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

REPORT 4 OF THE COUNCIL ON MEDICAL EDUCATION (A-25)
Access to Restricted Health Services When Completing Physician Certification Exams (Res. 307-A-24)
(Reference Committee C)

EXECUTIVE SUMMARY

AMA Policy D-275.944, Access to Reproductive Health Services When Completing Physician Certification Exams calls on our AMA to "study the impact of laws restricting reproductive healthcare and gender-affirming care on examinees and examiners of national specialty board exams and existing alternatives to in-person board examinations."

The title of this report was modified to "Access to Restricted Health Services When Completing Physician Certification Exams" to reflect the report's wider scope for potentially restricted health services.

This report reviews the history and context of national specialty board examinations, and examples of current format, location, and accommodation information for these exams. The report also reviews information available on legal restrictions on health care and any known impacts to patients or physicians at the time of the report's writing. It then estimates how many board examinees could specifically be impacted. This report may not reflect legal or social changes occurring after its initial drafting.

Finally, the report discusses the challenges and nuances involved in equity and assessing safety within rapidly changing sociopolitical environments, including differing assessments and perceptions of risk to personal safety. The report recommends amending existing AMA policy on access to reproductive health care during board certification exams with new AMA policy to support the physical and psychological safety of board examination candidates when taking certification examinations.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-A-25

Subject:	Access to Restricted Health Services When Completing Physician Certification Exams (Res. 307-A-24)
Presented by:	Krystal Tomei, MD, MPH, Chair
Referred to:	Reference Committee C

Resolution 307-A-24, "Access to Reproductive Health Services When Completing Physician Certification Exams," was introduced by the California delegation at the 2024 Annual Meeting of the American Medical Association (AMA). Alternate language was proposed in Reference Committee C to reduce the risk of unintended consequences from implementation, while supporting the original resolution's intentions as an urgent issue regarding the potential for personal health and/or legal risk in states with laws restricting health services, particularly reproductive and gender-affirming care.

Alternate Resolution 307 was adopted by the House of Delegates, becoming AMA Policy D-275.944, Access to Reproductive Health Services When Completing Physician Certification Exams. The first resolve was already implemented, and states: "Our American Medical Association will encourage national specialty boards who hold in-person centralized mandatory exams for board certification to provide alternate options when those exams take place in states with laws banning or restricting abortion, gender-affirming care, or reproductive healthcare services such that travel to those states would present either a limitation in access to necessary medical care, or threat of civil or criminal penalty against the examinees and examiners."

The second resolve states that the AMA will "study the impact of laws restricting reproductive healthcare and gender-affirming care on examinees and examiners of national specialty board exams and existing alternatives to in-person board examinations." This report is that study. The title has been modified to "Access to Restricted Health Services When Completing Physician Certification Exams" to reflect the report's wider scope for potentially restricted health services.

BACKGROUND

National specialty board examinations are one mechanism by which specialty boards determine whether a physician has the knowledge and skills to practice safely and effectively in their area of specialization, both initially and on a continuing basis. As discussed in Council on Medical Education Report 4-I-23, "Recognizing Specialty Certifications for Physicians," the history of specialty board examinations is as follows:

"In 1933, the [AMA] established the American Board of Medical Specialties (ABMS) to bring order to the proliferation of specialty boards and address conflicts arising between specialty boards. Other entities later emerged as certification boards and have varying standards for obtaining initial board certification and maintaining continuing certification over time. AMA support of these entities is contingent with the certification program meeting accepted standards that include offering an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty."[1]

Historically, there has been discrimination against osteopathic board certification,[2] which is changing over time,[3] and some osteopathic boards, such as Obstetrics & Gynecology and Emergency Medicine, are open to MDs as well as DOs.[4] AMA policy Medical Specialty Board Certification Standards H-275.926 opposes discrimination against physicians based solely on lack of ABMS or equivalent American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certification. However, in the current health care system, board certification is "no longer as discretionary as it once was."[5]

