2, A-11 Modified: CME Rep. 2, A-12)

H-255.966, Abolish Discrimination in Licensure of IMGs
Medical Licensure of International Medical Graduates
1. Our AMA 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 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 Federation of State Medical Boards 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.
(BOT Rep. 25, A-15)

H-255.985, Graduates of Foreign Health Professional Schools
(1) Any United States or alien graduate of a foreign health professional education program must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States' programs. Agencies recognized to license or certify health professionals in the United States should have mechanisms to evaluate the entry-level competence of graduates of foreign health professional programs. The level of competence and the means used to assess it should be the same or equivalent to those required of graduates of U.S. accredited programs. (2) All health care facilities, including governmental facilities, should adhere to the same or equivalent licensing and credentialing requirements in their employment practices.
(BOT Rep. NN, A-87 Reaffirmed: Sunset Report, I-97 Reaffirmed: Res. 320 and Res. 305, A-03 Reaffirmed: CME Rep. 1, I-03 Reaffirmed: CME Rep. 2, A-13)

H-255.988, AMA Principles on International Medical Graduates
Our AMA supports:
1. 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. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. 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. 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, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. 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. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That 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. 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.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The 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 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. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. 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. 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. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. 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. 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. 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. 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.
(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)

D-275.989, Credentialing Issues
1. Our AMA shall: (A) continue to encourage the Federation of State Medical Boards (FSMB) and its licensing jurisdictions to widely disseminate information about the Federation Credentials Verification Service; and (B) encourage the FSMB and the Educational Commission for Foreign Medical Graduates to work together to develop a system for the prompt and reliable verification of the medical education credentials of international medical graduates and to serve as a repository and a body for primary source verification of credentials.

2. Our AMA encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept the Educational Commission for Foreign Medical Graduates certification as proof of primary source verification of an IMG's international medical education credentials.
(CME Rep. 3, A-02 Appended: CME Rep. 10, A-11)

D-255.991, Visa Complications for IMGs in GME
1. Our AMA 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 to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.
(Res. 844, I-03 Reaffirmation A-09 Reaffirmation I-10 Appended: CME Rep. 10, A-11 Appended: Res. 323, A-12 Reaffirmation: A-19)

D-255.985, Conrad 30 - J-1 Visa Waivers
1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGS members to share information and best practices in order to fully utilize and expand the Conrad 30 program.
2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.
3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.
4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.
5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.
(Res. 233, A-06 Appended: CME Rep. 10, A-11 Appended: Res. 303, A-11 Reaffirmation I-11 Modified: BOT Rep. 5, I-12 Appended: BOT Rep. 27, A-13 Reaffirmation A-14)

D-255.980, Impact of Immigration Barriers on the Nation's Health
1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.
(Alt. Res. 308, A-17 Modified: CME Rep. 01, A-18 Reaffirmation: A-19)
H-200.972, Primary Care Physicians in Underserved Areas
1. Our AMA should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:

(a) Encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care.
(b) Encourage the affiliation of these family health clinics with local medical schools and teaching hospitals.
(c) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.
(d) Encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence.
(e) Urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations.
(f) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations.
(g) Urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.
2. Our AMA supports efforts to: (a) expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and (b) increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.
(CMS Rep. I-93-2 Reaffirmation A-01 Reaffirmation I-03 Modified: CME Rep. 13, A-06 Reaffirmed: CMS Rep. 01, A-16 Modified: CME Rep. 04, I-18 Appended: Res. 206, I-19)

5. PROMISING PRACTICES AMONG PATHWAY PROGRAMS TO INCREASE DIVERSITY IN MEDICINE

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies H-60.917, H-200.951, H-350.960, D-200.982, D-200.985, D-295.963 and D-350.980

INTRODUCTION

AMA Policy D-200.985 (13), "Strategies for Enhancing Diversity in the Physician Workforce," asks that the AMA (a) support the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs, and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.

The Council on Medical Education offers this report to provide an overview of interventions used by "pathway programs" based on targeted milestones along the journey to becoming a physician; to identify institutional and structural factors that interfere with or create attrition on the journey; and to discuss recommendations to minimize interference/attrition on the journey to becoming a physician.

DEFINITION OF PIPELINE/PATHWAY PROGRAMS IN MEDICINE

Historically, the term "pipeline" in medical education has been used as a metaphor to describe the progression of individuals from one level of medical education to the next.[1] However, it should be noted that use of this term has been criticized as the model erroneously presents a series of invariant steps necessary to pursue a career in medicine. This rigid and reductionist approach can have an especially negative impact on women and underrepresented groups in their pursuit of medical careers.[2] More recently the adoption of the term "pathway" has gained favor as it symbolizes a more flexible and less restrictive course that individuals can take on their path to becoming physicians. For the purposes of this report, the term "pathway programs" will be used to describe the progression of individuals from one level of medical education to the next. The pathway therefore begins as early as prekindergarten and extends through college, medical school, graduate medical education (GME), and up to faculty development. Pathway programs are designed to assist individuals, particularly those who have been historically underrepresented in medicine (URM), to

envision a career in medicine and successfully transition from any one stage of education to the next with the goal of bolstering care for historically marginalized and minoritized patients. Some of the ways that pathway programs support learners include providing supplemental academic enrichment programs, experiential learning in medical/clinical settings, research experience, career/college counseling, standardized exam preparation, and mentorship.

