

**HOD ACTION: Recommendations in Council on Medical Education Report 2 adopted as amended and the remainder of the report filed**

REPORT 2 OF THE COUNCIL ON MEDICAL EDUCATION (I-22)

Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process

(Reference Committee C)

EXECUTIVE SUMMARY

American Medical Association (AMA) Policy D-295.963 (5) calls on our AMA to:

work with appropriate stakeholders to study reforms to mitigate demographic and socioeconomic inequities in the residency and fellowship selection process, including but not limited to the selection and reporting of honor society membership and the use of standardized tools to rank applicants, with report back to the House of Delegates.

This report, which is in response to this directive, reviews the current status of the residency selection process, which has led to increasing pressures for both applicant and program; responses to those pressures; and the potential downstream consequences of the residency selection process on perpetuating demographic and socioeconomic inequities. (Note: This report uses the term “residency selection process” to comprise both residency and fellowship program selection.)

To provide context, the report starts by providing data regarding recent trends in application processing, including specific factors used by program directors when determining which applicants to interview for residency. Specific discussion about the use of “filters” of objective metrics is included. Next the report reviews three medical honor societies—Alpha Omega Alpha, Gold Humanism Honor Society, and Sigma Sigma Phi—and their efforts to address the perpetuation of inequities within their honoree selection processes.

Lastly, the report reviews various attempts, including several pilot programs, designed to optimize the residency selection process, including a review of various standardized tools and other innovations designed to help minimize the burden on program directors while ensuring ample opportunity for applicants and programs to find a good “fit” with each other. It concludes with recommendations calling for AMA action to promote equity in the residency application and selection process.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-I-22

Subject: Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

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1 American Medical Association (AMA) Policy D-295.963 (5) calls on our AMA to:

2  
3 work with appropriate stakeholders to study reforms to mitigate demographic and  
4 socioeconomic inequities in the residency and fellowship selection process, including but not  
5 limited to the selection and reporting of honor society membership and the use of standardized  
6 tools to rank applicants, with report back to the House of Delegates.  
7

8 This report is in response to that directive and encompasses a review of the current residency  
9 selection process, which has led to increasing pressures for both applicant and program; responses  
10 to those pressures, including the use of innovative processes and tools; and the potential  
11 downstream consequences of the residency selection process on perpetuating demographic and  
12 socioeconomic inequities. Examination of these issues is important as disparities in the medical  
13 student population are transmitted into residency and fellowship, as matriculants of U.S. medical  
14 schools comprise the largest pool of applicants to those programs.  
15

16 **BACKGROUND**

17  
18 *Current Medical Student and Resident/Fellow Demographics*

19  
20 Racial, ethnic, socioeconomic, and geographic diversity is lacking in the physician workforce. A  
21 2019 study of allopathic medical school programs revealed that, “Hispanic individuals are  
22 underrepresented among medical school applicants and matriculants by nearly 70% relative to the  
23 age-adjusted US population; black male applicants and matriculants, nearly 60%; black female  
24 applicants, nearly 30%; and black female matriculants, nearly 40%. Similarly, [American Indian  
25 and Alaska Native] AIAN individuals are underrepresented by more than 60% among applicants  
26 and matriculants.”<sup>1</sup> Likewise, data from the Association of American Medical Colleges (AAMC)  
27 for academic years 2018-2019 through 2021-22 show little appreciable change in disparities in  
28 socioeconomic status among applicants and matriculants to medical school as determined by  
29 parental occupation and highest level of education completed.<sup>2</sup> Examination of family income of  
30 medical students also indicates a lack of diversity, with approximately three-quarters of medical  
31 school matriculants from the top two household-income quintiles—a distribution that has not  
32 changed in three decades.<sup>3</sup>  
33

34 Furthermore, Shipman et al. reported a 15-year decline in the number of medical students from  
35 rural areas, to fewer than five percent of all incoming medical students in 2017. In addition, fewer  
36 than 0.5 percent of new medical students in 2017 with rural backgrounds were from

1 underrepresented racial/ethnic minoritized groups in medicine (URM). The authors conclude,  
 2 “Both URM and non-URM students with rural backgrounds are substantially and increasingly  
 3 underrepresented in medical school. If the number of rural students entering medical school were to  
 4 become proportional to the share of rural residents in the US population, the number would have to  
 5 quadruple.”<sup>4</sup>

6  
 7 Current trends, however, have shown positive outcomes stemming from efforts to diversify the  
 8 physician workforce in recent years. For allopathic medical schools, the number of Black or  
 9 African American students increased by 21.0 percent from 2020 to 2021, which is likely due to a  
 10 9.5 percent increase in matriculants (first-year students), with Black or African American men  
 11 making the most significant gains. Likewise, matriculants who identify as Hispanic, Latino, or of  
 12 Spanish origin increased by 7.1 percent (although American Indian or Alaska Native matriculants  
 13 declined by 8.5 percent during this time period).<sup>5</sup> While these gains are important, disparities  
 14 remain.