Current Examination Locations

Each entity engaged in specialty board examination has different procedures for examination, and this varies between specialties. As a non-comprehensive example of differences—not representing the hundreds of possibilities for board certification—the following table compares a few different entities and specialty board examinations within these entities' standards, based on data publicly available in December 2024:

Umbrella Entity	**Specialty**	**Types of exams for board certification**	**Location of in-person exams**
American Board of Medical Specialties (ABMS)	American Board of Obstetrics & Gynecology (ABOG)	In-person certifying exam	Dallas, TX
American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS)	American Osteopathic Board of Obstetrics & Gynecology (AOBOG)	Written AOBOG exam (or ABOG qualifying exam) and in-person oral exam	Chicago, IL
American Board of Physician Specialties (ABPS)	Obstetrics & Gynecology	Initial certification not offered,[6] recertification requires ABOG or AOBOG initial certification	N/A
ABMS	American Board of Pediatrics (ABP)	In-person computer-based exam	Prometric testing centers (multiple locations)
AOA-BOS	American Osteopathic Board of Pediatrics (AOBP)	Written exam	N/A (remotely proctored)
ABMS	American Board of Emergency Medicine (ABEM)	Written qualifying exam and in-person certifying exam[7]	Written exam at Pearson-Vue testing centers; Raleigh, NC certifying exam in 2026[8]
AOA-BOS	American Osteopathic Board of Emergency Medicine (AOBEM)	Written and oral exam	N/A (remotely proctored)

Examiners and Examinees

When safety concerns arise, attention to concerns from both board examiners and examinees is important. However, differences exist between examinees and examiners. If they wish to be board certified, examinees must take mandatory examinations to achieve board certification for their career within a specific time frame. Examiners are also examinees (board certified, with varying requirements for continuing certification) but in the role of examiner are typically optional volunteers who choose to participate for a variety of reasons, such as leadership and professional development, deeper involvement in the specialty, and credit toward continuing certification. This report will focus primarily on initial board certification and examinees due to the disproportionate impact, though the needs of both groups are important, deserve attention, and often overlap.

Pre-Existing General Accommodations

For all specialty boards in the United States, reasonable accommodations must be provided in alignment with the Americans with Disabilities Act, a federal civil rights law prohibiting discrimination against people with disabilities in everyday activities.[9] A 2024 article on structural bias in board examinations points out, however, that "society often overlooks individuals who do not qualify for federally protected disability benefits but are nevertheless unable to overcome hurdles equitably."[10] In practice, accommodations—disability-related and otherwise—vary between specialties.[11] A non-comprehensive sample of current accommodation policies (as of December 2024) is below:

According to ABMS Standards for Initial Certification, "Test accommodations must be offered to candidates with documented disabilities (e.g., learning and reading disabilities; physical disabilities; visual impairments) to comply with the Americans with Disabilities Act; Member Boards may also offer accommodations in other situations (e.g., extra break time for nursing mothers). Applicants should be provided with information describing the documentation to be submitted with the request for accommodations and the timeframe within which an accommodation decision will be made. Procedures for responding to these requests should be equitable and consistent and should include a mechanism for handling candidate appeals of these decisions."[12]

According to AOA Testing Accommodation Policies & Procedures, "Reasonable and appropriate accommodations are provided in accordance with the Americans with Disabilities Act (ADA) for individuals with documented disabilities, as well as to those requiring accommodations for use/availability of specific personal items, nursing/breastfeeding and/or related to religious observation. All requests for accommodation must be submitted at least 90 days before the applicable examination."[13] Materials also note a procedure for late requests.

