HOD Action: Council on Medical Education Report 5 adopted as amended with a change in title and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-A-25

Subject:	Disaffiliation from Honor Medical Societies due to Perpetuation of Racial Inequities in Medicine (Res. 309-A-24)
Presented by:	Krystal Tomei, MD, MPH, Chair
Referred to:	Reference Committee C

Resolution 309-A-24, "Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine," was introduced by the Resident and Fellow Section at the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates and was referred for study.

This resolution originally stated the following:

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

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

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

Reference Committee C heard testimony about historical inequities exhibited by Alpha Omega Alpha (AΩA) Honor Medical Society, and an amendment was offered in the online testimony to add an osteopathic medical honor society to this resolution. Testimony also noted that such inequities may be a chapter level problem. The Council on Medical Education noted that the broader issue has been studied and addressed in its report CME 2-I-22, which considered the potential of bias fostered by several honor societies including AΩA, resulting in policy D-310.945, "Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process." Among other clauses, in this policy, AMA advocates "to remove membership in medical honor societies as a mandated field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting its use as an automated screening mechanism…"

Testimony also discussed AMA's own history of discrimination, with only recent efforts to rectify this, and suggested a restorative justice informed approach to address past and current harms. In addition, testimony noted that AΩA recently secured new leadership six months prior and requested time for that leader to demonstrate AΩA's commitment to diversity, equity, and belonging. Reference Committee C recommended that D-310.945 be reaffirmed in lieu of

Resolution 309 and noted that calling for disaffiliation from AΩA could induce reputational risk to the AMA when amicable relationships are needed to encourage and assist such groups to collaborate with us to build a diverse physician workforce. In the full House of Delegates meeting, the complexities of Resolution 309 were emphasized, and the resolution was referred for study.

The Medical Student Section submitted comments to the Council on Medical Education suggesting disaffiliation from both AΩA and the osteopathic equivalent, Sigma Sigma Phi (SSP) would give further emphasis on holistic review of medical students in residency applications, allowing for a more level application field for underrepresented medical students.

The Council on Medical Education acknowledges the potential conflict of interest that, at the time of this writing, some Council members are members of AΩA and/or SSP.

BACKGROUND

CME Report 2-I-22, "Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process," previously provided an extensive review of multiple medical honor societies, including AΩA and SSP. Within this report, we presented the background of these honor societies and discussed the ongoing efforts to reduce bias and mitigate inequities that may result from these honor society memberships. The report resulted in AMA Policy D-310.945, which includes but is not limited to language that encourages "medical schools, medical honor societies, and residency/fellowship programs to work toward ethical, equitable, and transparent recruiting processes, which are made available to all applicants," advocates "for residency and fellowship programs to avoid using objective criteria available in the Electronic Residency Application Service (ERAS) application process as the sole determinant for deciding which applicants to offer interviews," and advocates "to remove membership in medical honor societies as a mandated field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting its use as an automated screening mechanism…" This policy also emphasizes AMA's support of innovation work to improve medical education transitions.

It is also noteworthy that while SSP was hypothetically suggested for inclusion in the resolution's call for disaffiliation, SSP has significantly different in criteria than AΩA, as referenced in that report, and known studies about specific honor society inequities did not investigate SSP. There are also several other honor society organizations, and each has different, varied, and unknown impacts. AΩA also committed to tackling bias within the organization after concerns were raised.

Updated Information Since 2022

Since the House of Delegates adopted the previous Council report in November 2022, the following new information has been made available.

One November-December 2022 perspectives piece was published in the *Journal of Surgical Education* that proposed that AΩA leadership overhaul national criteria in the following ways: "(1) convene a national task force to review current selection criteria and make actionable recommendations, (2) incorporate standardized diversity goals into selection criteria to hold chapters accountable and limit internal bias, and 3) report diversity and inclusivity statistics annually to the public to promote organizational accountability."[1]

One institution's November 2023 study described holistic review of applicants within one neurosurgery program with the intention of reducing bias and shifting the focus away from traditional metrics such as USMLE scores and AΩA status, which no longer predict rank lists in

this program.[2] Actual diversity impacts, if any, were not directly studied due to a lack of retrospective data. Another study published in November 2023 explored natural language processing in an effort to reduce bias in medical student clerkship assessments, researching the use of a statement provided to clinical performance assessors that included the following language: "As medical educators, we value diversity and inclusion and strive to treat our students fairly and equitably. Data show that, despite our intentions, bias continues to impact student assessment. This leads to persistent inequities in grades, residency attainment, and Alpha Omega Alpha Honors Society achievement."[3] Results on the impact on narrative language use at two institutions were inconsistent, which the authors suggested may be related to the optionality of the module.

