

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

COUNCIL ON MEDICAL EDUCATION REPORT 3 – A-26
Support for the Establishment of Indigenous-Led Medical Schools in the United States

EXECUTIVE SUMMARY

Resolves 2 and 4 of Resolution 303-A-25, Support for the Establishment of Indigenous-Led Medical Schools in the United States, were referred for study on the following topics:

RESOLVED (2), that our AMA work collaboratively with Tribal Nations, Indigenous-led organizations, academic institutions, and relevant governing bodies to explore the feasibility, infrastructure, and resource needs for such an institution (Directive to Take Action); and be it further

RESOLVED (4), that our AMA advocate for funding and resource development, including through partnerships with academic, philanthropic, health system, and governmental stakeholders, to support sustainable development and operation of an Indigenous-led medical school. (Directive to Take Action)

This report reviews the history and context of physician workforce shortages in Indigenous communities, including the difficulties present early in the educational and other pathways leading up to medical school and the current absence of any Indigenous-led medical school. The report then summarizes the basic process to create a medical school and discusses unique challenges related to implementing this process on tribal land. Finally, the report explores activity in the wider medical education community related to tribally affiliated medical schools, a selection of other relevant Indigenous-focused programs, and AMA's current work related to Indigenous workforce and possible Indigenous medical schools.

The report recommends additional AMA policy in convening, collaboration, feasibility assessment, and advocacy spaces related to Indigenous medical schools as well as pathway and mentorship programs prior to undergraduate medical education.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-A-26

Subject: Support for the Establishment of Indigenous-Led Medical Schools in the United States

Presented by: Kelly Caverzagie, MD, MPH, Chair

Referred to: Reference Committee C

1 Resolution 303-A-25, “Support for the Establishment of Indigenous-Led Medical Schools in the
2 United States,” was introduced by the Underrepresented in Medicine Advocacy Section (formerly
3 the Minority Affairs Section), with resolves 2, 3, and 4 being referred. Resolve 3 will be studied in
4 a separate report while the study of resolves 2 and 4 are the focus of this report. These resolves
5 asked the following:
6

7 RESOLVED (2), that our AMA work collaboratively with Tribal Nations, Indigenous-led
8 organizations, academic institutions, and relevant governing bodies to explore the feasibility,
9 infrastructure, and resource needs for such an institution (Directive to Take Action); and be it
10 further
11

12 RESOLVED (4), that our AMA advocate for funding and resource development, including
13 through partnerships with academic, philanthropic, health system, and governmental
14 stakeholders, to support sustainable development and operation of an Indigenous-led medical
15 school. (Directive to Take Action)
16

17 “Such an institution” in resolve 2 refers to the original resolve 1 in the resolution, which became
18 AMA Policy H-295.840, “[Support for the Establishment of Indigenous-Led Medical Schools in the](#)
19 [United States](#),” and reads: “Our AMA supports efforts to establish Indigenous-governed medical
20 schools in the United States, with governance and leadership structures grounded in tribal
21 sovereignty and cultural integrity, and guided by principles of accountability to Indigenous
22 Nations, inclusion of Indigenous leadership, and alignment with community-defined values and
23 priorities.”
24

25 BACKGROUND

26 *Workforce Shortages*

27 Tribal health care is in crisis, with disproportionately poor health outcomes for Indigenous people
28 in the United States. One major basis of this crisis is a severe workforce shortage of Indigenous
29 physicians who are more likely than their peers to serve Indigenous populations.^{1,2} However, as
30 discussed in Council on Medical Education Report 8-A-25, [Disaggregation of Demographic Data](#)
31 [for Indigenous Individuals](#): “AI/AN people experience significant challenges based on wider
32 systemic oppression and difficulty in accessing education in general and, therefore, also are
33 underrepresented in the number achieving high school and college degrees as well as in medical
34 degrees.³ According to the AAMC, in 2023, there were only 90 total AI/AN self-reported
35 applicants to U.S. MD-granting medical schools, and 57 Native Hawaiian or Other Pacific Islander
36
37

