

Reference Committee C

Report(s) of the Board of Trustees

- 31 The Morrill Act and Its Impact on the Diversity of the Physician Workforce

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REPORT 31 OF THE BOARD OF TRUSTEES (A-24)
The Morrill Act and Its Impact on the Diversity of the Physician Workforce
Reference Committee C

EXECUTIVE SUMMARY

This report was written in response to Resolution 308 brought forth by the Medical Student Section at the 2022 Annual Meeting of the House of Delegates. This resolution was referred for decision due to concern about legal implications of the first resolve related to both federal and state laws regarding affirmative action, land grant status, and federal trust responsibilities. To inform this action, a management report was subsequently submitted to the Board of Trustees (BOT) entitled “University Land Grant Status in Medical School Admissions.” The management report summarized concerns about implementing original Resolution 308-A-22 due to unknown legal implications and potentially unintended and negative consequences for communities that have been historically excluded from medicine. Also, it emphasized the importance of improving the health status of American Indian and Alaska Native (AI/AN) communities and increasing the number of AI/AN physicians who are uniquely qualified to provide care to these communities as well as the need to better understand the Morrill Act and its impact on efforts to diversify the physician workforce. Thus, the management report recommended that in lieu of Resolution 308-A-22, the AMA “study the historical and economic significance of the Morrill Act as it relates to its impact on diversity of the physician workforce.”

This report summarizes the extensive history of land acquisition, public education, federal recognition of tribes, the Morrill Act, economic impacts, and current physician workforce. It also reviews the role of the American Medical Association in that history as well as more recent improvement efforts. The report addresses concerns cited by the original author and notes the substantial role that medical education and organized medicine has played and can continue to play for the betterment of the physician workforce and AI/AN students and populations. Diversification of the physician workforce is imperative to meeting the health care needs in underserved communities across the U.S., particularly AI/AN populations. Medical education and organized medicine have much to learn from tribal nations, schools, and agencies to provide more culturally responsive information, understanding, and support. The report offers recommendations to strengthen its existing policies and provide leadership in more actionable efforts.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 31-A-24

Subject: The Morrill Act and Its Impact on the Diversity of the Physician Workforce

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee C

1 INTRODUCTION

2
3 At the 2022 Annual Meeting of the House of Delegates, the Medical Student Section authored
4 Resolution 308 that asked the American Medical Association (AMA) to:

5 (1) work with the Association of American Medical Colleges, Liaison Committee on Medical
6 Education, Association of American Indian Physicians, and Association of Native American
7 Medical Students to design and promulgate medical school admissions recommendations in
8 line with the federal trust responsibility; and (2) amend Policy H-350.981, “AMA Support of
9 American Indian Health Career Opportunities,” by addition to read as follows: (2) Our AMA
10 support the inclusion of American Indians in established medical training programs in numbers
11 adequate to meet their needs. Such training programs for American Indians should be operated
12 for a sufficient period of time to ensure a continuous supply of physicians and other health
13 professionals. These efforts should include, but are not limited to, priority consideration of
14 applicants who self-identify as American Indian or Alaska Native and can provide some form
15 of affiliation with an American Indian or Alaska Native tribe in the United States, and robust
16 mentorship programs that support the successful advancement of these trainees. (3) Our AMA
17 utilize its resources to create a better awareness among physicians and other health providers of
18 the special problems and needs of American Indians and that particular emphasis be placed on
19 the need for stronger clinical exposure and a greater number of health professionals to work
20 among the American Indian population. (5) Our AMA acknowledges long-standing federal
21 precedent that membership or lineal descent from an enrolled member in a federally recognized
22 tribe is distinct from racial identification as American Indian or Alaska Native and should be
23 considered in medical school admissions even when restrictions on race-conscious admissions
24 policies are in effect. (6) Our AMA will engage with the Association of Native American
25 Medical Students and Association of American Indian Physicians to design and disseminate
26 American Indian and Alaska Native medical education curricula that prepares trainees to serve
27 AI/AN communities.

28
29 This resolution was referred for decision, due to concern about legal implications of the first
30 resolve related to both federal and state laws regarding affirmative action, land grant status, and
31 federal trust responsibilities. To inform this action, a management report was subsequently
32 submitted to the Board of Trustees (BOT) entitled “University Land Grant Status in Medical
33 School Admissions.” That report noted the central issue is improving the health status of AI/AN
34 communities and the need to increase the number of AI/AN physicians who are uniquely qualified
35 to provide culturally humble care to these communities. Further, it noted there may be risks
36 associated with implementing original Resolution 308-A-22 due to unknown legal implications and
37 potentially unintended and negative consequences for communities that have been historically

1 excluded from medicine. The management report identified a need to further understand all
2 components of the Morrill Act that may impact efforts to diversify the physician workforce prior to
3 developing any new policy recommendations. It recommended that in lieu of Resolution 308-A-22,
4 the AMA:

- 5
6 1. Work with the Association of American Medical Colleges, American Association of
7 Colleges of Osteopathic Medicine, Association of American Indian Physicians, and
8 Association of Native American Medical Students to increase representation of American
9 Indian physicians in medicine by promoting effective practices in recruitment,
10 matriculation, retention and graduation of American Indian medical students. (Directive to
11 Take Action)
- 12 2. Amend Policy H-350.981, “AMA Support of American Indian Health Career
13 Opportunities,” by addition and deletion to read as follows:
14 (2) Our AMA support the inclusion of American Indians in established medical training
15 programs in numbers adequate to meet their needs. Such training programs for American
16 Indians should be operated for a sufficient period of time to ensure a continuous supply of
17 physicians and other health professionals, prioritize consideration of applicants who self-
18 identify as American Indian or Alaska Native and can provide some form of affiliation
19 with an American Indian or Alaska Native tribe in the United States, and support the
20 successful advancement of these trainees. (3) Our AMA utilize its resources to create a
21 better awareness among physicians and other health providers of the special problems and
22 needs of American Indians and that particular emphasis be placed on the need for stronger
23 clinical exposure and a greater number of health professionals to work among the
24 American Indian population. (5) Our AMA acknowledges long-standing federal precedent
25 that membership or lineal descent from an enrolled member in a federally recognized tribe
26 is distinct from racial identification as American Indian or Alaska Native and should be
27 considered in medical school admissions even when restrictions on race-conscious
28 admissions policies are in effect. (Modify Current HOD Policy)
- 29 3. **Study the historical and economic significance of the Morrill Act as it relates to its**
30 **impact on diversity of the physician workforce. (Directive to Take Action)**

31
32 This BOT report is in response to Recommendation #3 above.

33 34 BACKGROUND

35
36 To better understand the Morrill Act and its impact, it is important to review the history of land
37 acquisition and public education as well as the federal recognition of tribes.

38 39 *Public education and land acquisition*

40
41 Support for public education was realized early in the formation of the republic. According to the
42 [Northwest Ordinance](#) of 1787, “Knowledge, being necessary to good government and the
43 happiness of mankind, schools and the means of education shall forever be encouraged.”¹ Those
44 who did receive instruction were primarily white children. Financing for early schools varied and
45 often charged tuition. Thus, many children were not included, depending on income, race,
46 ethnicity, gender, geographic location, and other reasons. Some rural areas had no schools. The
47 nation’s leaders at the time “believed strongly that preserving democracy would require an
48 educated population that could understand political and social issues and would participate in civic
49 life, vote wisely (only white men could vote), protect their rights and freedoms, and resist tyrants

1 and demagogues.”² Free public education began to expand in the 1830s, with states taking on the
2 provision of public education. Land acquisition, however, was key to implementing such education
3 widely. The largest occupier and ‘owner’ of such land at the time were American Indians — the
4 native and original caregivers of what is now the United States.

5
6 By 1887, American Indian tribes owned 138 million acres. However, the passage of the [General](#)
7 [Allotment Act](#) of 1887 (The Dawes Act) greatly impacted such ownership as their land became
8 subject to state and local taxation, of which many could not afford. By 1934, the total had dropped
9 to 48 million acres.³ [The Indian Reorganization Act](#) of 1934 (IRA) tamed this era of allotment and
10 marked a shift toward the promotion of tribal self-government. Subsequent Congressional acts
11 impacting tribes and their land — ownership, use, and development — include the following:

- 12 • [Indian Mineral Leasing Act](#): 1938
- 13 • [Indian Self-Determination and Education Assistance Act](#): 1975
- 14 • [Indian Mineral Development Act](#): 1982
- 15 • [Indian Tribal Energy Development and Self-Determination Act](#): 2005
- 16 • [Indian Tribal Energy Development and Self-Determination Act Amendments](#): 2017

17
18 There are approximately 2.4 billion acres in today’s United States.⁴ About 56 million acres of that
19 land (2.3%) is currently held in trust by the U.S. for various American Indian tribes and
20 individuals, making up the majority of American Indian land.² With trust land, the federal
21 government holds legal title but the beneficial interest remains with the individual or tribe. Trust
22 lands held on behalf of individuals are known as allotments. Fee land, on the other hand, is
23 purchased by tribes whereby the tribe acquires legal title under specific statutory authority.

24 *The Morrill Act and land-grant universities*

25
26
27 In 1862, Congress passed the [Morrill Act](#) named after Senator Justin Morrill of Vermont. “This act
28 made it possible for states to establish public colleges funded by the development or sale of
29 associated federal land grants. The original intention was to fund colleges of agriculture and
30 mechanical arts.⁵ Over 10 million acres provided by these grants were expropriated from tribal
31 lands of Native communities. The new land-grant institutions, which emphasized agriculture and
32 mechanic arts, opened opportunities to thousands of farmers and working people previously
33 excluded from higher education.”⁶ Much of this land was taken from American Indian tribes for the
34 benefit of white people by way of treaties and agreements (many of which the federal government
35 did not uphold its end) as well as seizure. In other words, “The government took the land for which
36 it paid little or nothing, from tribes with little bargaining power, that were impoverished, and that
37 were sometimes subject to threats to withhold rations and other benefits if they did not comply.”⁷
38 These now ‘public lands’ were surveyed into townships, and sections were reserved for public
39 schools; however, the land itself was often sold off, with proceeds used to fund the school program.
40 “The system invited misuse by opportunists, and substantial portions of the educational land-grants
41 never benefited education.”⁶ Support for land-grants was a significant factor in providing education
42 to white American children.

43
44 By way of the Morrill Act, the government granted each state 30,000 acres of public land, issued to
45 its Congressional representatives and senators to be used in establishing a “land grant” university.
46 Some of the land sales financed existing institutions while others chartered new schools. This
47 allocation grew to over 100 million acres. The Morrill land grants put into place a national system
48 of state colleges and universities. Examples of major universities that were chartered as land-grant
49 schools are Cornell University, Washington State University, Clemson University, and University
50 of Nebraska-Lincoln.

1 Following the Civil War, a [Second Morrill Act](#) was passed in 1890 to address the exclusion of
2 Black individuals from these educational opportunities due to their race. “It required states to
3 establish separate land-grant institutions for Black students or demonstrate that admission was not
4 restricted by race. The act granted money instead of land.”⁶ The [1890 Foundation](#) provides
5 additional information about these 19 historically Black colleges and universities (HBCUs), which
6 include Tuskegee University, Tennessee State University, and Alabama A&M University. In 1994,
7 a third land-grant act was passed — the Equity in Educational Land-Grant Status Act — that
8 bestowed land-grant status to American Indian tribal colleges. As a result, these colleges are
9 referred to as the “1994 land-grants.”⁸ Today’s land grant university (LGU) system is comprised of
10 institutions resulting from the above-mentioned acts passed in 1862 (57 original), 1890 (19
11 HBCUs), and 1994 (35 Tribal). “LGUs are located in all 50 states as well as the District of
12 Columbia and six U.S. territories. Of note, the “1994 institutions receive fewer federal funds
13 administered by National Institute of Food and Agriculture — in total — than 1862 and 1890
14 institutions, and they are ineligible for certain grant types available to 1862 and 1890 institutions.
15 Whereas the 1862 and 1890 institutions receive federal capacity funds specific to agricultural
16 research and extension (which brings research to the public through nonformal education
17 activities), 1994 institutions do not. Although 1994 institutions have more limited enrollment and
18 offer fewer postsecondary degrees than 1862 and 1890 institutions, some argue that funding for
19 agricultural research and extension at the 1994 institutions is insufficient and should be increased.”⁹

20

21 *Education of American Indians*

22

23 The inaccurate perception of American Indians as unintelligent and uncivilized led Congress to
24 pass the Indian Civilization Act in 1819 which paid missionaries to educate Natives and promote
25 the government’s notion of civility. Most American Indian children at that time were forcefully
26 relocated and brought to these schools to begin the assimilation into the “Western way of life”
27 under the authority of that Act — thus beginning the troubled history of American Indian boarding
28 schools that is still felt by current generations. One such school built in 1879, the Carlisle Indian
29 Industrial School, coined the term “Kill the Indian to save the man” summarizing a belief system to
30 erase Native culture through assimilation.¹⁰ These children were forcibly separated from their
31 families and not allowed to practice their spirituality, speak their language, or live according to
32 their culture under threat of punishment. They were even given new names. These practices
33 continued through the 1960s. In 1969, a Senate report of the Committee on Labor and Public
34 Welfare, entitled “Indian Education: A National Tragedy--A National Challenge“,” summarized
35 the devastating effects of forced assimilation of Native children and the failures of the education
36 system where students also experienced physical abuse, sexual violence, hunger, forced
37 sterilizations, and exposure to diseases. The trauma associated with this contributes to a well-
38 documented historical trauma that has been correlated to the high number of suicides and health
39 inequities experienced by American Indians in the U.S.¹¹ This trauma has had a devastating impact
40 on the potential number of students who consider enrollment in higher education due to a distrust
41 of any system associated with the U.S. government. Many who have been directly affected by
42 historical traumas have to overcome barriers like depression or other chronic diseases to participate
43 in a system that still does not align to their way of knowing. There was little consideration for the
44 higher education of American Indians (nor how to include a non-colonial perspective) until 1972
45 with the formation of the [American Indian Higher Education Consortium](#) (AIHEC). Through its
46 network of tribal colleges and universities (TCUs), AIHEC “provides leadership and influences
47 public policy on American Indian higher education issues through advocacy, research, and program
48 initiatives; promotes and strengthens indigenous languages, cultures, communities, and tribal
49 nations; and through its unique position, serves member institutions and emerging TCUs.”¹²

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American Indian affairs and federal recognition of tribes

In 1775, Congress created a Committee on Indian Affairs under the leadership of Benjamin Franklin. The [U.S. Constitution](#) (Article I, Section 8, Clause 3) gave Congress the power “to regulate commerce with foreign nations, and among the several States, and with the Indian tribes.” The [Bureau of Indian Affairs](#) (BIA) — known over the years as the Indian Office, the Indian Bureau, the Indian Department, and the Indian Service — was established in 1824 to oversee and carry out the government’s trade and treaty relations with the tribes. The BIA received statutory authority from Congress in 1832; in 1849, it was transferred to the newly created U.S. Department of the Interior.¹³ “Over the years, the BIA has been involved in the implementation of federal laws that have directly affected all Americans. The General Allotment Act of 1887 opened tribal lands west of the Mississippi to non-Indian settlers, the [Indian Citizenship Act](#) of 1924 granted American Indians and Alaska Natives U.S. citizenship and limited rights to vote, and the New Deal and the Indian Reorganization Act of 1934 restored self-determination and dictated a model the United States expected tribal governments to use. The World War II period of relocation and the post-War termination era of the 1950s led to the activism of the 1960s and 1970s that saw the takeover of the BIA’s headquarters and resulted in the creation of the Indian Self-Determination and Education Assistance Act of 1975. This act as well as the [Tribal Self-Governance Act](#) of 1994 have fundamentally changed how the federal government and the tribes conduct business with each other.”¹³ Although the BIA was once responsible for providing health care services to American Indians and Alaska Natives, that role was legislatively transferred to the U.S. Department of Health, Education, and Welfare (now known as the Department of Health and Human Services) in 1954.¹³ It remains there under the auspices of the [Indian Health Service](#) (IHS). However, funding for this continues to be a problem. In 2019, IHS spending per capita was only \$4,078 while the national average spending per capita was \$9,726.¹⁴ At that time, it was also reported that American Indians and Alaska Natives (AI/AN) had a life expectancy 5.5 years less than the U.S. all races population (73.0 years compared to 78.5 years) and “die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases.”¹⁵ Groups such as the [Tribal Sovereign Leaders on the national Tribal Budget Formulation Workgroup](#) (TBFWG) have provided, and continue to provide, significant insights to inform IHS budget requests.

According to the BIA, “a federally recognized tribe is an AI/AN tribal entity that is recognized as having a government-to-government relationship with the United States, with the responsibilities, powers, limitations, and obligations attached to that designation, and is eligible for funding and services from the BIA. Furthermore, federally recognized tribes are recognized as possessing certain inherent rights of self-government (i.e., tribal sovereignty) and are entitled to receive certain federal benefits, services, and protections because of their special relationship with the United States.”¹⁶ Over the years, most of today’s federally recognized tribes received federal recognition status by way of treaties, acts of Congress, presidential executive orders or other federal administrative actions, or federal court decisions. In 1978, the Department of the Interior issued procedures for federal acknowledgment of Indian tribes to more uniformly handle requests — found in Part 83 of Chapter 25 of the [Code of Federal Regulations](#).¹⁷ In 1994, Congress enacted the [Federally Recognized Indian Tribe List Act](#). It formally established three ways to achieve federal recognition: (1) by act of Congress, (2) by the administrative procedures under 25 C.F.R. Part 83, or (3) by decision of a United States court. Congress has the authority to terminate a relationship with a tribe, and only Congress can restore its federal recognition. The act also requires the Secretary of the Interior to annually publish information on federally recognized tribal entities.¹⁸

1 As of January 2023, there were 574 federally recognized Tribal entities.¹⁹ There are also many
2 tribes that are not state or federally recognized. There are 324 federally recognized American
3 Indian reservations where 13 percent of the AI/AN population lives. The 2020 Census indicates
4 that 87 percent live outside of tribal statistical areas. It also shows that 9.1 million people identify
5 as AI/AN alone or in combination (2.9 percent of total U.S. population).²⁰

6 7 DISCUSSION

8 9 *Economic and educational impacts*

10
11 The Morrill Act, as well as the [Homestead Act](#) of 1862, had a significant impact on American
12 expansion. The Homestead Act encouraged western migration by providing settlers with 160 acres
13 of land. Such settlers were required to live on and cultivate the land. After five years, they were
14 entitled to the property upon payment of a small filing fee. While they certainly fostered prosperity
15 and educational opportunities for new American settlers, these came at the expense of the original
16 people — American Indians. The economic significance of these acts cannot be understated. In
17 2019, sixteen land-grant universities retained over half a million acres of Indigenous lands,
18 generating at least \$8.7 million.²¹ See Appendix A for a table of remaining Morrill Act lands and
19 revenue by university.

20
21 In addition to the economic impact, thousands of American Indian families were affected by the
22 Indian Civilization Act and boarding schools. Given the lingering effects to this day, it stands to
23 reason that many AI/AN students have a negative attitude toward the education system. According
24 to the Bureau of Indian Education (BIE), “Native youth have the lowest high school graduation rate
25 of students across all schools. Nationally, the AI/AN high school graduation rate is 69 percent, far
26 below the national average of 81 percent.”²² The BIE funds elementary and secondary schools on
27 64 reservations in 23 states, serving approximately 42,000 Indian students.²³ These BIE schools
28 hold an average graduation rate of 53 percent. The BIE also serves AI/AN post-secondary students
29 through higher education scholarships, supports funding for tribal colleges and universities, and
30 directly operates two post-secondary institutions — Haskell Indian Nations University in Kansas
31 and the Southwestern Indian Polytechnic Institute in New Mexico.

32 33 *Medical education and the physician workforce*

34
35 Significant school dropout rates and lower enrollment in higher education have negatively
36 impacted AI/AN representation in medical education and the physician workforce. According to
37 2023-2024 data from the Association of American Medical Colleges (AAMC), 1,0451 AI/AN
38 students were enrolled in MD-granting medical schools (about 1percent of the total student
39 population). Further, only 188 AI/AN students graduated from MD-granting medical schools.²⁴
40 This significant decline from enrollment to graduation is very concerning; medical education needs
41 to figure out why and what to do about it. The entire educational pathway (PreK-12 and
42 undergraduate) may need to be considered to help AI/AN students to prepare for their studies,
43 promote a sense of belonging, and avail themselves of mentorship opportunities. Tribes have a
44 vested interest in the training of AI/AN students, given they are more likely to return to and serve
45 their own communities as physicians. Such efforts will ultimately foster tribal self-governance and
46 self-determination.

47
48 Several universities have taken steps to increase AI/AN representation in medical schools. In 1973,
49 the University of North Dakota launched the Indians Into Medicine (INMED) program, which has
50 recruited, supported, and trained 250 AI/AN physicians. This program has served as a model for
51 other health professions within the university as well as for other medical schools that receive IHS

1 funding. Since many students face financial hardship, INMED offers a free summer program called
2 Med Prep that provides students with stipends, and it helps its medical school students identify
3 potential scholarship options. The university went one step further in 2020 to launch the country's
4 first PhD. program in Indigenous health.²⁵ Another example is Oregon Health & Science
5 University (OHSU) School of Medicine and its Wy'east Pathway, a 10-month postbaccalaureate
6 program for AI/AN students who unsuccessfully applied to medical school, have an MCAT score
7 below a certain cutoff, or lack clinical experience. The program provides biomedical and MCAT
8 classes as well as cultural support and skills-building to promote success in medical school.²⁶ Not
9 only do programs like these directly support AI/AN students, but they also promote collaboration
10 with and inclusion of non-indigenous allies. This combination can help to turn the tide on the
11 workforce issue.

12
13 The impact of low representation in medical schools is evident when examining the diversity of
14 physician workforce. In 2022, 0.3% of active physicians identified as AI/AN.²⁷ According to a
15 2018 [report](#) from the U.S. Government Accountability Office, the vacancy rate at IHS clinics
16 among staff physician positions was about 29% across the eight IHS geographic regions; the
17 highest vacancy was 46% in the areas servicing Bemidji, Minnesota, and Billings, Montana.²⁸ In
18 addition to representation in practicing medicine, there are also deficits in AI/AN representation in
19 academic positions. One study found that, compared with their white peers, AI/AN individuals had
20 48% lower odds of holding a full-time faculty position post residency.²⁹

21
22 As mentioned in other parts of this report, there is distrust in colonial constructs (U.S. laws,
23 policies, and institutions), but there may also be distrust in the colonial medicine through IHS
24 because of the history of forced sterilization and because traditional forms of medicine were
25 outlawed (as well as any religious/cultural beliefs associated with them). In fact, the Department of
26 the Interior's 1883 Code of Indian Offenses noted that "any medicine man convicted of
27 encouraging others to follow traditional practices was to be confined in the agency prison for not
28 less than 10 days or until he could provide evidence that he had abandoned his beliefs."³⁰ This
29 context has given rise to a distrust of medicine and medical education that continues today.

30
31 In June 2023, the Supreme Court of the U.S. (SCOTUS) issued a ruling on affirmative action that
32 eliminated race as a consideration in college and universities' admission processes. This ruling
33 should not change tribal colleges; however, will it likely impact AI/AN students who attend non-
34 tribal institutions because most wrongly collect tribal identity as a racial category. "Most, if not all,
35 mainstream colleges and universities rely entirely on self-reporting when it comes to determining
36 tribal identity of students. This means if a Native student doesn't indicate they are a tribal citizen,
37 then they are not counted as such."³¹ This lack of data can impact the understanding of student
38 enrollment as well as funding opportunities. It is critical to re-emphasize that "Native American" is
39 not only a racial category but also the designation which gives those who are enrolled in federally
40 recognized tribes a protected classification by treaty and is not subject to the SCOTUS decision on
41 race/ethnicity. Many schools may not include identifying Native Americans in their admissions
42 consideration as they may fear violation of the SCOTUS decision.