15  
 16 Existing disparities in the applicant pool may also be exacerbated as URM applicants match  
 17 disproportionately into certain specialties (e.g., primary care fields) versus more competitive and  
 18 remunerative specialties (e.g., surgical subspecialties). Overall, these disparities influence the  
 19 composition of the physician workforce, which may have repercussions for patient care. For  
 20 example, studies have demonstrated that health outcomes are improved when there is racial  
 21 concordance between physician and patient.<sup>6</sup>

22  
 23 *Residency Selection Process*

24  
 25 After completion of medical school, nearly all medical students enter a residency program to  
 26 continue their training. The competition for these programs can be intense, especially for some  
 27 specialties with a limited number of residency positions. While competition between students is  
 28 nothing new, the pressure felt by a student to match into a residency program in their specialty of  
 29 choice has increased over recent years. A proxy measure for this perceived pressure is an increase  
 30 in the number of applications per applicant.

31  
 32

|  | 2017   | 2021   | % change |
|--|--------|--------|----------|
| 33 Applicants using Electronic Residency |        |        |          |
| 34 Application Service (ERAS)            | 45,395 | 50,830 | +12.0%   |
| 35 Average number of applications        |        |        |          |
| 36 per applicant                         | 90     | 101    | +12.3%   |
| 37 Average number of applications        |        |        |          |
| 38 received by program (all applicants)  | 1,206  | 1,058  | -13.3%   |
| 39 Average number of applications        |        |        |          |
| 40 received by program (USMGs only)      | 387    | 469    | +21.2%   |

41  
 42 Source: [AAMC ERAS Statistics website](#)

43  
 44 The reasons for this increase in the number of applications per applicant are numerous and likely  
 45 include the perception of an increasing number of students applying to a relatively static number of  
 46 residency positions, the ever-increasing medical education debt in relation to potential future  
 47 earning potential, and lifestyle priorities of younger generations. The increasing number of  
 48 applications likely has been exacerbated since the onset of the COVID-19 pandemic, when  
 49 residency interviews transitioned to a fully virtual format, thereby allowing students to apply to,  
 50 accept, and conduct interviews at a larger number of programs.

1 This trend causes significant pressure on program directors, as the administrative burden to review  
 2 such a large volume of applications per residency position can understandably lead to the use of  
 3 objective metrics such as GPA, standardized test scores, or honor society membership to narrow a  
 4 large pool of applications to a more manageable size for detailed review. Program directors can use  
 5 these and other objective metrics that are reported on the ERAS application as searchable “filters”  
 6 to help determine which candidates to consider.

7  
 8 The National Resident Matching Program (NRMP) program director survey provides insight into  
 9 how program directors review applications and choose to offer interview positions. The 2021  
 10 survey<sup>7</sup> showed the percentage of program directors (all specialties) who cite a specific factor when  
 11 considering whether to offer an interview to an applicant and, for those who cite these factors, their  
 12 average importance on a scale of 1 (not important at all) to 5 (very important). These factors can be  
 13 broken out into those that reflect academic performance and those that reflect personal  
 14 characteristics. The following tables highlight the top five factors identified for each category; see  
 15 Appendix C for graphics illustrating the full data. (Note: The survey response rate was 24.3  
 16 percent.)