1 (though some Indigenous applicants may have been aggregated under other ethnic categories, such
2 as multiracial.)”⁴ By contrast, in 2023, there were 3.3 million people in the country who identified
3 solely as American Indian/Alaska Native (AI/AN), with 581,100 more identifying as Native
4 Hawaiian/Pacific Islander.⁵ This is about 1.5 percent of the U.S. population, but AI/AN individuals
5 account for only 0.28 percent of medical school applicants, with even fewer being accepted and
6 graduating.⁶ Among active physicians, in 2018 there were 3,511 total physicians identifying as
7 American Indian, Alaska Native, Native Hawaiian, or other Pacific Islander, in contrast to
8 Indigenous patient populations in the multiple millions.⁷

9
10 Challenges related to AI/AN health outcomes, such as those connected to the Indian Health
11 Service, also include inadequate funding, challenges associated with transitioning services from
12 federal to Tribal control through contracting and compacting, evolving federal and state programs,
13 the need for culturally sensitive services, and the promise and challenges of health technology.
14 However, limited human resources are considered one of the top challenges.⁸

15
16 Given significant underrepresentation of AI/AN learners and physicians, it is critical to work
17 directly with tribes on the creation of scholarships and programs to support the preparation of
18 AI/AN individuals for medical school.³ To support AI/AN access to medicine as a career, there are
19 also significant needs that start as early as birth, pre-K, and K-16.^{9,10,11} AMA currently has policy
20 related to the importance of early childhood resources ([Disparities in Public Education as a Crisis
21 in Public Health and Civil Rights H-60.917](#)), as well as pre-K-16 pathway pilot programs ([AMA
22 Support of U.S. Pathway Programs D-200.970](#)), and is engaged in grant work in this area, which
23 includes but is not specifically for Indigenous populations.

24 25 *Tribal and Indigenous Sovereignty*

26
27 The multiplicity of Indigenous communities have varying priorities, including 574 American
28 Indian and Alaska Native tribes and villages formally recognized by the U.S. federal government.
29 Each of these entities has “a government-to-government relationship with the United States, with
30 the responsibilities, powers, limitations, and obligations attached to that designation, and is eligible
31 for funding and services from the Bureau of Indian Affairs. Furthermore, federally recognized
32 tribes are recognized as possessing certain inherent rights of self-government (i.e., tribal
33 sovereignty) and are entitled to receive certain federal benefits, services, and protections because of
34 their special relationship with the United States.”¹² Solutions to severe Indigenous health
35 disparities, such as an Indigenous medical school, may potentially involve direct ties to one or
36 more tribal nations and must be driven by and for the unique needs and goals of those nations or
37 communities.

38 39 *Medical School Creation*

40
41 A scoping review by Kirubakaran et al., published in 2024 in *Advances in Health Science
42 Education*, reviewed the existing literature on the process for establishing new medical schools,
43 noting that doing so is “a complex undertaking with high financial and political stakes.” Though
44 “the literature on new medical school establishment is empirically and theoretically under-
45 developed, it is still useful and reveals a number of important considerations that could assist
46 founding leaders and teams to maximize the outcomes and impact of their establishment efforts.”¹³
47 Generally speaking, plans for a new medical school must be both descriptive and substantive—a
48 vision for what the values and purpose of a new medical school will be, in addition to specific
49 plans related to both the creation and sustainability of the school.

50

1 The Liaison Committee on Medical Education (LCME) accredits allopathic medical schools in the
2 United States. The LCME accreditation standards are included in the document “Functions and
3 Structure of a Medical School: Standards for Accreditation of Medical Education Programs
4 Leading to the MD Degree,” available on the LCME website.¹⁴ A developing medical school must
5 demonstrate its potential to meet the requirements in accreditation standards by providing specific
6 information in the Data Collection Instrument for Preliminary Accreditation Surveys.¹⁴ The
7 American Osteopathic Association, specifically the Commission on Osteopathic College
8 Accreditation (COCA), accredits osteopathic medical schools in the United States and provides
9 accreditation guidelines and policies on their website.¹⁵

10
11 While the administrative processes, resources, and other requirements may be similar to any other
12 medical school in regard to creating a school and seeking allopathic or osteopathic accreditation, a
13 tribal medical school may potentially have differences due to a tribe’s status as a sovereign nation.
14 No literature currently exists in this area, given that no tribal medical schools currently exist.