43 44 *The AMA's role: accountability and restitution*

45
46 The AMA and its members play a complicated role in the history of American Indians. AMA
47 members were party to the claiming of land in the "Western territories" in the mid-1850s, as
48 described in the A-1857 report "[Report on the Fauna and Medical Topography of Washington](#)
49 [Territory](#). AMA archives contain a 1865 report entitled "[On Some Causes Tending to Promote the](#)
50 [Extinction of the Aborigines of America](#)" which details study of the Onondoga tribe, concluding
51 "But those of us who pity and strive to arrest the downward course of this remnant of the original

1 lords of the forest, may delay what we are wholly unable to prevent, for I much fear that before the
2 poor Indian has learned the laws of his physical nature and how to obey them, economy of time and
3 means, industry, and reliance upon his own muscles and broad acres for his support, instead of
4 looking for the government to hire his teacher and physician, and for his wants to be met by others,
5 without forecast and plan of us own — before these radical changes in his habits are effected — the
6 waning remnant of the Onondagas will forever have passed away.”³²

7
8 Physicians were involved in American Indian boarding schools, the development of the Indian
9 Health Service, and the study of illnesses and healing practices on AI/AN tribes. Their works were
10 published in JAMA and included:

- 11 • [The Medicine and Surgery of the Winnebago and Dakota Indians \(1883\)](#)
- 12 • [Improved Sanitary and Social Conditions of the Seminoles of Florida \(1896\)](#)
- 13 • [Indian Method of Treating Measles \(1903\)](#)
- 14 • [The Indian Medical Service \(1913\)](#)

15
16 Past harms also include the AMA’s role in promulgating discriminatory practices resulting from
17 the [Flexner Report](#), a landmark 1910 criticism of U.S. medical education resulting in a reduction in
18 the number of medical schools including the closing of 5 out of the 7 historically black medical
19 schools. Past decisions such as these continue to negatively impact populations in need. The AMA
20 acknowledges that AI/AN populations experience significant health disparities up to the present
21 including lower access to care and underfunding of public programs such as the Indian Health
22 Service serving AI/AN communities. In addition, AI/AN persons continue to be severely
23 underrepresented in the physician and healthcare workforce.

24
25 The AMA launched various supportive efforts such as:

- 26 • Asked the federal government to step in to stop the spread of trachoma in Native
27 communities ([A-1924](#)) and provide better health services for the population ([A-1929](#));
 - 28 • Issued AMA Statement on Infant Mortality ([A-1968](#));
 - 29 • Advocated for the transfer of functions relating to health and hospitalization of American
30 Indians from the Bureau of Indian Affairs to the U.S. Public Health Service ([I-1953](#));
 - 31 • Appealed for more funding for hospitals and health services on reservations ([I-1957](#));
 - 32 • Collaborated with the IHS on efforts related to health care delivery and health aide training
33 programs ([I-1970](#));
 - 34 • Led large-scale study of health care for American Indians that was used to guide the
35 Senate’s “Indian Health Care Improvement Act” of 1976 ([I-1973](#));
 - 36 • Created Project USA to recruit physicians to medically underserved areas, including
37 AI/AN reservations ([I-1975](#));
 - 38 • Sought to exempt Indian Health Services from competitive procurement practices
39 regulations ([A-1984](#));
 - 40 • Initiated a project with the AAIP to improve health care for American Indians ([A-1995](#));
 - 41 • With the National Medical Association, established the Commission to End Health Care
42 Disparities in 2004 – a collaboration of health care organizations to address racial and
43 ethnic health care disparities and diversity in the physician workforce.
 - 44 • In 2013, the AMA launched its innovative “Accelerating Change in Medical Education”
45 initiative to rebuild medical education from the ground up. Now known as the
46 [ChangeMedEd](#) initiative, this effort has fostered collaborations with schools like Oregon
47 Health & Science University School of Medicine and the University of Washington School
48 of Medicine to increase the numbers of AI/AN students and faculty.
- 49

1 Although the Commission was retired in 2016, a new effort emerged in 2018 through the adoption
2 of policy calling for a strategic framework to address health equity on a national scale — resulting
3 in the creation of the [AMA Center for Health Equity](#). Among other things, the Center is leading a
4 task force that will “guide organizational transformation within and beyond the AMA toward
5 restorative justice to promote truth, reconciliation, and healing in medicine and medical education.
6 ...The task force will inform and advise the AMA on ways to establish restorative justice dialogues
7 between AMA leaders, physicians from historically marginalized racial and ethnic groups and their
8 physician associations, and other critical stakeholders.”³³

9
10 Recently, an AMA [article](#) from December 2023 addressed vacancies at the Indian Health Service.
11 Also, an [AMA Update](#) on January 8, 2024 discussed how tribal medical education programs could
12 solve the rural health care crisis. Featuring Oklahoma State University College of Osteopathic
13 Medicine’s unique partnership with The Cherokee Nation, the discussion addressed the importance
14 of physicians truly understanding the communities they serve.

15
16 AMA Advocacy has been actively participating in efforts to support AI/AN populations and related
17 physicians. Federal efforts in just the last two years include:

- 18 • May 2022: [Letter](#) sent to Senators Mastro and Murkowski in support of the Indian Health
19 Service Health Professions Tax Fairness Act (S.2874).
- 20 • April 2023: [Letter](#) sent to U.S. Department of Agriculture addressing Menu Planning
21 Options for American Indian and Alaska Native Students.
- 22 • October 2023: [Letter](#) sent to U.S. Department of Health and Human Services and Indian
23 Health Service to highlight the importance of high quality, timely care for American
24 Indians, Alaska Natives, and Native Hawaiians, particularly as it related to physician and
25 medical student members.
- 26 • February 2024: Multi-organizational [letter](#) sent to both the House Appropriations
27 Subcommittee on Interior and Senate Appropriations Subcommittee on Interior,
28 Environment, and Related Agencies, Environment, and Related Agencies. This letter
29 detailed support for the inclusion of \$30 million in new funding in the FY2025 Interior,
30 Environment, and Related Agencies appropriations bills to address chronic clinical staff
31 shortages across Indian Country through GME programming.

32
33 The AMA Foundation (AMAF) funds the [Physicians of Tomorrow Program](#). This program
34 distributes a \$10,000 tuition assistance scholarship to medical students approaching their final year
35 of school with the goal of creating a diverse cohort of students who are dedicated to serving
36 underserved communities. The AMAF is also bringing attention to AI/AN issues in medical
37 education, as seen in a 2022 [article](#) featuring AMA members.

38 The [AMA Ed Hub](#)TM offers a variety of equity-related educational opportunities — from its panel
39 discussion on [Truth and Reconciliation in Medicine](#) to its Prioritizing Equity series. Titles of
40 relevance include:

- 41 • [For Us, By Us: Advocating for Change in Native Health Policy](#)
- 42 • [Getting to Justice in Education](#)
- 43 • [The Root Cause and Considerations for Health Care Professionals](#)
- 44 • [How the Past Informs the Present in Healthcare](#)

45 46 RELEVANT AMA POLICIES

47
48 The AMA has several policies in support of AI/AN tribes and communities as well as students and
49 trainees in order to foster diversity of the physician workforce in an effort to improve public health
50 including AI/AN populations. For example:

- 1 • [AMA Support of American Indian Health Career Opportunities H-350.981](#) promotes
2 recruitment of AI/AN into health careers including medicine and the concept of AI/AN
3 self-determination.
- 4 • [Promising Practices Among Pathway Programs to Increase Diversity in Medicine D-
5 350.980](#) establishes a task force to guide organizational transformation within and beyond
6 the AMA toward restorative justice to promote truth, reconciliation, and healing in
7 medicine and medical education.
- 8 • [Underrepresented Student Access to US Medical Schools H-350.960](#) recognizes some
9 people have been historically underrepresented, excluded from, and marginalized in
10 medical education and medicine because of their race, ethnicity, disability status, sexual
11 orientation, gender identity, socioeconomic origin, and rurality, due to racism and other
12 systems of exclusion and discrimination.
- 13 • [Strategies for Enhancing Diversity in the Physician Workforce H-200.951](#) supports
14 increased diversity across all specialties in the physician workforce in the categories of
15 race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin,
16 and rurality.
- 17 • [Cultural Leave for American Indian Trainees H-350.957](#) recognizes the importance of
18 cultural identity in fostering trainee success and supports accommodating cultural
19 observances.

20
21 See Appendix B for the full policies. Additional policies can be accessed in the [AMA Policy](#)
22 [Finder](#) database, which include:

- 23 • [Strategies for Enhancing Diversity in the Physician Workforce D-200.985](#)
- 24 • [Continued Support for Diversity in Medical Education D-295.963](#)
- 25 • [AMA Support of American Indian Health Career Opportunities H-350.981](#)
- 26 • [Indian Health Service H-350.977](#)
- 27 • [Desired Qualifications for Indian Health Service Director H-440.816](#)
- 28 • [Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987](#)
- 29 • [Improving Health Care of American Indians H-350.976](#)
- 30 • [Plan for Continued Progress Toward Health Equity H-180.944](#)

31 32 SUMMARY AND RECOMMENDATIONS

33
34 This report illuminates these concerns as well as the substantial part that medical education and
35 organized medicine has played and can continue to play for the betterment of the physician
36 workforce and AI/AN students and populations. Organizations like the [Association of American](#)
37 [Indian Physicians](#) (AAIP) hold an esteemed role in such efforts. AAIP was established in 1971 by a
38 group of 14 AI/AN physicians to support AI/AN communities and serve as an educational,
39 scientific, and charitable nonprofit.

40
41 As stated in the AAMC's [2018 publication](#), *Reshaping the Journey: American Indians and Alaska*
42 *Natives in Medicine*, "Medical schools are chiefly responsible for the development of what the
43 physician workforce looks like today and what it will look like in the future.... We must view this
44 issue as a national crisis facing not just the American Indian-Alaskan Native (AI/AN)
45 communities, but all medical schools and teaching hospitals.... We need transformative thinking
46 and a new systems-based approach if we are to resolve this crisis with a plausible solution."³⁴
47 Diversification of the physician workforce is imperative to meeting the health care needs in
48 underserved communities across the U.S., particularly AI/AN populations. Also, medical education
49 has much to learn from tribal nations, schools, and organizations to provide more culturally
50 responsive information, understanding, and support.

1 The Board of Trustees that the following recommendations be adopted, and the remainder of this
2 report be filed. That our AMA:

- 3
4 1. Amend [AMA Support of American Indian Health Career Opportunities H-350.981](#) by
5 addition to read:
6 (4) Our AMA will continue to support the concept of American Indian self-
7 determination as imperative to the success of American Indian programs and recognize
8 that enduring acceptable solutions to American Indian health problems can only result
9 from program and project beneficiaries having initial and continued contributions in
10 planning and program operations to include training a workforce from and for these
11 tribal nations.
12 (6) Our AMA acknowledges the significance of the Morrill Act of 1862, the resulting
13 land-grant university system, and the federal trust responsibility related to tribal
14 nations.
15
16 2. Amend [AMA Support of American Indian Health Career Opportunities D-350.976](#) by
17 deletion of clause (2) as having been accomplished by this report.
18 ~~(2) study the historical and economic significance of the Morrill Act as it relates to~~
19 ~~its impact on diversity of the physician workforce.~~
20
21 3. Amend [AMA Support of American Indian Health Career Opportunities D-350.976](#) by
22 addition of a new clause to read:
23 Convene key parties, including but not limited to the Association of American Indian
24 Physicians (AAIP) and American Indian/Alaska Native (AI/AN) tribes/entities such as
25 Indian Health Service and National Indian Health Board, to discuss the representation
26 of AI/AN physicians in medicine and promotion of effective practices in recruitment,
27 matriculation, retention, and graduation of medical students.
28
29 4. Reaffirm the following policies:
30 a. [Indian Health Service H-350.977](#)
31 b. [Underrepresented Student Access to US Medical Schools H-350.960](#)
32 c. [Strategies for Enhancing Diversity in the Physician Workforce H-200.951](#)
33 d. [Continued Support for Diversity in Medical Education D-295.963](#)
34 e. [AMA Support of American Indian Health Career Opportunities D-350.976.](#)
35
36
37

38 Fiscal note: \$1,000

APPENDIX A: Remaining Morrill Act lands and revenue by university

University	Total Morrill acres found	Endowment raised as of 1914	Remaining acres with surface rights	Surface royalties raised, FY 2019	Remaining acres with mineral rights	Mineral royalties raised, FY 2019
Colorado State University	89,321	\$185,956	19,130	\$77,526	42,572	\$662,596
Kansas State University	87,290	\$491,746	0	N/A	6,080	\$163,345
Montana State University	140,385	\$533,149	63,474	\$623,941	77,929	\$6,670
New Mexico State University	248,964	\$241,909	194,571	\$1,217,672	254,200	\$353,587
North Dakota State University	130,471	\$455,924	15,117	\$308,142	66,109	\$2,874,800
South Dakota State University	159,832	\$128,804	36,617	\$608,583	160,000	\$27,365
University of Arizona	143,684	\$450,000	UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN
University of California	150,525	\$732,233	0	N/A	441.6	\$1,947
University of Idaho	87,445	\$129,615	33,527	\$358,258	70,000	\$1,188
University of Minnesota	94,631	\$579,430	0	N/A	240	\$0
University of Missouri	270,613	\$363,441	14,787	UNKNOWN	0	N/A
University of Nebraska	89,920	\$560,072	6,173	\$426,619	0	N/A
University of Wisconsin	235,690	\$303,594	0	N/A	6,400	\$0
University of Wyoming	89,849	\$73,355	71,066	UNKNOWN	UNKNOWN	UNKNOWN
Utah State University	198,837	\$194,136	27,577	\$83,769	51,724	\$943,843
Washington State University	90,081	\$247,608	71,147	\$4,250,000	86,657	\$1,936

[The land-grant universities still profiting off Indigenous homelands](#), High Country News, 2020.

APPENDIX B – RELEVANT AMA POLICIES

[AMA Support of American Indian Health Career Opportunities H-350.981](#)

AMA policy on American Indian health career opportunities is as follows:

(1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded. (2) Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees. (3) Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population. (4) Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations. (5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.

[Promising Practices Among Pathway Programs to Increase Diversity in Medicine D-350.980](#)

Our AMA will 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.

[Underrepresented Student Access to US Medical Schools H-350.960](#)

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; (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; (3) recognizes 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; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; (5) recognizes 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; (6) will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine; (7) will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school; (8) will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants; (9) will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine; and (10) will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, (1) (a) encouraging state and local governments to make quality elementary and secondary education available to all.

[Strategies for Enhancing Diversity in the Physician Workforce H-200.951](#)

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (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; (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 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 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.

[Cultural Leave for American Indian Trainees H-350.957](#)

Our AMA recognizes the importance of cultural identity in fostering trainee success and encourages residency programs, fellowship programs, and medical schools to accommodate cultural observances for trainees from American Indian, Alaska Native, and Native Hawaiian communities.

[Strategies for Enhancing Diversity in the Physician Workforce D-200.985](#)

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 their 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 and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities. 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 unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population. 13. 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.

[Continued Support for Diversity in Medical Education D-295.963](#)

Our AMA will: (1) publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (2) request that the Liaison Committee

on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) 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; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement; (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty; (8) recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts; and (9) collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure.

[AMA Support of American Indian Health Career Opportunities H-350.981](#)

AMA policy on American Indian health career opportunities is as follows:

(1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded. (2)) Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees. (3) Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population. (4) Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations. (5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.

[Indian Health Service H-350.977](#)

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population. (2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian

care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation. (3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps. (4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued. (5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population. (6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs. (7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.

[Desired Qualifications for Indian Health Service Director H-440.816](#)

Our AMA supports the following qualifications for the Director of the Indian Health Service:

1. Health profession, preferably an MD or DO, degree and at least five years of clinical experience at an Indian Health Service medical site or facility.
2. Demonstrated long-term interest, commitment, and activity within the field of Indian Health.
3. Lived on tribal lands or rural American Indian or Alaska Native community or has interacted closely with an urban Indian community.
4. Leadership position in American Indian/Alaska Native health care or a leadership position in an academic setting with activity in American Indian/Alaska Native health care.
5. Experience in the Indian Health Service or has worked extensively with Indian Health Service, Tribal, or Urban Indian health programs.
6. Knowledge and understanding of social and cultural issues affecting the health of American Indian and Alaska Native people.
7. Knowledge of health disparities among Native Americans / Alaska Natives, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities.
8. Experience working with Indian Tribes and Nations and an understanding of the Trust Responsibility of the Federal Government for American Indian and Alaska Natives as well as an understanding of the sovereignty of American Indian and Alaska Native Nations.
9. Experience with management, budget, and federal programs.

[Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987](#)

1. Our AMA will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers.
2. Our AMA will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service.
3. Our AMA adopts as new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction.
4. In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service.
5. Our AMA will request that Congress: (A) amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; (B) include our recommendation for the Indian Health Service (IHS) Advanced Appropriations in the Budget Resolution; and (C) include in the enacted appropriations bill IHS Advanced Appropriations.
6. Our AMA supports an increase to the Federal Medical Assistance Percentage (FMAP) to 100% for medical services which are received at or through an Urban Indian Organization that has a grant or contract with the Indian Health Service (IHS) and encourages state and federal governments to reinvest Medicaid savings from 100% FMAP into tribally driven health improvement programs.

[Improving Health Care of American Indians H-350.976](#)

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens. (2) The federal government provide sufficient funds to support needed health services for American Indians. (3) State and local governments give special attention to the health and health-related needs of non-reservation American Indians in an effort to improve their quality of life. (4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs. (5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians. (6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents. (7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems. (8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians. (9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside. (10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians. (11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

[Plan for Continued Progress Toward Health Equity H-180.944](#)

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.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-A-24

Subject: Council on Medical Education Sunset Review of 2014 House of Delegates’ Policies

Presented by: Cynthia Jumper, MD, MPH, Chair

Referred to: Reference Committee C

1 Policy [G-600.110](#), “Sunset Mechanism for AMA Policy,” calls for the decennial review of American
2 Medical Association (AMA) policies to ensure that our AMA’s policy database is current, coherent, and
3 relevant:
4

- 5 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will
6 typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action
7 of our AMA House that reaffirms or amends an existing policy position shall reset the sunset “clock,”
8 making the reaffirmed or amended policy viable for another 10 years.
9
- 10 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following
11 procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are
12 subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the
13 appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies
14 shall develop and submit a report to the House of Delegates identifying policies that are scheduled to
15 sunset; (d) For each policy under review, the reviewing council can recommend one of the following
16 actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the
17 policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy
18 in any fashion, the reviewing council shall provide a succinct, but cogent justification; (f) The
19 Speakers shall determine the best way for the House of Delegates to handle the sunset reports.
20
- 21 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its
22 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been
23 accomplished.
24
- 25 4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset:
26 (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been
27 accomplished; or (c) when the policy or directive is part of an established AMA practice that is
28 transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of
29 Delegates Reference Manual: Procedures, Policies and Practices.
30
- 31 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
32
- 33 6. Sunset policies will be retained in the AMA historical archives.
34

35 See Appendix for a table of 2014 policies and recommended actions.

36 RECOMMENDATION

37

- 1 The Council on Medical Education recommends that the House of Delegates policies listed in the
- 2 appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.
- 3 (Directive to Take Action)

Fiscal Note: \$1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendations
D-275.958	USMLE Step 1 Timing	<p>Our AMA will ask the appropriate stakeholders to track United States Medical Licensing Examination (USMLE) Step 1 Exam timing and subsequently publish aggregate data to determine the significance of advanced clinical experience on Step 1 Exam performance.</p> <p>(Res. 911, I-14)</p>	<p>Sunset - accomplished.</p> <p>After I-14, the Association of American Medical Colleges (AAMC), National Board of Medical Examiners (NBME), and Federation of State Medical Boards (FSMB) were notified of the HOD directive. It was also communicated via the <i>MedEd Update</i> newsletter to each medical school, residency program director, directors of medical education at U.S. teaching hospitals, and other interested groups.</p>
D-275.981	Potential Impact of the USMLE Step 2 CS and COMLEX-PE on Undergraduate and Graduate Medical Education	<p>Our AMA will: (1) continue to closely monitor the USMLE Step 2 CS and the COMLEX-USA Level 2-PE, collecting data on initial and final pass rates, delays in students starting residency training due to scheduling of examinations, economic impact on students, and the potential impact of ethnicity on passing rates; and (2) encourage residency program directors to proactively evaluate their access to resources needed to assist resident physicians who have not passed these examinations to remediate.</p> <p>(CME Rep. 4, A-04; Modified: CME Rep. 2, A-14)</p>	<p>Sunset – no longer relevant.</p> <p>USMLE Step 2 CS and the COMLEX-USA Level 2-PE were discontinued in 2021 and 2022 respectively.</p>
D.275.983	Physicians? Right to Reasonable Privacy Protection and the Federation Credentials Verification Service	<p>Our AMA will request the Federation Credentials Verification Service (FCVS) to (1) add to its "Affidavit and Release" and "Authorization for Release of Records" forms appropriate language that: (a) allows physicians to revoke a prior authorization to the FCVS at any time through an affirmative action on the part of the physician (e.g., written notice) and (b) informs physicians their authorization will remain in effect unless and until revoked by the physician in accordance with guidance provided by the FCVS; and (2) clarify its release does not extend to liability which arises from the gross negligence or willful misconduct of FCVS.</p> <p>(BOT Rep. 22, A-04; Reaffirmed: CMS Rep. 1, A-14)</p>	<p>Retain – still relevant. Amend title to read as follows:</p> <p>Physicians? Right to Reasonable Privacy Protection and the Federation Credentials Verification Service</p> <p>After A-04, the FSMB was notified of this HOD directive.</p> <p>The current FCVS waiver does not contain language contained in the AMA policy. FSMB has shared this AMA policy with their FCVS department and legal staff for review and welcome any AMA language for consideration.</p>

<p>D-275.995</p>	<p>Licensure and Credentialing Issues</p>	<p>Our AMA will: (1) support recognition of the Federation of State Medical Boards' (FSMB) Credentials Verification Service by all licensing jurisdictions; and (2) encourage the National Commission on Quality Assurance (NCQA) and all other organizations to accept the Federation of State Medical Boards' Credentials Verification Service, the Educational Commission for Foreign Medical Graduates' Certification Verification Service, and the AMA Masterfile as primary source verification of credentials. Res. 303, I-00; Reaffirmation A-04; Modified:</p> <p>(CCB/CLRPD Rep. 2, A-14; Reaffirmed: BOT Rep. 3, I-14)</p>	<p>Retain - still relevant. Amend policy with change in title to read as follows:</p> <p>Licensure and Credentialing Issues <u>Primary Source Verification of Credentials</u></p> <p>Our AMA will: (1) supports recognition of the Federation of State Medical Boards' (FSMB) Credentials Verification Service by all licensing jurisdictions; and (2) encourages the National Commission on Quality Assurance (NCQA) and all other organizations to accept recognition of the Federation of State Medical Boards' Credentials Verification Service, the Educational Commission for Foreign Medical Graduates' Certification Verification Service, and the AMA Masterfile as primary source verification of credentials.</p>
<p>D-300.984</p>	<p>Physician Reentry</p>	<p>Our AMA:</p> <ol style="list-style-type: none"> 1. Will continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs. 2. Will work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice. 3. Will work with interested parties to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics. 4. Will support efforts to ensure the affordability and accessibility, and to address the unique liability issues related to PREPs. 5. Will make available to all interested parties the physician reentry program (PREP) system Guiding Principles for use as a basis for all reentry programs: a. Accessible: The PREP system is accessible by geography, time and cost. Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is 	<p>Retain – in part. Sunset clauses (2) and (3) as having been accomplished and (6) as no longer relevant. Amend policy to read as follows:</p> <p>Our AMA:</p> <ol style="list-style-type: none"> 1. Will continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs. 2. Will work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice. 3. Will work with interested parties to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics. 4. Will support efforts to ensure the affordability and accessibility and to address the unique liability issues related to PREPs <u>physician reentry programs</u>. 5. Will make available to all interested parties the continue to support physician reentry program (PREP) system these guiding principles for use as a basis for all reentry programs: (a)- Accessible: The PREP system is accessible Obtainable by geography, time, and cost. Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is commensurate with the assessed clinical and