Given that health inequities are identified in all areas, URM individuals can be expected to enhance outcomes in any clinical discipline and deserve the opportunity for a rewarding career in medicine. The rationale for encouraging the creation of programs to enhance medical student diversity is that racial and ethnic diversity among health professionals has been shown to promote better access to health care, improve health care quality for underserved populations, and better meet the health care needs of an increasingly diverse population.[3] While it is a duty of all physicians to aid serving the underserved and support primary care, URM physicians have been found to be more likely to work in underserved areas and thereby increase access to health care for historically marginalized and minoritized patients. Additionally, diverse learners add value to medical education and research environments by broadening perspectives represented in discussions, thus influencing peers and improving the cultural competence of the entire physician workforce.[4,5]

HISTORY OF THE CREATION OF PATHWAY PROGRAMS IN THE UNITED STATES

For the first two-thirds of the twentieth century, U.S. medical schools were de facto segregated, since few medical schools would admit Black students. In 1900, Black students who aspired to have a career in medicine could only choose from 10 schools in the U.S.[6] Following the establishment of the Council on Medical Education in 1904, the Council adopted an "ideal standard" that medical schools ought to require preliminary education sufficient to enable the candidate to enter a recognized university; a five-year medical course; and a sixth year as an intern in the hospital. In 1906, the Council was tasked with rating medical schools and surveyed 160 schools regarding performance of graduates on state licensure examinations. The schools were graded as "acceptable," "doubtful," or "nonacceptable" based on a set of 10 defined qualifications. Only 82 schools receive an "acceptable" rating. The Council partnered with the Carnegie Foundation in 1909 to conduct a follow up study, entitled "Medical Education in the United States and Canada, a Report to the Carnegie Foundation for the Advancement of Teaching," which was known as the Flexner Report of 1910.

The Flexner Report of 1910, which shaped medical education in the subsequent century, alleged support of medical education at the historically Black colleges and universities to provide a physician workforce that would serve Black Americans, yet its recommendations resulted in the closure of 89 medical schools, including five of the remaining seven medical schools that trained Black physicians, due to these schools' inability to meet the standards set at the time.[7] The report also went beyond describing the substandard conditions at medical schools; it prescribed a limited role for Black physicians in their practices and hinted that Black physicians possessed less potential and ability than their white counterparts. Among his other findings, Flexner concluded that "educating the [Black] race to know and to practice fundamental hygienic principles" fell naturally to the Black doctor. Thus, "a well-taught negro sanitarian will be immensely useful." Flexner not only limited the role of African American physicians to caring for other African Americans but further restricted Black doctors to matters of public health.[8] While he viewed both Meharry Medical College and Howard University as being suitable for training Black physicians, he recommended divestment from the five underperforming institutions serving Black medical students and reallocation of those resources to Meharry Medical College in Nashville, Tennessee, and Howard University Medical Department in Washington, DC.

As recently as 1964, 93 percent of all medical students in the United States were men and 97 percent of those students were non-Hispanic white. Of the remaining three percent of medical students, all but a few were enrolled in Howard University and Meharry Medical College. At that time, less than 0.2 percent of all medical students were Mexican American, Puerto Rican, American Indian, or Alaska Native. Prevailing societal values and practices within the profession were reflected in restricted opportunities for URM medical school graduates to participate in specialty training, medical society membership, hospital staff membership, and other professional activities.[7]

Beginning in the early 1960s, cross-sectional efforts began to support increased diversification of the medical workforce. In 1963, Congress passed the Health Professions Educational Assistance Act (P.L. 88-129, amending the Public Health Service Act or PHSA) in response to a projected nationwide shortage of physicians. The act was the first comprehensive legislation to address the supply of health care providers and initially authorized grants for the construction of new teaching facilities and loans to support students in the study of medicine, dentistry, and osteopathic

medicine. The emphasis of Title VII programs shifted through several reauthorizations in the 1970s and 1980s. Title VII programs were seen as a means to improve the maldistribution of physicians and other health professionals. Programs were authorized to increase the numbers of health professionals in underserved (mostly rural or inner-city) areas and to improve the racial and ethnic diversity of the health workforce by increasing the numbers of those who had been historically excluded from careers in medicine. In addition, programs were developed to counter the nationwide trend of medical specialization. The major objective of these programs was to increase support for training and curriculum development in primary care.[9] Title VII programs are administered by the Bureau of Health Professions at the Health Resources and Services Administration (HRSA) in the Department of Health and Human Services (HHS).

The adoption of pathway programs by the Association of American Medical Colleges (AAMC) as a strategic way to increase the number of URM physicians also emerged from the civil rights activism of the 1960s. Nickens et al. explain that "actions to promote diversity in medical schools reflected the heightened sensitivity to racial injustice spurred by the civil rights movement."[10] In 1964, only 2.2 percent of the total 32,000 medical students enrolled nationwide were Black, and the two historically Black colleges and universities (HBCUs) enrolled 76 percent of these students. On average all other medical schools enrolled a single Black student every two years.[8] At the 1968 AAMC annual meeting, medical students, faculty, and administrators asked for the creation of a task force and strategies to increase enrollment among URM students. The underrepresentation of these groups was found to be so great that the task force placed highest priority on increasing the number of URM medical students from 2.8 percent to 12 percent within five years.[9] The other recommendations centered around retention of students on the medical career pathway, providing financial assistance, and recruitment of students into the medical pathway.[9] At the same time, there was widespread implementation of new "academic-enrichment programs" for premedical and post-baccalaureate students.[8] These enrichment programs as well as a rise in Black college student enrollment and the use of affirmative action in medical school admission led to a rapid increase in medical student enrollment among URM students from 3 percent in 1968 to 10 percent by 1974.[11] Data on the enrollment of non-Black minoritized individuals was not collected until 1971.