15
16 The LCME accredits educational programs that lead to the MD degree; it does not accredit
17 institutions. A medical school or its sponsoring institution, such as a university, must hold
18 institutional accreditation from an accrediting body recognized by the U.S. Department of
19 Education for Title IV purposes.¹⁶ This institutional accreditation is what allows students to access
20 federal financial aid, such as low-interest student loans under Title IV of the Higher Education Act.
21 In contrast, the COCA accredits DO-granting colleges of osteopathic medicine and is recognized
22 by the U.S. Department of Education as an institutional accreditor, meaning COCA accreditation
23 can satisfy Title IV institutional eligibility requirements for osteopathic medical schools.

24 25 *Resource Development to Open and Sustain a Medical School*

26
27 According to LCME staff, funding for a prospective medical school may come from a variety of
28 sources and specifically requires a feasible plan and evidence for financial sustainability. The
29 resources a school has access to prior to opening may differ from those in place later but must be
30 sustainable for a period of time: often a clear, specific, and realistic budget for the next six years. A
31 new school needs to consider the revenue sources available at the beginning and how these will
32 change but remain sufficient over time.

33 34 *Characteristics of Tribally-Owned Higher Education Institutions*

35
36 According to the American Indian Higher Education Consortium (AIHEC), “Tribal Colleges and
37 Universities (TCUs) are chartered by their respective Tribal governments, including the ten Tribes
38 within the largest reservations in the United States. The 35 accredited TCUs operate more than 90
39 campuses and sites in 15 states—covering most of Indian Country—and serve students from more
40 than 250 federally recognized Indian Tribes. TCUs vary in enrollment (size), focus (liberal arts,
41 sciences, workforce development/training), location (woodlands, desert, frozen tundra, rural
42 reservation, urban), and student population (predominantly American Indian). However, Tribal
43 identity is the core of every TCU, and they all share the mission of Tribal self-determination and
44 service to their respective nations.”¹⁷ Though most students attending TCUs identify as Indigenous,
45 all students are welcome, including international students.¹⁸ Two additional institutions are not
46 Title IV-eligible nor accredited by mainstream organizations¹⁹ but are considered “developing”
47 members of AIHEC.²⁰ It is possible that tribes, as sovereign nations, could have different
48 educational priorities or hypothetically wish to develop differing accreditation standards. However,
49 all current TCUs appear to be either accredited or in the process of obtaining accreditation, which
50 ensures transferability of credits and access to federal financial aid for learners. An Indigenous
51 medical school would need accreditation from a recognized institutional accreditor for it to be

1 eligible for LCME programmatic accreditation. LCME or COCA accreditation currently is required
 2 for the students/graduates to access medical licensing examinations and accredited graduate
 3 medical education.

4
 5 *Unique Resource Challenges for Tribal Land*

6
 7 Environmental injustice can result in infrastructure and transportation challenges on tribal lands.
 8 The same factors that create difficulties accessing basic needs such as food and health care also
 9 create difficult conditions for the development of schools. “For tribes, multiple and cumulative
 10 risks and impacts cannot be separated from the historical legacy of land loss. Indigenous nations in
 11 the United States have lost 98.9 percent of their historical land base since European settlers began
 12 colonizing the continent.”²¹ The General Allotment Act of 1887 often resulted in reservations
 13 placed on more difficult land, with more productive or “high-quality” land taken for non-
 14 Indigenous settlement.²² In some cases, there are also significant location-based health risks from
 15 pollution on or near tribal lands, such as uranium exposure from toxic waste either improperly
 16 managed or dumped.^{23,24}

