**DISCLAIMER**

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# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES
# (November 2021 Meeting)

Report of Reference Committee [C]

Kimberly Jo Templeton, MD, Chair

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## RECOMMENDED FOR ADOPTION AS AMENDED

1. Council on Medical Education Report 1 – Guiding Principles and Appropriate Criteria for Assessing the Competency of Late Career Physicians (CME Report 1-I-18)
2. Council on Medical Education Report 2 – Study to Evaluate Barriers to Medical Education for Trainees with Disabilities
3. Council on Medical Education Report 3 – Rural Health Physician Workforce Disparities
4. Council on Medical Education Report 4 – Medical Student Debt and Career Choice
5. Council on Medical Education Report 5 – Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations
6. Resolution 301 – Equitable Reporting of USMLE Step 1 Scores

## RECOMMENDED FOR ADOPTION IN LIEU OF

7. Resolution 305 – Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status
8. Resolution 309 – Protecting Medical Student Access to Abortion Education and Training

## Recommended for Adoption as Amended

(1) COUNCIL ON MEDICAL EDUCATION REPORT 1 – GUIDING PRINCIPLES AND APPROPRIATE CRITERIA FOR ASSESSING THE COMPETENCY OF LATE CAREER PHYSICIANS (CME REPORT 1-I-18)

**RECOMMENDATION A:**

**Recommendation 1 in Council on Medical Education Report 1 be amended by addition and deletion, to read as follows:**

**1. That our American Medical Association (AMA) support the following Guiding Principles on the Assessment of ~~Late Career~~ Physicians Across the Professional Continuum:**

**a) Evidence-based: Guidelines for screening and assessing ~~and screening~~ ~~late career~~ physicians across the professional continuum should be based on evidence of the importance of cognitive changes associated with aging and other factors that ~~are relevant to~~ may impact physician performance. Some physicians may suffer from declines in practice performance with advancing age, acquired disability, or other influences. Research ~~also~~ suggests that the effect of age on an individual physician's competency can be highly variable. ~~; and s~~Since wide variations are seen in cognitive performance with aging, age alone should not be a precipitating factor.**

**b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines and ~~/~~ standards for monitoring and assessing both their own and their colleagues' competency.**

**c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment.**

**d) Accountable: The ethical obligation of the profession to the health of the public and patient safety**

**should be the primary driver<u>s</u> for establishing guidelines and informing decision making about physician screening and assessment results.**

**e) Fair and equitable: The goal of screening and assessment is to optimize physician competenc<u>e</u>~~y~~ and performance through education, remediation, and modifications to a physician's practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care.**

**f) Transparent: Guidelines, procedures, or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations, and standards against which performance will be judged and the possible outcomes of ~~the~~ screening <u>and</u> ~~or~~ assessment.**

**g) Supportive: Education and/or remediation practices that result from screening and~~/or~~ assessment procedures should be <u>proactive, ongoing, and</u> ~~be~~ supportive of physician <u>well-being</u> ~~wellness, ongoing, and proactive~~.**

**h) ~~Cost conscious~~ <u>Nonburdensome</u>: Procedures and screening mechanisms that are distinctly different from "for cause" assessments should not result in undue cost or burden to ~~late career~~ physicians ~~providing patient care~~. Hospitals and health care systems should provide easily accessible screening assessments for their employed ~~late career~~ physicians. Similar procedures and screening mechanisms should be available to ~~late career~~ physicians who are not employed by hospitals and health care systems.**

**<u>i) Due Process: Physicians subjected to screening and assessment must be afforded due process protections, including a fair and objective hearing, before any action that may be taken against the physician.</u> (Directive to Take Action)**

**RECOMMENDATION B:**

**Recommendation 2 in Council on Medical Education Report 1 be amended by addition and deletion, to read as follows:**

**2. That our AMA encourage the Council of Medical Specialty Societies and other interested organizations to develop educational materials regarding decline of cognitive and psychomotor performance throughout a physician's career and the resulting impact on the quality and safety of ~~on the effects of age on~~ physician practice. (Directive to Take Action)**