Although these programs remained in place from 1974-1990, the general population rate of minoritized communities increased faster than medical school enrollment among those who had been historically excluded from medicine, so there was greater underrepresentation of these groups in medical schools in 1990 than in 1975. By 1990, the general minoritized population was 20 percent while URM medical students represented 9 percent of all medical students. In 1990, the AAMC launched the *3000 by 2000* initiative, which aimed to enroll 3000 URM medical students annually by the year 2000. As part of this initiative, the AAMC adopted the "pipeline" metaphor that had been previously used in the science and engineering fields.[10] The first major aspect of this initiative encouraged medical schools to partner with local magnet high schools to provide minoritized students early exposure to the health professions and to academically prepare students to undertake rigorous pre-medical or pre-health professional coursework in college. The second aspect of the initiative included forming more articulated agreements between undergraduate institutions and medicals schools to encourage the enrollment and advancement of URM students into and through medical school. Last, the initiative encouraged science-education partnerships between academic health education centers (AHECs) and local primary school systems wherein AHEC faculty helped design scientific curricula that encouraged critical thinking and problem solving rather than simple memorization in the public school system. Although the *3000 by 2000* initiative did not achieve its enrollment goal, partially due to national resistance against affirmative action at the time, it paved the way for widespread pathway partnerships between medical schools, undergraduate institutions, and primary schools, many of which remain to this day.[10]

In 2009, the Liaison Committee on Medical Education (LCME), which accredits medical education school programs in the United States and Canada, revised its diversity standards to require that all U.S. allopathic medical schools engage in systemic efforts to attract and retain students from diverse backgrounds. The diversity standards were defined by the medical schools and the standards did not set numerical goals, but sought to ensure that all medical schools had a "mission-appropriate" diversity policy.[12] Evaluation of these medical school programs, some of which are pathway programs, has demonstrated modest enrollment increases in the proportions of URM medical students.[4] According to data collected for the 2019-2020 academic year, 149 (97 percent) of LCME-accredited medical schools have or support at least one pathway program to prepare participants (from the school's diversity categories) for potential admission to medical school. Table 1 summarizes the types of "pipeline programs" in U.S. MD-granting medical schools.

Table 1 Types of Pipelines Programs in U.S. MD-Granting Medical Schools, 2019-2020

Type of Pipeline Program[a]	No. (%) of Medical Schools[b]
Pre-college-level only	6 (4.0)
College-level only	13 (8.7)
Postbaccalaureate only	1 (0.7)
Pre-college and college-levels	59 (39.6)
Pre-college, college, and postbaccalaureate levels	54 (36.2)
College and postbaccalaureate levels	12 (8.1)
Pre-college and postbaccalaureate levels	4 (2.7)

Source: LCME, 2020

[a]Pre-college level includes programs at the middle school and/or high school levels

College level includes programs at the college/university level and/or BA/MD programs/guaranteed medical school admission programs

Postbaccalaureate programs include programs for college graduates to complete additional course requirements or other pre-medical requirements

[b]149 medical schools reported having one or more pipeline programs: middle school (69 schools), high school (122 schools), college/university (123 schools), BA/MD or guaranteed admission programs (49 schools), postbaccalaureate programs (71 schools)

Table 2 summarizes the number of new medical students matriculating into a U.S. MD- or DO-granting medical school who came from at least one of a school's supported pathway programs.

Table 2 New Medical Students Who Came from a Pathway Program in 2019-2020

Type of Program	# Matriculating to Respondent's Medical School	# Matriculating to Another U.S. MD/DO Granting Medical School
Middle school program only	7	0
High school program only	158	55
College program only	872	580
BA/MD/guaranteed-admission program only	921	47
Postbaccalaureate program only	907	637
More than one type of the school's pipeline program	210	39

Source: LCME, 2020

However, although absolute numbers of Black and Hispanic/Latinx matriculants have increased since 2009, representation of these groups in medicine as a proportion of the general population has not increased.[5] Additionally, Lett et al. found "no statistically significant trend towards increased representation of Black and Hispanic/Latinx male individuals and a modest trend towards increased representation for Hispanic/Latinx female applicants." In fact, they found "that Hispanic/Latinx individuals are underrepresented among medical school applicants and matriculants by nearly 70% relative to the age-adjusted U.S. population; Black male applicants and matriculants, nearly 60%; Black female applicants, nearly 30%; and Black female matriculants, nearly 40%." Additionally, Lett et al demonstrated that the representation of minoritized faculty relative to the general population has actually decreased in almost all specialties and across all faculty rankings since 2009.[13]

EVOLUTION FROM "PIPELINE" TO "PATHWAY" PROGRAM

It is important to consider the implications of using specific terminology about programs focused on increasing diversity in medicine. The term "pathway program" is gaining favor as it suggests a more open and flexible path to becoming a physician; the term "pipeline program," however, is still prevalent both in the literature and in everyday conversations. Some believe the metaphor of the "pipeline" is misleading and inaccurate. The pipeline metaphor suggests there is a single path to becoming a doctor with a single entry and exit point.[14] Many URM medical students follow a non-traditional path to medical school, such as participating in post-baccalaureate programs to strengthen their academic profile, so the idea of a rigid pipeline that requires early access and success in science and medicine may be particularly discouraging to minoritized students.[13] Giordani et al. demonstrated that non-traditional students with lower Medical College Admission Test (MCAT) scores and undergraduate GPAs who pursue post-baccalaureate programs are just as likely as their traditional peers to succeed once they enter medical school.[15] Another reason some criticize the term "pipeline" is its allusion to the "school-to-prison pipeline," a phenomenon known to disproportionately impact minoritized youth.[16] While the criminalization of minoritized children in schools is a

worthwhile concern to address in pathway programs—minoritized students cannot be guided toward academic success when trapped in a "pipeline" of isolation, punishment, aggressive school policing, and inadequate academic preparation due to lack of resources—echoing the same terminology for a program promoting equity is inappropriate. Additionally, the word "pipeline" has negative connotations in Native American communities that are a prioritized group for recruitment. "Pipelines" within Indigenous communities are often literal, calling to mind current struggles with oil industries against environmental degradation, threats to communities' health and safety, and continued colonization. Alternatively, the term "pathway" implies learners' agency and offers more than a single path to medicine, which can include non-traditional students, individuals who change careers later in life, and those who did not have early exposure to medicine.[13]

CURRENT FEDERAL PATHWAY PROGRAMS

The Title VII health professions and Title VIII nursing workforce development programs, which are authorized under the Public Health Service Act and administered by the HRSA, increase the supply, distribution, and diversity of the health care workforce, reaching over 400,000 participants.[17] These programs improve access to, and quality of care for, vulnerable populations, including children and families living on low incomes and in rural and underserved communities. In addition, as ever-changing public health threats such as the COVID-19 pandemic and substance use disorder epidemics, impact patients across the country, continued investment in Title VII programs is essential to addressing the health challenges of today and the future.