	<p>commensurate with the assessed clinical and educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions or the health care system. b. Collaborative: The PREP system is designed to be collaborative to improve communication and resource sharing. Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible. c. Comprehensive: The PREP system is comprehensive to maximize program utility. Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice. d. Ethical: The PREP system is based on accepted principles of medical ethics. Physician reentry programs will conform to physician licensure statutes. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed. e. Flexible: The PREP system is flexible in structure in order to maximize program relevancy and usefulness. Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians. f. Modular: Physician reentry programs are modularized, individualized and competency-based. They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need. g. Innovative: Innovation is built into a PREP system allowing programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians. Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation. h.</p>	<p>educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions, or the health care system. (b)- Collaborative: The PREP system is <u>Designed</u> to be collaborative to improve communication and resource sharing. Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible. (c)- Comprehensive: The PREP system is comprehensive <u>Broad</u> to maximize program utility. Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice. (d)- Ethical: The PREP system is <u>Based</u> on accepted principles of medical ethics. Physician reentry programs will conform to physician licensure statutes. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed. (e)- Flexible: The PREP system is flexible <u>Pliable</u> in structure in order to maximize program relevancy and usefulness. Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians. (f)- Modular: Physician reentry programs are modularized, individualized, and competency-based. They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need. (g)- Innovative: Innovation is built into a PREP system allowing <u>Allows</u> programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians. Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation. (h)- Accountable: The PREP system Has mechanisms for assessment and is open to evaluation. Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate physician's competence at time of entry, during the program and at time of completion. Program outcomes are measured. Reliability and validity of</p>
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		<p>Accountable: The PREP system has mechanisms for assessment and is open to evaluation. Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate physician's competence at time of entry, during the program and at time of completion. Program outcomes are measured. Reliability and validity of the measures are established. Standardization of measures exist across programs to assess whether or not national standards are being met. i. Stable: A funding scheme is in place to ensure the PREP system is financially stable over the long-term. Adequate funding allows physician reentry programs to operate at sufficient and appropriate capacity. j. Responsive: The PREP system makes refinements, updates and other changes when necessary. Physician reentry programs are equipped to address systemic changes such as changes in regulations. Additionally, the PREP system is prepared to respond efficiently to urgent health care needs within society including mobilizing clinically inactive physicians temporarily into the workforce to attend to an acute public health crisis, such as a terrorist, biological, chemical, or natural disaster.</p> <p>6. Our AMA encourages each state which does not grant a full and unrestricted license to physicians undergoing reentry to develop a non-disciplinary category of licensure for physicians during their reentry process.</p> <p>(CME Rep. 6, A-08; Reaffirmed: CME Rep. 11, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 310, A-14)</p>	<p>the measures are established. Standardization of measures exists across programs to assess whether or not national standards are being met. (i) Stable: A funding scheme is in place to ensure the PREP system is financially stable stability over the long-term. Adequate funding allows physician reentry programs to operate at sufficient and appropriate capacity. (j) Responsive: The PREP system <u>m</u>akes refinements, updates, and other changes when necessary. Physician reentry programs are equipped to address systemic changes such as changes in regulations. Additionally, the PREP system <u>It</u> is prepared to respond efficiently to urgent health care needs within society including mobilizing clinically inactive physicians temporarily into the workforce to attend to an acute public health crisis, such as a terrorist, biological, chemical, or natural disaster.</p> <p>6. Our AMA Will encourages each states that which does not grant a full and unrestricted license to physicians undergoing reentry to develop a non-disciplinary category of licensure for physicians during their reentry process.</p> <p>Sunset clause (2) as having been accomplished. Records indicate the AMA and the American Academy of Pediatrics hosted joint conferences in 2008 and 2011. They also launched the National Inactive Physicians Survey, which was published in 2011. Plans are underway for a similar study that will ask many of the same questions as the previous study.</p> <p>Sunset clause (3) as having been accomplished. FSMB developed a directory of physician assessment and remedial education programs.</p> <p>Regarding clause (6), state board requirements for reentry are listed on the FSMB website. FSMB's Workgroup on Reentry to Practice developed a draft report that discusses difficulties obtaining licensure based on time away from practice and speaks to differing reentry requirements when absences from practice result from disciplinary action or criminal conviction. Open comment period ended Feb 16, 2024.</p> <p>Remove references to "PREP" as it does not reflect current nomenclature.</p>
<p>D-300.988</p>	<p>Implications of the "Stark II" Regulations for Continuing Medical Education</p>	<p>Our AMA will (1) request that the Centers for Medicare & Medicaid Services develop an explicit exception within the regulations for Section 1877 of the Social Security Act (Stark law) that permits physician compensation without financial limit in the form of continuing medical education that is</p>	<p>Retain – in part. Amend policy to read as follows:</p> <p>Our AMA will (1) request that the Centers for Medicare & Medicaid Services develop an explicit exception within the regulations for Section 1877 of the Social Security Act (Stark law) that permits</p>

		<p>offered for the purpose of ensuring quality patient care; and (2) monitor the impact of the Section 1877 (Stark II) regulations on the ability of health care institutions to provide continuing medical education to their medical staffs.</p> <p>(CME Rep. 6, I-04; Reaffirmed: CME Rep. 2, A-14)</p>	<p>physician compensation without financial limit in the form of continuing medical education that is offered for the purpose of ensuring quality patient care; and (2) monitor the impact of the Section 1877 (Stark II) regulations on the ability of health care institutions to provide continuing medical education to their medical staffs.</p> <p>Sunset clause (1) as having been accomplished. After I-04, Centers for Medicare & Medicaid Services was notified of this HOD directive.</p> <p>Retain clause (2) as there remain situations where health care institutions seek guidance on whether providing certain types of continuing medical education violates section 1877.</p>
D-300.994	Reduced Continuing Medical Education (CME) Fees for Retired Physicians	<p>Our AMA supports reduced registration fees for retired physicians at all continuing medical education (CME) programs and encourages CME providers to consider a reduced fee policy for retired physicians.</p> <p>(Res. 302, I-01; Reaffirmed: CME Rep. 2, A-11; Modified: CME Rep. 2, A-14)</p>	Retain - still relevant.
D-310.967	Resident Pay During Orientation	<p>Our AMA will advocate that all resident and fellow physicians should be compensated, and receive benefits, at a level commensurate with the pay that they will receive while in their training program, for all days spent in required orientation activities prior to the onset of their contractual responsibilities.</p> <p>(Res. 302, A-07; Modified: CCB/CLRPD Rep. 2, A-14)</p>	Retain - still relevant.
D-310.980	Increase in ACGME Fees	<p>Our AMA will work with the Accreditation Council for Graduate Medical Education to limit the increase of the ACGME fees.</p> <p>(Res. 311, A-04; Reaffirmed: CME Rep. 2, A-14)</p>	<p>Sunset – not practical.</p> <p>ACGME has limited increases for many years. It is incumbent on organizations to be able to control their own fees.</p>
D-310.982	Protecting the Privacy of Physician Information Held by the ACGME	<p>Our AMA will request the Accreditation Council for Graduate Medical Education and any other organization with a similar case and procedure log for resident physicians to (1) develop and implement a system to remove or sufficiently protect identifying data from individual physicians' data logs; and (2) adopt a policy not to disseminate any data specific to individual physicians without the written consent of the physician.</p> <p>(Res. 301, A-04; Reaffirmed: CME Rep. 2, A-14)</p>	<p>Sunset – accomplished.</p> <p>After A-04, ACGME was notified of this HOD directive. Records of the correspondence state that “in discussing this issue last week with John Nysten, he assured me this is already ACGME policy.”</p> <p>The ACGME data systems include the Accreditation Data System (ADS), the Case Log System, the Medical School Portal, and ACGME surveys. Public-facing data is available here. The majority of data are available only to individuals with login credentials. Logins are provided to</p>

			<p>designated institutional officials (DIOs), program directors, program coordinators, residents, fellows, and designated medical school users. Users have access to the following systems:</p> <ul style="list-style-type: none"> • Program directors: ADS, including Case Logs for viewing reports. • DIOs: ADS, including Case Logs for viewing reports. • Residents and fellows: Case Logs and ACGME Surveys. • Faculty members: ACGME Surveys • Medical school users: Medical School Portal. • Others: ADS Public.
<p>D-310.992</p>	<p>Limits on Training Opportunities for J-1 Residents</p>	<p>Our AMA will request that the Bureau of Educational and Cultural Affairs, Accreditation Council for Graduate Medical Education (ACGME), American Board of Medical Specialties and the Educational Commission for Foreign Medical Graduates develop criteria by which J-1 exchange visitor physicians could seek extension of the length of their visa beyond the 7-year limit in order to participate in fellowship or subspecialty programs accredited by the ACGME.</p> <p>(Res. 303, A-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmation A-14)</p>	<p>Sunset – accomplished.</p> <p>After A-01, the Bureau of Educational and Cultural Affairs and the Educational Commission for Foreign Medical Graduates were notified of this HOD directive. It was also communicated to each residency program director and directors of medical education at U.S. teaching hospitals via the <i>Medical Education Bulletin</i>.</p> <p>According to ECFMG’s (now a member of Intealth) Exchange Visitor Sponsor Program (EVSP), “any international medical graduate seeking to extend his/her participation in ECFMG-sponsored training beyond seven years must file a formal extension request with the Department of State (DOS) through ECFMG.” In addition to the ECFMG fee and DOS fee, documentation must include: complete application for ECFMG sponsorship, letter of support from applicant’s current and proposed program directors, statement of educational objectives from applicant, and letter of “exceptional need” from the home country government; this letter must be signed by either the home country’s ambassador to the United States or the home country’s minister of health confirming an “exceptional need” for the applicant to be trained in the field of medicine being pursued.</p>
<p>D-373.999</p>	<p>Informed Patient Choice and Shared Decision Making</p>	<p>1. Our AMA will work with state and specialty societies, medical schools, and others as appropriate to educate and communicate to medical students and to physicians about the importance of shared decision-making guidance through publications and other educational methods and assist the medical community in moving towards patient-centered care.</p> <p>(Res. 817, I-08; Modified: Res. 301, A-14)</p>	<p>Retain - still relevant.</p>

<p>D-480.999</p>	<p>State Authority and Flexibility in Medical Licensure for Telemedicine</p>	<p>Our AMA will continue its opposition to a single national federalized system of medical licensure.</p> <p>(CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: BOT Rep. 3, I-14)</p>	<p>Retain - still relevant.</p> <p>This policy is central to Advocacy’s work on telehealth licensure.</p>
<p>G-620.065</p>	<p>Dues Exemption/ Adjustment for Physicians Unable to Attain Residency Training Program</p>	<p>Our AMA urges state societies to offer membership at significantly discounted rates for example, equal to the charge for medical students or residents, to physicians who have graduated from American medical schools or who have successfully completed Educational Commission on Foreign Medical Graduate (ECFMG) and United States Medical Licensing Examination (USMLE) examinations but have been unable to obtain American residency positions.</p> <p>(Res. 611, A-14)</p>	<p>Retain - still relevant.</p>
<p>H-40.977</p>	<p>Pay Equity for Physicians in Active and Reserve Uniformed Services</p>	<p>For reservists called to active duty or on short-term mobilization assignments, the AMA supports the adjustment of pay and allowances upwards to approach pay and allowances for those with similar rank and qualifications in regular and long-term reserve status.</p> <p>(Sub. Res. 233, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, I-04; Reaffirmed: CMS Rep. 1, A-14)</p>	<p>Retain - still relevant.</p>
<p>H-40.983</p>	<p>Active and Reserve Physicians and Physicians-In-Training</p>	<p>(1) Our AMA requests the Residency Review Committees and Specialty Boards to develop flexible policies to ensure that (a) resident physicians and fellows who are members of the active or reserve components of the uniformed services of the United States retain their academic and training status within their respective training programs during periods of reserve activation or active duty with the uniformed services; and (b) active duty or deployment time with the uniformed services during a residency or fellowship should be credited toward the usual training period for eligibility for matriculation and Board examinations when the trainee's experiences have been educationally appropriate.</p> <p>(2) Our AMA strongly encourages state licensing boards to waive requirements for continuing medical education credits for</p>	<p>Retain – still relevant.</p> <p>ACGME works closely with the Department of Defense around issues with deployment of both residents and faculty. The institutional review group is revising their requirements, which will likely be released in fall 2024 with an open comment period.</p>

		<p>physicians during periods of reserve or national guard activation or active duty with the uniformed services.</p> <p>(3) Our AMA supports the position that, at the time of national emergency, residents and fellows called to support their country in military service should be placed, when possible, in positions consistent with their specialty and level of training.</p> <p>(Res. 187, I-90; Modified: Sunset Report, I-00; Reaffirmed: CME Rep. 2, I-04; Modified: CME Rep. 2, A-14)</p>	
H-95.943	MDs/DOs as Medical Review Officers	<p>Our AMA: (1) reaffirms its policy that only licensed MDs/DOs with knowledge of substance use disorders should serve as Medical Review Officers (MROs); (2) reaffirms its policy that all MDs/DOs who serve as MROs should obtain continuing medical education credit in this subject area; (3) vigorously advocates that any legislation concerning drug testing in the workplace include a provision for a Medical Review Officer (MRO) who will review all positive test results and further that only a licensed physician may serve as the MRO and further that this physician MRO has knowledge of substance abuse disorders and has appropriate medical training to interpret and evaluate an individual's positive test results together with his or her medical history and any other relevant biomedical information ; and (4) vigorously opposes legislation that is inconsistent with these policies.</p> <p>(CCB/CLRPD Rep. 3, A-14)</p>	<p>Retain – still relevant. Amend policy to read as follows:</p> <p>Our AMA: (1) reaffirms its policy <u>affirms</u> that only licensed MDs/DOs with knowledge of substance use disorders should serve as Medical Review Officers (MROs); (2) reaffirms its policy <u>affirms</u> that all MDs/DOs who serve as MROs should obtain continuing medical education credit in this subject area; (3) vigorously advocates <u>affirms</u> that any legislation concerning drug testing in the workplace include a provision for a Medical Review Officer (MRO) who will review all positive test results and further that only a licensed physician may serve as the MRO and further that this physician MRO has knowledge of substance abuse disorders and has appropriate medical training to interpret and evaluate an individual's positive test results together with their medical history and any other relevant biomedical information-; and (4) vigorously opposes legislation that is inconsistent with these policies.</p> <p>Clauses (1) and (2) are consistent with ACOEM's MRO training. Language in clause (3) is redundant.</p>
H-275.929	Additions to United States Medical Licensure Examination and Comprehensive Osteopathic Medical Licensure Examination	<p>Our AMA opposes additions to the United States Medical Licensing Examination and Comprehensive Osteopathic Medical Licensure Examination that lack predictive validity for future performance as a physician.</p> <p>(Res. 308, A-04; Reaffirmed: CME Rep. 2, A-14)</p>	<p>Retain - still relevant. Amend policy with change in title to read as follows:</p> <p><u>Oppose</u> Additions to United States Medical Licensure Examination and Comprehensive Osteopathic Medical Licensure Examination</p>
H-275.930	Opposition to Clinical Skills Examinations	<p>Our AMA: (1) opposes clinical skills examinations for the purpose of physician medical relicensure; (2) reaffirms its</p>	<p>Retain- in part. Amend policy to read as follows:</p>

	<p>for Physician Medical Relicensure</p>	<p>support for continuous quality improvement of practicing physicians, and supports research into methods to improve clinical practice, including practice guidelines; and (3) continues to support the implementation of quality improvement through local professional, non-governmental oversight.</p> <p>(Res. 307, A-04; Reaffirmed: CME Rep. 2, A-14)</p>	<p>Our AMA: (1) opposes clinical skills examinations for the purpose of physician medical relicensure; and (2) reaffirms its supports for continuous quality improvement of practicing physicians, and supports; research into methods to improve clinical practice, including practice guidelines; and (3) continues to support the implementation of quality improvement through local professional, non-governmental oversight.</p> <p>Retain clause (1) as still relevant.</p> <p>Sunset clause (2) which is addressed in policies H-450.970, H-450.965, and D-478.984.</p> <p>Retain clause (3) and append to H-450.970 where it better aligns with the content and title.</p>
<p>H-275.945</p>	<p>Self-Incriminating Questions on Applications for Licensure and Specialty Boards</p>	<p>The AMA will:</p> <p>(1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information;</p> <p>(2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards; and</p> <p>(3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked.</p> <p>(BOT Rep. 13, I-93; Reaffirmed: CME Rep. 10-I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)</p>	<p>Sunset – accomplished.</p> <p>Sunset clause (1) as having been accomplished. FSMB Physician Data Center (PDC) and Disciplinary Alert Service (DAS) foster the appropriate sharing of information and uniformity of definitions and nomenclature.</p> <p>Sunset clause (2) as having been accomplished. FSMB adopted policy Physician Wellness and Burnout (2018) that addresses the ADA related to licensing.</p> <p>Sunset clause (3), as it is addressed in policy H-275.970.</p>
<p>H-275.973</p>	<p>State Control of Qualifications for Medical Licensure</p>	<p>(1) The AMA firmly opposes the imposition of federally mandated restrictions on the ability of individual states to determine the qualifications of physician candidates for licensure by endorsement. (2) The AMA actively opposes the enactment of any legislation introduced in Congress that promotes these objectives.</p> <p>(Res. 84, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07; Reaffirmed: BOT Rep. 3, I-14)</p>	<p>Retain - still relevant. Amend policy with change in title to read as follows:</p> <p><u>Support</u> State Control of Qualifications for Medical Licensure</p>

<p>H-275.977</p>	<p>Verifying Physicians' Credentials</p>	<p>The AMA endorses the use of pluralistic approaches to the verification and validation of physicians' credentials. The AMA will seek legislation that managed care companies be required to request credentialing information in a uniform standardized format which all groups involved in credentialing would accept.</p> <p>(Sub. Res. 91, A-87; Amended by Res. 736, A-97; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07; Reaffirmed: BOT Rep. 3, I-14)</p>	<p>Sunset – duplicative.</p> <p>Sunset the first sentence as superseded by policy D-275.995 that supports primary source verification of credentials via the AMA Masterfile, FSMB’s Federation Credentials Verification Service, and the Educational Commission for Foreign Medical Graduates' Certification Verification Service.</p> <p>Sunset the second sentence, which is already addressed by policy H-285.979.</p>
<p>H-275.988</p>	<p>Identifying Persons with Illegally Obtained Medical Degrees</p>	<p>The AMA supports appropriate efforts of private and governmental agencies in identification of persons possessing illegally obtained medical degrees.</p> <p>(Res. 43, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)</p>	<p>Retain- still relevant.</p>
<p>H-275.996</p>	<p>Physician Competence</p>	<p>Our AMA:</p> <p>(1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence;</p> <p>(2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure; and</p> <p>(3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base.</p> <p>(CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 302, A-10; Reaffirmed in lieu of Res. 320, A-14)</p>	<p>Sunset – accomplished.</p> <p>Sunset clause (1) as having been accomplished. According to the ABMS, “member board certification is a voluntary specialty credential that indicates a physician or medical specialist’s proficiency in a particular specialty area of medicine.”</p> <p>Sunset clause (2) as having been accomplished, given the FSMB was notified of this policy after A-80. In 2012, the FSMB House of Delegates adopted a policy that states “The Federation of State Medical Boards (FSMB) supports the use of, and encourages state boards to recognize, a licensee’s participation in an ABMS MOC and/or AOA BOS OCC program as an acceptable means of meeting CME requirements for license renewal.” FSMB is aware of a small but growing number of state medical boards that accept participation in continuing certification as evidence of substantive compliance with CME requirements.</p> <p>Sunset clause (3) as duplicative. Addressed in AMA policy Support for Continuing Medical Education H-300.958.</p>
<p>H-295.863</p>	<p>Impairment Prevention and Treatment in the Training Years</p>	<p>Our AMA: (1) reaffirms the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; (2) strongly encourages medical schools and teaching</p>	<p>Retain - still relevant. Amend policy to read as follows:</p> <p>Our AMA: (1) reaffirms the importance of preventing and treating psychiatric illness,</p>

		<p>hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents and fellows; (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse; (4) advocates (a) further study (and continued monitoring of other studies) concerning the problem of substance abuse among students, residents, and faculty in U.S. medical schools, and (b) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians.</p> <p>(CCB/CLRPD Rep. 3, A-14)</p>	<p>alcoholism, and substance abuse use in medical students, residents, and fellows; (2) strongly encourages medical schools and teaching hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents, and fellows; (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse use; (4) advocates (a) further study (and continued monitoring of other studies) concerning the problem of substance abuse use among students, residents, and faculty in U.S. medical schools, and (b) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents, and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians.</p> <p>Change from “abuse to “use” in keeping with policy Destigmatizing the Language of Addiction H-95.917.</p>
H-295.880	Service Learning in Medical Education	<p>Our AMA will support the concept of service learning as a key component in medical school and residency curricula, and that these experiences should include student and resident collaboration with a community partner to improve the health of the population.</p> <p>(Res. 321, A-04; Reaffirmed: CME Rep. 2, A-14)</p>	Retain - still relevant.
H-295.929	Faculty/Staff Appointments at More Than One Medical School	<p>The AMA encourages medical schools that currently do not permit volunteer faculty members to hold appointments at more than one medical school to review this policy, to ensure that it is in the best interests of medical education and program integrity. Nonsalaried faculty members of medical schools should be allowed to hold concurrent appointments at more than one medical school as long as the individual physician agrees to carry out all responsibilities assigned by each medical school.</p> <p>(CME Rep. 3, I-93; Reaffirmed: CME Rep. 2, A-05; Modified: CME Rep. 2, A-14)</p>	Retain - still relevant.
H-295.983	Extramural Clerkships and	<p>The AMA (1) recognizes the essential role of the medical school faculty in the</p>	Retain - still relevant.

	Early Career Decisions	determination of the core clinical education of medical students; and (2) opposes resident recruitment practices which would interfere with scheduled core clinical clerkships at the student's medical school. (Res. 77, I-84; CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)	
H-295.985	Humanism in Graduate Medical Education	The AMA encourages medical schools and teaching hospitals to strengthen educational programs for undergraduates and resident physicians in recognizing and meeting the emotional needs of patients and their families. (Sub. Res. 154, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)	Retain - still relevant.
H-305.950	Fairness in Publication of Names of Loan Defaulters	The AMA opposes the selective publication of names of defaulters on federally funded student loans. (Res. 309, A-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)	Retain - still relevant.
H-310.990	Shared Residency Positions	The AMA supports the concept of shared residency positions and the continued collection and publication of data on these positions, and encourages residency program directors to offer such positions where feasible. (Res. 81, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Modified: CME Rep. 2, A-14)	Retain – still relevant. Amend policy to read as follows: The AMA supports the concept of shared residency positions and the continued collection and publication of data on these positions, and encourages residency program directors to offer such positions where feasible.
H-355.977	Reporting of Resident Physicians to the National Practitioner Data Bank	1. Our AMA: (A) seeks opportunities to limit reports concerning residents to the National Practitioner Data Bank to only those situations where a final adverse action has been taken by a medical licensing jurisdiction; (B) opposes attempts to extend reports concerning residents to the National Practitioner Data Bank beyond those covered in Item 1 of this policy; and (C) advocates for legislation amending, as appropriate, the NPDB reporting requirements regarding resident physicians to be consistent with this policy, and opposes the expansion of existing reporting requirements. (CCB/CLRPD Rep. 3, A-14)	Retain - still relevant. Amend policy to read as follows: 1. Our AMA: (A) seeks opportunities to support <u>the limiting of</u> reports concerning residents to the National Practitioner Data Bank to only those situations where a final adverse action has been taken by a medical licensing jurisdiction; and (B) opposes attempts to extend reports concerning residents to the National Practitioner Data Bank beyond those covered in Item 1 of this policy; and (C) advocates for legislation amending, as appropriate, the NPDB reporting requirements regarding resident physicians to be consistent with this policy, and opposes the expansion of existing reporting requirements.