**RECOMMENDATION C:**

**Recommendations in Council on Medical Education Report 1 be adopted as amended and the remainder of the report be filed.**

**RECOMMENDATION D:**

**The title of Council on Medical Education Report 1 be changed, to read as follows:**

**GUIDING PRINCIPLES AND APPROPRIATE CRITERIA FOR ASSESSING THE COMPETENCY OF PHYSICIANS ACROSS THE PROFESSIONAL CONTINUUM**

**HOD ACTION: Recommendations in Council on Medical Education Report 1 adopted as amended with a change in title to read:**

**GUIDING PRINCIPLES AND APPROPRIATE CRITERIA FOR ASSESSING THE COMPETENCY OF PHYSICIANS ACROSS THE PROFESSIONAL CONTINUUM**

1. That our American Medical Association (AMA) support the following Guiding Principles on the Assessment of Late Career Physicians:

a) Evidence-based: Guidelines for assessing and screening late career physicians should be based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Some physicians may suffer from declines in practice performance with advancing age. Research also suggests that the effect of age on an individual physician's competency can be highly variable; and since wide variations are seen in cognitive performance with aging, age alone should not be a precipitating factor.

b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues' competency.

c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment.

d) Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.

e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to a physician's practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care.

f) Transparent: Guidelines, procedures, or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations, and standards against which performance will be judged and the possible outcomes of the screening or assessment.

g) Supportive: Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive.

h) Cost conscious: Procedures and screening mechanisms that are distinctly different from "for cause" assessments should not result in undue cost or burden to late career physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed late career physicians. Similar procedures and screening mechanisms should be available to late career physicians who are not employed by hospitals and health care systems. (Directive to Take Action)

2. That our AMA encourage the Council of Medical Specialty Societies and other interested organizations to develop educational materials on the effects of age on physician practice. (Directive to Take Action)

3. That Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Your Reference Committee received supportive testimony, with amendments offered to remove or replace language as well as to specify alignment with current policy. Testimony

questioned the definition of "late career"; your Reference Committee agrees with this concern and offers substitute language to the title and Recommendations which applies to the professional continuum. Your Reference Committee concurs with language offered in testimony, which replaces "Cost-conscious" with "Nonburdensome" in Recommendation 1 (h), and supports testimony to acknowledge alignment of 1 (b) with AMA Ethical Opinion 9.3.2. Your Reference Committee also notes the importance of developing education materials as stated in Recommendation 2 and offers clarifying language. Testimony was offered to add a clause to Recommendation 1 regarding "due process" as being foundational to fairness, which your Reference Committee supports. Therefore, your Reference Committee recommends that Council on Medical Education Report 1 be adopted as amended.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 2 – STUDY TO EVALUATE BARRIERS TO MEDICAL EDUCATION FOR TRAINEES WITH DISABILITIES

**RECOMMENDATION A:**

**Recommendation 2 in Council on Medical Education Report 2 be amended by addition and deletion, to read as follows:**

**2. That our AMA urge all medical schools and GME institutions to a) make available to students and trainees a designated, qualified person or committee ~~knowledgeable~~ trained in the application of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and available support services, ~~and~~ b) encourage students and trainees to avail themselves of any needed support services, and c) foster a supportive and inclusive environment where students and trainees with disabilities feel comfortable accessing support services. (Directive to Take Action)**

**RECOMMENDATION B:**

**Recommendation 3 in Council on Medical Education Report 2 be amended by addition and deletion, to read as follows:**

**3. That our AMA encourage the National Board of Medical Examiners, ~~and~~ National Board of Osteopathic Medical Examiners, and member boards of the American Board of Medical Specialties to evaluate and enhance their processes for reviewing requests for accommodations from applicants with disabilities in order to reduce delays in completion of licensing ~~the USMLE and COMLEX~~ and initial board certification**