Pre-Existing Security Policies

Some boards offer additional information about security for test-takers, such as ABOG, which noted on their website in February 2025, for instance: "ABOG always has security measures in place both during examination weeks as well as during off-examination timeframes. While we do not want to publicize every security measure taken, below are some of the security features you can expect during the Certifying Examination:

- No ABOG site (hotel meeting room for registration, building where the examinations are held, exam floors, etc.) is designated to the public as ABOG spaces by signage.
- ABOG staff is trained in security/emergency protocols including but not limited to fire evacuation, CPR and first aid, and active shooter response.

- The elevators in the ABOG building are badge access only. Only ABOG staff members can move freely about the building.
- The stairwells in the ABOG building are locked and can only be accessed with a code which is changed frequently.
- Additional security personnel are on-site during exam weeks in a number of high-traffic locations.
- Security cameras are live throughout the ABOG building."[14]

Alternatives to In-Person Board Examinations

Each specialty board decides on the best format and location for its respective examinations. During the height of the COVID-19 pandemic, several ABMS member boards pivoted from postponing their oral exams to converting to a virtual format.[15] Later research in 2023 found that the American Board of Emergency Medicine (ABEM)'s virtual oral exam had "substantial validity evidence and reliability to support ongoing use… to make confident and defensible certification decisions,"[16] and good satisfaction with comparable passing rates for the virtual general surgery certifying exam through the American Board of Surgery.[17] Research on the American Board of Anesthesiology's virtual exam, however, demonstrated both pros and cons of the virtual format and prompted a return to an in-person exam due to standardization and security concerns, as well as imperfect technology.[18]

Decisions about relocation, meanwhile, also vary between specialties. Some specialty boards partner with nationwide companies that already offer multiple testing locations, depending on the exam type, while others contract with one specific physical location only. Rapidly changing laws and political climates also offer difficulties as state policies on important issues may shift more rapidly in the future than in-person contracts and logistical planning reasonably allows for.

ABMS offered the following information highlighting some of the considerations Member Board Executives are taking into account when looking at existing and alternative test sites:

- Not all assessments measure the same things: "When ABMS Member Boards were required to move from in-person exams to virtual during COVID, data collected demonstrated that not all content or constructs could be tested equally in a virtual environment as in-person."
- "High variability in the content and components of assessments across specialties. Each Member Board designs assessments critical to the skills, knowledge, and behaviors that are specific to each specialty and sub-specialty."
- "Inability to include low fidelity simulations in remote exams."
- "Consistency to ensure, within each Member Board, every candidate is tested in the same way."
- "Ensuring exam security."
- "Increased exam costs to create and support alternate in-person testing facilities that are equal to existing assessment sites in equipment, staffing, timing and security. Projections by some Member Boards who have explored these options would result in a 4-fold increase in costs for all candidates."
- "How specific laws could impact individuals traveling from out-of-state during participation in certifying exams."

"All Member Boards," ABMS stated, "are committed to providing testing environments that minimize the stress to candidates and are exploring options for alternative test sites with respect to the above."[19]

Restricted Health Care and Safety Concerns

As described later in this report, some states in the U.S. currently have laws restricting reproductive and/or gender-affirming health care. National specialty board examination testing location concerns, for the purposes of this report, center multiple arenas, including but not limited to potential risks (physical and legal) to:

- pregnant examiners and examinees
- examiners and examinees who provide reproductive care
- transgender or gender non-conforming examiners and examinees
- examiners and examinees who are primary caregivers of and travel with transgender or gender non-conforming children
- examiners and examinees who provide gender-affirming care

These concerns regarding potential risks are also diverse in terms of levels of legal authorization and overt versus covert threat, including but not limited to:

- states with proposed bills that have not been implemented into law, but wherein overall societal hostility and violence toward people seeking and/or providing reproductive and/or gender-affirming care may be heightened;
- states with implemented laws against reproductive and/or gender-affirming care, but with no known examples of criminal or civil penalties enacted;
- states with implemented laws against reproductive and/or gender-affirming care, with known examples of actual criminal or civil penalties;
- states with implemented laws against reproductive and/or gender-affirming care, with known examples of physical harm to patients due to inadequate care;
- states with officials in authority who seek notoriety from threatening or harming individuals engaged in providing and/or receiving reproductive and/or gender affirming care.