17
 18 However, Indigenous communities also have many stories of transcending the harms experienced:
 19 “... life on Native American reservations cannot be defined by hardship alone. It is complex,
 20 layered, and often misunderstood. While the challenges are real, ranging from poverty and health
 21 disparities to underfunded infrastructure, so too are the stories of cultural preservation, grassroots
 22 leadership, and community-driven progress.”²⁵

23
 24 *Creating Pathways to Support Sustainable Development and Operation of an Indigenous-Led*
 25 *Medical School*

26
 27 Below is a brief review of some of the active collaborations that exist between medical schools and
 28 tribal nations that could inform the sustainable development and operation of an Indigenous-led
 29 medical school. At the time of this writing in January 2026, there are no tribal medical schools (in
 30 contrast to tribally affiliated).²⁶

31
 32 Oklahoma State University College of Osteopathic Medicine at the Cherokee Nation. At the time
 33 of this writing (January 2026), Oklahoma State University College of Osteopathic Medicine at the
 34 Cherokee Nation (OSU-COM CN) is the only tribally affiliated medical campus in the nation.
 35 The OSU-COM’s relationship with the Cherokee Nation deepened over 12 years, eventually
 36 leading to the creation of a new college of medicine campus: “In 2006, our medical students started
 37 completing clinical rotations at W.W. Hastings Hospital. In 2009, we established a family medicine
 38 residency program in Tahlequah. We now have the opportunity to take this partnership to the next
 39 level...”²⁷ Since 2021, the Cherokee Nation has invested more than \$440 million to improve and
 40 grow the tribe’s health care infrastructure in Oklahoma: “Most of the tribal nations have robust
 41 health centers... But they are in rural areas, so recruiting physicians can be difficult.”²⁸ This is a
 42 persistent problem, and students from underrepresented populations are those most likely to work
 43 in those communities.^{29, 30} OSU-COM has as high as 16 percent Native American medical school
 44 students, compared to the national average of 0.2 percent.³¹

45
 46 Oregon Health & Science University Northwest Native American Center of Excellence. The
 47 Northwest Native American Center of Excellence (NNACoE) was founded in 2017 with an initial
 48 five-year grant from the Health Resources and Services Administration (HRSA). The center
 49 “works to sustainably address the health care needs of all people by increasing AI/AN
 50 representation in the health professions workforce via culturally informed, evidence-based health
 51 education programming and research interventions designed for Indigenous health care learners

1 and professionals. NNACoE sits within the Department of Family Medicine and is an institution-
2 wide resource for AI/AN students and faculty. NNACoE's 12 study initiatives span five critical
3 points along the education continuum, beginning in high school and continuing through early
4 faculty development."³² Initiatives for high school students were also created via funding from the
5 Indian Health Service Indians into Medicine Program, foundation grants, and state-legislated funds
6 for expanded partnerships with the University of California, Davis and Washington State
7 University.³³

8
9 AMA Collaborations and Wider Medical Education Work. What follows is a brief overview of
10 current work related to the support for Indigenous medical schools, including but not limited to
11 AMA dialogues with existing groups, such as Indigenous School of Medicine (ISOM,
12 isomhealth.com) and the American Indian Higher Education Consortium's Indigenous Health,
13 Education, and Resources Taskforce (IHEART).

14
15 Since the initiation of this report at the A-25 meeting, AMA adopted new policies or amended
16 existing policies relevant to the important work of improving pathways for Indigenous physicians
17 and communities and developing the physician workforce based on societal needs. This includes
18 updates to Policy H-350.960, "[Underrepresented Student Access to US Medical Schools](#)" at the I-
19 25 meeting, stating that "Our AMA will partner with relevant public and private sector
20 organizations and relevant parties to advance restorative efforts that address the impact of the 1910
21 report Medical Education in the United States and Canada ("Flexner Report") and the resulting
22 actions by state medical licensing boards and other groups including the AMA, by promoting and
23 supporting the development, opening, and/or reopening of medical schools in historically
24 marginalized and underserved communities, including those affiliated with Historically Black
25 Colleges & Universities (HBCUs), Tribal Colleges & Universities (TCUs), and Minority-Serving
26 Institutions (MSIs) through collaborative feasibility assessments, resource development
27 partnerships, and community-guided planning processes, among others." This now guides further
28 work by the AMA and will be reported on in future documents.