Title VII programs play an essential role in improving the diversity of the health care workforce and connecting students to health careers by supporting recruitment, education, training, and mentorship opportunities. Inclusive and diverse education and training experiences expose physicians and other health care professionals to backgrounds and perspectives other than their own and heighten cultural awareness in health care, resulting in benefits for all patients. The Title VII programs include:

- *Centers of Excellence*: Provides grants for mentorship and training programs. In academic year 2018-19, this program supported over 1,300 trainees, of whom 99% were underrepresented minorities and 64% were from financially or educationally disadvantaged backgrounds.

- *Health Career Opportunity Program*: Invests in K-16 health outreach and education programs through partnerships between health professions, schools, and local community-based organizations. In academic year 2018-19, over 4,000 students from rural and disadvantaged backgrounds were exposed to the health professions pathway.

- *Primary Care Training and Enhancement (PCTE*): Supports training programs for physicians and physician assistants to encourage practice in primary care, promote leadership in health care transformation, and enhance teaching in community-based settings. In academic year 2018-19, PCTE grantees trained over 13,000 individuals at nearly 1,000 sites, with 61% in medically underserved communities and 30% in rural areas.

- *Medical Student Education:* Supports the primary care workforce by expanding training for medical students to become primary care clinicians, targeting institutions of higher education in states with the highest primary care workforce shortages. The grants develop partnerships between institutions, federally recognized tribes, and community-based organizations to train medical students to provide care that improves health outcomes for those living on tribal reservations or in rural and underserved communities.

- *Area Health Education Centers (AHECs)*: Responds to local health needs and serves as a crucial link between academic training programs and community-based outreach programs. In academic year 2018-19, AHECs supported 192,000 pathway program participants, provided over 34,000 clinical training rotations for health professions trainees, and placed over 92,000 trainees in rural and underserved training sites.

- *Mental and Behavioral Health*: Funds training programs to expand access to mental and behavioral health services for vulnerable and underserved populations. In academic year 2018-19, the Graduate Psychology Education program partnered with 184 sites to provide clinical training experiences for psychology students. Of these sites, 48% offered substance use disorder treatment services, and 38% offered telehealth services.

HRSA also administers the Minority Faculty Fellowships Program, with the goal of increasing the number of minoritized faculty at awardee institutions. The program awards 50 percent of faculty salary, with the institution matching funds. Fellows are prepared to assume tenured faculty positions at the institution and to provide services in underserved areas.[8]

Additionally, and as previously reported in Council on Medical Education Report 5-A-18, "Study of Declining Native American Medical Student Enrollment," the Indian Health Service (IHS) supports American Indian/Alaska Native (AI/AN) entry into the health professions and provides opportunities to explore career paths in AI/AN health care. The IHS Scholarship program has awarded more than 7,000 health professions scholarships since 1978. The IHS website provides links to allow potential students to arrange IHS externships (with salary) and to coordinate AI/AN clerkship opportunities for medical students. In addition, post-graduation financial support is available through the IHS, with a loan repayment program of $20,000 per year of commitment (maximum $40,000) for health professions education loans, as well as a supplemental loan repayment program. The IHS also participates in the National Health Service Corps loan repayment program, with awards up to $50,000 for a two-year commitment.[18]

CURRENT UNDERGRADUATE PATHWAY PROGRAMS

The CUNY School of Medicine (formerly Sophie Davis Biomedical Education Program), located in Harlem, recruits and educates a diverse, talented pool of students to its MD and physician assistant programs, expanding access to medical education to URM individuals from underserved communities of limited financial resources. The BS/MD degree program admits students directly from high school into an undergraduate biomedical program with a seamless transition into the medical school curriculum based on a seven-year curriculum. The program has graduated over 2,000 alumni who have become physicians, many of whom practice in underserved communities.

The Summer Health Professions Education Program (SHPEP) was initially established following a study by the Robert Wood Johnson Foundation (RWJF) in 1984 to identify strategies to reverse trends dating back to 1977 of declining URM medical school applicants. The program was originally known as the Minority Medical Education Program (MMEP), which was intended to increase the acceptance rates among medical school applicants who were African Americans, Mexican Americans, mainland Puerto Ricans, and AI/AN, as these groups have historically been underrepresented in medicine due to structural racism. Over the years, MMEP's intensive academic preparation program expanded to 11 medical school campuses and the AAMC assumed the role of National Program Office in 1993. The program changed its name in 2003 to the Summer Medical Education Program (SMEP) to reflect the inclusion of students representing a range of economic, cultural, and geographic diversity. The program continued to evolve in 2006 when it expanded to include dentistry and was renamed the Summer Medical and Dental Education Program (SMDEP). SMDEP focused on students in the first two years of their college education because the experience of previous programs indicated that this is when students derive the most benefit. Most recently, the program expanded again in 2016 to include a range of health professions due to the growing importance of team-based care and interprofessional collaboration, leading to the most recent change in the program name, to SHPEP.[19] As of 2020, the program has served 27,164 participants at 12 universities across the U.S.

Doctors Back to School (DBTS) was launched by the AMA Minority Affairs Consortium (now called the Minority Affairs Section) in 2002. The DBTS program encourages Black, Indigenous, and Hispanic/Latinx students to enter the health care pathway through conversations with these children in a classroom setting. DBTS has developed a Doctors Back to School™ Kit to support physicians and medical students who act as role models by visiting elementary and high schools to talk with marginalized students about careers in medicine. The program demonstrates to marginalized students that a medical career is well within their reach. In 2016, the program declared the second Wednesday in May as National Doctors Back to School™ Day.

The American Academy of Ophthalmology and the Association of University Professors of Ophthalmology partnered to provide first- and second-year URM medical students one-on-one mentorship, valuable guidance in medical career planning, networking opportunities, and access to a variety of educational resources through their Minority Ophthalmology Mentoring (MOM) program. The MOM Class of 2020 provided opportunities for 50 students. Additionally, the National Medical Association developed the Rabb-Venable Excellence in Ophthalmology Research Program to help increase exposure to ophthalmology as a potential specialty choice among URM students and residents/fellows.