Proposed bills fluctuate quickly and will not be tracked in this report. However, several of the below sections describe current state laws at the time of this writing, as well as known examples of additional tangible actions that have been taken, with acknowledgment that a social climate of hatred and fear has significant negative impacts on people, whether or not overt legal actions occurred against them.[20] As one of the goals of specialty board examination, as stated by ABMS, is consistency within each Member Board, ensuring every candidate is tested in the same way, such health and safety considerations are also relevant to the disproportionate impact some test-takers may experience in states with restrictions on health care.

Legal Restrictions to Reproductive Health Care

According to the New York Times abortion ban tracker, sourced from the Center for Reproductive Rights, the Guttmacher Institute, and KFF (formerly known as the Kaiser Family Foundation), as of December 3, 2024, the 13 states with the most restrictive laws for reproductive health care are: Idaho, South Dakota, Oklahoma, Texas, Arkansas, Louisiana, Indiana, Kentucky, Tennessee, Mississippi, Alabama, West Virginia, and Missouri.[21] Though Missouri voted to enshrine abortion

rights in the constitution at the end of 2024, ongoing regulatory complexities mean this medical procedure remains unavailable in that state.[22] However, according to Guttmacher, 27 states are predominantly restrictive toward reproductive health care.[23] The remaining 23 states have some protections, either paired simultaneously with restrictions, or primarily protective. Within restrictive states, many also have laws deemed "targeted regulation of abortion providers (TRAP)" laws, imposing standards beyond what the medical profession has deemed necessary for patient safety in order to make providing reproductive care more difficult.[24] Private litigation against physicians and health care workers is currently possible under Texas' SB8.[25] Although some states have proposed prison sentences for physicians who perform abortions past gestational limits,[26] to date no physician has been criminally prosecuted for this reason.[27]

Though no specific board exam related examples are publicly known, potential risks to pregnant examinees or examiners in emergency situations in states with abortion bans may include life-threatening delays in and/or inadequate care.[28,29] In response to this concern, ABOG's website states: "ABOG has a partnership with UT Southwestern to provide medical care in unanticipated, urgent, or emergency situations for examination candidates, examiners, or staff. [University of Texas Southwestern] is in close proximity to the ABOG offices and offers high standards of obstetrical care in medical emergencies." In July 2024, the Texas Medical Board clarified that "imminence of death or impairment of a major bodily function is not required" for legal emergency reproductive care.[30] However, nationwide more generally, laws tend to create situations of "hesitant medicine" that negatively impact the patient-physician relationship and destabilize decision-making within health care,[31] and many broader anecdotes exist about the dangers.[32]

At least one Texas woman was also arrested and indicted on murder charges following a self-managed abortion in 2022, though charges were later dropped and current Texas law exempts patients seeking abortions from criminal charges.[33]

Potential legal risks to examinees or examiners who provide reproductive health care may not currently be problematic for out-of-state test takers within Texas. ABOG, in regards to the Texas location of their specialty board exam, notes: "Any candidate taking a Certifying Exam, whether it be virtual or physically in Texas, should not be at legal risk. SB8 only applies to abortions performed in Texas. More importantly, SB8 text specifically references and pertains to the performance or induction of an abortion: '… a physician may not knowingly perform or induce an abortion on a pregnant woman' beyond the point in time when a fetal heartbeat is detected. Additionally, civil liability for aiding and abetting applies only to abortions performed in Texas. This should mean that the action for which a plaintiff is filing a lawsuit must be proven to be tied to a specific abortion performed. Care of patients on a case list and ensuing discussion with examiners during the Certifying Exam are not subject to SB8."[34] The only current, known instance of a suit against a physician related to SB8 was dismissed after a ruling that a bystander not directly impacted by an abortion service provided cannot sue the abortion provider.[35] Dallas and several other cities chose in 2022 to deprioritize using city resources to investigate abortions,[36] and several elected city prosecutors vowed in 2023 not to prosecute individuals who seek or provide abortion care.[37]