REPORT 2 OF THE COUNCIL ON MEDICAL EDUCATION (A-24)
The Current Match Process and Alternatives (Resolution 302-A-23)

EXECUTIVE SUMMARY

This report was written in response to Resolution 302, brought forth by the Resident and Fellow Section at the 2023 Annual Meeting of the House of Delegates. This resolution was referred for study. Now AMA Policy [D-310.944](#), it asks that that the American Medical Association “study alternatives to the current residency and fellowship Match process which would be less restrictive on free market competition for applicants.”

This report summarizes the history of The Match[®] and time before The Match, differentiates between the application process versus The Match, explains aspects of The Match process as well as independent match processes, and offers perspective from the National Resident Matching Program[®] (NRMP[®]). The Council on Medical Education understands the concerns presented by the authors of Resolution 302-A-23 and their frustrations related to lack of control over their own destinies. This report illuminates the importance of ongoing communication and transparency by the NRMP as well as collaboration among all invested parties. Further, this report makes clear that there are no currently identified alternatives other than an unstructured, open market approach, which the Council believes would be detrimental to the majority of trainees in comparison to the current Match process. Thus, attention should be focused on what can be done to improve The Match and other specialty matches rather than focusing on its replacement, as a match process continues to be the best solution for trainees at this time.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 02-A-24

Subject: The Current Match Process and Alternatives (Resolution 302-A-23)

Presented by: Cynthia Jumper, MD, MPH, Chair

Referred to: Reference Committee C

1 INTRODUCTION

2
3 At the 2023 Annual Meeting of the House of Delegates, Resolution 302-A-23 entitled “Antitrust
4 Legislation Regarding the AAMC, ACGME, NRMP and Other Relevant Associations or
5 Organizations” asked “that our American Medical Association study alternatives to the current
6 residency and fellowship Match process which would be less restrictive on free market competition
7 for applicants.” The Resident and Fellow Section (RFS), authors of the resolution, noted concerns
8 related to preservation of the process of free market competition, antitrust laws, and The Match®.
9 Their resolution stated, “The Match poses significant anticompetition concerns and the
10 procompetitive effect of streamlining residency job applications and increasing percentage of
11 position filled needs to be outweighed by the anticompetitive effect of the lack of negotiation
12 power of residents.”¹

13
14 The resolution, now American Medical Association (AMA) Policy [D-310.944](#), was referred for
15 study. This report seeks to address this directive by providing historical context, differentiating
16 between the application process versus The Match, explaining aspects of The Match process as
17 well as independent match processes, and offering perspective from the National Resident
18 Matching Program® (NRMP®). It seeks to illuminate what can be done within the confines of The
19 Match to make it better and clarify that there are no currently identified “alternatives” other than
20 the free market approach. To provide context, The Match is defined by the NRMP as “a
21 computerized mathematical algorithm, ‘the matching algorithm,’ to place applicants into the most
22 preferred residency and fellowship positions at programs that also prefer them.”² It is intended to
23 favor the rank list of the applicant.

24 25 BACKGROUND

26 27 *History of The Match*

28
29 The trainee internship experience began in the late 1800s and was formalized shortly thereafter.
30 Such positions began to outnumber the students available. “In the early 1900s, competition among
31 hospitals for interns and among medical students for good internships led to increasingly early
32 offers of internships to students. By the 1940s, appointments were often made as early as the
33 beginning of the junior year of medical school. ...From 1945 through 1951, efforts were made to
34 enforce a uniform date for accepting offers. However, students were still faced with offers having
35 very short deadlines, compelling them to accept or reject offers without knowing what other offers
36 might be forthcoming.”³ Such challenges led to the creation of a centralized clearinghouse to allow
37 for students to benefit from uniform appointment dates while reducing congestion and pressure.

1 The clearinghouse was created by the National Interassociation Committee on Internships, who
2 later changed its name to the National Intern Matching Program (NIMP). It included national
3 organizations such as the AMA (Council on Medical Education), American Hospital Association,
4 Association of American Medical Colleges (AAMC) and federal hospitals involved in resident
5 training.⁴ Dissatisfaction among students led to proposals of algorithms that were felt to be more
6 equitable.

7
8 The NIMP was established as a 501c(3) and operated through the 1960s. In 1966, the [Millis
9 Commission Report](#), authorized by the AMA Council on Medical Education, examined medical
10 education in the U.S., particularly the length and quality of graduate medical education. It
11 supported a broader move to integrated residency training.⁵ The NIMP became the NIRMP in
12 1968. The organization, in 1972, revised its participation requirements such that The Match
13 expanded to include all first-year resident positions and required all institutions participating in The
14 Match to select U.S. senior students in allopathic medical schools through it. By 1975, the NIRMP
15 had become the NRMP.

16
17 The NRMP oversees The Match, which is the mathematical algorithm to match applicants and
18 programs to their most preferred ranked choices. In 2012, researchers Lloyd Shapley and Alvin
19 Roth won the Nobel Prize in Economics for developing the “theory of stable allocations and the
20 practice of market design” which led to the development of the algorithm used for The Match.
21 They “pioneered theoretical concepts to understand and solve the matching problem and clarified
22 those ideas and applied them to engineer algorithms that are now widely used in the real world.”⁶
23 The current algorithm has been used since 1998. The Match continues to be updated to address the
24 changing needs of applicants and to yield a favorable match while producing a stable outcome.

25
26 In the past, osteopathic medical students could also participate in the [American Osteopathic
27 Association](#) (AOA) national match process through the [National Matching Services](#) (NMS).
28 Starting in July 2015, the AOA and the Accreditation Council for Graduate Medical Education
29 (ACGME) began a transition to a single accreditation system (SAS) to combine the AOA and
30 NRMP match programs. Between 2015 and 2020, AOA programs applied for accreditation to the
31 ACGME, and if granted, these programs could take residents through the NRMP match. By 2020,
32 most AOA programs had transitioned to the SAS or had withdrawn and were no longer taking new
33 residents but were allowed to complete the training of the residents remaining in their programs
34 under AOA accreditation until the last resident finished. The intent of the SAS was to foster
35 inclusion for osteopathic medical students as well as residents at former AOA programs. Data from
36 2020-2023 indicates that Doctor of Osteopathic Medicine (DO) applicants have an increased match
37 rate from 90.7% to 91.6%, which also correlates with the opening of more DO schools.⁷

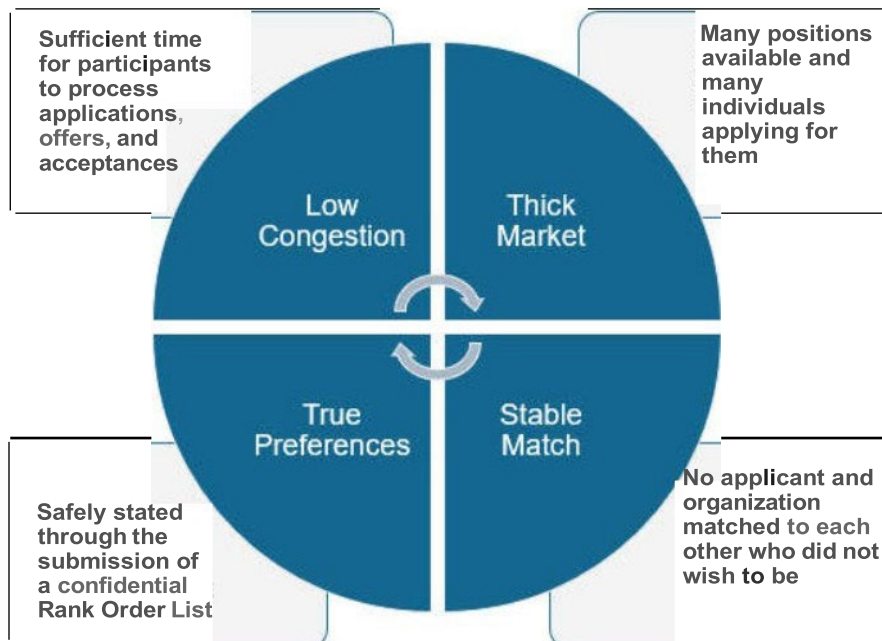
38 39 *The Match process*

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41 The intention of The Match is to make the best possible match for all participants and ensure the
42 uniform process is fair, efficient, transparent, and reliable. Referred to as the Main Residency
43 Match, it is part of a larger undertaking that begins with applying to and interviewing with training
44 programs. Most applicants use the [Electronic Residency Application Service](#)[®] (ERAS[®]), a product
45 of the AAMC, to apply to programs per their chosen specialty. This centralized online application
46 service delivers applications and supporting documents to residency programs. Next, applicants
47 register for The Match in the NRMP’s [Registration, Ranking, and Results](#)[®] (R3[®]) system.
48 Applicants are invited to interview per the criteria set by each program. Both applicants and
49 programs submit their rank order preferences in the R3 system by a predetermined deadline,
50 usually in early March. The NRMP runs their matching [algorithm](#) according to the preferences
51 submitted and all parties are notified of the results later that month. Matched applicants and

1 programs enter into an agreement. Unmatched applicants and programs may elect to participate in
 2 the NRMP’s [Supplemental Offer and Acceptance Program](#) (SOAP) during Match Week. See
 3 Appendix A for an infographic of this process. The NRMP website provides [data](#) on the Main
 4 Residency Match (including 2023) as well as research reports, survey reports, and research briefs.

5
 6 The NRMP’s [Main Residency All In Policy](#) asserts that if a program is registering for the Main
 7 Residency Match®, then they must register and attempt to fill all positions through the Match (or
 8 another national matching plan).⁸ This policy only applies to those positions a program wishes to
 9 fill. Programs planning to participate in The Match cannot offer positions outside The Match. If
 10 that were to happen prior to program registration and activation, then the program is ineligible to
 11 enroll in The Match (unless the NRMP grants an exception). Per the [Fellowship Match All In](#)
 12 [Policy, Specialties Matching Service](#)® (SMS®) Match sponsors may *voluntarily* implement the All
 13 In Policy for their fellowship matches. AMA Policy [D-310.977\(6\)](#) “does not support the current
 14 ‘All-In’ policy for the Main Residency Match to the extent that it eliminates flexibility within the
 15 match process.”⁹

16
 17 In its current form, the NRMP contends that The Match process is uncongested, defers acceptance,
 18 promotes true preferences, and establishes a thick market “which allows for multi-specialty
 19 applications and couple matching (including for mixed-specialty couples).”¹⁰ It is built upon the
 20 following core components:



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 42 [Principles of Market Design](#). Copyright National Resident Matching Program. Reprinted with permission.

43
 44 *Independent match processes*

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 46 According to the NRMP, “U.S. medical school graduates and students and graduates of
 47 international medical schools can be offered positions outside of the Main Residency Match
 48 provided it is in a program that does not participate in the Match and thus not subject to the All In
 49 Policy. No applicant can accept a position outside of the Match after the Rank Order List
 50 Certification Deadline.”¹¹ Some programs choose to participate in an early match process, and the
 51 percentage of outside-the-match offers varies by specialty.¹² Not all are affiliated with the NRMP.

1 For example, students in the Health Professions Scholarship Program and the Uniformed Services
2 University of the Health Sciences who wish to apply for military PGY-1 positions go through a
3 similar process overseen by the Joint Service Graduate Medical Education Selection Board. While
4 they still use the ERAS system, military medical students complete a different application that
5 includes ranking programs. Deadlines also differ, as materials are submitted late August through
6 mid-October, and results are announced in mid-December. The military does not use a computer-
7 generated algorithm, rather it is a process of discussions and negotiations. An applicant can be
8 placed in a program that they did not even rank.¹³ Other examples include:
9

- 10 • Preventive Medicine and Public Health: First implemented in 2017, the American College
11 of Preventive Medicine (ACPM) oversees their own match called the [Residency](#)
12 [Standardized Acceptance Process](#) (SAP).¹⁴
13
- 14 • Plastic Surgery and Ophthalmology: The San Francisco Residency Match, more commonly
15 referred to as [SF Match](#), is a residency and fellowship matching service that has been used
16 by several specialties and subspecialties for over 40 years. It includes residencies in plastic
17 surgery and ophthalmology, overseen by the American Council of Academic Plastic
18 Surgeons and Association of University Professors of Ophthalmology respectively. It also
19 currently includes 25 fellowship matches, ranging from abdominal transplant surgery to
20 rhinology.
21
- 22 • Urology: For over 30 years, the American Urological Association, in conjunction with the
23 Society of Academic Urologists, has overseen the [Urology Residency Match Program](#).
24
- 25 • Neuromuscular medicine: Starting in 2020, the American Association of Neuromuscular &
26 Electrodiagnostic Medicine started its own standardized match process called the
27 Neuromuscular Fellowship Application Portal that uses an online hub through which
28 residents submit application materials, communicate with programs, and receive offers.¹⁵
29 The first cycle hosted a partial match process, whereby programs submitted rank lists but
30 applicants did not rank programs. The following cycle was a full match process.¹⁵
31

32 DISCUSSION

33 *Before The Match and other match processes*

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35
36 The time before The Match and other match processes presented real challenges, added stress to
37 the residency application process, and fueled unequal treatment. One reflection written about the
38 time before The Match noted, “Medical students and hospitals once negotiated directly with each
39 other. Competition for talent was fierce amid a tight labor market, with residency programs
40 extending offers to medical students up to two years before graduation. This process had significant
41 downsides: Students had to deal with exploding offers and felt pressure to commit to a program
42 before getting sufficient exposure to different medical specialties. Medical students, residents, and
43 hospitals all backed reform.”¹⁶ While The Match offered solutions to those who experienced life
44 before it, a new generation of residency applicants has questioned its efficacy.
45

46 *Perceived challenges faced by residency applicants*

47
48 As summarized in the introduction, the RFS, as authors of the original resolution, noted concerns
49 about lack of negotiation power of residents. Consternations were also raised regarding the
50 possibility of residency/fellowship out-of-match offers being better than those in The Match;

1 however, there is no data to support this notion. Discussions of these concerns among trainees are
2 evident on social media platforms and the internet. For example, [The Student Doctor Network](#), “a
3 non-profit educational website dedicated to building a diverse doctor workforce,” has hosted
4 forums that debate this very issue.¹⁶ In a 2021 forum called “What are the alternatives to the
5 Match? What do you think would happen if it were abolished?”, trainees raised several points for
6 consideration. They shared that it is within the realm of possibility that programs would have zero
7 incentive to increase wages to be more competitive if The Match went away. Without The Match
8 or some unified system of application, programs could try to fill their spots earlier and such timing
9 may not align with the applicant’s desired specialty training. In the non-physician job market, a
10 candidate often has to make a decision about accepting a position without knowing the full extent
11 of the employment details.¹⁷ The NRMP and other matches are not involved in any negotiations or
12 agreements between programs and applicants, and if what a program is willing to offer to an
13 applicant is unacceptable to the applicant, the applicant can simply not include that program in
14 their rank list.

15 *The impact of The Match on competition for residency positions*

16 Another concern raised by the RFS is alleged lack of competition. In 1890, Congress passed The
17 Sherman Act, the first antitrust law, followed in 1914 by two additional antitrust laws—the Federal
18 Trade Commission Act (which formed the FTC) and the Clayton Act. Challenges to The Match
19 were brought forth in a class-action lawsuit in 2002, alleging The Match as violating the Sherman
20 Antitrust Act as described in the [AMA Journal of Ethics](#).¹⁸ However, [U.S. Code 37b](#) was passed
21 into law in 2004, entitled “Confirmation of antitrust status of graduate medical resident matching
22 programs,” to “confirm that the antitrust laws do not prohibit sponsoring, conducting, or
23 participating in a graduate medical education residency matching program, or agreeing to do so;
24 and ensure that those who sponsor, conduct or participate in such matching programs are not
25 subjected to the burden and expense of defending against litigation that challenges such matching
26 programs under the antitrust laws.”¹⁹

27 Concern was also raised about The Match possibly having a negative impact on resident salaries. A
28 2006 economic study by [Bulow and Levin](#) is frequently cited to support this claim²⁰. However,
29 Bulow and Levin also noted that The Match “was developed for efficiency reasons, and on that
30 score, it appears to do quite well.”²⁰ Research published since the Bulow-Levin paper does not
31 support their conclusions. Agarwal noted that “The Match is not the likely cause of low salaries.”²¹
32 According to Konishi & Sapozhnikov, “competitive salary vector is the best-case scenario for
33 applicants in the decentralized market. [... T]he reference salary vector adopted by Bulow and
34 Levin (2006) for the decentralized market outcome might not have a strong justification and could
35 be regarded as rather optimistic.”²² Also, it is important to consider that most resident salaries are
36 funded by clinical revenues from the sponsoring institution and federal government sources,
37 particularly Medicare graduate medical education funds from a budget set by Congress. Since
38 clinical revenue and institutional funding can vary by specialty and setting, disparities in pay may
39 result, even across residency programs at the same institution unfortunately.

40 Resolution 308 implied that a free-market approach may be more beneficial for trainees. As
41 described earlier in this report regarding the history of The Match and the era before its
42 implementation, the free market posed many problems. Returning to such a process would not
43 likely improve the challenges experienced previously. Economists agree that a free-market
44 approach is not without flaws.^{23,24} For example, “Apart from agriculture, few real-world markets
45 are perfectly competitive.”²⁵ Roth asserts that a centralized matching system can improve the
46 welfare of all participants in that market and, depending on its design, can address the problems of
47 unraveling and the congestion.²⁶ It seems that further analysis of what works well and what does
48
49
50
51

1 not work well is warranted in order to improve The Match process. As described in this report, the
2 NRMP and others are committed to continued review and improvement.

3
4 The Council on Medical Education recently addressed mechanisms to advocate for the needs of
5 residents in its report, “Organizations to Represent the Interests of Resident and Fellow Trainees”
6 ([CME 5-I-23](#)), which was adopted at the Interim 2023 Meeting. It also reviewed duty hour
7 standards; work conditions; the impact of private equity; and the roles of government agencies,
8 accreditors, medical staff organizations, associations, and unions. The adoption of that report
9 signifies renewed efforts to advocate for the interests of trainees.

10 11 *Coalition for Physician Accountability recommendations*

12
13 The [Coalition for Physician Accountability](#) (CPA) is comprised of representatives from national
14 organizations (including the AMA) responsible for the oversight, education, and assessment of
15 medical students and physicians throughout their medical careers. In April 2021, the CPA’s
16 Undergraduate Medical Education-Graduate Medical Education Review Committee (UGRC)
17 released 28 recommendations for comprehensive improvement of the UME-GME transition. The
18 UGRC was comprised of several workgroups, one of which focused on the mechanics of the
19 application/selection process from the graduate medical education perspective. The final
20 recommendations were categorized according to themes and refer to the residency application
21 process as well as The Match and other matching processes. Two themes of note address an
22 equitable, mission-driven application review (Recommendations #14-20) as well as optimization of
23 the application, interview, and selection processes (Recommendations #21-24). Specifically,
24 Recommendation #23 states that “Innovations to the residency application process should be
25 piloted to reduce application numbers and concentrate applicants at programs where mutual interest
26 is high, while maximizing applicant placement into residency positions. Well-designed pilots
27 should receive all available support from the medical community and be implemented as soon as
28 the 2022-2023 application cycle; successful pilots should be expanded expeditiously toward a
29 unified process.”²⁷

30 31 *Recent NRMP proposals*

32
33 The NRMP maintains that it is committed to considering ways to inform the transition to residency
34 or improve the matching process. In 2021, the NRMP issued a statement on the feasibility of an
35 early match. Specifically, NRMP was asked to pilot the Early Result and Acceptance Program
36 (ERAP) proposed for obstetrics and gynecology. This pilot program was created through a grant
37 provided by the AMA’s Reimagining Residency program. The NRMP concluded that an early
38 match would disadvantage applicants, and that changes to the process could potentially cause
39 behavior changes that could negatively affect outcomes for all participants.¹⁰

40
41 To consider the feasibility of a proposed Two-Phase Main Residency Match (that would replace
42 The Match and SOAP), the NRMP Board of Directors opened a call for comment period in
43 August-September 2022. The goal was to “alleviate some of the stressors inherent in the current
44 transition to residency based on available evidence.”²⁸ After considering the over 8,000 responses
45 to the call, the NRMP Board of Directors decided to not pursue the proposal as written, stating that
46 “Although the benefits/advantages articulated by the community are significant, the
47 risks/disadvantages are considered of greater consequence.”²⁹ The AAMC hosted several listening
48 sessions with their constituency to discuss this two-phase proposal and issued a statement
49 concluding that a long-term evaluation plan would be needed with a focus on “learners and
50 equity.”³⁰ The AAMC also noted that ERAS would still play a role in a two-phase match and
51 recommended further discussions.

1 AMA ENGAGEMENT

2
3 The AMA has been actively engaged in monitoring this process, is in regular communication with
4 the NRMP, and actively participates in the CPA. The AMA Medical Student Section (MSS) and
5 RFS each offer to their members the opportunity to apply to represent the AMA on the [NRMP](#)
6 [Board](#). Both AMA sections have solicited for or nominated members every year for at least the last
7 ten years. The NRMP board offers three seats for student directors and three seats for resident
8 physician directors. The NRMP no longer has designated AMA seats for students or residents due
9 to a change in their [bylaws](#) in 2017. To promote effective communication, fostering relationships
10 among key parties is vital. The AMA will continue to look for opportunities to collaborate with the
11 NRMP and other matching organizations.

12
13 Through the AMA's [ChangeMedEd](#) initiative, efforts are underway across the continuum with
14 visionary partners to create bold innovations. Specifically, [Reimagining Residency](#) is a grant
15 program dedicated to promoting systemic change in graduate medical education (GME). "It
16 supports bold and innovative projects that provide a meaningful and safe transition from
17 undergraduate medical education to graduate medical education."³¹ Several Reimagining Residency
18 projects directly address the transition from undergraduate medical education (UME) to GME.
19 "Right Resident, Right Program, Ready Day One," a collaboration with the Association of
20 Professors of Gynecology & Obstetrics (APGO), raises cross-specialty standards for the residency
21 application and interview process. It promotes signaling to reduce the number of applications
22 submitted by formalizing communication about true preferences. APGO has also developed an
23 Alignment Check Index (ACI). This adjunct to AMA's FREIDA platform seeks to better align
24 applicant preferences and characteristics with those being sought by specific residency programs. A
25 project at New York University (NYU), called the "Transition to Residency Advantage," builds on
26 experience with UME coaching to train a cadre of GME coaches and then effect a learner-driven
27 warm handoff from UME to GME. Two additional projects, the "California Oregon Medical
28 Partnership to Address Rural Disparities in Rural Education and Health" (COMPADRE) and the
29 University of North Carolina's "Fully Integrated Readiness for Service Training" (FIRST) are
30 creating pathways to rural practice that entail dedicated pathways from medical school to residency
31 that meet the needs of those areas. Also, the AMA helps to inform future GME advocacy by
32 addressing concerns regarding the challenges faced by the current GME system. A 2023
33 [compendium](#) of such GME advocacy initiatives is available for review.

34 35 *Council on Medical Education efforts*

36
37 Since 2012, the Council on Medical Education has offered several reports that address residency
38 and The Match as listed below. Additional Council reports can be accessed in the [AMA Council](#)
39 [Report Finder](#) database.