In December 2023, AΩA elected Dr. Bradley E. Barth as nationwide Executive Director, noting in Dr. Barth's biography the priority of increasing diversity within the organization: "While a Councilor at KUSM [the University of Kansas School of Medicine], Dr. Barth increased the number of newly elected AΩA students traditionally underrepresented in medicine from 6% to 24%, a trend that has continued since he stepped down as Councilor in 2022. His work on diversity, equity, and inclusion at KUSM has been used as an example of a best practice for numerous other AΩA Chapters across the country."[4]

The original Council report noted that according to the 2021 National Resident Matching Program (NRMP) data set, "student membership in AΩA was 13th on the list of important factors of an applicant, cited by 50.6 percent of program directors. Comparable data showed GHHS [Gold Humanism Honor Society] membership at 14th (50.5 percent) and SSP membership at 22nd (21 percent)."[5] Updated data from the 2024 NRMP program director survey indicated AΩA status became less important when determining which applicants to interview: 43 percent of program directors considered it important. Reported GHHS importance also declined (48 percent), while SSP stayed the same at 21 percent.[6]

DISCUSSION

Beyond the specifics of any individual organization, honors societies conceptually are part of a hierarchy-based framework of medical education, and one piece of a larger system. As also discussed in the Council's report, CME Report 04-A-23, "Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance," attempting to eliminate hierarchy in only one facet of an inequitable system is a challenge that may result in a cascade where inequities are shifted to another domain rather than alleviated.

The inherent concept of competition between learners, and exclusivity in honors (rather than a focus on every learner eventually meeting high standards of competency for workforce needs) would need to be overhauled within a competency-based medical education model. However, this is not specific to any single honor society, nor would reform or even elimination of honor societies necessarily tackle wider issues related to the current system, such as competition between learners to secure a limited number of highly desired residency positions due to specialty, geography, perceived prestige, and/or other factors, despite discordance between medical student choices and public demand for certain specialties and geographies. Within the current system, all measures of student performance and achievement during medical school play a role in competition and can be potentially subject to bias.

AΩA's new efforts in addressing immediate bias concerns specific to AΩA, as discussed above, have not yet been studied and should be reviewed once enough time has passed for impact data to be gathered and analyzed. AΩA also functions as individual chapters within medical schools, so successful program-specific efforts toward equity would be eliminated with a broad disaffiliation.

AMA policy should also, generally, put forth wider values to inform AMA's mission, rather than targeting specific organizations whose impacts are unknown as in the case of SSP and whose practices may shift over time after a recent commitment to change as in the case of AΩA.

Many of these values are already expressed within D-310.945, "Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process."

RELEVANT AMA POLICY

AMA has several policies related to honor societies, fairness in residency and fellowship selection processes, decreasing bias, and supporting diversity within medical education. These are listed in Appendix A.

SUMMARY

Valid concerns exist regarding bias within medical education. This includes AMA's own history of harms within structural and institutional racism and research on bias within honor society selection processes, including AΩA's past practices. At a structural level, many concerns exist centered around the negative impacts of hierarchy-based educational systems, of which honor societies are one small, downstream component. There is a significant need to tackle wider challenges related to the inherent issues with competitive and time-based medical education systems. In the context of AΩA's recent commitment to changed processes and equity, unknown equity data on selection processes for the other organization in question (SSP), and potential unintended negative consequences to minoritized groups by broadly rejecting ranking learners in one context alone, regardless of the heterogeneity of individual honor society chapters, official AMA disaffiliation from AΩA and/or SSP is not appropriate. Consideration of these issues does, however, further emphasize the need for equity work and competency-based medical education more broadly. Educational institutions are encouraged to discern in their own contexts what practices and affiliations are most beneficial for equity among their learners. AMA has existing policies in place promoting ethical, equitable, and transparent processes within the current system, as well as policies supporting innovation toward necessary structural changes.

RECOMMENDATIONS

1. That our AMA study and report back at the 2030 Annual Meeting on the impact of efforts to increase representation of individuals historically underrepresented in medicine within Alpha Omega Alpha and Sigma Sigma Phi and assess whether institutional disaffiliation from these organizations should be considered based on the progress made.