Fears remain, however. Unrelated to board examinations, in December 2024, the Texas Attorney General sued a New York physician for allegedly providing telemedicine and mailing abortion pills to a patient who lived in Texas—however, enforcement, even in the event the plaintiff wins, is ambiguous due to New York's shield laws.[38] In Indiana, a physician was publicly targeted by the state's Attorney General and reprimanded and fined by the Indiana Medical Licensing Board after publicly recounting a case where an abortion was provided to a young patient who was a victim of rape.[39] While there is reason for physicians to be concerned about legal repercussions in many

states, no known successful prosecutions of physicians resulting in criminal or civil penalties have thus far taken place. AMA advocates for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion (Preserving Access to Reproductive Health Services D-5.999).

In November 2023, the Attorneys General of New York, Arizona, California, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, North Carolina, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and Wisconsin collectively began correspondence with ABOG regarding concerns around OB/GYN specialty exam required travel to Texas and has engaged with ABOG on the possibility of establishing testing exemptions related to restrictive laws under certain circumstances. At the time of this writing, this is under consideration by ABOG.[40]

Legal Restrictions to Gender-Affirming Care and Facilities

According to the American Civil Liberties Union (ACLU) "Mapping Attacks on LGBTQ Rights in U.S. State Legislatures in 2024," seven states have official, active laws restricting LGBTQ+ rights within health care specifically as of December 2024. These states are: Idaho, New Hampshire, Ohio, South Carolina, Tennessee, Utah, and Wyoming.[41] The Human Rights Campaign"Attacks on Gender Affirming Care by State" notes 26 states with law or policy banning gender affirming care when states with litigation proceedings challenging the bans are included.[42] Related to other health impacts, according to the Movement Advancement Project's "Equality Maps: Bans on Transgender People's Use of Public Bathrooms & Facilities According to Their Gender Identity,"[43] both Florida and Utah currently make it a criminal offense in certain circumstances for transgender people to use bathrooms or facilities consistent with their gender identity, and these two states, as well as North Dakota, Louisiana, Mississippi, Alabama, and Ohio ban transgender people from using bathrooms consistent with their gender identity in some or all government-owned buildings and locations, including some colleges. K-12 school bathroom bans are even more extensive, though outside the direct scope of this report regarding physicians and travel. Restrictions such as these can lead to significant physical health impacts,[44] and bathroom discrimination is associated with poorer mental health outcomes.[45]

No specific board exam related examples are publicly known regarding enforcement of the above policies. Several non-comprehensive general examples of enforcement thus far include the following: in 2022, Texas Attorney General office and governor encouraged the Texas Department of Family and Protective Services to consider gender-affirming care to constitute child abuse,[46] and some investigations have taken place for this reason,[47] prompting fear for parents or caregivers of transgender children. Physicians who provide transgender care have in some cases been threatened with violence.[48] There are no known arrests of physicians providing gender-affirming care, but Texas Attorney General Ken Paxton has, at the time of this writing, sued three Texas physicians for providing gender-affirming care to minors.[49]

DISCUSSION

Little data currently exists on the impact of these issues on board examiners and examinees directly, and state laws restricting reproductive and gender affirming care have been only recently enforced against patients and physicians. The most obvious impact is a threat to physical safety due to inappropriate or reduced access to care and facilities, which has been demonstrated more broadly in research discussed above, though no public anecdotes exist related to taking board exams. In terms of criminal or civil liability, many laws have not currently been officially enforced at all,

serving instead to perpetuate bias and fear without direct legal action. While there is genuine reason for physicians to be concerned about legal repercussions in many states, few actual successful prosecutions of physicians resulting in criminal or civil penalties have taken place.

