

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

COUNCIL ON MEDICAL EDUCATION REPORT 4 – A-26

Reflecting the Values and Priorities of Tribal Communities in Indigenous-Led Medical Schools in the United States

EXECUTIVE SUMMARY

Resolve 3 of Resolution 303-A-25, Support for the Establishment of Indigenous-Led Medical Schools in the United States, was referred for study on the following topics:

RESOLVED (3), that our AMA support initiatives to develop culturally centered medical curricula, recruit Indigenous faculty and leadership, and facilitate pathways to institutional accreditation that reflect the values and priorities of Tribal communities. (Directive to Take Action)

This report reviews the history and context of physician workforce shortages in Indigenous communities and explores activity and research in the wider medical education community related to culturally centered medical curricula, Indigenous-focused programs, and faculty and leadership recruitment and development. The report also discusses AMA's current work related to Indigenous workforce needs. Programmatic versus institutional accreditation is also defined and discussed, with resources related to both offered.

The report recommends additional AMA policy supporting the development of leadership training programs for Indigenous physicians, encouraging Indigenous faculty and leadership recruitment/retention, developing and disseminating an Indigenous-centered undergraduate medical education (UME) curricular resource with collaboration and guidance from tribal communities, convening an Indigenous Medical Education Design & Partnership Workshop, and advocating for sustainable funding and workforce policies.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-A-26

Subject: Reflecting the Values and Priorities of Tribal Communities in Indigenous-Led Medical Schools in the United States (Res 303-A-25, R3)

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). The original resolve 1 was amended and adopted becoming Policy
4 H-295.840, “Support for the Establishment of Indigenous-Led Medical Schools in the United
5 States.” Resolves 2, 3, and 4 were referred. Resolves 2 and 4 will be addressed in CME 3-A-26,
6 with the study of resolve 3 as the focus of this report. This resolve asked the following:

7
8 RESOLVED (3), that our AMA support initiatives to develop culturally centered medical
9 curricula, recruit Indigenous faculty and leadership, and facilitate pathways to institutional
10 accreditation that reflect the values and priorities of Tribal communities. (Directive to Take
11 Action)

12 13 BACKGROUND

14
15 The contextual factors informing this report’s analysis, namely, persistent physician workforce
16 shortages affecting Indigenous communities and the foundational principles of tribal and
17 Indigenous sovereignty as they relate to health professions education are addressed in detail in
18 CME 3-A-26, Support for the Establishment of Indigenous-Led Medical Schools in the United
19 States. That report provides a comprehensive review of historical, policy, and workforce dynamics
20 that shape the need for Indigenous-led medical education pathways. To avoid duplicating that
21 discussion, this report builds on the established background and focuses specifically on
22 considerations unique to development of culturally centered medical curricula, recruitment of
23 Indigenous faculty and leadership, and facilitation of pathways to institutional accreditation that
24 reflect the values and priorities of Tribal communities.

25 26 *Existing Activities*

27
28 Below is a brief review of some of the active collaborations that exist between medical schools and
29 tribal nations regarding culturally centered curricula and/or faculty and leadership development for
30 Indigenous physicians.

31
32 Oklahoma State University College of Osteopathic Medicine at the Cherokee Nation. The
33 Oklahoma State University College of Osteopathic Medicine at the Cherokee Nation (OSU-COM
34 CN) is the only tribally affiliated medical school campus in the nation. This program offers the
35 following: “The Tribal Medical Track prepares medical students for a primary care residency at

1 tribal facilities and a successful practice in tribal, rural and underserved Oklahoma... [with] unique
2 learning opportunities for motivated students to fully develop their skills, knowledge and abilities
3 to succeed in a challenging practice environment while learning about the rich cultures of
4 American Indians.”¹