29
30 Some of AMA's work in this space also centers around the AMA's Truth, Reconciliation, and
31 Healing Task Force (TRHT),³⁴ which advised the AMA Board of Trustees related to amelioration
32 of past harms. AMA also has an Advisory Committee on American Indian and Alaska Native
33 (AI/AN) Affairs which "provides guidance to the AMA Board of Trustees and AMA management
34 on policy and advocacy initiatives impacting AI/AN medical students, physicians, and patients,
35 while also contributing to broader AMA efforts aimed at improving health outcomes for this
36 population."³⁵ This was created via [Advisory Committee on Tribal Affairs D-615.976](#) and a report
37 is expected at a future HOD meeting.

38
39 AMA Board of Trustees Report 31-A-24, [The Morrill Act and Its Impact on the Diversity of the](#)
40 [Physician Workforce](#), discussed the history of Indigenous lands appropriated for higher education
41 institutions, called for additional AMA work in collaboration with other relevant organizations
42 related to Indigenous health, and described recent AMA activity, including federal advocacy
43 efforts.

44
45 The California Oregon Medical Partnership to Address Disparities in Rural Education and Health
46 (COMPADRE) received a \$1.8 million AMA grant through the Reimagining Residency initiative
47 that started in 2019. This network of residency programs serving rural and underserved
48 communities offers elective opportunities to existing medical students, including in tribal health.³⁶

49
50 More recently, the AMA awarded an Innovation Grant to the University of Hawaii John A. Burns
51 School of Medicine for "Evaluation of an Indigenous Approach to Professional Identity Formation

1 through Coaching.”³⁷ AMA staff and the AMA’s TRHT task force also led the project planning
2 and implementation for convenings for Equity and Justice in Medical Education (EJME), with
3 participants from nine organizations, including but not limited to the Association of American
4 Indian Physicians (AAIP) and Association of Native American Medical Students (ANAMS).
5 EJME’s goals centered participatory trust building between organizations engaged in equitable
6 workforce development strategies responsive to the June 2023 Supreme Court of the United States
7 (SCOTUS) ruling against race as a consideration in holistic review of medical school applications.
8 These convenings led to explorations of best practices for power sharing within collaborative work
9 and a commitment to future collaboration.³⁸ AMA staff are also working to develop trainings
10 related to population health as well as genocide remembrance and prevention, broad topics that in
11 some areas include information related to Indigenous health for the AMA EdHub. AMA
12 Excellence in Medical Education grants also aim to improve the pathway toward becoming a
13 physician, including for underrepresented groups such as Indigenous learners.

14
15 The Robert Wood Johnson Foundation awarded a grant of \$999,994 on September 12, 2025, to
16 Indigenous School of Medicine for a timeframe of 8/31/2025 - 8/30/2027, titled “Redefining
17 medical education by centering and incorporating Indigenous voices.”³⁹ One of ISOM’s leaders,
18 Dr. Donald Warne, also a leader on the AMA’s TRHT task force, emphasizes that current modern
19 medicine is also Indigenous medicine, though often uncredited—citing examples of traditional
20 Indigenous science and medicine like cranial surgery, aspirin, and the field of osteopathic
21 medicine. Stated goals for ISOM include traditional Indigenous medicine men/women/elders on
22 faculty, not just as advisers; incorporating traditional medicines, beliefs, and practices; and for the
23 culture of medical education to be overhauled to be healing rather than traumatizing to the
24 learner.²⁶ AMA has engaged in dialogues with ISOM leaders at several meetings and conferences,
25 including the most recent Association of American Indian Physicians conference.