In addition to these national programs, there are numerous programs in the U.S. to boost diversity across the medical continuum. Mentoring in Medicine (MIM) prepares marginalized students in 3rd grade to become biomedical professionals by enabling them to interact with, and learn from, experienced health care professionals and scientists from health professional schools around the U.S. MIM offers an array of age-appropriate programs that involve reaching out to students on a regular basis, creating supportive social circles, providing academic enrichment, exposing students to hospital and research environments, coaching them on leadership and life skills, and providing prospective medical students with exposure to a supportive, but rigorous boot camp. Tour for Diversity (T4D) educates, inspires, and cultivates the future generation of URM physicians, dentists, and pharmacists by conducting national tours in February and September to provide comprehensive workshops to high school and college students that focus on motivating them toward a strong career path, building critical skills, optimizing the application process, and developing mentoring relationships. T4D also provides students with virtual opportunities via hosted webinars that are both interactive and recorded. Building the Next Generation of Academic Physicians (BNGAP) was established in 2008 to address the lack of URM individuals serving as faculty at academic health centers and works to promote diversity and inclusion in the academic medicine workforce.

There are also programs that focus on the development of the health care workforce to increase access to care for underserved people such as those in rural communities. Successfully Training and Educating Pre-medical Students (STEPS) aims to increase the number of primary care physicians in northeast Kentucky by providing opportunities such as physician shadowing, mock interviews, and MCAT practice exams for pre-medical students in the Appalachian region. Frontier Area Rural Mental Health Camp and Mentorship Program (FARM CAMP) strives to reduce the shortage of behavioral health professionals in rural Nebraska. FARM CAMP offers a week-long camp to teach high school students in rural and tribal communities about different career options in behavioral health and provides mentorship after the camp ends. Frontier and Rural Workforce Development New Mexico (FORWARD NM) Pathways to Health Careers was established to address the chronic shortages of primary care physicians and other health care professionals in New Mexico's southwestern counties of Hidalgo, Catron, Luna, and Grant; additionally, New Mexico has the oldest physician population in the country. This comprehensive workforce pathway program includes programming for middle and high school students, undergraduate and graduate students, primary care program students, and medical and dental residents.[20]

Additionally, in 2010, Columbia University College of Physicians and Surgeons and Bassett Medical Center joined forces to launch a new model of medical training to address the severe shortage of rural physicians and train a new generation of doctors capable of leading health systems that promote both quality of practice and cost-effective delivery of care. Students begin their training for 18 months in Manhattan and then head to Cooperstown, N.Y., for two and a half years to obtain clinical training. Students experience both an urban health care setting and a rural health care environment, while being exposed to features not typically part of the medical school curriculum, such as finance, risk management, patient safety, quality improvement, and medical informatics. In addition, every Columbia-Bassett student receives grant funding at a minimum of $30,000 per year for all four years.

To help highlight the needs of the Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) community, in 2020 the American Medical Association Foundation (AMAF) established its LGBTQ Fellowship Program to influence the future of LGBTQ health. The new initiative will create a cadre of LGBTQ health specialists through a national fellowship program to promote best practices and shared outcomes, while improving the quality of LGBTQ health care across the nation. The program was created to address the intersectional issues of discrimination, stigma, and limited access to and lower quality of care experienced by lesbian, gay, bisexual, and transgender individuals. A primary goal of the program is to create a pathway for LGBTQ health specialists who are able to serve the health care needs of the LGBTQ community while growing the pool of competent instructors able to "pay it forward" by passing on their knowledge to the next generation of LGBTQ physicians.

CURRENT GRADUATE MEDICAL EDUCATION PATHWAY PROGRAMS

There are also initiatives to increase diversity in competitive specialties such as orthopaedic surgery and radiology, as well as expand gender equity in the specialties of family medicine and obstetrics and gynecology. Nth Dimensions was founded in 2004 by orthopaedic surgeons working collaboratively with academic institutions, community surgeons, and industry to address the dearth of women and other URM groups in orthopaedic surgery. Nth Dimensions offers an eight-week clinical and research internship with a practicing researcher, which also includes a full-day orientation and culminates in the student presenting a research poster at the annual National Medical Association assembly. Following successful completion of the summer internship program, students receive scholarships to

participate in a designated Step 1 board review course, which is conducted throughout their second year in medical school. Nth Dimension also offers clinical correlations lectures and hands-on workshops to increase awareness of the specialty being addressed through surgeon-led lectures and hands-on workshops with target groups of URM groups and women. The American College of Radiology established the Pipeline Initiative for the Enrichment of Radiology (PIER) internship program for first-year medical students at institutions across the U.S. in hopes of giving women and other URM groups an opportunity to explore the radiology specialty and engage in research. The internship begins in June and culminates with presentation of the students' research to the radiology section of the National Medical Association. Additionally, the AMA Reimagining Residency initiative is currently sponsoring two innovative pathway programs. California Oregon Medical Partnership to Address Disparities in Rural Education and Health (COMPADRE) is a collaboration between Oregon Health & Science University and University of California, Davis, 10 health care systems, 10 institutional sponsors, and a network of federally qualified health centers that aims to jointly address workforce shortages in rural, tribal, urban, and other disadvantaged communities between Sacramento and Portland. The University of North Carolina has developed Fully Integrated Readiness for Service Training (FIRST): Enhancing the Continuum from Medical School to Residency to Practice, which expands the geographic and specialty reach of the University of North Carolina School of Medicine's established residency readiness program. Its additional aims include developing and implementing a generalizable health systems science curriculum for GME and competency-based assessment tools that span the educational continuum.