5
6 UC Davis PRIME Tribal Health Pathway. The UC Davis Programs in Medical Education (PRIME)
7 Tribal Health Pathway focuses on recruiting new physicians to serve California’s tribal, urban, and
8 rural communities and reduce health inequities, as well as building partnerships with tribal
9 communities, improving training in relevant determinants of health, and building a deeper
10 understanding of self-determination and health advocacy.² Indigenous physicians are co-founders
11 of the Huwighurruk post-baccalaureate pathway program, as well as co-directors of the PRIME
12 Tribal Health Pathway,³ which accepts up to 6 students per academic year.⁴

13
14 Oregon Health & Science University Northwest Native American Center of Excellence. The
15 Northwest Native American Center of Excellence (NNACoE) was founded in 2017 with an initial
16 five-year grant from the Health Resources and Services Administration (HRSA). The center
17 “works to sustainably address the health care needs of all people by increasing AI/AN
18 representation in the health professions workforce via culturally informed, evidence-based health
19 education programming and research interventions designed for Indigenous healthcare learners and
20 professionals. NNACoE sits within the Department of Family Medicine and is an institution-wide
21 resource for AI/AN students and faculty. NNACoE’s 12 study initiatives span five critical points
22 along the education continuum, beginning in high school and continuing through early faculty
23 development.”⁵ Initiatives for high school students were also created via funding from the Indian
24 Health Service Indians Into Medicine Program, foundation grants, and state-legislated funds for
25 expanded partnerships with University of California, Davis and Washington State University.⁶

26 *AMA Efforts to Support the Development of an Indigenous Physician Workforce*

27
28
29 What follows is a brief overview of current AMA work related to Indigenous health curricula and
30 faculty development. AMA, though it does not play a role in creating specific medical school
31 curricula, does have extensive policy in support of culturally appropriate and evidence-based
32 curricula.

33
34 Since the initiation of this report at the A-25 meeting, AMA adopted new policies or amended
35 existing policies relevant to the important work of improving pathways for Indigenous physicians
36 and communities and developing the physician workforce based on societal needs. This includes
37 updates to [Underrepresented Student Access to US Medical Schools H-350.960](#) at the I-25
38 meeting, stating that “Our AMA will partner with relevant public and private sector organizations
39 and relevant parties to advance restorative efforts that address the impact of the 1910 report
40 Medical Education in the United States and Canada (“Flexner Report”) and the resulting actions by
41 state medical licensing boards and other groups including the AMA, by promoting and supporting
42 the development, opening, and/or reopening of medical schools in historically marginalized and
43 underserved communities, including those affiliated with Historically Black Colleges &
44 Universities (HBCUs), Tribal Colleges & Universities (TCUs), and Minority-Serving Institutions
45 (MSIs) through collaborative feasibility assessments, resource development partnerships, and
46 community-guided planning processes, among others.” This now guides further work by the AMA
47 and will be reported on in future documents.

48
49 Some of AMA’s work in this space also centers around the AMA’s Truth, Reconciliation, and
50 Healing Task Force (TRHT),⁷ which advised the AMA Board of Trustees related to amelioration of
51 past harms. AMA also has an Advisory Committee on American Indian and Alaska Native

1 (AI/AN) Affairs which “provides guidance to the AMA Board of Trustees and AMA management
2 on policy and advocacy initiatives impacting AI/AN medical students, physicians, and patients,
3 while also contributing to broader AMA efforts aimed at improving health outcomes for this
4 population.”⁸ This was created via [Advisory Committee on Tribal Affairs D-615.976](#) and will
5 receive a report in a future HOD meeting.
6

7 The California Oregon Medical Partnership to Address Disparities in Rural Education and Health
8 (COMPADRE) received a \$1.8 million AMA grant through the Reimagining Residency Initiative
9 that started in 2019. The program trained medical students and resident physicians in seven medical
10 specialties, including internal medicine, family medicine, emergency medicine, general surgery,
11 ob-gyn, pediatrics, and psychiatry at 10 health care systems, 16 hospitals, and a network of
12 Federally Qualified Health Center partners throughout Northern California and Oregon. The goal
13 of COMPADRE was to address health care workforce shortages in rural, tribal, urban, and other
14 communities that lack resources; increase access to health care professionals; and improve the
15 health of patients who are disproportionately affected by certain conditions.
16