26 27 DISCUSSION

28
29 Although AMA has not historically founded medical schools directly, AMA does serve in a role
30 developing the physician workforce. For instance, alongside the Association of American Medical
31 Colleges (AAMC), AMA jointly sponsors the Liaison Committee for Medical Education (LCME),
32 which accredits allopathic medical schools in the United States. When the resolution that initiated
33 this report was discussed within the HOD, one area of conversation surrounded potential concerns
34 regarding conflicts of interest if the AMA were to have a hand in any particular medical school or
35 schools. Discussions with LCME staff emphasized the firewall between AMA and the LCME
36 regarding accreditation: decisions about accreditation rest solely with the LCME, and no school is
37 given special treatment, regardless of a connection or lack thereof to AMA, just as allopathic
38 medical schools are members of AAMC, the other co-sponsor of the LCME, but AAMC also
39 cannot and does not influence accreditation decisions. AMA is free to pursue any projects it feels
40 would further its mission to promote the art and science of medicine and the betterment of public
41 health and need not avoid collaborative work in this space. Anyone can apply for LCME
42 accreditation, and the same standards are applied to all applicants.

43
44 As discussed in several examples above, AMA is engaged in work on Indigenous health and the
45 possibility of Indigenous medical schools. Although the AMA is not an Indigenous-led
46 organization and therefore cannot determine the best path forward for Indigenous-led work, work is
47 in progress to partner with several organizations on “collaborative feasibility assessments, resource
48 development partnerships, and community-guided planning processes” per Policy H-350.960,
49 “Underrepresented Student Access to US Medical Schools.” According to AMA Medical
50 Education staff focused on workforce challenges and attending relevant discussions: Indigenous-
51 governed higher education already in existence (i.e., TCUs, Tribal Colleges and Universities) may

1 either be worthwhile models for new medical schools, or, with sufficient resources and if a priority
2 for respective tribes, may even be places where medical school(s) may form. Indigenous-led
3 discussions center around where there may be greater potential for rotations as well as pathways
4 into graduate medical education for students, an important component of undergraduate medical
5 education. Three specific locations were discussed as possible areas where Indigenous schools of
6 medicine may form, though these details are under development and currently not publicly
7 available. AMA has also been in touch with Canadian Medical Association leadership on the topic
8 of reconciliation and advancing Indigenous health, including discussions of schools.⁴⁰
9

10 Beyond any hypothetical schools themselves, as noted above, significant challenges for Indigenous
11 learners begin far before reaching medical school. Therefore, work must also focus earlier, even
12 into early childhood.

13 14 RELEVANT AMA POLICY

15
16 AMA has several policies related to Indigenous communities and medical education. These are
17 listed in Appendix A.

18 19 CONCLUSION

20
21 AMA is engaged with and will continue to engage with ways to support its mission to promote the
22 art and science of medicine and the betterment of public health, including Indigenous health and
23 medical education workforce. Though tribally-led medical education institutions must by definition
24 be initiated by Indigenous communities according to their own priorities and needs, AMA
25 continues to engage directly with those leading this work to provide guidance and support where
26 appropriate.
27

28 29 RECOMMENDATIONS

30 The Council on Medical Education recommends that the following be adopted in lieu of Resolution
31 303-A-25, resolves 2 and 4, and the remainder of the report be filed:
32