**examinations.~~,~~ This should include~~ing~~ an assessment of the experience of those applicants and the development of a transparent communication process that keeps applicants informed about the expected timeline to address their requests. These processes should require neither proof of accommodation nor proof of poor academic performance prior to the time at which a need for accommodation was requested. (Directive to Take Action)**

**RECOMMENDATION C:**

**Council on Medical Education Report 2 be amended by the addition of a sixth Recommendation, to read as follows:**

**6. That AMA Policy D-90.991, "Advocacy for Physicians with Disabilities," be reaffirmed (Reaffirm HOD Policy)**

**RECOMMENDATION D:**

**Recommendations in Council on Medical Report 2 be adopted as amended and the remainder of the report be filed.**

**HOD ACTION: Recommendations in Council on Medical Report 2 adopted as amended and the remainder of the report filed.**

**Recommendation 3 in Council on Medical Education Report 2 amended by addition and deletion, to read as follows:**

**3. That our AMA encourage the National Board of Medical Examiners, ~~and~~ National Board of Osteopathic Medical Examiners, and member boards of the American Board of Medical Specialties and the American Osteopathic Association to evaluate and enhance their processes for reviewing requests for accommodations from applicants with disabilities in order to reduce delays in completion of licensing ~~the USMLE and COMLEX~~ and initial board certification examinations.~~,~~ This should include~~ing~~ an assessment of the experience of those applicants and the development of a transparent communication process that keeps applicants informed about the expected timeline to address their requests. These processes should require neither proof of accommodation nor proof of poor academic performance prior to the time at which a need for accommodation was requested. (Directive to Take Action)**

1. That our American Medical Association (AMA) urge that all medical schools and graduate medical education (GME) institutions and programs create, review, and revise technical standards, concentrating on replacing "organic" standards with "functional" standards that emphasize abilities rather than limitations, and that those institutions also disseminate these standards and information on how to request accommodations for disabilities in a prominent and easily found location on their websites. (Directive to Take Action)

2. That our AMA urge all medical schools and GME institutions to a) make available to students and trainees a designated, qualified person or committee knowledgeable of the Americans with Disabilities Act and available support services and b) encourage students and trainees to avail themselves of support services. (Directive to Take Action)

3. That our AMA encourage the National Board of Medical Examiners and National Board of Osteopathic Medical Examiners to evaluate and enhance their processes for reviewing requests for accommodations from applicants with disabilities in order to reduce delays in completion of the USMLE and COMLEX, including an assessment of the experience of those applicants and the development of a transparent communication process that keeps applicants informed about the expected timeline to address their requests. (Directive to Take Action)

4. That our AMA encourage research and broad dissemination of results in the area of disabilities accommodation in the medical environment that includes: the efficacy of established accommodations; innovative accommodation models that either reduce barriers or provide educational approaches to facilitate the avoidance of barriers; impact of disabled learners and physicians on the delivery of health care to patients with disabilities; and research on the safety of established and potential accommodations for use in clinical programs and practice. (Directive to Take Action)

5. That our AMA rescind Policy D-295.929, "A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities," as having been fulfilled by this report. (Rescind HOD Policy)

Your Reference Committee received largely supportive testimony for this report. Testimony in the online forum offered amendments for consideration, namely inclusion of language regarding fostering a supportive and inclusive environment for medical students, trainees, and faculty with disabilities and Section 504 of the Rehabilitation Act of 1973. Testimony also supported considerations for an equitable evaluation process for requesting accommodations for completion of USMLE, COMLEX-USA, and initial board certification based on the recognition that one may become disabled and needing of accommodations. Your Reference Committee believes that some of the amendments, while valid, are not germane to the body of the report and can be addressed via reaffirmation of existing AMA policy D-90.991, "Advocacy for Physicians with Disabilities." Therefore, your Reference Committee recommends that Council on Medical Education Report 2 be adopted as amended.