17 More recently, the AMA awarded an Innovation Grant to the University of Hawaii John A. Burns
18 School of Medicine for “Evaluation of an Indigenous Approach to Professional Identity Formation
19 through Coaching.”⁹ AMA staff and the AMA’s TRHT task force also led the project planning and
20 implementation for convenings for Equity and Justice in Medical Education (EJME), with
21 participants from nine organizations, including but not limited to the Association of American
22 Indian Physicians (AAIP) and Association of Native American Medical Students (ANAMS).
23 EJME’s goals centered participatory trust building between organizations engaged in equitable
24 workforce development strategies responsive to the June 2023 Supreme Court of the United States
25 (SCOTUS) ruling against race as a consideration in holistic review of medical school applications.
26 These convenings led to explorations of best practices for power sharing within collaborative work
27 and a commitment to future collaboration.¹⁰ AMA staff are also working to develop trainings
28 related to population health as well as genocide remembrance and prevention, broad topics that in
29 some areas include information related to Indigenous health for the AMA EdHub. AMA
30 Excellence in Medical Education grants also hope to improve the pathway toward becoming a
31 physician, including for underrepresented groups such as Indigenous learners. The AMA EdHub
32 has [other resources](#) available to help faculty develop deeper cultural sensitivity when practicing
33 with Indigenous populations on topics such as: Ethics Talk: Representation, Sovereignty, and
34 Caring for Native American Patients¹¹ and Disparities in Telehealth Use for Mental Health Care
35 Among American Indian/Alaska Native Veterans.¹² Similarly, JAMA Network hosts relevant
36 resources to increase physician faculty understanding of Indigenous health issues, such as
37 Feasibility of an Indigenous Food Is Medicine Program for Patients With Heart Failure in Rural
38 Navajo Nation.¹³
39

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

1 The American Indian Higher Education Consortium’s Indigenous Health, Education, and
2 Resources Taskforce (IHEART) is “a national collaborative, formed in 2021 to address the scarcity
3 of American Indian and Alaska Native (AI/AN) communities in the health professions...led by the
4 Association of American Indian Physicians, American Indian Higher Education Consortium,
5 Association of Native American Medical Students, Association of American Medical Colleges, and
6 the Indian Health Service.”¹⁶ One IHEART objective is “Develop regional infrastructure to identify
7 educational pathways programs to support and encourage American Indian/Alaska Native students
8 to enter into the health professions workforce.” AMA has also been invited to attend and engage in
9 these discussions.

10
11 AMA staff was also engaged with some work in this space with Johns Hopkins Center for
12 Indigenous Health,¹⁷ although as of January 14, 2026, five Indigenous health programs at this
13 institution were ended due to federal budget cuts.¹⁸

14 15 *Culturally Centered Indigenous Medical Curricula*

16
17 The Association of American Medical Colleges (AAMC) offers a blueprint for overall cultural
18 competence within medical school curricula, including a tool for assessing its effectiveness.¹⁹ More
19 specific to Indigenous health, AAMC also convenes the Indigenous Health Educators Alliance
20 (IHEAL), a “national collective of scholars and leaders committed to advancing the contribution of
21 Indigenous principles and practices in health professions education and training.”²⁰ This includes
22 publications and resources on how to develop and implement curricula, and is also related to the
23 recruitment and development of Indigenous faculty. Other work has been done in this space,
24 including guiding principles in the development of Indigenous health curricula²¹ and research
25 demonstrating the potentially harmful assumptions that must be understood prior to succeeding at
26 truly incorporating Indigenous knowledge into curricula.²² One study showed that first-year
27 medical students of all identities had improved Indigenous health knowledge, cultural intelligence,
28 ethnocultural empathy, and social justice beliefs immediately after a lecture series and six months
29 later.²³

30
31 In Canada, the National Consortium for Indigenous Medical Education published “Guidelines for
32 the Development of Indigenous Studies, Cultural Safety & Antiracism Assessment in Medical
33 Education” in 2024, and this may be useful within the context of the United States as well.²⁴