INSTITUTIONAL AND STRUCTURAL FACTORS THAT INTERFERE WITH PATHWAY PROGRAM SUCCESS

Although many students who indicate an early interest in medicine do not progress from one phase to the next, the attrition rate of URM medical students is even higher than those of their non-minoritized counterparts.[1,21] This disproportionate attrition rate is multifactorial and occurs in all phases of the pathway. Some factors that disproportionally affect URM students include attending lower performing high schools and colleges, financial barriers to higher education, lower levels of academic attainment among parents of minoritized students (which has been found to link to a child's outcomes such as academic achievement), and experiences of racism and implicit bias that deter students from continuing with their trajectory.[4,10] A 2019 study published in *JAMA* found that while the U.S. population of male and female 24- to 30-year-olds, who are Black, Hispanic/Latinx, and Native Hawaiian or Pacific Islander (NHOPI) increased between 2002 and 2017, there were no significant increases in medical school applicants and attendees from these groups over the same period. The study also found that from 2002 to 2012, the proportion of Black, Hispanic/Latinx, NHOPI, and AI/AN medical school matriculants remained relatively unchanged and Black, Hispanic/Latinx, and AI/AN students remain underrepresented among medical school matriculants compared with the U.S. population.[5] Another study the same year found that as medical school enrollment doubled over the past two decades, the percentage of entering underrepresented students actually fell by 16%.[22] There are several possible factors that may explain why these groups are still underrepresented in medicine.

While affirmative action efforts helped initially increase enrollment among URM medical students, these initiatives have been met with resistance. In 1974, a reverse discrimination lawsuit brought by Allan Bakke against the University of California (UC) transformed how colleges think about race and equality in admissions. Bakke was a white man who had twice been denied admission to the medical school at UC Davis during the time when positions in the entering class were "reserved" for qualified minoritized students. The case was ultimately heard by the U.S. Supreme Court. Justice Lewis Powell, in the deciding opinion in the case, wrote "the State has a substantial interest that legitimately may be served by a properly devised admissions program involving the competitive consideration of race and ethnic origin" and concluded that "you could use race as a factor in admissions, but that you could not use quotas" (Powell L. 1978. Bakke, 438 US at 312–13 n.48). The Court's decision in *Regents of the University of California v. Bakke* changed the definition of the Equal Protection Clause and inadvertently changed how colleges approached recruiting and enrolling URM in medicine. According to law professor Kevin Brown at Indiana University, the Equal Protection Clause is a short but critical line in the Fourteenth Amendment that states that Americans in similar circumstances should be treated equally under the law. This clause historically aimed to help "discrete and insular minoritized groups."[23] The decision upended that view. Bakke was admitted to medical school at UC Davis and the school transitioned to a panel of markers that they term "distance traveled," which is not race-based but serves to support marginalized people based on non-race indicators of socioeconomic disadvantage. However, the Court's decision affirmed the use of race as one among many factors that could be considered as part of the medical school admissions process.[10] The Court's decision provided the window to weaken the practice of race-based affirmative action and as a result enrollment among minoritized groups stagnated.

There were additional anti-affirmative action initiatives to follow that negatively impacted efforts to increase diversity in medicine. Most notable was *Hopwood v. University of Texas* in 1996, in which the United States Court of Appeals for the Fifth Circuit held that "any consideration of race or ethnicity by the law school for the purpose of achieving a diverse student body is not a compelling interest under the Fourteenth Amendment."[24] This decision prohibited public universities under its jurisdiction (in Texas, Mississippi, and Louisiana) from taking race into account in their admissions policies. The same year, Proposition 209 was passed in California with nearly 55 percent of the vote, banning consideration of race and gender in admissions in the state's public universities. In 2008, the University of California (UC) "clarified" their policy in recognition that Native Americans enrolled in a federally recognized tribe enjoy a political status that enables them to be offered affirmative action, even when the consideration of race or ethnicity is banned. This policy shift led to a statistically significant surge in the Native American applicant share, acceptance rate, admit share, and enrollment share. Enrollment share increased by 56% from 2008 to 2010 at the UC.[25] In November 2020, nearly 25 years later, voters in California had the opportunity to repeal Proposition 209 through the work of Assemblywoman Shirley Weber (D-San Diego), chairwoman of the Legislative Black Caucus and principal author of the proposed constitutional amendment.[26] This effort was unsuccessful, and the amendment was not approved by voters. Presently, Arizona, Georgia, Michigan, Nebraska, New Hampshire, Oklahoma, and Idaho have banned affirmative action. A study of 19 public universities in six of these states (Arizona, Georgia, Michigan, Nebraska, New Hampshire, and Oklahoma) found that the elimination of affirmative action has led to persistent declines in the share of URM medical students among students admitted to and enrolling in flagship public universities in these states.[27]

In June 2003, the US Supreme Court ruled on two separate but parallel admissions cases, *Grutter v. Bollinger* and *Gratz v. Bollinger*, involving the University of Michigan and the constitutionality of using race-conscious decisions as part of its admissions process. Although neither case directly involved the medical school or other health profession admissions, the Court's ruling was widely recognized as one that would have profound bearing on the future of affirmative action in public higher education nationwide. With these rulings, the Supreme Court recognized the value of diversity in higher education and preserved the ability to consider race as a factor in admissions decisions.[10]

Aside from the impact of court rulings on affirmative action, support for Title VII programs has been inconsistent over the last decade. In 2005, the Office of Management and Budget (OMB) published its review of the health professions training programs under Title VII. After years of effective ratings for Title VII programs, the OMB concluded that these programs were ineffective. As a result, the HRSA administrator, Elizabeth Duke, informed COE and HCOP grantees that the administration would no longer support their programs, and in 2006, the federal government cut its funding abruptly and drastically reduced the number of Centers of Excellence and Health Careers Opportunity Programs. In February 2006, the Government Accountability Office (GAO) issued a report entitled *Health Professions Education Programs: Action Still Needed To Measure Impact,* which reviewed HRSA's evaluation of the Title VII and VIII (nursing) programs against its overall performance goals and found that these goals did not apply to all of the health professions programs and that HRSA's tracking data was problematic.[28] HRSA was criticized for failing to publish national supply, demand, and distribution projections for the physician and dentist workforces.