17  
 18 *Factors Reflecting Education and Academic Performance*

|   | Percent Citing as a Factor | Average Weight |
|---|----------------------------|----------------|
| 20 United States Medical Licensing Examination <sup>®</sup> |                            |                |
| 21 (USMLE <sup>®</sup> ) Step 1 Score                       | 86.2                       | 3.7            |
| 22 Medical Student Performance Evaluation                   |                            |                |
| 23 (MSPE/Dean’s Letter)                                     | 85.9                       | 4.0            |
| 24 USMLE Step 2 CK Score                                    | 78.8                       | 3.8            |
| 25 Grades in required clerkships                            | 74.6                       | 3.9            |
| 26 Any failed attempt at USMLE                              | 74.1                       | 4.4            |

27  
 28  
 29 *Factors Reflecting Personal Characteristics*

|   | Percent Citing as a Factor | Average Weight |
|---|----------------------------|----------------|
| 31 Letters of recommendation in specialty | 85.1                       | 4.2            |
| 32 Personal statement (overall)           | 83.8                       | 3.9            |
| 33 Diversity characteristics              | 80.9                       | 4.1            |
| 34 Perceived commitment to specialty      | 79.5                       | 4.3            |
| 35 Having overcome significant obstacles  | 75.5                       | 4.1            |

36  
 37  
 38 While providing insight into what program directors consider important, this survey only  
 39 tangentially looks at the process of filtering the objective metrics that are available through the  
 40 ERAS application. Other data available in the same survey show that of those programs that use  
 41 USMLE Step 1 scores in determining which applicants to interview, 60 percent use a set target  
 42 score while 41 percent require only a passing score. These numbers are 68 percent and 25 percent,  
 43 respectively, for those programs that screen using USMLE Step 2 CK. Comparable data for  
 44 graduates of osteopathic medical school programs who take the Comprehensive Osteopathic  
 45 Medical Licensing Examination of the United States (COMLEX-USA) Level 1 are 51 percent and  
 46 31 percent, respectively, with COMLEX-USA Level 2-CE scores 57 percent and 23 percent,  
 47 respectively. (Note: These data on USMLE and COMLEX were gathered before conversion of  
 48 USMLE Step 1 and COMLEX Level 1 reporting to pass/fail, which may have impact on program  
 49 interpretation of Step 1/Level 1 and Step 2/Level 2 scores.)

1 It should be noted that while considering academic performance as a factor in choosing whom to  
2 interview, the weight provided to those factors is relatively low compared to some other factors,  
3 with the exception of “any USMLE failure.” Still, a significant number of programs acknowledge  
4 filtering applicants based upon academic performance on standardized exams.

5  
6 One positive sign is that a significant number of program directors use an applicant’s diversity  
7 characteristics as an influence on their decision regarding whether to interview that applicant. This  
8 practice is in alignment with the intent of the Common Program Requirements of the Accreditation  
9 Council for Graduate Medical Education, which state that residency programs and their sponsoring  
10 institutions “must engage in practices that focus on mission-driven, ongoing, systematic  
11 recruitment and retention of a diverse and inclusive workforce of residents, fellows, faculty  
12 members, senior administrative staff members and other relevant members of the academic  
13 community.”<sup>8</sup>

14  
15 Overall, in the 2021 Residency Match, the average number of residency positions for all programs  
16 was nine, for which the average number of applications received by a program was 1,013. Of these  
17 applications, 506 (49.9 percent) were rejected based upon a standardized screening process and 423  
18 (41.8 percent) received an in-depth holistic review.<sup>7</sup>

19  
20 Although these data do not provide information on what the standardized screening process  
21 entailed, one survey of internal medicine program directors (who can receive up to 3,000 applicants  
22 per program) found that USMLE Step 2 CK score, USMLE Step 1 score, and attendance at a  
23 specific medical school were the top three filters used for initial application review.<sup>9</sup>

24  
25 While evidence is limited, there is concern that the use of test scores for this type of initial  
26 screening review may introduce and exacerbate racial and socioeconomic biases into the selection  
27 process. Numerous studies have demonstrated the link between standardized tests—common in K-  
28 12 as well as higher education, along with the medical education continuum—and perpetuation of  
29 racial and socioeconomic bias. It is not the examinations themselves, however, that are the issue  
30 (for example, the Medical College Admission Test, or MCAT, for which the psychometric  
31 literature shows no evidence of bias) but rather the larger and more insidious patterns of systemic  
32 racism, which limit economic success and educational opportunity for minoritized populations.  
33 Finally, and most importantly, research shows that the ability to pass a test is not especially  
34 relevant to one’s ability to provide quality medical care. Emotional intelligence, empathy, and  
35 communication are more valuable to the successful practice of medicine than sheer raw  
36 intelligence. Indeed, as Lucey and Saguil note, “the MCAT exam is designed to measure  
37 applicants’ academic preparation for medical school . . . not . . . to measure or predict their  
38 performance related to other, essential competencies, such as interpersonal skills and  
39 communication, professionalism, and ethical behavior, or to take the place of other attributes that  
40 nonexam aspects of the admissions process evaluate.”<sup>10</sup>