34 35 *Indigenous Faculty Recruitment, Development, and Retention*

36
37 In one publication related to faculty recruitment best practices, the author emphasized, “Residency
38 leadership can benefit from maintaining a mindset that they are always recruiting faculty, even
39 when recruiting students, where mentorship and role modeling efforts can help expand students’
40 imagination of what an academic career can look like.”²⁵ To this point, recruitment and retention of
41 Indigenous faculty can be especially challenging when there are already disproportionate
42 challenges to Indigenous learners even before entering medical school: “American Indian and
43 Alaska Native individuals had a 63% lower odds of applying to medical school... and 48% lower
44 odds of holding a full-time faculty position... compared with their White counterparts, yet had 54%
45 higher odds of working in a residency specialty deemed as a priority by the Indian Health
46 Service.”²⁶ Unfortunately this is a circular problem, as the lack of diverse faculty mentorship also
47 serves as an obstacle for medical trainees who may otherwise be interested in pursuing a career in
48 medicine.²⁶

49

1 As keynote speaker for the 2024 National Diversity in STEM Conference, Dr. Donald Warne’s
2 vision for an Indigenous school of medicine included tribal medicine people as faculty—elders and
3 healers who are not necessarily exclusively physicians, though physicians would clearly also be
4 important.²⁷ This corresponds with other research on the importance of respect for Indigenous
5 elders’ teachings within health professions education.²⁸ This may also increase the pool of
6 appropriate mentors for Indigenous physicians. Pragmatic solutions²⁹ to existing issues—such as
7 funding shortages and threatened layoffs to Indian Health Service physicians³⁰—may also be
8 helpful. Organized advocacy also can play a critical supporting role. The AMA conducts advocacy
9 in the areas of GME funding and student loan forgiveness.³¹

10
11 Some initial research on best practices in developing existing faculty has been done, noting the
12 importance of Indigenous-specific space, skill building, networking, and ongoing mentorship,
13 “each of which were included to specifically mitigate isolation and tokenism that negatively affects
14 promotion and advancement.” Next steps in this research include longitudinal evaluation.³²

15 *Pathways to Accreditation*

16
17
18 One area of the original resolution that was referred for study references facilitating “pathways to
19 institutional accreditation.”

20
21 AMA policy [Preserving Accreditation Standards on Diversity, Equity, and Inclusion H-310.896](#)
22 does oppose “any federal actions or executive orders that threaten the ability of accreditation
23 bodies, including the Accreditation Council for Graduate Medical Education (ACGME), the
24 Commission on Osteopathic College Accreditation (COCA), and the Liaison Committee on
25 Medical Education (LCME), to enforce appropriate accreditation standards.”

26
27 For the accreditation of allopathic medical schools in the United States (programmatic
28 accreditation), the Liaison Committee on Medical Education (LCME) publishes a document called
29 “Functions and Structure of a Medical School: Standards for Accreditation of Medical Education
30 Programs Leading to the MD Degree,” available on their website, describing what is required of a
31 medical school for accreditation. LCME also publishes a Data Collection Instrument for
32 Preliminary Accreditation Surveys, which details the types of questions a new medical school
33 would need to answer in order to work toward preliminary accreditation.³³

34
35 The American Osteopathic Association, specifically COCA, accredits osteopathic medical schools
36 in the United States and also provides accreditation guidelines and policies on their website.³⁴

37
38 While the administrative process for accreditation of an Indigenous medical school may be similar
39 to any other medical school in regard to the requirements to create a school and seek allopathic or
40 osteopathic accreditation, a tribal medical school may potentially have differences due to a tribe’s
41 status as a sovereign nation (see discussion in CME 3-A-26, Support for the Establishment of
42 Indigenous-Led Medical Schools in the United States). Accreditation of medical education
43 programs by the LCME does not grant access low-interest student loans via Title IV funding.
44 Eligibility for this depends on institutional accreditation, which is via national accreditors and
45 differs from specialized accreditation for a specific profession (such as medicine).³⁵ Many existing
46 tribal colleges and universities (TCUs) already have institutional accreditation, though they do not
47 currently have medical schools.