In July 2020, the House Appropriations Committee released their Committee Report accompanying the Labor-HHS-Education FY 2021 allocations, which would provide Title VII Health Professions and Title VIII Nursing Workforce Development Programs with a total of $782.5 million, a $48 million increase (6.5%) from FY 2020 enacted levels.[29] In December 2020, the Consolidated Appropriations Act of 2021 passed which includes $50,000,000 for grants to public institutions of higher education to expand or support graduate education for physicians provided by such institutions. Priority will be given to public institutions located in states with a projected primary care physician shortage in 2025 and are limited to public institutions in states in the top quintile of states with a projected primary care physician shortage in 2025.[30]

Historically, disparities in medical school admissions have encompassed more than racial and ethnic gaps. One root cause for this disparity is a lack of resources to support the development of education necessary to be an adequate applicant for medical school admission. While overall educational attainment is increasing, college completion rates and attainment patterns differ considerably across demographic groups. Household income and education levels are tightly linked. Consequently, lower levels of education are correlated with lower household income as well.[31] This has direct implications for the economic diversity of applicants to medical school. According to a 2018 study conducted by AAMC, roughly three quarters of medical school matriculants come from the top two household-income quintiles, and this distribution has not changed in three decades. Black and Hispanic/Latinx medical students are three times as likely as their white counterparts to come from families with combined parental incomes of less than $50,000.

Black and Hispanic/Latinx students are also much more likely than white students to have attended high poverty primary and secondary schools which strongly affects educational achievement and often leaves these individuals less competitive on traditional academic measures such as MCAT scores and grade-point averages.

The lower admission rate for URM groups is another challenge to diversification of the medical workforce due to bias. Community college attendance is often viewed negatively by medical schools in the admissions process, despite being a critical educational pathway for many URM students.[31] To counter this bias, there is a growing trend of holistic review as an admissions strategy to assess an applicant's unique experiences alongside traditional measures of academic achievement such as grades and test scores. It is designed to help admission committees consider a broad range of factors reflecting the applicant's academic readiness, contribution to the incoming class, and potential for success, both in school and later as a professional. Holistic review, when used in combination with a variety of other mission-based practices, constitutes a "holistic admission" process. A key element is that this review concomitantly reduces historical singular focus on metrics that are flawed from the perspective of equity for URM medical students, specifically standardized testing and GPA or the "caliber" of college attended. A holistic admission process is necessary at the collegiate level to increase the pool for subsequent undergraduate medical education, GME, and faculty recruitments. In 2003, the U.S. Supreme Court officially described the strategy as a "highly individualized, holistic review of each applicant's file, giving serious consideration to all the ways an applicant might contribute to a diverse educational environment" (*Grutter v. Bollinger*, 539 US 306, 2003). The AAMC has promoted holistic review in the admissions process to broadly assess how a candidate might contribute value as a medical student and physician. Although practices vary widely, a national survey of health professional schools showed that institutions incorporating "many elements of holistic review" reported increases in class diversity as compared with institutions incorporating few or no elements.[32]

Diversity in the ranks of faculty and administration of medical schools is central to creating a welcoming environment for all students.[31] However, a study to evaluate trends in racial, ethnic, and gender representation at U.S. medical schools across 16 specialties from 1990–2016 found that the gap between the URM population in the academic physician workforce widened over time for nearly all specialties and faculty rankings.[33] This is problematic, as URM faculty often serve as important role models and mentors for URM medical students and trainees who may struggle with systemic racism in their schools and training environments.[34] URM faculty can also promote academic excellence and enhance training across all domains to improve outcomes for all students related to cultural humility, humanism, empathy, and professionalism. "Most institutions recognize the value of multi-cultural outreach and engagement, but often fail in reconciling the associated implications for organizational decision-making. In other words, institutional leaders recognize the benefits of recruiting URM groups into medicine and gaining ideas from diverse sources but lack the understanding or will to ensure that they are integrated into an environment of respect, inclusion and meaningful engagement."[34]

Lastly, negative social integration into the campus environment impacts retention among minoritized and marginalized groups. Tinto's theory of student departure claims that a student's individual characteristics (including personal attributes, family background, and high school experiences) directly influence the student's commitments to an institution, the goal of graduation, and, ultimately, the departure decision.[35] Braxton et al. revised the model in 2004 by placing social integration as the pivotal factor in retention and claiming that student characteristics (e.g., gender, race/ethnicity, socioeconomic status, academic ability, high school preparation, and self-efficacy) shape initial commitments to attaining a degree and to the institution.[36] Significant factors for minoritized and marginalized student retention include racial climate, presence of an ethnic community, community orientation, campus involvement, acclimation to the academic culture, social connectedness, and the role of religion.[37] These factors may be interconnected as having the presence of a similar ethnic community may increase a student's feelings of support in the event of a racially insensitive incident. Some recent examples of these type of incidents include white students posting photographs of themselves in blackface and disseminating the photos via social media, along with graffiti with swastikas and other "hateful language" in dormitories and on campus buildings; however, incidents do not have to be blatant to be harmful.[38] Microaggressions which are brief yet common verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color can also negatively impact one's experience in the classroom, training environment and workplace. URM groups have reported commonly experiencing microaggressions in school and in the workplace. These experiences of microaggressions have been associated with harmful psychological outcomes including anxiety and depression. Moreover, because microaggressions seem benign, they are rarely reported in the workplace.[39] The absence of a supportive affinity community may lead a student to experience an estrangement process, which begins

with feelings of alienation that evolve into disillusionment and emotional rejection, and end with the student physically rejecting the campus environment and withdrawing from the institution.[40]

ADDITIONAL CONSIDERATIONS FOR PATHWAY PROGRAMS

As the focus of this report is on existing promising practices to promote a diverse medical workforce, the Council would like to address the importance of gender equity across medical specialties. Table 3 highlights the gender imbalances among the medical specialties according to the 2018 National GME Census, which is compiled by the AMA and the AAMC. It is worth noting the lack of data on physicians who identify as non-binary when evaluating the balances in the specialties.