## 41 42 MEDICAL HONOR SOCIETIES AND THEIR ROLE IN RESIDENCY SELECTION

### 43 44 *Background*

45  
46 Similar to concerns about overreliance on standardized testing for advancement in higher education  
47 and medical education, the use of medical honor society membership to screen applicants has  
48 become a subject of increasing scrutiny in recent years. The next section considers three medical  
49 honor societies, their role in the residency selection process, and their respective work to increase  
50 attention to diversity and equity.

1 Alpha Omega Alpha

2  
3 Formed in 1902, Alpha Omega Alpha (AΩA) has as its mission recognizing high educational  
4 achievement, honoring gifted teaching, encouraging the development of leaders in academia and  
5 the community, supporting the ideals of humanism, and promoting service to others. With over  
6 200,000 members, AΩA has chapters in the majority of Liaison Committee on Medical Education  
7 (LCME)-accredited medical schools in the US, including all historically Black colleges and  
8 universities (HBCUs).

9  
10 According to the AΩA website, “Membership in AΩA may be attained as a medical student,  
11 resident, fellow, faculty member, alumni, clinician, or distinguished leader in medicine. Each  
12 school may elect up to 20% of the graduating class of students, up to 25 residents/fellows, up to 10  
13 faculty, and three to five alumni, who, based on merit, demonstrate the characteristics of excellent  
14 physicians in alignment with AΩA’s mission and values.”<sup>11</sup> Each chapter makes decisions on  
15 proposed members in alignment with that institution’s mission statement. As to diversity of  
16 membership, individual chapters may collect those data, but at the national level, the AΩA collects  
17 only member name, school, year of induction, and contact information (along with specialty if  
18 provided by the member).

19  
20 Gold Humanism Honor Society

21  
22 The Gold Foundation was founded in 1988 to preserve and elevate the tradition of humanism in  
23 health care. To focus and enhance the foundation’s efforts, the Gold Humanism Honor Society  
24 (GHHS) was founded in 2002; this international program now comprises 180 chapters and has  
25 close to 45,000 members. As stated in a February 7, 2022, memorandum from the Gold Foundation  
26 to the AMA (see Appendix A), the GHHS “identifies medical student exemplars of humanism  
27 using a validated, peer-nomination system.” No information is available regarding the diversity of  
28 its membership.

29  
30 Sigma Sigma Phi

31  
32 Founded in 1921, Sigma Sigma Phi (SSP) is an honorary service organization for osteopathic  
33 medical students who are selected by peers. Selection into SSP includes a blinded process that  
34 considers a minimum grade requirement and good standing by the medical school and then  
35 predominately the contributions made by the candidate to serve the community and humanity.  
36 Membership is open to all who apply and meet the minimum standards and is limited to no more  
37 than 25 percent of the total population of the student body. Students must have completed at least  
38 one semester of classroom work and show a high degree of scholarship and service to the college  
39 and/or profession. The SSP website lists 47 chapters as of February 2022. No information is  
40 available regarding the diversity of its membership.

41  
42 *Role of honor societies in the residency selection process*

43  
44 Medical honor societies are intended to recognize excellence in academic achievement and other  
45 markers of future success as physicians, including scholarship, aptitude for research, humanism,  
46 and professionalism. As with other variables previously mentioned, induction into these  
47 organizations may be used by program directors and other program personnel to evaluate  
48 applicants during the residency selection process; evidence suggests, however, that this factor is not  
49 as important as others.

1 In the 2021 NRMP data set, student membership in AΩA was 13<sup>th</sup> on the list of important factors  
2 of an applicant, cited by 50.6 percent of program directors. Comparable data showed GHHS  
3 membership at 14<sup>th</sup> (50.5 percent) and SSP membership at 22<sup>nd</sup> (21 percent).