48
49 In terms of institutional accreditation, as of this writing (February 2026), only freestanding colleges
50 of osteopathic medicine are eligible to seek COCA accreditation as a pathway to participation in
51 Title IV programs³⁶ through one of the six institutional accreditors recognized by the United States

1 Department of Education that convey Title IV eligibility.³⁶ COCA also provides guidance and
2 resources for new and developing colleges of osteopathic medicine,³⁷ and the full 2026 COCA
3 accreditation standards for new and developing colleges of medicine are available on their
4 website.³⁸

5
6 DISCUSSION

7
8 Existing AMA policy and actions do support initiatives to develop culturally centered medical
9 curricula and recruit Indigenous faculty and leadership. However, AMA does not facilitate specific
10 pathways to institutional nor programmatic accreditation, although the AMA can participate in
11 feasibility planning alongside other groups, as discussed above.

12
13 RELEVANT AMA POLICY

14
15 AMA has several policies related to Indigenous communities and medical education. These are
16 listed in Appendix A.

17
18 CONCLUSION

19
20 AMA is engaged with and will continue to engage with ways to support its mission to promote the
21 art and science of medicine and the betterment of public health, including Indigenous health and
22 medical education workforce. AMA continues to engage directly with those leading this work to
23 provide guidance and support where appropriate.

24
25 RECOMMENDATIONS

26
27 The Council on Medical Education recommends that the following be adopted in lieu of Resolution
28 303-A-25, resolve 3, and the remainder of the report be filed:

- 29
30 1. Our AMA supports the development of leadership training programs for Indigenous
31 physicians, equipping them with the skills and knowledge to assume leadership roles in
32 academic medicine, health care administration, and public health. (New HOD policy)
33 2. Our AMA encourages Indigenous faculty and leadership recruitment/retention through an
34 Indigenous Faculty & Leadership Development Initiative in collaboration with AMA Ed
35 Hub. (New HOD policy)
36 3. That our AMA develop and disseminate an Indigenous-centered undergraduate medical
37 education curricular resource with collaboration and guidance from tribal
38 communities.(Directive to Take Action)
39 4. That our AMA convene an Indigenous Medical Education Design & Partnership Workshop
40 to advance Indigenous educational principles and partnerships. (Directive to Take Action)
41 5. That our AMA advocate for sustainable funding and workforce policies that support
42 Indigenous learners, faculty, and clinical training partnerships. (New HOD policy)
43 6. Reaffirm AMA policies H-295.840 “Support for the Establishment of Indigenous-Led
44 Medical Schools in the United States” and H-350.960 “Underrepresented Student Access
45 to US Medical Schools.” (Reaffirm HOD Policy)

Fiscal note: Major

APPENDIX A: RELEVANT AMA POLICY

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.

Providing Transparent and Accurate Data Regarding Students and Faculty at Medical Schools D-295.306

Our American Medical Association will work with the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation to encourage their respective accredited medical schools to make publicly available without charge transparent and accurately reported race and ethnicity demographic data regarding students and faculty.

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.

Preserving Accreditation Standards on Diversity, Equity, and Inclusion H-310.896

1. Our American Medical Association opposes any federal actions or executive orders that threaten the ability of accreditation bodies, including the Accreditation Council for Graduate Medical Education (ACGME), the Commission on Osteopathic College Accreditation (COCA), and the Liaison Committee on Medical Education (LCME), to enforce appropriate accreditation standards.
2. Our AMA supports ACGME, COCA, and LCME in advocating for their accreditation standards focused on diversity, equity, and inclusion for the betterment of patient care and public health.
3. Consistent with applicable laws, our AMA supports allopathic and osteopathic medical education accreditation bodies in strengthening accreditation standards focused on diversity, equity, and inclusion.

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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