In some cases, legal restrictions may be intended primarily to have an overall "chilling effect,"[50] which has unfortunately been "successful" to some degree. For instance, research has found that there is a lower OB/GYN supply in abortion-ban states, despite minimal tangible state-level changes in the 2 years post-*Dobbs*.[51] The difficult balance becomes balancing legitimate psychological and physical safety concerns with strategies to counter the chilling effect of a fear-driven political climate, particularly encouragement for providers of gender-affirming care and providers of reproductive care to continue delivering high-quality, legal patient care in defiance of disinformation and social pressure, when feasible and appropriate. This is a challenging balance, and policy around the concept tends to focus around high-risk public health crises and emphasizes institutional responsibility as well, such as AMA's Pandemic Ethics and the Duty of Care H-140.821, which includes statements such as: "The duty to treat is foundational to the profession of medicine but is not absolute. The health care work force is not an unlimited resource and must be preserved to ensure that care is available in the future. For their part, physicians have a responsibility to protect themselves, as well as a duty of solidarity to colleagues to share risks and burdens in a public health crisis. So too, health care institutions have responsibilities to support and protect health care professionals and to apportion the risks and benefits of providing care as equitably as possible."

Hypothetical risk during direct patient care is also different than hypothetical risk during certification exams, when educational environments should ideally remain as physically and psychologically safe as possible for appropriate learning.[52,53]

Numbers of Impacted Examiners or Examinees

The numbers of those who could be directly impacted by physical safety concerns (i.e., pregnant examiners and examinees, transgender examiners and examinees) are not readily available for a variety of reasons within most medical education demographic information. These reasons include privacy and discrimination concerns, particularly in a political climate when this information may be misused against individuals, as well as the tendency for gender-related data collection to focus on a male/female binary based on birth sex, despite the problematic nature of this framing.[54] Some respondents within binary male/female gender demographic questions are likely transgender but this disaggregation is not available.

ABMS board certification data does list those who chose not to report their gender, which may partially include but is not limited to non-binary or gender non-conforming people. As of June 2024 data, the number of ABMS active diplomates in the United States who did not report gender was 59,498 individuals, or about six percent of the 957,915 active U.S. diplomates, though this does not accurately reflect actual transgender information. Not specific to physicians, approximately 1.1 percent of the U.S. population openly identifies as transgender, with an additional 1.5 percent neither trans, cis male, nor cis female, for a total of 2.6 percent, according to a Jan-Apr census pulse 2024.[55] This nationwide data is likely underreported, although within medicine, transgender and gender non-conforming physicians are likely to be underrepresented compared to general proportions within the overall U.S. population.[56] In general, transgender medical students and physicians already experience significant barriers,[57] signaling a need for systemic and individual responses to improve gender equity within medical education.[58]

Approximations of pregnancy or potential for pregnancy are also highly problematic to calculate, especially because gender is not inherently tied to pregnancy and health information is unknown. Regarding pregnancy, in 2020, research focusing on "reproductive age women" approximated that 3.9% of this population subset was pregnant at any given time.[59] Compared loosely to ABMS diplomate data for "female" diplomates under age 45 (131,331 individuals), this may be approximately 5,121 people pregnant at any given time, though this data describes those who hold board certification status through ABMS, not those taking exams.

Within the field of OB/GYN specifically, according to 2024 National Resident Matching Program (NRMP) data,[60] applicants who obtained a position and ranked their preferred specialty as OB/GYN were approximately 90 percent "female" in 2024.[61] There were 1,533 matches into OB/GYN, 1,103 of which were MD seniors.[62] An additional six positions were filled with SOAP, for a total of 1,539 filled residency positions. Thus, approximately 1,385 individuals (who may be more likely to be capable of pregnancy) matched into residency in 2024 alone. Approximately 54 of these individuals may be pregnant at any given time based on above pregnancy likelihood calculations. These individuals may sit for board exams in the near future in one state with restrictive laws (Texas), if specialty certified by ABOG (not if certified by AOBOG). Note, however, that laws restricting reproductive care may also feel or be threatening to anyone capable of pregnancy, regardless of actual pregnancy status.