Policy D-90.991, "Advocacy for Physicians with Disabilities"

1. Our AMA will study and report back on eliminating stigmatization and enhancing inclusion of physicians with disabilities including but not limited to: (a) enhancing representation of physicians with disabilities within the AMA, and (b) examining support groups, education, legal resources and any other means to increase the inclusion of physicians with disabilities in the AMA.

2. Our AMA will identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable physicians with disabilities to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration.

3. Our AMA supports physicians and physicians-in-training education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities.

(3) COUNCIL ON MEDICAL EDUCATION REPORT 3 – RURAL HEALTH PHYSICIAN WORKFORCE DISPARITIES

**RECOMMENDATION A:**

**Recommendation 3 in Council on Medical Education Report 3 be amended by addition and deletion, to read as follows:**

**3. That our AMA amend Policy H-200.954, "US Physician Shortage," by addition and deletion to read as follows: "(13) will ~~monitor~~ work to augment the**

**impact of initiatives to address rural physician workforce shortages." (Modify Current HOD Policy)**

**RECOMMENDATION B:**

**Council on Medical Education Report 3 be amended by the addition of a fifth Recommendation, to read as follows:**

**5. That our AMA amend Policy H-465.981, "Enhancing Rural Physician Practices," by addition to read: "(5) Our AMA will undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities." (Modify Current HOD Policy)**

**RECOMMENDATION C:**

**Recommendations in Council on Medical Education Report 3 be adopted as amended and the remainder of the report be filed.**

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

1. That our AMA amend Policy H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage," by addition and deletion to read as follows: ~~Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.~~ (4) Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas. (5) Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs. (Modify Current HOD Policy)

2. That our AMA monitor the status and outcomes of the 2020 Census to assess the impact of physician supply and patient demand in rural communities. (Directive to Take Action)

3. That our AMA amend Policy H-200.954, "US Physician Shortage," by addition to read as follows: "(13) will monitor the impact of initiatives to address rural physician workforce shortages." (Modify Current HOD Policy)

4. That our AMA reaffirm Policy H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage," which states, in part "(1.a) Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical

preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents. (1.b) Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians." (Reaffirm HOD Policy).

Your Reference Committee received predominately supportive testimony on this report. Testimony in the online forum expressed concern that the report did not address the intent of the original resolution and noted opposition to striking language calling for study of federal payment policy issues. Your Reference Committee is sensitive to this point. The Council on Medical Education (CME) testified during the hearing to acknowledge that the study focused on educational strategies to address the rural health physician shortage, which falls under the purview of this Council. The Council appreciates the concerns from the online testimony and recognizes that federal payment issues are beyond its purview. Testimony articulated an interest in examining the declining physician availability and access in rural communities with particular attention to the lack of specialists in rural areas. Proposed amendments to the report included language to advocate for equitable incentives for physicians who work in rural areas. Your Reference Committee believes the issues raised in testimony merit further study. Therefore, your Reference Committee recommends that CME Report 3 be adopted as amended.

Policy 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.

Policy H-465.981, “Enhancing Rural Physician Practices”

The AMA: (1) supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the area's Health Professional Shortage Area (HPSA) status; (2) encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements; (3) will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result; and (4) supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.

(4) COUNCIL ON MEDICAL EDUCATION REPORT 4 –
MEDICAL STUDENT DEBT AND CAREER CHOICE

**RECOMMENDATION A:**

**Recommendation 3 in Council on Medical Education Report 4 be <u>amended by addition and deletion</u>, to read as follows:**

**3. That our AMA amend Policy H-305.925 (20), “Principles of and Actions to Address Medical**

**Education Costs and Student Debt," by addition and deletion, to read as follows:**

**Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician ~~benefits~~ participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status ~~of the employer~~; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; ~~and~~ (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental**

**extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s). (Modify Current HOD Policy)**

**RECOMMENDATION B:**

**Recommendations in Council on Medical Education Report 4 be adopted as amended and the remainder of the report be filed.**

**HOD ACTION: Recommendations in Council on Medical Education Report 4 adopted as amended and the remainder of the report filed.**