- 33 1. Our AMA convenes a collaborative with Tribal Nations, Tribal Colleges and Universities
34 (TCUs), Indigenous-led medical education organizations, and academic partners to conduct
35 structured feasibility assessments that lead to the development of Indigenous-led medical
36 schools, including infrastructure needs, accreditation pathways, financing models, and
37 governance structures grounded in tribal sovereignty. (New HOD Policy)
- 38 2. Our AMA advocates for the development and funding of comprehensive mentorship and
39 pathway programs connecting Indigenous pre-medical students with physician and other
40 mentors, guiding academic preparation, MCAT preparation, the medical school application
41 process, and career development. (New HOD Policy)
- 42 3. Our AMA encourages collaboration between our AMA, medical schools, TCUs, and
43 community organizations to increase pathways and funding for Indigenous students in
44 medicine. (New HOD Policy)
- 45 4. Reaffirm AMA policies H-60.917 “Disparities in Public Education as a Crisis in Public
46 Health and Civil Rights,” H-295.840 “Support for the Establishment of Indigenous-Led
47 Medical Schools in the United States,” and H-350.960 “Underrepresented Student Access
48 to US Medical Schools.” (Reaffirm HOD Policy)

Fiscal note: Major

APPENDIX A: RELEVANT AMA POLICY

Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917

1. Our American Medical Association:
 - a. considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation.
 - b. will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century.
 - c. acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.
2. Our AMA will work with:
 - a. the Health and Human Services Department (HHS) and Department of Education (DOE) to raise awareness about the health benefits of education.
 - b. the Centers for Disease Control and Prevention and other stakeholders to promote a meaningful health curriculum (including nutrition) for grades kindergarten through 12.
3. Our AMA will encourage the U.S. Department of Education and Department of Labor to develop policies and initiatives in support of students from marginalized backgrounds that:
 - a. Decrease the educational opportunity gap.
 - b. Increase participation in high school Advanced Placement courses.
 - c. Increase the high school graduation rate.
4. Our AMA will advocate for universal access to high-quality and affordable childcare and preschool.

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

1. Our American Medical Association 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. Our AMA 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. Our AMA 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. Our AMA encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine.
5. Our AMA 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.
6. Our AMA continues 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.

US Physician Shortage H-200.954

1. Our AMA explicitly recognizes the existing shortage of physicians in many specialties and areas of the US.
2. Our AMA supports efforts to quantify the geographic maldistribution and physician shortage in many specialties.
3. Our AMA supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US.
4. Our AMA encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations.
5. Our AMA encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations.
6. Our AMA encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations.
7. Our AMA will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas.
8. Our AMA will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification.
9. Our AMA will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need.
10. Our AMA continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
11. Our AMA continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
12. Our AMA will:
 - a. promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians;
 - b. work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and
 - c. monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
13. Our AMA will work to augment the impact of initiatives to address rural physician workforce shortages.
14. Our AMA supports opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas.

AMA Support of U.S. Pathway Programs D-200.970

Our American Medical Association supports development of pilot grant programs advised by a diverse body of AMA member physicians, trainees, staff, and allied organization representatives in medicine and public health (i.e., administration; grantee criteria and selection; periodic reporting) that will:

1. Support existing and new pre-K-16 pathway, Science, Technology, Engineering, Math, and Medicine (STEMM), and pre-med programs;
2. Include program goals of scaling organizational grantees' ability to expand their reach among youth, increasing diversity in medicine, achieving health equity, and improving medical education; and
3. Convene a summit among pathway and STEMM programs regarding best practices, collaboration, and strategic planning.

Support for the Establishment of Indigenous-Led Medical Schools in the United States H-295.840

Our AMA supports efforts to establish Indigenous-governed medical schools in the United States, with governance and leadership structures grounded in tribal sovereignty and cultural integrity, and guided by principles of accountability to Indigenous Nations, inclusion of Indigenous leadership, and alignment with community-defined values and priorities.

Enhancing the Cultural Competence of Physicians H-295.897

1. Our American Medical Association continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence and cultural humility, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.
7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula.

Support Permanent Funding and Expansion of Native Hawaiian Healthcare H-350.933

1. Our American Medical Association supports federal policies that uphold the federal trust obligations to improve the health of Native Hawaiian communities by strengthening access to comprehensive, culturally informed, and physician-led health care.
2. Our AMA supports stable, long-term federal funding and infrastructure for Native Hawaiian health care programs to ensure continuity of care, workforce development, and equitable access to services across all islands.
3. Our AMA supports the expansion of Native Hawaiian Health Care Systems, including additional sites, mobile clinics, transportation support, workforce development, and

culturally grounded health services that integrate traditional Indigenous healing alongside physician-led care.