- 40 • [Organizations to Represent the Interests of Resident and Fellow Trainees" \(CME 5-I-23\)](#)
- 41 • [Optimizing Match Outcomes \(CME Report 3-A-21\)](#)
- 42 • [Standardizing the Residency Match System and Timeline \(CME Report 3-A-19\)](#)
- 43 • [The Transition from Undergraduate Medical Education to Graduate Medical Education](#)
44 [\(CME Report 5-I-19\)](#)
- 45 • [Options for Unmatched Medical Students \(CME Report 5-A-17\)](#)
- 46 • [Standardizing the Allopathic Residency Match System and Timeline \(CME Report 6-A-](#)
47 [17\)](#)
- 48 • [Resident and Fellow Compensation and Health Care System Value \(CME Report 4-A-16\)](#)
- 49 • [Transparency in the National Resident Matching Program Match Agreement \(CME Report](#)
50 [12-A-12\)](#)

1 *Relevant AMA Policy*

2
3 The AMA has ample policy in support of trainees that address such topics as The Match, other
4 match processes, residency application process, and graduate medical education. These policies
5 exemplify the AMA’s commitment to closely monitor these issues and engage with the NRMP and
6 others to optimize successful, equitable matching. See Appendix B for the following full policies:

- 7 • [Study of the Current Match Process and Alternatives D-310.944](#)
- 8 • [Residents and Fellows’ Bill of Rights H-310.912](#)
- 9 • [Preliminary Year Program Placement H-310.910](#)
- 10 • [Closing of Residency Programs H-310.943](#)
- 11 • [Protection of Resident and Fellow Training in the Case of Hospital or Training Program](#)
12 [Closure D-310.948](#)
- 13 • [Residency Interview Schedules H-310.998](#)

14
15 Of note, Policy [D-310.977](#) “National Resident Matching Program Reform” includes the following
16 clauses that state the AMA:

- 17 (4) will continue to review the NRMP’s policies and procedures and make
18 recommendations for improvements as the need arises, to include making the conditions of
19 the Match agreement more transparent while assuring the confidentiality of the match;
- 20 (5) will work with the Accreditation Council for Graduate Medical Education (ACGME)
21 and other appropriate agencies to assure that the terms of employment for resident
22 physicians are fair and equitable and reflect the unique and extensive amount of education
23 and experience acquired by physicians;
- 24 (6) does not support the current the “All-In” policy for the Main Residency Match to the
25 extent that it eliminates flexibility within the match process;
- 26 (7) will work with the NRMP, and other residency match programs, in revising Match
27 policy, including the secondary match or scramble process to create more standardized
28 rules for all candidates including application timelines and requirements;
- 29 (8) will work with the NRMP and other external bodies to develop mechanisms that limit
30 disparities within the residency application process and allow both flexibility and standard
31 rules for applicants;

32
33 Additional related policies, such as those listed below, can be accessed in the [AMA Policy Finder](#)
34 database:

- 35 • [Strengthening Interview Guidelines for American Indian and Alaska Native Medical](#)
36 [School, Residency, and Fellowship Applicants H-295.852](#)
- 37 • [Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship](#)
38 [Selection Process D-310.945](#)
- 39 • [Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or](#)
40 [Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion](#)
41 [During the Residency and Fellowship Application Process H-310.919](#)
- 42 • [Strategies for Enhancing Diversity in the Physician Workforce D-200.985](#)
- 43 • [US Physician Shortage H-200.954](#)
- 44 • [Collective Bargaining: Antitrust Immunity D-383.983](#)
- 45 • [AMA’s Aggressive Pursuit of Antitrust Reform D-383.990](#)
- 46 • [Antitrust Relief for Physicians Through Federal Legislation H-383.990](#)
- 47 • [Antitrust Relief H-383.992](#)

48
49 SUMMARY AND RECOMMENDATIONS

50

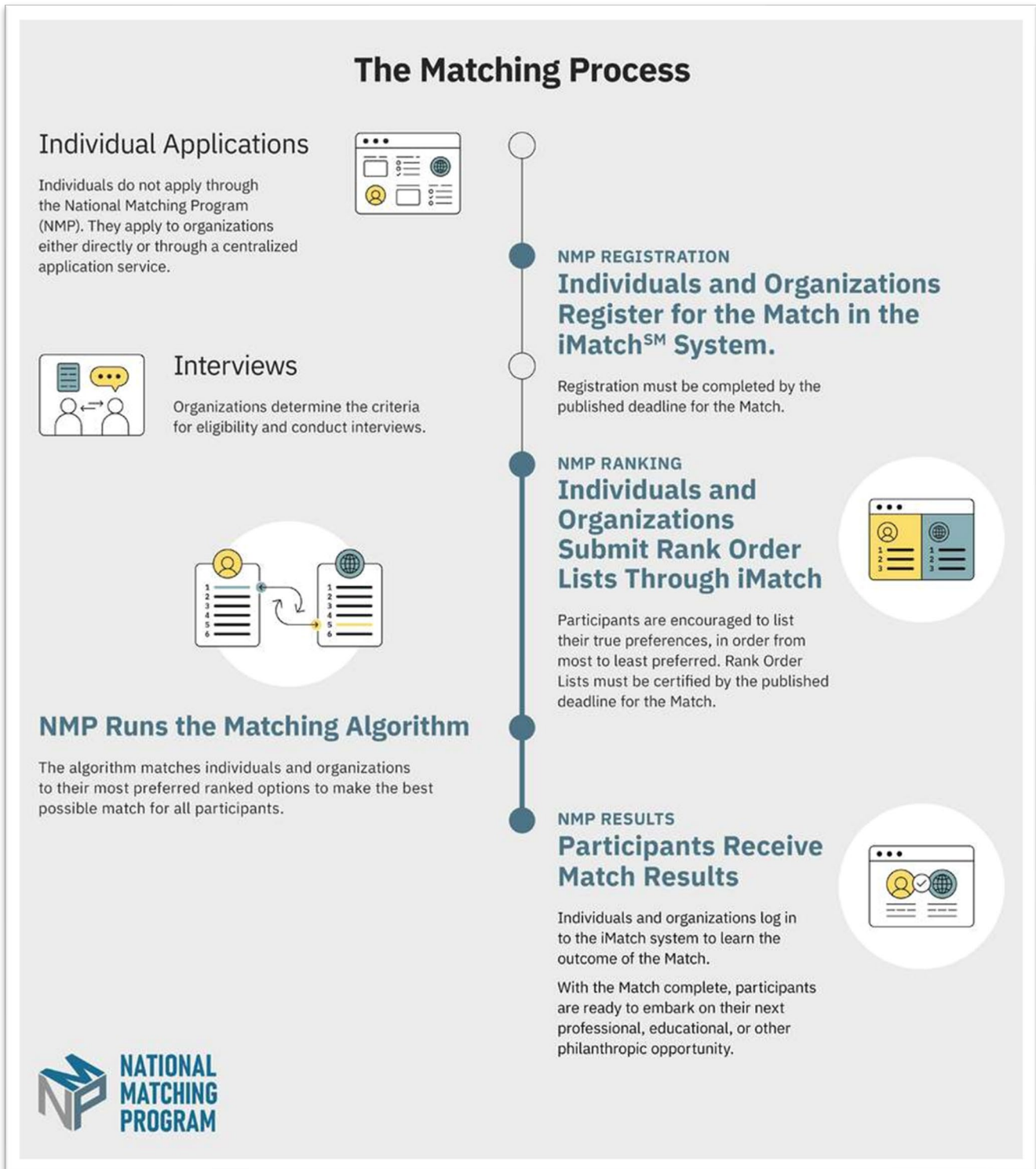
1 The Council on Medical Education understands the concerns presented by the authors of
2 Resolution 302-A-23 and their frustrations related to lack of control over their own destinies. This
3 report describes the origins of The Match and its current state as well as information about
4 independent match processes. It also clarifies the difference between the AAMC's ERAS
5 application process versus NRMP's Match process, acknowledges challenges, and summarizes
6 recent considerations and recommendations. This report illuminates the importance of ongoing
7 communication and transparency by the NRMP as well as collaboration among all invested parties.
8 Further, this report makes clear that there are no currently identified alternatives other than an
9 unstructured, open market approach, which the Council believes would be detrimental to the
10 majority of trainees in comparison to the current Match process. Accordingly, attention should be
11 focused on what can be done to improve The Match and other specialty matches rather than
12 focusing on its replacement, as a match process continues to be the best solution for trainees at this
13 time.

14
15 The Council on Medical Education therefore recommends that the following recommendations be
16 adopted and the remainder of this report be filed. That our AMA:

- 17
18 1. AMA Policy [D-310.977](#), "National Resident Matching Program Reform" be amended by
19 addition to read as follows. Our AMA:
20
21 (20) Encourages the piloting of innovations to the residency application process with aims
22 to reduce application numbers, focus applicants on programs with reciprocal interest, and
23 maximize residency placement. With support from the medical education community,
24 successful pilots should be expanded to enhance the standardized process.
25
26 (21) Continues to engage the National Resident Matching Program® (NRMP®) and other
27 matching organizations on behalf of residents and medical students to further develop
28 ongoing relationships, improve communications, and seek additional opportunities to
29 collaborate including the submission of suitable nominees for their governing bodies as
30 appropriate. (Modify Current HOD Policy)
31
32 2. Reaffirm AMA Policies [H-310.900](#) "Resident and Fellow Physicians Seeking to Transfer
33 GME Program" and [H-310.912](#) "Residents and Fellows' Bill of Rights." (Reaffirm HOD
34 Policy)
35
36 3. Rescind AMA policy [D-310.944](#), "Study of the Current Match Process and Alternatives,"
37 as having been accomplished by this report. (Rescind HOD Policy)
38
39

40 Fiscal note: \$1,000

APPENDIX A: THE MATCH PROCESS



APPENDIX B: RELEVANT AMA POLICY

[National Resident Matching Program Reform D-310.977](#)

Our AMA:

- (1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;
- (2) 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, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;
- (5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
- (6) 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 applicants;
- (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 NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; 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;

(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;

(18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency; and

(19) will work with appropriate stakeholders to study options for improving transparency in the resident application process.

[Study of the Current Match Process and Alternatives D-310.944](#)

Our American Medical Association will study alternatives to the current residency and fellowship Match process which would be less restrictive on free market competition for applicants.

[Residents and Fellows' Bill of Rights H-310.912](#)

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.

3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.

4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.

6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.

7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.

8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with

educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.

10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).

11. The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.

12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

[Preliminary Year Program Placement H-310.910](#)

1. Our AMA encourages the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.

2. Our AMA encourages appropriate stakeholders to explore options to decrease the burden upon medical students who must apply to separate preliminary PGY-1 and categorical PGY-2 positions.

3. Our AMA will work with the Accreditation Council for Graduate Medical Education to encourage programs with PGY-2 positions in the National Resident Matching Program (NRMP) with insufficient availability of local PGY-1 positions to create local PGY-1 positions that will enable coordinated applications and interviews for medical students.

4. Our AMA encourages the NRMP, the San Francisco Match, the American Urological Association, the Electronic Residency Application Service, and other stakeholders to reduce barriers for medical students, residents, and physicians applying to match into training programs, including barriers to "couples matching," and to ensure that all applicants have access to robust, informative statistics to assist in decision-making.

5. Our AMA encourages the NRMP, San Francisco Match, American Urological Association, Electronic Residency Application Service, and other stakeholders to collect and publish data on a) the impact of separate matches on the personal and professional lives of medical students and b) the impact on medical students who are unable to successfully "couples match" with their significant others due to staggered entry into residency, utilization of unlinked match services, or other causes.

[Closing of Residency Programs H-310.943](#)

1. Our AMA: (a) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs; (b) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (c) encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing; (d) will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training; (e) urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements; (f) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding; and (g) will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.

2. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:

A. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;

B. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;

C. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and

D. Protections against the discrimination of displaced residents and fellows consistent with H-295.969.

3. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.

4. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:

A. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;

B. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and

C. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.

[Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure D-310.948](#)

Our AMA will:

1. ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution;

2. encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to develop a process

similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure;

3. encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger;

4. work with AAMC, AACOM, ACGME, and relevant state and specialty societies to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity;

5. encourage ACGME to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will ensure professional liability coverage for residents in the event of an institution or program closure; and

6. continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training programs run by nonprofit and for-profit entities and their effect on medical education.

[Residency Interview Schedules H-310.998](#)

1. Our AMA encourages residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. Our AMA encourages the ACGME and other accrediting bodies to require programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. Our AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of application and ongoing changes in the status of consideration of the application.

2. Our AMA will: (a) oppose changes to residency and fellowship application requirements unless (i) those changes have been evaluated by working groups which have students and residents as representatives, (ii) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate, (iii) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of bias that affects medical students and residents from underrepresented minority backgrounds, and (iv) the costs to medical students and residents are mitigated; and (b) continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(A-24)

Introduced by: Medical Student Section

Subject: Fairness for International Medical Students

Referred to: Reference Committee C

1 Whereas, international students comprise over 10% of US graduate students but only 0.6% of
2 US medical students, indicating that the US recruits globally for academia, research, and other
3 highly educated professions, but not for medicine¹⁻³; and
4

5 Whereas, only 35% of medical schools consider international applicants, only 17% of whom are
6 admitted compared to 38% of domestic applicants⁴⁻⁷; and
7

8 Whereas, international medical students are ineligible for public loans, may be ineligible for
9 medical school scholarships, require a US cosigner for private loans, and may be required to
10 deposit up to four years of tuition upfront into an escrow account prior to matriculation⁷⁻¹⁰; and
11

12 Whereas, many common national medical student scholarships, including the AMA Physicians
13 of Tomorrow scholarship, the Tylenol Future Care scholarship, and the National Medical
14 Fellowships awards, are restricted to domestic students only¹¹⁻¹³; and
15

16 Whereas, international medical students offer valuable diversity of thought, cultural
17 perspectives, and unique life experiences that enrich medical schools, complement efforts to
18 improve physician workforce diversity, address physician shortages, and allow the US to attract
19 and retain the best and brightest future doctors from around the world^{9,14}; therefore be it
20

21 RESOLVED, that our American Medical Association encourage additional medical schools to
22 consider applications from and to admit international students to their programs alongside
23 domestic students (New HOD Policy); and be it further
24

25 RESOLVED, that our AMA amend policy H-255.968 "Advance Tuition Payment Requirements
26 for International Students Enrolled in US Medical Schools" by addition and deletion to read as
27 follows;
28

29 Advance Tuition Payment Requirements for International Students
30 Enrolled in US Medical Schools H-255.968

31 Our AMA:

- 32 1. supports the autonomy of medical schools to determine optimal tuition
33 requirements for international students;
- 34 2. encourages medical schools and undergraduate institutions to fully
35 inform international students interested in medical education in the US of
36 the limited options available to them for tuition assistance;
- 37 3. supports the Association of American Medical Colleges (AAMC) in its
38 efforts to increase transparency in the medical school application process
39 for international students by including school policy on tuition requirements
40 in the Medical School Admission Requirements (MSAR); and

- 1 4. supports efforts to re-evaluate and minimize the use of pre-payment
2 requirements specific to international medical students; and
3 5. encourages medical schools to explore alternative means of
4 prepayment, such as a letter of credit, for four years for covering the costs
5 of medical school. (Modify Current HOD Policy); and be it further
6

7 RESOLVED, that our AMA advocate for increased scholarship and funding opportunities for
8 international students accepted to or currently attending United States medical schools.
9 (Directive to Take Action)
10

Fiscal Note: Minimal - less than \$1,000

Received: 3/28/2024

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RELEVANT AMA POLICY

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; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 210, A-23]

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 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; Reaffirmed: CME Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(A-24)

Introduced by: Private Practice Physicians Section

Subject: The Role of Maintenance of Certification

Referred to: Reference Committee C

- 1 Whereas, the principle of lifelong learning is fundamental to maintaining and enhancing the
2 quality of patient care delivered by physicians; and
3
4 Whereas, certified medical education (CME) already plays a pivotal role in facilitating lifelong
5 learning by offering opportunities for physicians to stay current with advances in medical
6 knowledge and technology; and
7
8 Whereas, specialty boards contend that the process of re-certification and maintenance of
9 certification (MOC) contributes to the enhancement of patient care quality by counteracting a
10 natural decline in medical knowledge and skills over time during active practice, although
11 existing evidence is at odds with this assertion and does not suggest that re-certification and
12 MOC significantly enhance the quality of care provided by physicians^(1,2); and
13
14 Whereas, the current landscape of board certification lacks sufficient competition which has
15 resulted in elevated costs for physicians seeking certification in their respective specialties,
16 competition policy experts noting the harms of consolidation in the market for certification,
17 spirited public debate amongst physicians about the value of MOC to both patients and
18 physicians, and the Department of Justice advocating for efforts to increase competition in the
19 market for physician board certification⁽³⁻⁶⁾; and
20
21 Whereas, the obligation of high-stakes testing as part of MOC is not a comprehensive or optimal
22 way to assess clinical knowledge or competence for physicians who have maintained active
23 clinical practice; and
24
25 Whereas, our American Medical Association has a responsibility to investigate issues that
26 impact physicians and their patients; therefore be it
27
28 RESOLVED, that our American Medical Association adopt a policy that states that maintenance
29 of certification requirements should not be duplicative of continuing medical education
30 requirements and not be used to determine or dictate hospital privileges, insurance network
31 credentialing, or hiring practices (New HOD Policy); and be it further
32
33 RESOLVED, that our AMA recognizes the importance of fostering competition in the market for
34 board certification, allowing physicians to have the autonomy to choose the most suitable
35 pathway for their individual learning and professional development needs (New HOD Policy);
36 and be it further
37
38 RESOLVED, that our AMA undertake a comprehensive review of the available evidence
39 concerning the impact of maintenance of certification on the quality and safety of patient care
40 and report the findings of this investigation to its members and stakeholders, including

1 policymakers and legislators, to inform future healthcare policy with a report back to the House
2 of Delegates by Annual 2025 (Directive to Take Action).
3

Fiscal Note: Minimal - less than \$1,000

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RELEVANT AMA POLICY

Continuing Board Certification D-275.954

Our AMA will:

1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a report regarding the CBC process at the request of the House of Delegates or when deemed necessary by the Council on Medical Education.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician's current practice.

12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.
22. Continue to participate in the Coalition for Physician Accountability, formerly known as the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's CBC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff

membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.

34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.

35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.

36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.

37. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.

38. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development and release of new, integrated standards for continuing certification programs that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.

39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.

40. Our AMA will continue to publicly report its work on enforcing AMA Principles on Continuing Board Certification.

Citation: CME Rep. 2, I-15; Appended: Res. 911, I-15; Appended: Res. 309, A-16; Appended: CME Rep. 02, A-16; Appended: Res. 307, I-16; Appended: Res. 310, I-16; Modified: CME Rep. 02, A-17; Reaffirmed: Res. 316, A-17; Reaffirmed in lieu of: Res. 322, A-17; Appended: CME Rep. 02, A-18; Appended: Res. 320, A-18; Appended: Res. 957, I-18; Reaffirmation: A-19; Modified: CME Rep. 02, A-19; Appended: CME Rep. 1, I-20; Appended: Res. 310, A-21; Modified: CME Rep. 2, A-22; Appended: Res. 310, I-22

MOC Provisions of Interstate Medical Licensure Compact D-275.955

Our American Medical Association will, in collaboration with the Federation of State Medical Boards and interested state medical boards, request a clarifying statement from the Interstate Medical Licensure Compact Commission that the intent of the language in the model legislation requiring that a physician "holds" specialty certification refers only to initial specialty certification recognized by the American Board of Medical Specialties or the American Osteopathic Association's (AOA's) Bureau of Osteopathic Specialists and that there is no requirement for participation in ABMS's Maintenance of Certification or AOA's Osteopathic Continuous Certification (OCC) program in order to receive initial or continued licensure under the Interstate Medical Licensure Compact.

Citation: Res. 235, A-15

An Update on Maintenance of Licensure D-275.957

Our American Medical Association will: 1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue.

2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOL issues.

3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician workforce.

4. Work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL.

5. Explore the feasibility of developing, in collaboration with other stakeholders, AMA products and

services that may help shape and support MOL for physicians.

6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians.

7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards.

8. Encourage rigorous evaluation of the impact on physicians of any future proposed changes to MOL processes, including cost, staffing, and time.

Citation: CME Rep. 3, A-15; Modified: CME Rep. 2, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(A-24)

Introduced by: Young Physicians Section

Subject: Amend Policy D-275.948 Title "Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training". Creation of an AMA Task Force to Address Conflicts of Interest on Physician Boards.

Referred to: Reference Committee C

1 Whereas, physicians strive for the highest degree of patient care and professionalism¹; and

2

3 Whereas, professionalism in medicine has been achieved through self-governance and self-

4 regulation¹; and

5

6 Whereas, non-physicians serving in executive and board leadership roles in physician

7 organizations compromises the objective of self-regulation and self-governance; and

8

9 Whereas, the president and CEO of the National Resident Matching Program (NRMP) is a non-

10 physician, holds the following credentials D.H.Sc., M.B.A., B.S.N., has never participated in the

11 MATCH, never completed a residency or fellowship, and yet has held prior leadership positions

12 overseeing accreditation of physician residency and fellowship programs, was an executive

13 director at the ACGME, and held the position of designated institution official (DIO) for a

14 graduate medical education (GME) program²; and

15

16 Whereas, the newly elected vice chair of the National Board of Medical Examiners (NBME) is a

17 non-physician, holds the following credentials R.N., Ph.D., received a bachelor of science in

18 nursing, received a master of science in nursing education, received a doctor of philosophy in

19 theory development and research in nursing, has never taken any NBME examination for board

20 certification, and yet now holds the position of vice chair for the organization³; and

21

22 Whereas, the current chair of the Accreditation Council for Graduate Medical Education

23 (ACGME) is a non-physician, holds the following credentials M.A., and is co-founder of a

24 strategic human resource consulting firm⁴; and

25

26 Whereas, the recently elected President and current Vice President of the American College of

27 Cardiology (ACC) is a non-physician, holds the following credentials R.N., M.S.N., and is

28 president and CEO of Cardiovascular Management of Illinois, a cardiology physician practice

29 management company⁵; and

1 Whereas, non-physicians, who do not themselves go through physician education,
2 accreditation, certification, licensing, and credentialing, may have difficulty appreciating the
3 needs and challenges of physician trainees and practicing physicians from lack of personal
4 experience, and therefore should not be making major decisions for physicians or representing
5 physicians in the highest roles of these organizations; and
6

7 Whereas, the purpose of having non-physicians on physician boards is to have a public voice
8 on these boards, not to lead the organization itself (i.e. in the highest roles of the organizations);
9 and
10

11 Whereas, non-physicians can participate on physician boards as a public member without
12 leading these organizations in the highest roles; and
13

14 Whereas, one of the focal points of the AMA Recovery Plan is to fight scope creep, and works
15 to educate legislators about the differences in training between physicians and non-physicians⁶;
16 and
17

18 Whereas, having non-physicians lead physician boards is contradictory to the AMA message
19 about scope creep and the importance of physician-led teams; and
20

21 Whereas, our advocacy to legislators about the importance of physician education is
22 compromised by a conflict of interest if we have non-physicians in the highest roles determining
23 physician standards; and
24

25 Whereas, there are highly qualified physicians that could hold these leadership roles now held
26 by non-physicians⁶; and
27

28 Whereas, having these non-physicians lead national standard-setting organizations in our
29 physician profession undermines physician confidence in these organizations; and
30

31 Whereas, the current title of policy D-275.948 does not match the content of the policy;
32 therefore be it
33

34 RESOLVED, that our American Medical Association amend the title of policy D-275.948 by
35 substitution and deletion as follows:

36 ~~Education, Training and Credentialing of Non-Physician Health Care Professionals and Their~~
37 ~~Impact on Physician Education and Training~~ Addressing Non-physician Positions and
38 Participation on Physician Regulatory Boards and Bodies and Potential Conflicts of Interest D-
39 275.948 (Modify Current HOD Policy); and be it further
40

41 RESOLVED, that our AMA work with relevant stakeholders and regulatory bodies and boards
42 involved in physician education, accreditation, certification, licensing, and credentialing to
43 advocate for physician leadership of these regulatory bodies and boards in order to be