1. That our American Medical Association (AMA) encourage key stakeholders to collect and disseminate data on the impacts of medical education debt on career choice, especially with regard to the potentially intersecting impacts of race/ethnicity, socioeconomic status, and other key sociodemographic factors. (New HOD Policy)

2. That our AMA monitor new policies and novel approaches to influence career choice based on the key factors that affect the decision to enter a given specialty and subspecialty. (New HOD Policy)

3. That our AMA amend Policy H-305.925 (20), "Principles of and Actions to Address Medical Education Costs and Student Debt," by addition and deletion, to read as follows:

"Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician ~~benefits~~ participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status ~~of the employer~~; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors

to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; and (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unacceptably high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program." (Modify Current HOD Policy)

4. That our AMA rescind Policy H-305.925 (22), "Principles of and Actions to Address Medical Education Costs and Student Debt," as having been fulfilled through this report:

"~~Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice~~." (Rescind HOD Policy)

Your Reference Committee heard testimony in support of this report and the work of the task force, which comprised broad representation among AMA sections. An amendment by addition of two new clauses was proffered by the Medical Student Section, which reflects a resolution that the MSS had drafted for this meeting, to expand our AMA's policy in this regard and encourage advocacy efforts in collaboration with the U.S. Department of Education, where appropriate, to reduce the complexity and bureaucratic burden of the Public Service Loan Forgiveness Program. This resolution called for changes to the same policy amended in Recommendation 3 of the Council report. In the interest of expediency and efficiency in HOD business, the Council on Medical Education agrees to this amendment as germane to its report and its recommendations, and therefore calls for adoption as amended. Your Reference Committee recommends that CME Report 4 be adopted as amended.

(5) COUNCIL ON MEDICAL EDUCATION REPORT 5 – INVESTIGATION OF EXISTING APPLICATION BARRIERS FOR OSTEOPATHIC MEDICAL STUDENTS APPLYING FOR AWAY ROTATIONS

**RECOMMENDATION A:**

**Recommendation 1 in Council on Medical Education Report 5 be amended by addition and deletion, to read as follows:**

**1. That our American Medical Association (AMA) amend Policy H-295.876 (2), "Equal Fees for Osteopathic and Allopathic Medical Students," by**

**addition and deletion as shown below. (Modify Current HOD Policy)**

**Our AMA encourages equitable access to and equitable fees for clinical electives for allopathic and osteopathic medical students ~~in access to clinical electives, while respecting the rights of individual allopathic and osteopathic medical schools to set their own policies related to visiting students~~.**

**RECOMMENDATION B:**

**Recommendations in Council on Medical Education Report 5 be adopted as amended and the remainder of the report be filed.**

**HOD ACTION: Recommendations in Council on Medical Education Report 5 adopted as amended and the remainder of the report filed.**

1. That our American Medical Association (AMA) amend Policy H-295.876 (2), "Equal Fees for Osteopathic and Allopathic Medical Students," by addition and deletion as shown below. (Modify Current HOD Policy)

> Our AMA encourages equitable access to and equitable fees for clinical electives for allopathic and osteopathic medical students ~~in access to clinical electives~~, while respecting the rights of individual allopathic and osteopathic medical schools to set their own policies related to visiting students.

2. That our AMA encourage the Association of American Medical Colleges to request that its member institutions promote equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students. (New HOD Policy)

3. That our AMA encourage the Accreditation Council for Graduate Medical Education to require its accredited programs to work with their respective affiliated institutions to ensure equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students. (New HOD Policy)

Your Reference Committee heard testimony in support of the recommendations in this report. Testimony suggested amendments to Recommendation 1 to clarify language and highlight our AMA's commitment to equity for MD and DO students. Testimony also suggesting adding language to Recommendation 2 asking that our AMA request stakeholders to "mandate" equitable access to clinical electives. Your Reference Committee had concerns given that our AMA does not usually encourage such a charge and believes that the amendments offered by the Medical Student Section satisfy the intent of Recommendation 1 while ensuring equity for MD and DO students. Therefore,

your Reference Committee recommends that Council on Medical Education Report 5 be adopted as amended.