4. Our AMA encourages collaboration with Native Hawaiian organizations, leaders, and communities to ensure that federally supported health care initiatives are responsive to local needs, culturally respectful, and community-driven.

Underrepresented Student Access to US Medical Schools H-350.960

1. Our American Medical Association 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. Our AMA 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. Our AMA 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. Our AMA is committed to promoting truth and reconciliation in medical education as it relates to improving equity.
5. Our AMA 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. Our AMA 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. Our AMA 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. Our AMA 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. Our AMA will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine.
10. Our AMA will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, encouraging state and local governments to make quality elementary and secondary education available to all.
11. Our AMA will partner with relevant public and private sector organizations and relevant parties to advance restorative efforts that address the harms of the 1910 Flexner Report by promoting and supporting the development, opening, and/or reopening of medical schools in historically marginalized and underserved communities, including those affiliated with Historically Black Colleges & Universities (HBCUs), Tribal Colleges & Universities (TCUs), and Minority-Serving Institutions (MSIs) through collaborative feasibility assessments, resource development partnerships, and community-guided planning processes, among others.

Improving Health Care of American Indians and Alaska Natives H-350.976

1. Our American Medical Association recommends that all individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens.
2. Our AMA recommends that the federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives.

3. Our AMA recommends that state and local governments give special attention to the health and health-related needs of nonreservation American Indians and Alaska Natives in an effort to improve their quality of life.
4. Our AMA recommends that American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
5. Our AMA recognizes practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives.
6. Our AMA monitors Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care.
7. Our AMA supports consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs.
8. Our AMA recommends strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
9. Our AMA recommends 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.
10. Our AMA will 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.
11. Our AMA recommends that state and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside.
12. Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian and Alaska Native 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 and Alaska Natives.
13. 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 Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

Indian Health Service H-350.977

The policy of the American Medical Association 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. Our 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. Personnel:
 - a. Compensation scales 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 specialty and primary care service in remote areas;
 - c. In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers and other federal health agencies, thus increasing both the available staffing 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 without detracting from physician compensation;
 - 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 burnout; 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 supports 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.
8. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate, but incremental, loan forgiveness when they practice in an Indian Health Service, Tribal, or Urban Indian Health Program.
9. Our AMA supports reform of the Indian Health Service (IHS) Loan Repayment Program eligibility for repayment with either a part-time or full-time employment commitment to IHS and Tribal Health Programs.

AMA Support of American Indian Health Career Opportunities H-350.981

Our American Medical Association 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 to include training a workforce from and for these tribal nations.
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.
6. Our AMA acknowledges the significance of the Morrill Act of 1862, the resulting land-grant university system, and the federal trust responsibility related to tribal nations.

Advisory Committee on Tribal Affairs D-615.976

1. Our AMA will establish and report back at the 2025 Interim Meeting on the formation of a Task Force on Tribal Affairs composed of AMA members who themselves identify as American Indian and Alaska Native (AI/AN), close professional relationships with AI/AN communities (e.g., members of Association of Native American Medical Students and Association of American Indian Physicians), or have direct experience working with AI/AN communities at Indian Health Service federal direct-care, Tribally-operated and/or Urban Indian Health Programs (I/T/U) to advise the Board of Trustees on how to implement policy specific to AI/AN communities and that the Task Force report back at the 2026 Annual Meeting with recommendations for the establishment of an Advisory Committee to ensure sustained attention to tribal health equity and Indigenous physician representation.
2. Our AMA will promote and foster educational opportunities for AMA members and the medical community to better understand the contributions of AI/AN communities to medicine and public health, including cultivating a rich understanding and appreciation of AI/AN perspectives on health and wellness.

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