- 1 consistent with the AMA Recovery Plan's efforts to fight scope creep, and prevent undermining
2 physician confidence in these organizations (Directive to Take Action); and be it further
3
4 RESOLVED, that our AMA create a task force with the mission to increase physician awareness
5 of and participation in leadership positions on regulatory bodies and boards involved in
6 physician education, accreditation, certification, licensing, and credentialing through
7 mechanisms including but not limited to mentorship programs, leadership training programs,
8 board nominations, publicizing the opportunities to the membership, and creating a centralized
9 list of required qualifications and methods to apply for these positions. (Directive to Take Action)

Fiscal Note: To Be Determined

Received: 4/8/2024

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4. <https://www.acgme.org/about-us/board-and-staff/board-of-directors/>
5. <https://www.acc.org/About-ACC/Leadership/Officers-and-Trustees>
6. <https://www.ama-assn.org/practice-management/scope-practice/advocacy-action-fighting-scope-creep>

RELEVANT AMA POLICY

Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training D-275.948

1. Our AMA acknowledges that a conflict of interest exists when non-physician health care professionals hold positions on physician regulatory bodies or physician boards when these individuals represent a field that either possesses or seeks to possess the ability to practice without physician supervision.
2. Our AMA will encourage key regulatory bodies involved with physician education, accreditation, certification, licensing, and credentialing to: (A) increase transparency of the process by encouraging them to openly disclose how their board is composed and members are selected; and (B) review and amend their conflict of interest and other policies related to non-physician health care professionals holding formal leadership positions (e.g., board, committee) when that non-physician professional represents a field that either possesses or seeks to possess the ability to practice without physician supervision. [CME Rep. 5, A-22; Modified: Res. 323, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(A-24)

Introduced by: Academic Physicians Section

Subject: Spirituality in Medical Education and Practice

Referred to: Reference Committee C

1 Whereas, current AMA policy recognizes the importance of spirituality concerns to many
2 patients and encourages patient access to spiritual care services (H-160.900) but does not
3 detail how the provision of spiritual care to patients would optimally involve physicians,
4 physicians-in-training, or other members of the care team; and
5

6 Whereas, the term “spiritual care” does not require, yet does not exclude, the invoking of any
7 general or specific religious beliefs; rather, spirituality is broadly defined as seeking meaning,
8 purpose, and connectedness, and is inclusive of all ways people may understand spirituality in
9 their lives; and
10

11 Whereas, our AMA’s policies on diversity, equity, and inclusion note the need to respect people
12 and their diverse backgrounds, which applies specifically to the quality and equity of patient
13 care, in that members of medical care teams should demonstrate respect for the culture and
14 spirituality of the patient (and the patient’s family); and
15

16 Whereas, many health organizations, including the World Health Organization (WHO), via its
17 Resolution on Palliative Care, have noted the need for prevention and relief of suffering by
18 means of early identification and correct assessment and treatment of pain and other problems,
19 whether physical, psychosocial, or spiritual – and in the case of WHO, have declared that the
20 treatment of all severe pain, including spiritual pain, is a human right;¹ and
21

22 Whereas, many patients value clinicians who are able to integrate inquiry about patients’
23 spirituality as related to their health, and benefit from access to specialist spiritual care services,
24 when such access is enabled for them; and
25

26 Whereas, a Delphi review of the literature found sufficient evidence to recommend education on
27 spirituality and health in the care of patients with serious and/or chronic illness;^{2,3} and
28

29 Whereas, patient referral and access to spiritual care services would be enhanced if all
30 physicians and medical students had learned how to provide generalist spiritual care through
31 the assessment and treatment of spiritual distress as a clinical symptom, with treatment options
32 to include compassionate listening and presence to patients’ suffering, reflective inquiry to
33 enable patients to fully express their spiritual distress, referral to and collaboration with spiritual
34 care specialists, and continued follow up with the patient on spiritual issues as indicated; and
35

36 Whereas, instruction in medical education regarding spiritual health as part of whole person
37 care, assessment, and treatment of spiritual distress could be expected to enhance “emotional
38 intelligence” and the recognition of opportunities for either providing spiritual care or referring
39 the patient to a spiritual care specialist; and

1 Whereas, burnout—a condition characterized by feelings of pervasive energy depletion or
2 exhaustion, negativism or cynicism about one’s occupation or occupational role, and/or a sense
3 of inadequacy or ineffectiveness in one’s occupational role, is a pervasive emotion and state
4 among clinicians and clinicians-in-training; and
5

6 Whereas, spiritual distress can contribute to burnout across the continuum of medical education
7 and practice, with an association between increased burnout and decreased meaning in work,
8 while the practice of spirituality may be a protective factor against burnout, with such
9 interventions as “reflection rounds” helping health professionals and students rekindle their
10 sense of meaning in their chosen vocation;⁴ and
11

12 Whereas, it is therefore reasonable to hope that by providing physicians and physicians-in-
13 training with opportunities to become more well-educated regarding matters of spirituality, and
14 by enabling them to implement a spiritual approach to their own life and life stresses—including
15 use of spiritual resources such as meditation, seeking professional spiritual care if needed,
16 and/or finding a spiritual community of support—that these individuals may be favorably
17 impacted and be less susceptible to burnout; and
18

19 Whereas, by extension, increased knowledge and awareness of spiritual principles may
20 enhance the abilities of caregivers to not only provide more effective care to others, but also to
21 provide more effective self-care to themselves; therefore be it
22

23 RESOLVED, that our American Medical Association amend Policy H-160.900 to read as
24 follows:
25

26 Addressing Patient Spirituality in ~~Medicine~~ Medical Education and Practice
27

28 (1) Our AMA recognizes the importance of individual patient spirituality and its impact on
29 health and encourages patient access to spiritual care services.
30

31 (2) Our AMA encourages the availability of education about spiritual health, defined as
32 meaning, purpose, and connectedness, in curricula in medical school, graduate medical
33 education, and continuing physician professional development as an integral part of
34 whole person care, which could include:

35 (a) assessing spiritual health as part of the history and physical;

36 (b) addressing treatment of spiritual distress by the clinician, with appropriate referral to
37 spiritual care professionals;

38 (c) acknowledging patients’ spiritual resources;

39 (d) developing compassionate listening skills;

40 (e) ensuring ongoing follow-up of patients’ spiritual health by clinicians as appropriate;

41 (f) describing respect for the spiritual, religious, existential, and cultural value of those
42 they serve and understanding why it is important to not impose their own personal
43 values and beliefs on those served; and

44 (g) self-reflection on one’s own spirituality within professional development courses,
45 especially as related to their vocation and wellbeing. (Modify Current HOD Policy)
46

Fiscal Note: Minimal - less than \$1,000

Received: 4/17/2024

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RELEVANT AMA POLICY

Addressing Patient Spirituality in Medicine H-160.900

Our AMA recognizes the importance of individual patient spirituality and its impact on health and encourages patient access to spiritual care services.

Redesigning the Medicare Hospice Benefit D-330.895

Our American Medical Association advocates for:

1. A 21st century evolution of the Medicare hospice benefit that meets the quadruple aim of health care; advances health equity; and improves access, support, and outcomes for seriously ill patients across all geographies, including underserved and low-resource communities; and
2. A reformed Medicare hospice benefit that may incorporate the following components:
 - a. Hospice eligibility should not be based solely on a specified prognosis or life expectancy but rather on patients' needs.
 - b. Patients must continue to have an open choice of hospice providers.
 - c. Hospice services, including telehealth or telemedicine, should be provided by a full, physician-led interdisciplinary team.
 - d. Patients and their caregivers should receive adequate support using home- or facility-based hospice services, identified by a thorough assessment of their social determinants of health. This would incorporate 24-hour a day care for beneficiaries with very limited life expectancy who lack around the clock caregivers.
 - e. Patients should have concurrent access to disease-directed treatments along with palliative services.
 - f. Payments to hospices should be sufficient to support the quality, experience, scope, and frequency of care that beneficiaries deserve throughout the later stages of serious illness as dictated by their physical, psychological, social, spiritual, and practical needs.
 - g. The hospice benefit should be consistent, including with regard to the quality and intensity of services, regardless of which Medicare program or entity pays for services.
 - h. Metrics for health provider accountability should focus on those aspects of care and experience that matter most to patients, families, and caregivers.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(A-24)

Introduced by: Oklahoma

Subject: Public Service Loan Forgiveness Reform

Referred to: Reference Committee C

1 Whereas, there is a physician shortage across all specialties, locations, and practice types in
2 the United States¹; and
3

4 Whereas, the federal government is responsible for direct healthcare services through the
5 Veteran's Health Administration (VHA) and Indian Health Service (IHS); and
6

7 Whereas, the VHA and IHS both experience chronic, nationwide physician shortages (12.9% at
8 VHA as of 2022², 25% at IHS as of 2018³), paralleling the nation's physician shortage; and
9

10 Whereas, the VHA loan repayment program offers up to \$200,000 in relief to physicians over
11 five years, with no service commitment, while the IHS loan repayment program offers up to
12 \$50,000 in relief to physicians, with a two-year service commitment^{4,5}; and
13

14 Whereas, the VHA has bolstered physician retention and reduced physician burnout by offering
15 competitive financial relief to physicians and making improvements in workload, organizational
16 satisfaction, and psychological safety^{6,7}; and
17

18 Whereas, the VHA compensates physicians using Title 38 pay scales, which provides special
19 authority to recruit and retain employees in certain health care occupations, and also allows the
20 agency to be competitive with other healthcare facilities in the area^{8,9}; and
21

22 Whereas, the IHS compensates physicians using Title 5 pay scales, which are generally less
23 than Title 38 pay scales^{10,11}; and
24

25 Whereas, the Partnership for Public Service and Boston Consulting Group (PPS-BCG) reported
26 that the IHS ranked in the bottom-quartile of agencies within the U.S. Department of Health and
27 Human Services for employee engagement and satisfaction (332 of 432) in 2022¹²; and
28

29 Whereas, the PPS-BCG reported that nearly half of IHS physicians and other employees were
30 not satisfied with their pay and nearly a third were not satisfied with their work-life balance in
31 2022¹²; and
32

33 Whereas, the AMA recommends that compensation for IHS physicians be increased to a level
34 competitive with other federal agencies and non-governmental service (H-350.977); and
35

36 Whereas, physicians employed by the federal government may be eligible for the Public Service
37 Loan Forgiveness Program, which forgives qualifying federal loans after a standard ten-year
38 repayment plan¹³; and

1 Whereas, loan repayment can address physician retention and decrease physician burnout in
2 facilities that may not provide competitive pay or are in geographically remote locations^{14,15,16};
3 and
4

5 Whereas, the AMA has stated that reducing physician burnout should be an urgent priority¹⁷;
6 and
7

8 Whereas, the AMA already supports immediate changes in the Public Service Loan
9 Forgiveness Program to allow physicians to receive immediate loan forgiveness when they
10 practice in a Veteran's Health Administration facility (D-510.990) due to the VA physician
11 shortage; therefore be it
12

13 RESOLVED, that our American Medical Association amend Indian Health Service H-350.977 by
14 addition and deletion as follows:
15

16 Indian Health Service H-350.977

17 The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to
18 meet its obligation to bring American Indian health up to the general population level. The AMA
19 specifically recommends: (1) Indian Population: (a) In current education programs, and in the
20 expansion of educational activities suggested below, special consideration be given to involving
21 the American Indian and Alaska native population in training for the various health professions,
22 in the expectation that such professionals, if provided with adequate professional resources,
23 facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration
24 with American Indian leaders of the possibility of increased numbers of nonfederal American
25 Indian health centers, under tribal sponsorship, to expand the American Indian role in its own
26 health care; (c) Increased involvement of private practitioners and facilities in American Indian
27 care, through such mechanisms as agreements with tribal leaders or Indian Health Service
28 contracts, as well as normal private practice relationships; and (d) Improvement in
29 transportation to make access to existing private care easier for the American Indian population.
30 (2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities
31 and roads, and the availability of alternative nonfederal resources, the AMA recommends that
32 those Indian Health Service facilities currently necessary for American Indian care be identified
33 and that an immediate construction and modernization program be initiated to bring these
34 facilities up to current standards of practice and accreditation.

35 (3) Personnel Manpower: (a) Compensation scales for Indian Health Service physicians be
36 increased to a level competitive with other Federal agencies and nongovernmental service; (b)
37 Consideration should be given to increased compensation for specialty and primary care service
38 in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made
39 to establish closer ties with teaching centers and other federal health agencies, thus increasing
40 both the available staffing manpower and the level of professional expertise available for
41 consultation; (d) Allied health professional staffing of Service facilities should be maintained at a
42 level appropriate to the special needs of the population served without detracting from physician
43 compensation; (e) Continuing education opportunities should be provided for those health
44 professionals serving these communities, and especially those in remote areas, and, increased
45 peer contact, both to maintain the quality of care and to avert professional isolation and burnout;
46 and (f) Consideration should be given to a federal statement of policy supporting continuation of
47 the Public Health Service to reduce the great uncertainty now felt by many career officers of the
48 corps.

49 (4) Medical Societies: In those states where Indian Health Service facilities are located, and in
50 counties containing or adjacent to Service facilities, that the appropriate medical societies
51 should explore the possibility of increased formal liaison with local Indian Health Service
52 physicians. Increased support from organized medicine for improvement of health care provided

- 1 under their direction, including professional consultation and involvement in society activities
2 should be pursued.
- 3 (5) Our AMA also support the removal of any requirement for competitive bidding in the Indian
4 Health Service that compromises proper care for the American Indian population.
- 5 (6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic
6 Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical
7 schools and ACGME-accredited residency programs.
- 8 (7) Our AMA will encourage the development of funding streams to promote rotations and
9 learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.
- 10 (8) Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program
11 to allow physicians to receive immediate loan forgiveness when they practice in an Indian
12 Health Service, Tribal, or Urban Indian Health Program. (Modify Current HOD Policy)
13

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

Received: 4/22/2024

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RELEVANT AMA POLICY

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

(6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.

(7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.

Fixing the VA Physician Shortage with Physicians D-510.990

1. Our AMA will work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities.
2. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility.
3. Our AMA will work with the Veterans Administration to minimize the administrative burdens that discourage or prevent non-VA physicians without compensation (WOCs) from volunteering their time to care for veterans.
4. Our AMA will: (a) continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions; and (b) collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process.
5. Our AMA supports postgraduate medical education service obligations through programs where the

expectation for service, such as military service, is reasonable and explicitly delineated in the contract with the trainee.

6. Our AMA opposes the blanket imposition of service obligations through any program where physician trainees rotate through the facility as one of many sites for their training.

Physician Burnout D-405.972

Our AMA will work with: (1) Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians; and (2) hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications.

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/20 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish

collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician 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; (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; (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).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

23. Continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt.

24. Encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels.

25. Support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including educational and cost of attendance debt.

26. Support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services or are determined to have financial need through another formal mechanism.

Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953

In the setting of the COVID-19 pandemic, our AMA will advocate for additional financial relief for physicians to reduce medical school educational debt.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(A-24)

Introduced by: Edmond Cabbabe, MD

Subject: Unmatched Graduating Physicians

Referred to: Reference Committee C

- 1 Whereas, the U.S. is expected to have an alarming and deeply concerning shortage of
2 physicians in primary and specialty care; and
3
4 Whereas, the number of practicing physicians is decreasing due to burnout, retirement,
5 pursuing non-clinical practices, and other causes; and
6
7 Whereas, the current number of medical students, residents, and fellows will not prevent such a
8 shortage; and
9
10 Whereas, the U.S. Congress has repeatedly failed to provide funding to educate the necessary
11 number of physicians to provide needed care of our aging and expanding population; and
12
13 Whereas, physician assistants (PAs), and advanced practice providers (APPs)/Nurse
14 Practitioners (NPs) have increasingly replaced licensed physicians in providing primary and
15 some specialty care due to geographic and economic shortage of physicians; and
16
17 Whereas, many states have allowed non-physician extenders to practice medicine
18 independently rather than in collaboration with licensed physicians; and
19
20 Whereas, a large number of physicians graduate from medical schools in the U.S. or abroad
21 take and pass USMLE part one and two, then apply for residency, but fail to get one of the
22 limited number of post graduate training spots in the U.S.; and
23
24 Whereas, these graduating physicians spend six to eight years in undergraduate and graduate
25 studies before graduating, and some of them serve a year of internship required to graduate.
26 They spend huge sums of money to complete their studies, sit for and pass the rigorous USMLE
27 tests, spend thousands of dollars on their applications for the matching programs and
28 interviews; and
29
30 Whereas, these unfortunate physicians face the very hard reality of a sudden irreversible
31 interruption of their careers, including, but not limited to large outstanding debts they cannot
32 repay, temporary to permanent interruption of their education, and the threat of never being able
33 to care for patients, while others who are less qualified, less educated, and less financially
34 burdened, such as APPs/NPs can practice medicine with or without collaborating with a
35 licensed physician; and
36
37 Whereas, in 2014, Missouri passed a law allowing these unfortunate graduating physicians to
38 obtain a license called Assistant Physician (AP) which allow these physicians without residency
39 to work in underserved areas in primary care, and only in collaboration with a licensed Missouri
40 physician; and

1 Whereas, many other states have passed similar or much less restrictive laws, under different
2 titles and processes such as Graduate Physician, Associate Physician, etc., some of them
3 allowing this group to gradually practice independently without a residency; and
4

5 Whereas, the number of these unfortunate graduating physicians has grown by the thousands
6 each year, yet Congress did not provide the needed funding to create enough residency slots to
7 train these physicians who would partially solve the expected shortages; and
8

9 Whereas, many of these graduating physicians, after practicing in collaboration with licensed
10 physicians, acquiring additional skills and experience, were able to match into a residency
11 program; therefore be it
12

13 RESOLVED, that our American Medical Association Board of Trustees study the role these
14 unmatched physicians can play in providing care to our patients, their impact of lessening the
15 impact of physician shortages, and provide recommendations on how to enroll these graduating
16 physicians with a uniform title, privileges, geographic restrictions, and collaboration choices, and
17 report to the House of Delegates at the next Interim meeting. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 4/22/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(A-24)

Introduced by: California

Subject: Access to Reproductive Health Services When Completing Physician Certification Exams

Referred to: Reference Committee C

1 Whereas, the Supreme Court’s 2022 ruling in Dobbs. v. Jackson overturned the 1972 Roe v
2 Wade decision; and
3
4 Whereas, at least 26 states immediately enacted laws to ban or restrict abortion care in
5 response to the Supreme Court’s ruling in Dobbs v. Jackson; and
6
7 Whereas, national specialty societies host mandatory board certification exams in locations that
8 often require interstate travel for trainees completing residency and fellowship programs; and
9
10 Whereas, existing AMA policy supports encouraging American Board of Medical Specialties
11 member boards to assess whether initial board certification processes should be revised to
12 allow for testing requirements and arrangements that accommodate physicians' training and
13 employment schedules; and
14
15 Whereas, pregnant trainees may encounter health emergencies during the time frame of
16 completing mandatory board certification exam requirements that necessitate access to a full
17 spectrum of reproductive healthcare services, interventions and treatment options, including
18 abortion; therefore be it
19
20 RESOLVED, that our American Medical Association encourage national specialty boards who
21 hold in-person centralized mandatory exams for board certification to offer alternative methods
22 of taking mandatory board certification examinations, such as virtual boards examinations, or to
23 locate them outside of states that are in the process of banning or restricting or that have
24 banned or restricted abortion, gender affirming care or reproductive healthcare services. (New
25 HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 4/23/2024

RELEVANT AMA POLICY

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 will advocate for the availability of abortion education and clinical exposure to medication and procedural abortion for medical students and resident/fellow physicians and opposes efforts to interfere

with or restrict the availability of this education and training.

3. In the event that medication and procedural abortion are limited or illegal in a home institution, our AMA will support pathways for medical students and resident/fellow physicians to receive this training at another location.

4. Our AMA will advocate for funding for institutions that provide clinical training on reproductive health services, including medication and procedural abortion, to medical students and resident/fellow physicians from other programs, so that they can expand their capacity to accept out-of-state medical students and resident/fellow physicians seeking this training.

5. 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 relevant Residency Review Committees.

[Modified: Res. 317, I-22; Modified: Res. 309, I-21; Appended: Res. 957, I-17; Modified: CME Rep. 1, A-15; Modified: CME Rep. 2, A-14; Reaffirmed: CME Rep. 2, A-04; Res. 315, I-94.]