Policy H-295.876 (2), "Equal Fees for Osteopathic and Allopathic Medical Students"

1. Our AMA, in collaboration with the American Osteopathic Association, discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training.

2. Our AMA encourages equitable fees for allopathic and osteopathic medical students in access to clinical electives, while respecting the rights of individual allopathic and osteopathic medical schools to set their own policies related to visiting students.

3. Our AMA will work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations, and generate a report with the findings by the 2020 Interim Meeting.

(6) RESOLUTION 301 – EQUITABLE REPORTING OF USMLE STEP 1 SCORES

**RECOMMENDATION A:**

**Resolution 301 be <u>amended by addition</u>, to read as follows:**

**RESOLVED, That our American Medical Association work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination <u>of the United States</u> Level 1 scores and students who received Pass/Fail scores. (Directive to Take Action)**

**RECOMMENDATION B:**

**Resolution 301 be <u>adopted as amended</u>.**

**RECOMMENDATION C:**

**The <u>title</u> of Resolution 301 be <u>changed</u>, to read as follows:**

**EQUITABLE REPORTING OF USMLE STEP 1 AND COMLEX-USA LEVEL 1 SCORES**

**HOD ACTION: Resolution 301 adopted as amended with a change in title to read:**

**EQUITABLE REPORTING OF USMLE STEP 1 AND COMLEX-USA LEVEL 1 SCORES**

RESOLVED, That our American Medical Association work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination Level 1 scores and students who received Pass/Fail scores. (Directive to Take Action)

Your Reference Committee heard testimony in support of this item. During the transition from numeric to pass/fail scoring, it is critical to both residency applicants and residency program personnel that no unintended consequences arise that would cause bias against individuals from either the scored or the pass/fail pool. Testimony noted that this transition will take years to fully occur, with potential concerns for dual-degree applicants (e.g., MD/PhD). That said, the move to pass/fail provides a welcome opportunity for further development of holistic review, which will help to ensure a more diverse and committed cadre of resident physicians. There was some sentiment expressed in online testimony for a deadline for release of any numeric scores after a specific date, but this proposal is overly specific and could present more issues than it solves. Testimony suggested an amendment to the title to include COMLEX-USA Level 1 scores, and to specify that these examinations pertain to the United States. Your Reference Committee accepts these amendments as friendly and therefore recommends that Resolution 301 be adopted as amended.

## RECOMMENDED FOR ADOPTION IN LIEU OF

(7) RESOLUTION 305 – INCREASE AWARENESS AMONG RESIDENCY, FELLOWSHIP, AND ACADEMIC PROGRAMS ON THE UNITED STATES-PUERTO RICO RELATIONSHIP STATUS

**RECOMMENDATION:**

**Alternate Resolution 305 be adopted in lieu of Resolution 305, to read as follows:**

**RESOLVED, That our American Medical Association work with the Liaison Committee on Medical Education (LCME), Middle States Commission on Higher Education (MSCHE), and Association of American Medical Colleges (AAMC) to inform residency and fellowship program directors and training programs in the United States that graduates of medical schools in Puerto Rico that are accredited by the LCME and MSCHE are U.S. medical school graduates (Directive to Take Action); and be it further**

**RESOLVED, That our AMA support policies that ensure equity and parity in the undergraduate and graduate educational and professional opportunities available to medical students and graduates from all LCME- and Commission on Osteopathic College Accreditation (COCA)-accredited medical schools. (New HOD Policy)**

**HOD ACTION: Alternate Resolution 305 adopted in lieu of Resolution 305**

RESOLVED, That our American Medical Association issue an official public statement regarding the academic status of Puerto Rican medical students and schools to inform residency, fellowship, and academic programs in the continental United States that all medical schools from Puerto Rico are Liaison Committee on Medical Education (LCME), Association of American Medical Colleges (AAMC), and Middle States Commission on Higher Education (MSCHE) accredited, and their medical students are not considered international medical graduates (Directive to Take Action); and be it further