Anyone practicing gender-affirming care or reproductive care may also have legal or safety concerns, particularly when treating patients who travel from out of state or via telemedicine or simply for being a known practitioner in general, regardless of their own personal experiences. Regardless of identity, the majority of providers of adolescent gender-affirming care in one study, for instance, reported receiving harassment and targeted threats.[63] Fear and harassment have increased even for those not directly impacted,[64] and some research suggests worsened negative impacts in states with restrictive laws.[65]

Social Injustice, Safety, and Educational Equity

One limitation regarding navigating safety, risk, and equity during certification exams is the difficulty of navigating safety threats for examinees and examiners across the many domains where genuine safety concerns arise in the face of systemic oppression. This is true for rapidly shifting legal landscapes, where bills are introduced but may not be implemented into law or laws may be enacted, challenged in courts, modified, and so on. Threats are particularly difficult to react to when significant but generally extrajudicial. For example, police murder of unarmed Black Americans has significant spillover effects on the sense of safety and mental health of Black Americans in the U.S. in general.[66] Experiences of racism and oppression negatively impact cognitive function due to trauma[67] already setting up inequity within education and testing compared to those with more social privilege, i.e., anyone less likely to be targeted by oppression, who need not use as many resources preparing oneself for the possibility of experiencing life-ending systemic violence. Certain areas of the U.S. may also informally be more dangerous for visibly Black examinees and other learners of color, depending on a variety of factors, even without overtly discriminatory laws in place.

For gender and LGBTQ+ rights specifically, it is also difficult to tackle a much wider problem with individualized testing location changes alone, as it is a systemic problem that continues to proliferate. Transgender people, for instance, particularly transgender women of color, have long been subject to violence, discrimination, and arrest for existing,[68] and genuine safety concerns or health inequities (such as inappropriately gendered restroom facilities) may exist in any public

location in the U.S., even in locations without overtly hostile laws—though those locations are on the face of it the most apparently dangerous.

Exemptions and other strategies for examiner and examinee safety, therefore, may be best understood as broadly as feasible within a social justice lens through a variety of thoughtful strategies as requested by those most impacted by injustice, rather than solely focused on the direct enforcement of specific hostile laws or an individual burden of proof at any given time.

RELEVANT AMA POLICY

AMA has robust policy in support of both gender-affirming and reproductive care, and already encourages "national specialty boards who hold in-person centralized mandatory exams for board certification to provide alternate options when those exams take place in states with laws banning or restricting abortion, gender-affirming care, or reproductive healthcare services such that travel to those states would present either a limitation in access to necessary medical care, or threat of civil or criminal penalty against the examinees and examiners" (Access to Reproductive Health Services When Completing Physician Certification Exams, D-275.944). AMA continues to advocate for the physician-patient relationship, as well as the improvement of medical education in other ways. Additional examples are listed in Appendix A.

SUMMARY

Concerns related to potential risk, both physical and legal, for those who provide and/or receive evidence-based reproductive and/or gender-affirming health care are genuine and can be particularly challenging to alleviate when comprised of a rapidly shifting blend of formal legal restrictions, ambiguity in enforcement, fear-provoking social contexts, and informal, extrajudicial threat. The AMA, through its Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted, as well as several other avenues, remains committed to engaging with issues related to federal and state policies on reproductive and gender-affirming care that may impact both physicians and patients, including but not limited to national specialty board examiners and examinees. AMA policy also encourages national specialty boards who hold in-person centralized mandatory exams for board certification to provide alternate options when those exams take place in states with laws banning or restricting abortion, gender-affirming care, or reproductive health care services. Although research is not yet available on the specific impacts of reproductive and gender-affirming care restrictions on board examiners and examinees, the Council on Medical Education supports the work of AMA's task force and continues to closely monitor these rapidly evolving issues.