D-5.999 Preserving Access to Reproductive Health Services

Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion. [Appended: Res. 711, A-23; Reaffirmation: A-23; Appended: Res. 317, I-22; Modified: BOT Rep. 4, I-22; Reaffirmed: Res. 224, I-22; Res. 028, A-22.]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(A-24)

Introduced by: Resident and Fellow Section

Subject: Transforming the USMLE Step 3 Examination to Alleviate Housestaff
Financial Burden, Facilitate High-Quality Patient Care, and Promote
Housestaff Well-Being

Referred to: Reference Committee C

- 1 Whereas, the United States Medical Licensing Examination (USMLE) Step 3 is the final
2 licensure examination in the USMLE series for physician licensure, which is taken during
3 residency training¹; and
4
5 Whereas, Step 3 is a two-day examination, with the first day (“Foundations of Independent
6 Practice,” 7 hours of testing) focused on basic science principles and the second day
7 (“Advanced Clinical Medicine,” 9 hours of testing) focused on application of clinical knowledge;
8 and
9
10 Whereas, the first testing day consists of multiple-choice questions and the second day consists
11 of a combination of multiple-choice questions and computer-based case simulations¹; and
12
13 Whereas, the cost of registering to take Step 3 was \$915 in 2023, with an increase to \$925 in
14 2024 and subsequent annual fee increases²; and
15
16 Whereas, the Step 3 test preparation question bank costs an individual resident \$429 in 2023,
17 which an increase for each renewal period³; and
18
19 Whereas, given that the computer-based simulation section utilizes software from a company
20 called *Primum*, which differs drastically from the Electronic Medical Record, trainees often
21 purchase CCS Cases to learn the software, which costs at minimum \$70; and
22
23 Whereas, therefore, the total cost of Step 3 preparation and examination is at least \$1,400 per
24 trainee, not including two missed days of work; and
25
26 Whereas, trainees may have to use their designated days off to prepare for and to sit for the
27 examination, exacerbating moral injury and burnout; and
28
29 Whereas, the objective of Step 3 is to test general medicine concepts primarily in an ambulatory
30 setting, which does not accurately reflect the sub-specialization and complexity of modern-day
31 medicine, and, therefore, does not justify a numerical score across disciplines; and
32
33 Whereas, Step 3 was designed for examination after successful completion of one’s medical
34 degree, however, USMLE recommends completion of one post-graduate year of training prior to
35 taking the exam⁴; and
36
37 Whereas, specialty choice is highly predictive of examination score; trainees in general
38 medicine fields (i.e. family medicine, emergency medicine, internal medicine, medicine-

1 pediatrics, and pediatrics) obtain significantly higher scores on Step 3 compared to more
2 specialized fields, supported by a retrospective study (n=36,805) of U.S. and Canadian medical
3 school graduates who took Step 3 for the first time between 1999 and 2002⁵; and
4

5 Whereas, the National Board of Medical Examiners (NBME) published data from 275,392
6 board-certified physicians who passed Step 3 between 2000 and 2017 indicating that a higher
7 score inversely correlated with likelihood of disciplinary action from the medical board (though
8 limitations included treating all disciplinary actions equally, which does not translate directly to
9 medical and/or surgical skills)⁶; and
10

11 Whereas, there are no published data that correlate one's numeric Step 3 score with true
12 clinical skills and beneficial patient outcomes; and
13

14 Whereas, preparing for Step 3 on top of clinical duties during residency may detract from on-
15 the-job learning and patient care, especially for trainees who pursue fellowships, as Step 3
16 scores are a component of the application process; and
17

18 Whereas, residency programs do not give residents protected study time for Step 3, thus,
19 residents must prepare for the examination on top of their 60-80+ hour work-weeks; and
20

21 Whereas, a one-day, pass/fail examination has the potential to reduce trainee costs, promote
22 trainee well-being, and encourage more learning via patient care in lieu of question banks;
23 therefore be it
24

25 RESOLVED, that our American Medical Association supports changing the United States
26 Medical Licensing Examination (USMLE) Step 3 from a numerically-scored examination to a
27 pass/fail examination (New HOD Policy); and be it further
28

29 RESOLED, that our AMA supports changing USMLE Step 3 from a two-day examination to a
30 one-day examination (New HOD Policy); and be it further
31

32 RESOLVED, that our AMA supports the option to take USMLE Step 3 after passing Step 2-
33 Clinical Knowledge (CK) during medical school (New HOD Policy); and be it further
34

35 RESOLVED, that our AMA advocates that residents taking the USMLE Step 3 exam be allowed
36 days off to take the exam without having this time counted for PTO or vacation balance.
37

(Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 4/24/24

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RELEVANT AMA POLICY:

Proposed Single Examination for Licensure H-275.962: Our AMA: (1) endorses the concept of a single examination for medical licensure; (2) urges the NBME and the FSMB to place responsibility for developing Steps I and II of the new single examination for licensure with the faculty of U.S. medical schools working through the NBME; (3) continues its vigorous support of the LCME and its accreditation of medical schools and supports monitoring the impact of a single examination on the effectiveness of the LCME; (4) urges the NBME and the FSMB to establish a high standard for passing the examination; (5) strongly recommends and supports actively pursuing efforts to assure that the standard for passing be criterion-based; that is, that passing the examination indicate a degree of knowledge acceptable for practicing medicine; and (6) will work with the appropriate stakeholders to study the advantages, disadvantages, and practicality of combining the USMLE Step 1 and Step 2 CK exams into a single licensure exam measuring both foundational science and clinical knowledge competencies. [CME Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: CME Rep. 2, A-10; Reaffirmed: BOT Rep. 3, I-14; Appended: Res. 309, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(A-24)

Introduced by: Resident and Fellow Section

Subject: Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine

Referred to: Reference Committee C

1 Whereas, founded in 1902, the Alpha Omega Alpha (AOA) Honor Medical Society consists of
2 over 200,000 medical student and physician members across 135 chapters with a mission to
3 recognize high educational achievement¹; and
4

5 Whereas, AOA membership is disproportionately White: a 2017 cohort study of 4,655 medical
6 students illustrated that AOA membership for White students was nearly 6 times greater than
7 that for Black students and nearly 2 times greater than that for Asian students²; and
8

9 Whereas, Black medical students are significantly less likely to be inducted into AOA compared
10 to other groups, according to a 2019 cohort study that examined data from 11,781 ERAS
11 applications³; and
12

13 Whereas, exclusion from AOA membership also disproportionately impacts Hispanic/Latino,
14 American Indian/Alaska Native, and Native Hawaiian/Pacific Islander students⁴; and
15

16 Whereas, these inequities are especially concerning given the differential access AOA
17 membership affords; AOA members are prioritized for interview invites and have greater odds of
18 matching into traditionally competitive specialties (i.e., dermatology, plastic surgery, orthopedic
19 surgery, urology, radiation oncology, and otolaryngology)⁵; and
20

21 Whereas, according to AOA's website, 75% of medical school deans are AOA members,
22 suggesting that membership can amplify success over the course of one's career¹; and
23

24 Whereas, entry into AOA relies heavily upon clerkship grades, which are subject to significant
25 biases, with studies showing students of color tend to receive lower clerkship grades compared
26 to their White counterparts, particularly those who are underrepresented in medicine (UIM),
27 even after controlling for test scores⁴; and
28

29 Whereas, in clinical evaluations, White medical students have a greater propensity to be
30 characterized by their professional attributes such as "knowledgeable," while Black students are
31 more likely to be described by personal characteristics like "pleasant"⁶; and
32

33 Whereas, UIM students face additional burdens and energy expenditures that non-UIM students
34 do not experience, such as activation via triggers, internal dialogue, and threat response, which
35 may negatively impact their clerkship grades; and
36

37 Whereas, UIM students additionally face difficulty finding peer support networks, trouble
38 establishing peer-working relationships, and experiences of racism while being expected to lead

1 uncompensated diversity, equity, and inclusion efforts at their institutions, all of which can
2 detract from academic and clinical duties; and
3

4 Whereas, multiple institutions have disaffiliated from AOA due to racial inequities in
5 membership, including the University of San Francisco School of Medicine, the Yale School of
6 Medicine, and the Icahn School of Medicine at Mount Sinai⁷⁻⁹; and
7

8 Whereas, in 2020, AOA evolved eligibility criteria to promote diversity by increasing the number
9 of members per class and by allowing chapters to develop their own metrics, although this
10 change has failed to address the structural issues perpetuated by AOA^{10,11}; and
11

12 Whereas, disaffiliation from AOA entails eliminating institutional ties to the AOA national
13 organization, and residency applicants select “no AOA chapter at my school” under the ERAS
14 awards section; and
15

16 Whereas, disaffiliation from AOA is a critical step toward promoting equity in admissions and
17 medical education at large, and disaffiliation sends a compelling message that medical
18 education needs alternative, equitable mechanisms to recognize the excellence of trainees;
19 therefore be it
20

21 RESOLVED, that our American Medical Association recognizes that the Alpha Omega Alpha
22 Honor Medical Society disproportionately benefits privileged trainees (New HOD Policy); and be
23 it further
24

25 RESOLVED, that our AMA supports institutional disaffiliation from the Alpha Omega Alpha
26 Honor Medical Society due to its perpetuation of racial inequities in medicine (New HOD Policy);
27 and be it further
28

29 RESOLVED, that our AMA recognizes that the Alpha Omega Alpha Honor Medical Society
30 perpetuates and accentuates discrimination against trainees of color that is inherent in medical
31 training. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 4/24/2024

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(A-24)

Introduced by: Jill Owens, MD, Pennsylvania Chair

Subject: Accountability & Transparency in GME funding with Annual Report

Referred to: Reference Committee C

- 1 Whereas, funding for Graduate Medical Education (GME) is derived from both public and
2 private sources; and
3
4 Whereas, the federal government is by far the largest contributor to GME; and
5
6 Whereas, various programs that support physician workforce development are managed by
7 agencies within the Departments of Health and Human Services, Veterans Affairs, and Defense;
8 and
9
10 Whereas, Medicare is the largest source of federal GME funding and Medicaid, a joint federal-
11 state program, is the second largest source of support for GME; and
12
13 Whereas, the ACGME does not control and has no involvement in resident/fellow salaries; and
14
15 Whereas, each Sponsoring Institution's Graduate Medical Education Committee must approve
16 annual recommendations to administration regarding resident/fellow salaries and benefits; and
17
18 Whereas, the Institute of Medicine's (IOM) Committee on Government and Financing of
19 Graduate Medical Education (GME) put out their report "Graduate Medical Education That
20 Meets the Nation's Health Needs" in 2014; and
21
22 Whereas, it was in 2016 that CME last gave its report on Accountability and Transparency in
23 GME funding (CME Report 5-A-16); and
24
25 Whereas, it was from CME report 5 at A-16 that our American Medical Association adopted
26 policy H305.929 with provisions 3) and 4) committing to overall transparency and specifically
27 financial transparency with regard to Graduate Medical Education; and
28
29 Whereas, The Consolidated Appropriations Act of 2021 added 1000 new Medicare-funded
30 residency positions for the first time since 1997; and
31
32 Whereas, it was in 2022 that our AMA, through house policy H305.930, called for appropriate
33 increases in resident salaries; and therefore be it
34
35 RESOLVED, that our American Medical Association work with interested parties (including but
36 not limited to the CMS, VA, DOD and others) to issue an annual report detailing the quantity of
37 GME funding for each year including how those funds are allocated on a per resident or fellow
38 basis, for a minimum of the previous 5 years (Directive to Take Action); and be it further,
39
40 RESOLVED, that our AMA reaffirm policy H 305.929 (Last modified 2016). (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 4/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(A-24)

Introduced by: Pennsylvania Delegation

Subject: Physician Participation in Healthcare Organizations

Referred to: Reference Committee C

1 Whereas, within Pennsylvania there have been discussions of healthcare organizations
2 expanding the involvement of Advanced Care Practitioners (APP) within the healthcare
3 organization boards; and
4

5 Whereas, in the state of Pennsylvania, the Pennsylvania Medical Society has passed a
6 prophylactic policy “that all doctor’s medical and surgical societies both existing and newly
7 established should be chaired by MD’s or DO’s”; and
8

9 Whereas, our AMA supports physician participation in healthcare organizations via H 405.953
10 (2017) which says:

- 11 1. Our AMA will advocate for and promote the membership of physicians on the boards of
12 healthcare organizations including, but not limited to, acute care providers; insurance
13 entities; medical device manufacturers; and health technology service organizations.
- 14 2. Our AMA will promote educational programs on corporate governance that prepare and
15 enable physicians to participate on health organization boards.
- 16 3. Our AMA will provide physicians, the public, and health care organizations information
17 on the positive impact of physician leadership; therefore be it
18

19 RESOLVED, that our American Medical Association reaffirm H 405.953. (Reaffirm HOD Policy)
20

Fiscal Note: Minimal - less than \$1,000

Received: 4/24/2024

RELEVANT AMA POLICY

Participation of Physicians on Healthcare Organization Boards H-405.953

1. Our AMA will advocate for and promote the membership of physicians on the boards of healthcare organizations including, but not limited to, acute care providers; insurance entities; medical device manufacturers; and health technology service organizations.
2. Our AMA will promote educational programs on corporate governance that prepare and enable physicians to participate on health organization boards.
3. Our AMA will provide physicians, the public, and health care organizations information on the positive impact of physician leadership.

Citation: Res. 001, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(A-24)

Introduced by: Georgia

Subject: AMA Collaboration with FSMB to Assist in Licensing Reentrant Physicians

Referred to: Reference Committee C

1 Whereas, physicians take time out of continuous practice for a variety of reasons, such as for
2 mental or physical health issues, family or personal life events; and
3
4 Whereas, such time off from practice raises questions about a physician's fitness to return to
5 active practice; and
6
7 Whereas, state medical boards are charged with protecting the public and must evaluate
8 physicians wishing to return to practice to determine their readiness to practice in a safe and
9 competent manner; and
10
11 Whereas, the Federation of State Medical Boards (FSMB) established the Workgroup on
12 Reentry in 2023 to evaluate and revise its existing policies on physician reentry to practice; and
13
14 Whereas, the FSMB Workgroup on Reentry found a paucity of research to support
15 development of reentry policies, procedures, and resources for state medical boards; and
16
17 Whereas, a survey of state medical boards found that only 57% have a policy or formal process
18 for the evaluation or retraining for physician reentry to practice; and
19
20 Whereas, no structured/consistent criteria or standardized processes exist across the country to
21 facilitate reentry without subjectivity, bias or possibly arbitrariness; and
22
23 Whereas, there is a need for a consistent approach to reentry to practice, informed by evidence
24 based criteria, where available; and
25
26 Whereas, the collection of relevant research and data will require multiple sources of
27 information beyond state medical boards, including specialty societies, certification boards and
28 post licensure training programs; and
29
30 Whereas, the AMA, with its broad representation within the House of Medicine has the
31 resources to support such data collection and research; therefore be it
32
33 RESOLVED, that our American Medical Association work with the FSMB, specialty and
34 subspecialty societies, and other relevant stakeholders to study and develop evidence-based
35 criteria for determining a physician's readiness to reenter practice and identify resources for the
36 evaluation and retraining of physicians seeking to reenter active practice. (Directive to Take
37 Action)

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

Received: 4/24/2024

REFERENCES

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RELEVANT AMA POLICY

Physician Reentry D-300.984

Our AMA:

1. Will continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs.
2. Will work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice.
3. Will work with interested parties to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics.
4. Will support efforts to ensure the affordability and accessibility, and to address the unique liability issues related to PREPs.
5. Will make available to all interested parties the physician reentry program (PREP) system Guiding Principles for use as a basis for all reentry programs:
 - a. Accessible: The PREP system is accessible by geography, time and cost. Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is commensurate with the assessed clinical and educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions or the health care system.
 - b. Collaborative: The PREP system is designed to be collaborative to improve communication and resource sharing. Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible.
 - c. Comprehensive: The PREP system is comprehensive to maximize program utility. Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice.
 - d. Ethical: The PREP system is based on accepted principles of medical ethics. Physician reentry programs will conform to physician licensure statutes. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed.
 - e. Flexible: The PREP system is flexible in structure in order to maximize program relevancy and usefulness. Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians.
 - f. Modular: Physician reentry programs are modularized, individualized and competency-based. They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need.
 - g. Innovative: Innovation is built into a PREP system allowing programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians. Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation.
 - h. Accountable: The PREP system has mechanisms for assessment and is open to evaluation. Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate physician's competence at time of entry, during the program and at time of completion. Program outcomes are measured. Reliability and validity of the measures are established. Standardization of measures exist across programs to assess whether or not national standards are being met.
 - i. Stable: A funding scheme is in place to ensure the PREP system is financially stable over the long-term. Adequate funding allows physician reentry programs to operate at sufficient and

appropriate capacity. j. Responsive: The PREP system makes refinements, updates and other changes when necessary. Physician reentry programs are equipped to address systemic changes such as changes in regulations. Additionally, the PREP system is prepared to respond efficiently to urgent health care needs within society including mobilizing clinically inactive physicians temporarily into the workforce to attend to an acute public health crisis, such as a terrorist, biological, chemical, or natural disaster.

6. Our AMA encourages each state which does not grant a full and unrestricted license to physicians undergoing reentry to develop a non-disciplinary category of licensure for physicians during their reentry process.

Citation: (CME Rep. 6, A-08; Reaffirmed: CME Rep. 11, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 310, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(A-24)

Introduced by: Oklahoma

Subject: CME for Rural Preceptorship

Referred to: Reference Committee C

1 Whereas, rural Americans are more likely to die from heart disease, cancer, unintentional injury,
2 chronic lower respiratory disease, and stroke than their urban counterparts¹; and
3
4 Whereas, there are fewer health care providers per capita in nonmetropolitan areas; Although
5 nearly 20% of the U.S. population lives in rural areas, less than 10% of U.S. doctors practice in
6 rural areas²; and
7
8 Whereas, there are fewer health care providers per capita in nonmetropolitan areas; Although
9 nearly 20% of the U.S. population lives in rural areas, less than 10% of U.S. doctors practice in
10 rural areas²; and
11
12 Whereas, Continuing Medical Education (CME) credits are vital to all physicians; and
13
14 Whereas, being a “preceptor” for medical students, residents, fellows, and other allied health
15 professional students requires countless hours of preparation; and
16
17 Whereas, the American Osteopathic Association (AOA) offers category 1B credit to its members
18 for participation in the AOA Didactic and Preceptor Program⁴; and
19
20 Whereas, 60 AOA category 1B credits may be applied to the required 120 hours of CME for
21 AOA physicians⁴; and
22
23 Whereas, the American Academy of Family Physicians offers CME credits to its members for
24 teaching of medical students, residents, and other allied health professional students⁵; and
25
26 Whereas, the American Medical Association (AMA) does not recognize the AOA credits
27 awarded for teaching and being a preceptor; and
28
29 Whereas, recognizing such efforts would encourage more physicians to be involved in preceptor
30 programs especially rural, which in turn would expose more students to the practice of medicine
31 in more rural and underserved areas; therefore be it
32
33 RESOLVED, that our American Medical Association along with the Council of Medical
34 Education, formulate a “toolkit” to teach physicians who serve as preceptors, especially in rural
35 and underserved areas, how to be better preceptors and the process on claiming AMA Category
36 1 credits for preparation and teaching medical students, residents, fellows, and other allied
37 health professional students training in Liaison Committee on Medical Education/Accreditation
38 Council for Graduate Medical Education accredited institutions, thereby making them a more
39 effective preceptor (Directive to Take Action); and be it further

1 RESOLVED, that our AMA study formulating a plan, in collaboration with other interested
2 bodies, to award AMA Category 1 credits to physicians who serve as preceptors in rural and
3 underserved areas teaching medical students, residents, fellows, and other allied health
4 professional students training in Liaison Committee on Medical Education/Accreditation Council
5 for Graduate Medical Education accredited institutions thereby improving the rural healthcare
6 workforce shortage (Directive to Take Action); and be it further

7
8 RESOLVED, that our AMA devise a method of converting those credits awarded by other
9 organizations into AMA recognized credits for the purpose of CME. (Directive to Take Action)

10
Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 4/22/2024

REFERENCES

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2. <https://www.incrediblehealth.com/blog/8-statistics-that-explain-the-rural-doctor-shortage/#:~:text=There%20are%20fewer%20health%20care,doctors%20practice%20in%20rural%20areas.>
3. <https://meridian.allenpress.com/jgme/article/14/4/441/484914/Family-Medicine-Residencies-How-Rural-Training>
4. <https://osteopathic.org/cme/cme-faqs/>
5. <https://www.aafp.org/pubs/fpm/issues/2012/0300/p8a.html#:~:text=Learning%20hands%20on%20how%20a,rewarding%20way%20to%20earn%20CME>

RELEVANT AMA POLICY

H-300.977, Revisions to Physician's Registration Award

Our AMA has adopted the following changes in the Physician's Recognition Award:

to accept recertification by an AMA-recognized specialty board in satisfaction of requirements for a three-year PRA certificate;

(2) to allow credit for international conferences when these have been approved by the AMA prior to the event; and

(3) to allow credit for teaching to be reported for AMA PRA Category 2 Credit™ toward the award.

H-300.988, Restoring Integrity to Continuing Medical Education

The AMA (1) supports retention of the definitions of continuing medical education in the Physicians' Recognition Award ("Continuing medical education consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public."); (2) urges members of the medical profession to be attentive to the distinction between continuing medical education and continuing education which is not related directly to their professional activities; (3) believes that accredited sponsors should designate as continuing medical education only those continuing education activities which meet the definition of continuing medical education; (4) encourages the ACCME and state medical associations on the state level to weigh seriously, in considering the sponsor's continued accreditation, instances where an accredited sponsor identifies non-continuing medical education activities as continuing medical education; and (5) encourages state medical boards to accept for credit continuing education which relates directly to the professional activities of physicians, although each state with mandatory continuing medical education for reregistration of license has the prerogative of defining the continuing education it will accept for credit.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 314
(A-24)

Introduced by: Women Physicians Section

Subject: Reducing the Lifetime Earnings Gap in the U.S. with Similar Educational Attainment by Employing the Gainful Employment Rule

Referred to: Reference Committee C

1 Whereas, the value of a college education was demonstrated in a 2002 Census Bureau study
2 that “estimated in 1999, the average lifetime earnings of a Bachelor’s degree holder was \$2.7
3 million, and 75 percent more than that earned by high school graduates in 1999”; and
4

5 Whereas, according to the Georgetown’s College Payoff report, those who possess “some
6 postsecondary education, even without earning a degree, add nearly one quarter of a million
7 dollars to lifetime earnings...and earnings rise substantially for those with Doctoral and
8 Professional degrees...”; and
9

10 Whereas, the Social Security Administration reports that “lifetime earnings have important
11 implications for retirement outcomes, including the level of Social Security benefits”; and
12

13 Whereas, “there are substantial differences in lifetime earnings by educational attainment”; and
14

15 Whereas, the Social Security Administration states recent research reflects that “men with
16 graduate degrees earn \$1.5 million more in median lifetime earnings than high school
17 graduates, and women with graduate degrees earn \$1.1 million more”; and
18

19 Whereas, according to the Georgetown College Payoff report, “the largest gender gap in
20 earnings is for those with professional degrees...men earn about a million dollars more over a
21 lifetime than women with these degrees”; and
22

23 Whereas, the Federal Registrar states that gainful employment reflects the “reasonable
24 relationship between the loan debt incurred by students in a training program and income from
25 employment after the training”; and
26

27 Whereas, “the Higher Education Act requires that certificate programs at all institutions and
28 degree programs at private for-profit colleges must provide training that prepares students for
29 gainful employment in a recognized occupation;” and “programs would have to show that:
30

31 a. “Graduates can afford their yearly debt payments...and the share of their annual
32 earnings needed to devote to paying their debt must be equal to or less than 8 percent,
33 or equal to or less than 20 percent of their discretionary earnings.”
34

35 b. “At least half of graduates have higher earnings than a typical high school graduate in
36 their State’s labor force who never pursued a postsecondary education”; and
37

38 Whereas, according to the U.S. Department of Education, the Biden-Harris Administration
39 “released final regulations that establish the most effective set of safeguards ever against

1 unaffordable debt or insufficient earnings for postsecondary students” and continue to seek
2 ways to reduce the student debt burden; therefore be it

3
4 RESOLVED, that our American Medical Association collaborate with higher education
5 authorities to research physician career outcomes and explore financial value transparency
6 among higher educational institutional programs that grant professional and doctoral degrees
7 beyond six years following graduation in light of the new gainful employment regulations and
8 transparency provisions that will take effect July 1, 2024 (Directive to Take Action); and be it
9 further

10
11 RESOLVED, that our AMA continue to work with key stakeholders and advocate for the
12 resolution of the student loan crisis to protect physicians from unaffordable student debt and
13 poor earning outcomes. (Directive to Take Action)

14
Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 5/3/2024

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2. "Department of Education Releases Proposed Rules on Accountability for Certificate and For-Profit Programs and Transparency into Unaffordable Student Debt." 28 February 2024. <https://www.ed.gov/news/press-releases/department-education-releases-proposed-rules-accountability-certificate-and-profit-programs-and-transparency-unaffordable-student-debt>
3. Press Office. "Biden-Harris Administration Announces Landmark Final Rules to Protect Consumers from Unaffordable Student Debt and Increase Transparency." 27 September 2023. 28 February 2024. <https://www.ed.gov/news/press-releases/biden-harris-administration-announces-landmark-final-rules-protect-consumers-unaffordable-student-debt-and-increase-transparency>
4. Social Security Administration. "Research, Statistics & Policy Analysis." 28 February 2024. <https://www.ssa.gov/policy/docs/research-summaries/education-earnings.html>

RELEVANT AMA POLICY

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with

educational debt.

7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician 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; (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; (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).
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
23. Continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt.
24. Encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels.
25. Support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including educational and cost of attendance debt.

26. Support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services or are determined to have financial need through another formal mechanism. [CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21; Reaffirmation: A-22; Appended: CME Rep. 02, A-23; Appended: Res. 311, A-23]

Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic D-305.951

Our AMA will study the issue of medical education debt cancellation and consider the opportunities for integration of this into a broader solution addressing debt for all medical students and physicians. [Res. 301, A-22]

Exclusion of Medical Debt That Has Been Fully Paid or Settled H-373.996

Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner. [Res. 226, I-10; Reaffirmed: BOT Rep. 04, A-20]

Medical Student Debt and Career Choice D-305.952

1. Our AMA encourages 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.
2. Our AMA will 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. [CME Rep. 4, I-21; Reaffirmed: CME Rep. 02, A-23]

Principles for Graduate Medical Education H-310.929

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.

(1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.

(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.

(3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.

(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) **INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS.** Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) **COMPENSATION OF RESIDENT PHYSICIANS.** All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) **LENGTH OF TRAINING.** The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) **PROVISION OF FORMAL EDUCATIONAL EXPERIENCES.** Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(10) **INNOVATION OF GRADUATE MEDICAL EDUCATION.** The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

(11) **THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION.** Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) **SUPERVISION OF RESIDENT PHYSICIANS.** Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution. [CME Rep. 9, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 14, A-09; Modified: CME Rep. 06, I-18; Reaffirmed: CME Rep. 01, I-22]

Abolish Discrimination in Licensure of IMGs H-255.966

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 (FSMB) and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.

2. Our AMA will continue to work with the FSMB to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.

3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.