RESOLVED, That our AMA support policies that ensure equity and parity in the undergraduate and graduate educational and professional opportunities available to medical students and graduates from Puerto Rican medical schools. (New HOD Policy)

Your Reference Committee heard supportive testimony for this resolution, recognizing the frustration experienced by students from LCME-accredited medical schools located in Puerto Rico. The Council on Medical Education (CME) provided online testimony to

improve the accuracy of the resolution, which was accepted by the author as a friendly amendment. Your Reference Committee appreciates the clarifying language provided by the CME and offers an additional amendment to the end of the first resolve to further clarify its intent. Therefore, your Reference Committee recommends that alternate Resolution 305 be adopted in lieu of Resolution 305.

(8) RESOLUTION 309 – PROTECTING MEDICAL STUDENT ACCESS TO ABORTION EDUCATION AND TRAINING

**RECOMMENDATION:**

**Alternate Resolution 309 be adopted in lieu of Resolution 309, to read as follows:**

**RESOLVED, That our American Medical Association amend policy H-295.923, "Medical Training and Termination of Pregnancy," by addition and deletion to read as follows:**

**H-295.923 – MEDICAL TRAINING AND TERMINATION OF PREGNANCY**

**1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.**

**2. Our AMA supports the availability of abortion education and exposure to procedures for termination of pregnancy, including medication abortions, for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.**

**3. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations. (Modify Current HOD Policy)**

**HOD ACTION: Alternate Resolution 309 adopted in lieu of Resolution 309.**

RESOLVED, That our American Medical Association amend policy H-295.923, "Medical Training and Termination of Pregnancy," by addition and deletion to read as follows:

H-295.923 – MEDICAL TRAINING AND TERMINATION OF PREGNANCY

1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.

2.~~,~~ ~~a~~ Although observation of, attendance at, or any direct or indirect participation in ~~an~~ abortion procedures should not be required~~.~~, our AMA does support opt-out curriculum on abortion education. Further, the AMA supports the opportunity for medical students and residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training.

~~2~~3. Our AMA encourages the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations. (Modify Current HOD Policy)

Your Reference Committee received unanimous and passionate testimony in support of the intent of this resolution, addressing great concern for recent legislative changes that violate the privacy of the patient-physician relationship and prevent resident physicians and medical students in certain states from access to education on this medical procedure. The AMA has been outspoken on this issue in recent months. It was noted that the AMA has a history of not supporting curricular mandates. Further, it was pointed out that the resolution assumes that an institution has a such a curriculum from which one can "opt-out." Your Reference Committee is cognizant that this issue goes beyond the actual procedure to include the initial counseling for and potential ramifications of such a procedure, whether physical and/or mental.

The resolution seeks to divide clause 1 of AMA Policy H-295.923 into two clauses and offers amendments to new clause 2. Testimony was largely focused on this new second clause and its support for "opt-out curriculum," with both sides of the issue having testified for or against the "opt-out." To address the concerns raised and to ensure that medical students are included in policy but without calling for institution-level obligations to offer opt-out curricula, your Reference Committee offers substitute language for a new clause 2 and supports renumbered clauses 1 and 3. Your Reference Committee is sensitive to and appreciative of the concerns and sentiments raised in this resolution and by those who testified. Therefore, your Reference Committee recommends that alternate Resolution 309 be adopted in lieu of Resolution 309.

Mister/Madam Speaker, this concludes the report of Reference Committee C. I would like to thank Daniel Dent, MD; Betty Drees, MD; Alysa Edwards; Douglas Martin, MD; Debra Perina, MD; Kenath Shamir, MD; and all those who testified before the committee, as well as our AMA staff, including Amber Ryan, Tanya Lopez, Fred Lenhoff, and John Andrews, MD.

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