2. That AMA Policy D-310.945, "Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process," and AMA Policy D-295.317, "Competency Based Medical Education Across the Continuum of Education and Practice," be reaffirmed in lieu of Resolution 309-A-24, and the remainder of the report be filed.

Fiscal note: $1,000

APPENDIX A: RELEVANT AMA POLICY

Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process D-310.945

1. Our American Medical Association will encourage medical schools, medical honor societies, and residency/fellowship programs to work toward ethical, equitable, and transparent recruiting processes, which are made available to all applicants.
2. Our AMA will advocate for residency and fellowship programs to avoid using objective criteria available in the Electronic Residency Application Service (ERAS) application process as the sole determinant for deciding which applicants to offer interviews.
3. Our AMA will advocate to remove membership in medical honor societies as a mandated field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting its use as an automated screening mechanism—and encourage applicants to share this information within other aspects of the ERAS application.
4. Our AMA will advocate for and support innovation in the undergraduate medical education to graduate medical education transition, especially focusing on the efforts of the Accelerating Change in Medical Education initiative, to include pilot efforts to optimize the residency/fellowship application and matching process and encourage the study of the impact of using filters in the Electronic Residency Application Service (ERAS) by program directors on the diversity of entrants into residency.
5. Our AMA will encourage caution among medical schools and residency/fellowship programs when utilizing novel online assessments for sampling personal characteristics for the purpose of admissions or selection and monitor use and validity of these tools.

Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance H-295.851

1. Our American Medical Association will continue to encourage work in support of the Coalition for Physician Accountability's Undergraduate Medical Education-Graduate Medical Education Review Committee "Recommendations for Comprehensive Improvement of the UME-GME Transition."
2. Our AMA will encourage and support UME institutions' investment in
    a. developing more valid, reliable, and unbiased summative assessments for clinical clerkships, including development of assessors' awareness regarding structural inequities in education and wider society, and
    b. providing standardized and meaningful competency data to program directors.
3. Our AMA will encourage institutions to publish information related to clinical clerkship grading systems and residency match rates, with subset data for learners from varied groups, including those that have been historically underrepresented in medicine or may be affected by bias.
4. Our AMA will encourage UME institutions to include grading system methodology with grades shared with residency programs.

Supporting Two-Interval Grading Systems for Medical Education H-295.866

Our American Medical Association will work with stakeholders to encourage the establishment of a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum.

Competency Based Medical Education Across the Continuum of Education and Practice D-295.317

1. Our American Medical Association Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-

based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients.
2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation.
3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents' compensation and lifetime earnings.

Competency-Based Portfolio Assessment of Medical Students D-295.318

1. Our American Medical Association will work with the Association of American Medical Colleges, the American Osteopathic Association and the Accreditation Council for Graduate Medical Education, and other organizations to examine new and emerging approaches to medical student evaluation, including competency-based portfolio assessment.
2. Our AMA will work with the NRMP, ACGME and the 11 schools in the AMA's Accelerating Change in Medical Education consortium to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency match process and off-cycle entry into residency programs.

Filtering International Medical Graduates During Residency or Fellowship Applications H-255.963

1. Our American Medical Association recognizes the exclusion of certain residency applicants from consideration, such as international medical graduates.
2. Our AMA opposes discriminatory use of filters designed to inequitably screen applicants, including international medical graduates, using the Electronic Residency Application Service® (ERAS®) system.

Continued Support for Diversity in Medical Education D-295.963

1. Our American Medical Association will publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training.
2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.
3. Our AMA will work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations.
4. Our AMA will advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population.
5. Our AMA will directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education.
6. Our AMA will advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement.
7. Our AMA will investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty.

8. Our AMA will recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts.
9. Our AMA will collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure.

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.

1 REFERENCES

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[3] Dolan BM, Maimone C, Gates KL, et al. Employing Natural Language Processing to Evaluate the Impact of an Intervention to Reduce Narrative Bias Within Medical Student Clerkship Assessments. *Academic Medicine*. 2023;98(11S):S199-S200. doi:https://doi.org/10.1097/acm.0000000000005411

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[5] Council on Medical Education Report 2-I-22, Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process. American Medical Association House of Delegates. November 2022. Accessed March 4, 2025. https://councilreports.ama-assn.org/councilreports/downloadreport?uri=/councilreports/CME_2_I_22_final_annotated.pdf

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