4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.

5. Our AMA will: (a) encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas; and (b) encourage the FSMB and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure--including successes, failures, and barriers to implementation. [BOT Rep. 25, A-15; Appended: CME Rep. 4, A-21]

Recommendations for Future Directions for Medical Education H-295.995

Our AMA supports the following recommendations relating to the future directions for medical education:

(1) The medical profession and those responsible for medical education should strengthen the general or

broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.

(2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.

(3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.

(4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.

(5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.

(6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.

(7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.

(8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.

(9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.

(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.

(11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.

(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.

(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.

(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.

(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.

(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.

(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b)

Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.

(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.

(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.

(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.

(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.

(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.

(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.

(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.

(25) Specialty boards should consider having members of the public participate in appropriate board activities.

(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.

(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US.

Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.

(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.

(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and

to develop new methods having an acceptable degree of reliability and validity should be supported.

(30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.

(31) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.

(32) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.

(33) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.

(34) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.

(35) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.

(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education.

(37) Our AMA will publicize to medical students, residents, and fellows their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation. [CME Rep. B, A-82; Amended: CLRPD Rep. A, I-92; Res. 331, I-95; Reaffirmed by Res. 322, A-97; Reaffirmation I-03; Modified: CME Rep. 7, A-05; Modified: CME Rep. 2, I-05; Appended: CME Rep. 5, A-11; Reaffirmed: CME Rep. 3, A-11; Modified: CME Rep. 01, I-17; Appended: Res. 961, I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315
(A-24)

Introduced by: Maryland

Subject: Cease Reporting of Total Attempts of USMLE STEP1 and COMLEX-USA
Level 1 Examinations

Referred to: Reference Committee C

1 Whereas, in September 2021, the United States Medical Licensing Examination (USMLE) made
2 an official announcement regarding the implementation of a revised assessment format for
3 STEP1, wherein the conventional numeric scoring system and binary pass/fail outcomes would
4 be replaced solely with a pass/fail designation for examinations commencing in January 2022¹;
5 and
6
7 Whereas, alongside this transition, the passing threshold for STEP1 was heightened, and the
8 permissible number of attempts was reduced from six to four,¹ with the aim of alleviating the
9 psychological burden commonly associated with the examination process, while concurrently
10 fostering a more comprehensive evaluation of applicants; and
11
12 Whereas, the pass rate for all examinees in 2022 declined to 82%, compared to the previous
13 rate of 88% in 2021 prior to the introduction of the new scoring system² and
14
15 Whereas, studies have indicated significant performance disparities between men and women
16 taking STEP1, as well as variations based on the age at the time of examination;^{3,4} and
17
18 Whereas, the process of preparing for and undertaking the USMLE STEP1 exam has been
19 associated with excessive stress and social isolation⁵; and
20
21 Whereas, research has revealed that medical students encounter higher levels of burnout,
22 depressive symptoms, suicidal ideation, and substance use compared to the general
23 population;^{6,7} and
24
25 Whereas, the transition to a binary scoring system has led to heightened pressure to pass the
26 exam on the first attempt; and
27
28 Whereas, the implementation of the pass/fail scoring system has also led to an increased
29 emphasis on extracurricular activities and the STEP2 exam, a more clinically relevant exam, as
30 the primary means of distinguishing applicants and maintaining competitiveness;⁸ and
31 Whereas, in contrast to the STEP2 exam, STEP1 is considered less clinically relevant and an
32 inadequate indicator of future professional competence as a physician;⁹ and
33
34 Whereas, given that STEP1 has moved to pass/fail and is now a mere threshold to be crossed,
35 lacks clinical significance compared to STEP2, and is an inadequate indicator of future
36 professional competence as a physician, it is reasonable to move away from reporting failed
37 attempts or total number of attempts to residency and fellowship programs, as well as licensure
38 authorities; and

1 Whereas, transitioning away from reporting failed attempts on the STEP1 and Level 1
2 examinations would be another potential avenue to better support medical student mental
3 health and wellness and would align with the goal of creating a more comprehensive and
4 balanced evaluation of medical students; and

5
6 Whereas, our AMA has ample policy regarding supporting the mental health and wellness of
7 trainees in both the undergraduate and graduate medical education levels (H-345.970); and

8
9 Whereas, our AMA has expressed its support for the holistic review of medical school applicants
10 and has encouraged residency directors not to utilize ranked passing scores as a screening
11 criterion (H-275.953); therefore be it

12
13 **RESOLVED**, that our American Medical Association advocate that NBME and NBOME cease
14 reporting the total number of attempts of the STEP1 and COMLEX-USA Level 1 examinations to
15 residency and fellowship programs and licensure. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 5/6/2024

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RELEVANT AMA POLICY

The Grading Policy for Medical Licensure Examinations H-275.953

1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.
3. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board

of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.

4. Our AMA will 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 of the United States Level 1 scores and students who received Pass/Fail scores.

Improving Mental Health Services for Undergraduate and Graduate Students H-345.970

Our AMA supports: (1) strategies that emphasize de-stigmatization and enable timely and affordable access to mental health services for undergraduate and graduate students, in order to improve the provision of care and increase its use by those in need; (2) colleges and universities in emphasizing to undergraduate and graduate students and parents the importance, availability, and efficacy of mental health resources; and (3) collaborations of university mental health specialists and local public or private practices and/or health centers in order to provide a larger pool of resources, such that any student is able to access care in a timely and affordable manner

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316
(A-24)

Introduced by: New England

Subject: Reassessment of Continuing Board Certification Process

Referred to: Reference Committee C

1 Whereas, the continuing board certification process (CBC), previously known as maintenance of
2 certification (MOC) process put forth by the American Board of Medical Specialties (ABMS) and
3 American Osteopathic Association (AOA) has been recognized by a variety of state medical
4 societies and our American Medical Association (AMA) to be expensive and burdensome for
5 physicians without providing independent studies showing benefits for physicians, patients, or
6 the general public; and
7

8 Whereas, a 2023 Survey of Clinical Oncologists ([https://connection.asco.org/magazine/asco-](https://connection.asco.org/magazine/asco-member-news/asco-members-weigh-abim-maintenance-certification-program)
9 [member-news/asco-members-weigh-abim-maintenance-certification-program](https://connection.asco.org/magazine/asco-member-news/asco-members-weigh-abim-maintenance-certification-program)) found that an
10 overwhelming majority (82%) felt that MOC was an unnecessary addition beyond typical
11 Continuing Medical Education (CME) requirements, with additional, widespread agreement
12 (74%) that MOC does not improve their clinically relevant knowledge or improve the quality of
13 patient care; and
14

15 Whereas, the National Board of Physicians and Surgeons (NBPAS), was founded in 2015
16 specifically to address the acknowledged onerous CBC process and offers a less burdensome
17 and expensive alternative; and
18

19 Whereas, item 30 of policy D-275.954 calls to “Support a recertification process based on high
20 quality, appropriate Continuing Medical Education (CME) material directed by the AMA
21 recognized specialty societies covering the physician’s practice area...to ensure lifelong
22 learning”, which, along with requiring initial ABMS board certification, is one of the mechanisms
23 utilized by NBPAS to certify physicians; and
24

25 Whereas, our AMA policy, D-275.954¹ Continuing Board Certification, limits discussion of CBC
26 to only ABMS and member boards, thus imposing its imprimatur on these boards to the
27 exclusion of alternative boards, preempting an evidenced-based, thorough, and comprehensive
28 discussion and evaluation of the current CBC opportunities available to physicians; and
29

30 Whereas, our AMA policy, H-275.926² Medical Specialty Board Certification Standards,
31 specifically excludes our AMA from considering NBPAS as an accepted alternative CBC
32 pathway because it does not provide its own certification exam nor ongoing, thus limiting
33 physician choice and autonomy and discriminating against the approximately 11,000 physicians
34 who are currently certified by NBPAS; and
35

36 Whereas, policies D-275.954 and H-275.926 do not provide evidence to support accepting
37 ABMS CBC over NBPAS CBC nor provide evidence that NBPAS CBC is inferior to ABMS CBC
38 with respect to physician competence, patient safety, patient satisfaction, malpractice rates, or
39 any other measures of physician performance; and

1 Whereas, NBPAS CBC has demonstrated their legitimacy as a widely accepted certification
2 body as they are recognized by major national accrediting bodies, including, the Joint
3 Commission, the National Committee on Quality Assurance (NCQA), the Utilization Review
4 Accreditation Commission (URAC), the Council for Affordable Quality Healthcare (CAQH),
5 Medicare and Medicaid, and Det Norske Veritas, Inc. (DNV) and many insurers also accept
6 CBC through NBPAS including Blue Cross Blue Shield (BCBS), United Healthcare (UHC),
7 Aetna, Humana, Priority, and Geisinger Health Plan; and
8

9 Whereas, the Massachusetts Medical Society convened a meeting with the Accreditation
10 Council for Continuing Medical Education (ACCME®) followed by a joint meeting with AOA,
11 ABMS, and NBPAS that included presentations by each board. The data presented and
12 discussion in those meetings failed to offer substantial evidence that ABMS CBC process
13 subsequent to initial board certification resulted in improved quality of care and better patient
14 outcomes compared to NBPAS, leading us to question if the current reliance on ABMS CBC
15 and exclusion of NBPAS CBC meets the needs of physicians, patients, and the public; therefore
16 be it
17

18 RESOLVED, that our American Medical Association undertake a thorough review and analysis
19 of the available literature, data, and evidence to re-examine and update the accepted standards
20 for continuing board certification including policy H-275.926, Medical Specialty Board
21 Certification Standards, so the standards reflect the best manner to assess physicians'
22 knowledge and skills necessary to practice medicine. (Directive to Take Action)
23

Fiscal Note: Minimal - less than \$1,000

Received: 5/7/2024

REFERENCES

1. AMA Policy D-275.954 Continuing Board Certification
2. AMA Policy H-275.926

RELEVANT AMA POLICY

Continuing Board Certification D-275.954

Our AMA will:

1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a report regarding the CBC process at the request of the House of Delegates or when deemed necessary by the Council on Medical Education.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Councils ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.

7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physicians current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physicians decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.
22. Continue to participate in the Coalition for Physician Accountability, formerly known as the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty boards CBC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a

secure, high-stakes recertification examination.

30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physicians practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.

32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.

34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.

35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.

36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.

37. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.

38. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development and release of new, integrated standards for continuing certification programs that will address the Commissions recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.

39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.

40. Our AMA will continue to publicly report its work on enforcing AMA Principles on Continuing Board Certification.

Medical Specialty Board Certification Standards H-275.926

1. Our AMA:

(1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.

(2) Opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.

(3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet accepted standards for certification that include both a) a process for defining specialty-specific standards for knowledge and skills and b) offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.

(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.

(5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.

(6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.

American Medical Association House of Delegates

Resolution: 317
(A-24)

Introduced by: New York

Subject: Physician Participation in the Planning and Development of Accredited Continuing Education for Physicians

Referred to: Reference Committee C

1 Whereas, Accredited Continuing Education is recognized as essential for the continuing
2 professional and personal development for physicians in order to improve the health and
3 wellbeing of patients as well as the community; and
4
5 Whereas, Accredited Continuing Medical Education (ACCME) current policies and guidelines do
6 not require an accredited provider of Continuing Education (CE) providing education for
7 physicians to be organizations for (or led) by physicians; and
8
9 Whereas, many such non-physician led accredited CE provider entities are engaged in
10 providing accredited CE to physicians; and
11
12 Whereas, accredited providers are not required to disclose to its physician learners whether any
13 physicians were engaged in the planning and development of the CE activity; and
14
15 Whereas, ACCME policies require that all accredited CE identify professional practice gaps for
16 the development of CE activities; and
17
18 Whereas, to ensure that all accredited CE for physicians addresses the needs of physician
19 learners that CE for physicians is planned and developed with physician involvement; and
20
21 Whereas, MSSNY adopted policy 50.985 Requiring Physician Participation in the Planning and
22 Development of Accredited Continuing Medical Education for Physicians; therefore be it
23
24 RESOLVED, that our American Medical Association petition the Accredited Continuing Medical
25 Education to develop policies which require physician participation in the planning and
26 development of accredited continuing education for physicians. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 5/8/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 318
(A-24)

Introduced by: American Urological Association

Subject: Variation in Board Certification and Licensure Requirements for
Internationally-Trained Physicians and Access to Care

Referred to: Reference Committee C

- 1 Whereas, there exists significant variation in board certification requirements for physicians who
2 complete post-graduate training (i.e. resident/fellowship) outside of the United States,
3 “internationally trained physicians”; and
4
- 5 Whereas, while half of the American Board of Medical Specialties’ member boards allow board
6 certification from physicians accredited in other countries outside of Canada, the scope and
7 variations in board certification requirements is not well-documented and the degree to which
8 these requirements are able to ensure quality is not well understood; and
9
- 10 Whereas, according to projections published by the Association of American Medical Colleges,
11 the United States will face a physician shortage of up to 86,000 physicians by 2036; and
12
- 13 Whereas, the Health Resources and Services Administration projects a 34 percent non-metro
14 adequacy for all physician types by 2036; and
15
- 16 Whereas, two of five physicians are reaching the traditional retirement age of 65 within the next
17 10 years; and
18
- 19 Whereas, 87% of American physicians are board certified; and
20
- 21 Whereas, 25% of licensed physicians are international medical graduates; and
22
- 23 Whereas, approximately one in five U.S. physicians were born and attended medical school
24 outside of the United States and Canada (non-U.S. IMGs, as compared to Americans who
25 attend medical school abroad), totaling more than 203,500 physicians as of 2021; and
26
- 27 Whereas, the number of international medical graduates has grown by nearly 18% since 2010,
28 as compared to the 15% rise in U.S. medical graduates in the same time period; and
29
- 30 Whereas, while existing AMA and AMBS policy opposes the linkage between board certification
31 and medical licensure or staffing/clinical privileges, the true extent to which this continues to
32 occur is not well-understood and board certification may create a secondary barrier to practicing
33 and may limit the locations and types of practices available to internationally-trained physicians;
34 and
35
- 36 Whereas, licensing requirements in certain states can be an impediment to practice for
37 internationally-trained physicians, certain states, such as Tennessee, Florida, Wisconsin,
38 Virginia have begun to implement pathways for internationally-trained physicians to achieve

1 provisional licensure to practice medicine, and additional states such as Idaho and Arizona are
2 considering similar legislation; and

3
4 Whereas, board certification exceeds baseline requirements for state medical licensing,
5 assuring the public that physicians and specialists demonstrate the additional clinical skills and
6 professional behavior to provide safe and high-quality specialty care; and

7
8 Whereas, some states have begun to consider alternate pathways to licensure without
9 completion of an ACGME-accredited residency program for U.S. medical graduates under the
10 pretense that this will increase access to care particularly in rural areas, it is unclear the effects
11 these proposed pathways will actually have on rural access issues and there does not currently
12 exist a system to ensure the quality of the training they receive post medical school; and

13
14 Whereas, according to the AMA Workforce Mapper, there has not been an substantive increase
15 in non-physician providers practicing in rural and underserved areas, despite the broadening of
16 scope of practice for non-physician providers under the pretense of increasing access to care;
17 and

18
19 Whereas, advocating for increased funding for Graduate Medical Education funding continues
20 to be a major priority of our AMA, the allocation of these funds to require full re-training for a
21 fully-trained physician who has completed post-graduate training in another country may not be
22 good stewardship of limited resources; therefore be it

23
24 RESOLVED, that our American Medical Association work with the American Board of Medical
25 Specialties to study the variation in board certification requirements for internationally trained
26 physicians as well as the impact this may have on physician practices and addressing physician
27 shortages including the impact of these pathways on maintaining public assurance of a well-
28 trained physician workforce (Directive to Take Action); and be it further

29
30 RESOLVED, that our AMA study the potential effects of increasing access to board certification
31 for internationally-trained physicians on projected physician workforce shortages (Directive to
32 Take Action); and be it further

33
34 RESOLVED, that our AMA work with the Federation of State Medical Boards to study the
35 existing alternate pathways to licensure for physicians who have not completed an ACGME-
36 accredited post-graduate training program and the positive and negative impacts of these
37 pathways on addressing physician shortages. (Directive to Take Action)

38
Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 5/8/2024

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RELEVANT AMA POLICY

Medical Specialty Board Certification Standards H-275.926

1. Our American Medical Association opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Our AMA opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
3. Our AMA continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet accepted standards for certification that include both
 - a. a process for defining specialty-specific standards for knowledge and skills and
 - b. offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.
4. Our AMA 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.
5. Our AMA advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
6. Our AMA encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
7. Our AMA encourages continued advocacy to federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other interested parties to define physician board certification as the medical profession establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification.

Medical Licensure H-275.978

Our AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide **certification** until they are satisfied that the resident is clinically competent;

- (2) encourages licensing boards to require a certificate of competence for full and unrestricted **licensure**;
- (3) urges licensing boards to review the details of application for initial **licensure** to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;
- (4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;
- (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;
- (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine;
- (7) urges licensing boards to maintain strict confidentiality of reported information;
- (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical **licensure** and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;
- (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;
- (10) urges all physicians to participate in continuing medical education as a professional obligation;
- (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;
- (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;
- (13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;
- (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical **licensure** regulation;
- (15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;
- (16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;
- (17) urges licensing boards not to place time limits on the acceptability of National Board **certification** or on scores on the United States Medical Licensing Examination for endorsement of licenses;
- (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;
- (19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;
- (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for **licensure** by endorsement;
- (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for **licensure** by endorsement;
- (22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license;
- (23) vigorously opposes any state or other government agency plan for mandated recertification of physicians for the purpose of relicensure or reregistration;
- (24) supports the Federation of State Medical Boards' efforts to assure that organizations that use the Federation's copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards;

(25) urges that the state medical and osteopathic boards that maintain a time limit for completing licensing examination sequences for either USMLE or COMLEX to adopt a time limit of no less than 10 years for completion of the licensing exams; and

(26) urges that state medical and osteopathic licensing boards with time limits for completing the licensing examination sequence provide for exceptions that may involve personal health/family circumstances.

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

Our AMA will advocate that qualified international medical graduates have a pathway for **licensure** by encouraging state medical licensing boards and the member boards of the American Board of Medical Specialties to develop criteria that allow: (1) completion of medical school and residency training outside the U.S.; (2) extensive U.S. medical practice; 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**.

Credentialing Issues D-275.989

Our AMA encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept **certification** by the Educational Commission for Foreign Medical Graduates (a member of InTealth) as proof of primary source verification of an IMG's international medical education credentials.

Mechanisms to Measure Physician Competency H-275.936

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; and (3) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional **Licensure** of the Pew Health Professions Commission, as an additional measure of physician competency.

Physician Competence H-275.996

Our AMA: (1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board **certification** as evidence of continuing competence for the purpose of re-registration of **licensure**; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 319
(A-24)

Introduced by: Minority Affairs Section

Subject: AMA Support of U.S. Pathway Programs

Referred to: Reference Committee C

1 Whereas, Association of American Medical Colleges (AAMC) defines “underrepresented in
2 medicine” as those racial and ethnic populations that are underrepresented in the medical
3 profession relative to their numbers in the general population”¹; and
4

5 Whereas, AAMC reports that across the U.S. physician workforce, American Indian and Alaska
6 Natives represent 0.3%; Black / African Americans represent 5.2%; Hispanic, Latino, or of
7 Spanish Origin represent 6.3%; and Native Hawaiian / Other Pacific Islanders represent 0.1%,
8 and comprise racial and ethnic identities that are considered underrepresented in medicine
9 despite their significantly and respectively higher percentages in the U.S. population²; and
10

11 Whereas, a U.S. Supreme Court ruling in 2023 ended affirmative action in school admissions,
12 which is expected to result in a significant impact on medical education and diversity in
13 medicine; and
14

15 Whereas, the AMA invested \$14.1 million since 2019 through the Accelerating Change in
16 Medical Education initiative, which awarded grants to 37 medical schools and resulted in the
17 creation of a community of innovation aimed at creating the medical schools of the future³; and
18

19 Whereas, the AMA Reimagining Residency grant program was devised to transform residency
20 training to best address the workplace needs of our current and future health care system³; and
21

22 Whereas, the AMA’s ChangeMedEd Innovation Grant Program has awarded \$1.5 million in
23 grants since 2018³; and
24

25 Whereas, our AMA House of Delegates adopted Council on Medical Education Report 5 (June
26 2021), “Promising Practices Among Pathway Programs to Increase Diversity in Medicine”⁴; and
27

28 Whereas, the 1910 Flexner report caused significant harm to historically Black medical schools,
29 the diversity of the physician workforce, and the outcomes of minoritized and marginalized
30 patient populations⁵; therefore be it
31

32 RESOLVED, that our American Medical Association establish a grant program to support
33 existing and new K-16 pathway, STEMM and pre-med programs whose goals include, scaling
34 organizational grantees’ ability to expand their reach among youth; increasing diversity in
35 medicine; achieving health equity; improving medical education (Directive to Take Action); and
36 be it further
37

38 RESOLVED, that our AMA establish a diverse advisory body comprised of AMA member
39 physicians and trainees, staff, and allied organization representatives in medicine and public
40 health to co-develop the grant program (i.e., administration; grantee criteria and selection;
41 periodic reporting) (Directive to Take Action); and be it further

- 1 RESOLVED, that our AMA convene a summit among pathway and STEMM programs regarding
2 best practices, collaboration and strategic planning. (Directive to Take Action)

Fiscal Note: To Be Determined

Received: 5/8/2024

REFERENCES

1. <https://www.aamc.org/what-we-do/equity-diversity-inclusion/underrepresented-in-medicine>
2. <https://www.aamc.org/data-reports/data/2023-us-physician-workforce-data-dashboard>
3. <https://www.ama-assn.org/education/changemeded-initiative/ama-reimagining-residency-initiative>
4. https://policysearch.ama-assn.org/councilreports/downloadreport?uri=/councilreports/CME_Report_05_J
5. <https://journalofethics.ama-assn.org/article/how-should-we-respond-racist-legacies-health-professions-education-originating-flexner-report/2021-03>

RELEVANT AMA POLICY

Plan for Continued Progress Toward Health Equity H-180.944

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. [BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, I-21; Reaffirmed: CMS Rep. 1, I-23]

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

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 and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
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 unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population.

13. 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. [CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22; Modified: Res. 320, A-23]

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979

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 and undergraduate admissions committees to proactively implement policies and procedures that operationalize race-conscious admission practices in admissions decisions, among other factors.

(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.

(9) Recognizing the consideration of race in admissions is a necessary safeguard in creating a pipeline to an environment within medical education that will propagate the advancement of health equity through diversification of the physician workforce. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18; Modified: Res. 320, A-23; Appended: Res. 320, A-23]

Underrepresented Student Access to US Medical Schools H-350.960

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; (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; (3) recognizes 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; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; (5) recognizes 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; (6) will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine; (7) will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school; (8) will recommend that

medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants; (9) will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine; and (10) will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, (1) (a) encouraging state and local governments to make quality elementary and secondary education available to all. [Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21; Appended: Res. 305, I-22]

Revisions to AMA Policy on the Physician Workforce H-200.955

It is AMA policy that:

- (1) any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.
- (2) Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research.
- (3) The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.
- (4) In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.
- (5) There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups.
- (6) There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.
- (7) Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.
- (8) Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agency's physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.
- (9) Our AMA will consider physician retraining during all its deliberations on physician workforce planning. [CME Rep. 2, I-03; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CME Rep. 15, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 324, A-17; Appended: CME Rep. 01, A-19; Reaffirmation: I-22]

Promising Practices Among Pathway Programs D-350.980

Our AMA will 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. [CME Rep. 5, A-21]

Continued Support for Diversity in Medical Education D-295.963

Our AMA will: (1) publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) 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; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or

funding in medical education; (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement; (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty; (8) recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts; and (9) collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure. [Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13; Appended: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22; Appended: Res. 319, A-22; Modified: Res. 319, A-23]