RECOMMENDATION

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

1. That our AMA amend D-275.944 "Access to Reproductive Health Services When Completing Physician Certification Exams," by addition and deletion as follows:

   Our AMA advocates to relevant parties the physical and psychological safety of board examination candidates when taking certification examinations through mechanisms such as exam relocation to nonrestrictive states, remote examination, and/or exemption processes to ensure the protection of all physicians.

Fiscal note: $1,000

APPENDIX A: RELEVANT AMA POLICY

Access to Reproductive Health Services When Completing Physician Certification Exams D-275.944

1. Our American Medical Association will encourage national specialty boards who hold in-person centralized mandatory exams for board certification to provide alternate options when those exams take place in states with laws banning or restricting abortion, gender-affirming care, or reproductive healthcare services such that travel to those states would present either a limitation in access to necessary medical care, or threat of civil or criminal penalty against the examinees and examiners.
2. Our AMA will study the impact of laws restricting reproductive healthcare and gender-affirming care on examinees and examiners of national specialty board exams and existing alternatives to in-person board examinations.

Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted G-605.009

1. Our American Medical Association will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
    a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities.
    b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines.
    c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities.
    d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements.
    e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance.
    f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need.
    g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and

management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

h. Work with interested parties to encourage the development of institution-level guidance and protection for physicians practicing in states with restrictions potentially interfering with the patient-physician relationship.

3. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care.

Medical Specialty Board Certification Standards H-275.926

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

Accommodating Lactating Individuals Taking Medical Examinations H-295.861

1. Our American Medical Association urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give breastfeeding individuals additional break time and a suitable environment during examinations to express milk.
2. Our AMA encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump.

Clarification of Evidence-Based Gender-Affirming Care H-185.927

1. Our American Medical Association recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice.
2. Our AMA will work with state and specialty societies and other interested stakeholders to:
    a. advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence;
    b. oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care;
    c. support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, genderaffirming care and patients who seek and/or receive such care, as well as their parents and guardians; and
    d. communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence.
3. Our AMA will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers.

Principles for Advancing Gender Equity in Medicine H-65.961

Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and

9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

Effects of Work on Pregnancy H-420.960

1. Our American Medical Association supports the right of employees to work in safe workplaces that do not endanger their reproductive health or that of their unborn children.
2. Our AMA supports workplace policies that minimize the risk of excessive exposure to toxins with known reproductive hazards irrespective of gender or age.
3. Our AMA encourages physicians to consider the potential benefits and risks of occupational activities and exposures on an individual basis and work with patients and employers to define a healthy working environment for pregnant people.
4. Our AMA encourages employers to accommodate increased physical requirements of pregnant people; recommended accommodations include varied work positions, adequate rest and meal breaks, access to regular hydration, and minimizing heavy lifting.
5. Our AMA acknowledges that future research done by interdisciplinary study groups composed of obstetricians/gynecologists, occupational medicine specialists, pediatricians, and representatives from industry can best identify adverse reproductive exposures and appropriate accommodations.

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.

Encouraging LGBTQ+ Representation in Medicine D-200.972

1. Our American Medical Association will advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident, and provider diversity.
2. Our AMA encourages the inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables, including but not limited to governmental, AMA, and the Association of American Medical Colleges surveys, given respondent confidentiality and response security can be ensured.
3. Our AMA will work with the Association of American Medical Colleges to disaggregate data of LGBTQ+ individuals in medicine to better understand the representation of the unique experiences within the LGBTQ+ communities and their overlap with other identities.

Access to Basic Human Services for Transgender Individuals H-65.964
Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one's gender identity.

Support for Access to Preventive and Reproductive Health Services H-425.969
Our American Medical Association supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

Support for Access to Preventive and Reproductive Health Services H-425.969
Our American Medical Association supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

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