Table 3 Top Medical Specialties by Gender, 2018-2019

Female-dominated specialties		Male-dominated specialties	
Obstetrics and gynecology	83.4%	Orthopaedic surgery	84.6%
Allergy and immunology	73.5%.	Neurological surgery	82.5%
Pediatrics	72.1%	Interventional radiology (integrated)	80.8%
Medical genetics and genomics	66.7%	Thoracic surgery	78.2%
Hospice and palliative medicine	66.3%	Pain medicine	75.3%
Dermatology	60.8%	Radiology	73.2%

Source: 2018 National GME Census

While efforts are underway to increase diverse representation in orthopaedic surgery and radiology, recent attention has also been given to the dramatic decline of men in obstetrics/gynecology. In an effort to identify how to recruit more male students into the field of obstetrics/gynecology, a study was conducted to identify when students make their decisions on career choice and found that >70% of obstetrics/gynecology residents decided to pursue the specialty during or after their third-year clerkship.[41] Another study found that 78% of male students believed their gender adversely affected their obstetrics/gynecology clerkship experience.[42] The authors recommended the following efforts to increase representation of men in obstetrics/gynecology: improving the quality of the obstetrics/gynecology clerkship experience, engaging students early in their medical school careers, and frankly addressing gender and lifestyle issues that dissuade students from choosing obstetrics/gynecology.

RELEVANT AMA POLICY

Our AMA has a number of existing policies and directives that are relevant to the topic of pathway programs; these are shown in the appendix.

SUMMARY AND RECOMMENDATIONS

There is limited evidence on the effectiveness of pathway programs and more rigorous evaluation is needed. That said, the following promising practices to increase diversity across the various educational settings are supported in the literature: targeted recruitment; revised admissions policies; summer enrichment programs; and comprehensive programs that integrate multiple interventions such as financial, academic, and social support.[43] Snyder et al. found that "high quality studies suggest that pipeline program interventions can exert a meaningful, positive effect on student outcomes."[44] The limited evidence available provides reason to be optimistic that these programs are beneficial. For example, a study of three HCOP projects in Kentucky, Tennessee, and Virginia during the years 1990-1999 found that students who participated in HCOP programs were likely to enroll in college (93 percent), major in a health profession program (77 percent), and graduate (58 percent). A total of 87 percent of those who graduated from college were enrolled in a health professions program.[45] Efforts to increase diversity in medicine are needed across multiple levels. Where legally possible, institutions should utilize affirmative action policies to bolster efforts to increase diversity in medicine. University leaders committed to diversity should select deans of their medical programs with a record of active support in this area. Medical programs, through their leaders, at the school and department levels, should support continuing pathway efforts by making statements of support, by cultivating and funding programs that support a culture of diversity on campus, and by recruiting faculty and staff who share this goal. Policymakers at the state level must work to alleviate pre-K-12 educational disparities and improve the college readiness of URM students. Additionally, the efforts to increase gender equity across medical specialties should be encouraged as diverse learners add value to medical education and research environments by broadening perspectives represented in discussions, thus influencing peers and improving the cultural competence of the entire physician workforce.

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

1. That our AMA recognize some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination.

2. That our AMA commit to promoting truth and reconciliation in medical education as it relates to improving equity.

3. That our AMA recognize the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations.

4. That our AMA 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.

5. That our AMA amend Policy H-200.951, Strategies for Enhancing Diversity in the Physician Workforce, by addition and deletion to read as follows:

   Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, ~~gender~~ disability status, sexual orientation, ~~/~~gender identity, socioeconomic origin, and rurality ~~persons with disabilities~~; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; ~~and~~ (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that ~~articulating~~ articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this ~~and strategies to accomplish that~~ goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

6. That our AMA amend Policy H-60.917, Disparities in Public Education as a Crisis in Public Health and Civil Rights, by addition to read as follows:

   3. Our AMA will encourage the U.S. Department of Education and Department of Labor to develop policies and initiatives in support of students from marginalized backgrounds that 1) decrease the educational opportunity gap; 2) increase participation in high school Advanced Placement courses; and 3) increase the high school graduation rate.

7. That our AMA amend Policy D-200.985 (13), "Strategies for Enhancing Diversity in the Physician Workforce," by deletion to read as follows: ~~(a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and.~~

8. That our AMA reaffirm Policy D-200.982, "Diversity in the Physician Workforce and Access to Care."

9. That our AMA advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated

medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population.

10. That our AMA work with appropriate stakeholders to study reforms to mitigate demographic and socioeconomic inequities in the residency and fellowship selection process, including but not limited to the selection and reporting of honor society membership and the use of standardized tools to rank applicants, with report back to the House of Delegates.

11. That our AMA establish a task force to guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education.

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APPENDIX - Relevant AMA Policy

D-200.982, Diversity in the Physician Workforce and Access to Care
Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study

the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

D-200.985, Strategies for Enhancing Diversity in the Physician Workforce
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
13. Our AMA: (a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and (b) will work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.
14. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

D-305.972, Title VII Funding
Our AMA will (1) partner with all relevant stakeholders to petition Congress to reinstate funding for Title VII to at least fiscal year 2005 levels of $300 million and (2) endeavor to educate legislators in Congress about how Title VII-supported programs address health professional shortages, increase the diversity of the workforce, equip health professions students to work in health centers and underserved communities, and ensure that health professionals are ready to address health-related emerging issues.

H-180.944, Plan for Continued Progress Toward Health Equity
Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

H-200.951, Strategies for Enhancing Diversity in the Physician Workforce
Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.

H-350.960, Underrepresented Student Access to US Medical Schools
Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

H-350.970, Diversity in Medical Education
Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.

H-350.979, Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession
Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
(4) Increasing the supply of minority health professionals.
(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

Code of Ethics 8.5, Disparities in Health Care
Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.
This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.
To fulfill this professional obligation in their individual practices physicians should:
(a) Provide care that meets patient needs and respects patient preferences.
(b) Avoid stereotyping patients.
(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
(e) Encourage shared decision making.
(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.
The medical profession has an ethical responsibility to:
(g) Help increase awareness of health care disparities.
(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.