#### 4 5 *Concern about perpetuating disparities*

6  
7 Despite the perceived value of recognizing excellence, medical honor societies have come under  
8 criticism in recent years as potentially exclusionary if not antithetical to efforts to increase equity,  
9 diversity, and belonging (EDB) in medical education and practice. One of the first institutions to  
10 address this concern was the Icahn School of Medicine at Mount Sinai, which in 2018 put a  
11 moratorium on student nominations to AΩA “because it determined the selection process  
12 discriminates against students of color.”<sup>12</sup> Additionally, in May 2020, the University of California  
13 – San Francisco School of Medicine announced that it was suspending its AΩA affiliation,  
14 beginning with the class of 2021, stating, in part, that the selection process and membership  
15 limitations may subvert efforts toward increased equity, through a misplaced emphasis on grades,  
16 assessments, and performance and demonstrated bias against non-white students.<sup>13</sup>

17  
18 Evidence to support these concerns exists. One study, published in *JAMA*, found that, “the odds of  
19 AΩA membership for white students were nearly 6 times greater than those for black students and  
20 nearly 2 times greater than for Asian students” which “may undermine the pipeline of minorities  
21 entering the academic health care workforce.”<sup>14</sup> Other research shows that these trends extend  
22 beyond race/ethnicity to socioeconomic status, as students from backgrounds with lower income  
23 than their peers were less likely to be AΩA members.”<sup>15</sup> This phenomenon has been described as  
24 an “amplification cascade,” in which “small differences in assessed performance lead to larger  
25 differences in grades and selection for awards,” such that medical students from populations  
26 underrepresented in medicine (UIM) “received approximately half as many honors grades as not-  
27 UIM students and were three times less likely to be selected for honor society membership.”<sup>16</sup>

#### 28 29 *Addressing disparities in medical honor society selection*

#### 30 31 AΩA

32  
33 The upper limit for the percentage of medical student electees from a given chapter rose from 16  
34 percent to 20 percent in October 2020, when the organization changed its constitution. This change  
35 was intended to help reduce the focus on grades as one of the highest determinants of achievement  
36 and instead highlight character attributes such as “trustworthiness, character, caring, knowledge,  
37 scholarship, proficiency in the doctor-patient relationship, leadership, compassion, empathy,  
38 altruism, and servant leadership,” as described on the AΩA website. The move reflects changes at  
39 many medical schools to eliminate or reduce grading and use a more holistic approach to selection  
40 and advancement.

41  
42 In 2020, AΩA declared a renewed focus on EDB to mitigate both conscious and unconscious bias  
43 in medical education, including assessments of medical students, resident physicians, and faculty in  
44 the nominations, selection, and election processes for the AΩA.<sup>17</sup> These principles are reflected in  
45 a statement on the AΩA website, which notes that the organization “advocates for diversity in all of  
46 its forms – identity, cultural, geographic, experiential, race, ethnicity, gender, age, economic and  
47 social status, physical abilities, aptitude, and religious beliefs, political beliefs, and other  
48 ideologies.” In addition, an AΩA award recognizes medical schools that “demonstrate exemplary  
49 leadership, innovation, and engagement in fostering an inclusive culture that transforms the ideals  
50 of inclusion, diversity, and equity into successful programs.” This work has also included efforts to  
51 increase the diversity of the AΩA board. Potential future reforms include the annual reporting of

1 member demographic data; standardized, transparent criteria for selecting members that mitigate  
2 the potential for bias; and increased diversity within organizational leadership. Individual chapters  
3 also have a role to play, through such actions as implementing holistic review of potential members  
4 and annually reviewing newly elected cohorts to ensure that they match the institution's overall  
5 demographics.<sup>18</sup>

## 6 7 GHHS

8  
9 In the memo noted above, the Gold Foundation states, "In the past 23 months, the foundation and  
10 the GHHS have pivoted to respond vigorously to the challenges of COVID-19 and have redoubled  
11 our efforts to address [diversity, equity, and inclusion] in response to the racial reckoning following  
12 George Floyd's murder to support healthcare in which human interests, values, and dignity  
13 predominate." One of the organization's actions in this regard is the 2020-2021 GHHS national  
14 initiative, "Humanism and Healing: Structural Racism and its Impact on Medicine," which was  
15 followed by a virtual conference of the same name hosted by GHHS. In addition, the Gold  
16 Foundation is engaged in a continuous improvement project to determine best practices in diversity  
17 and inclusivity through work with the AAMC and individual GHHS chapters. To further the  
18 collective understanding of this issue, the Foundation and GHHS are also conducting research on  
19 the socio-demographic makeup of GHHS members to determine where differences exist to mitigate  
20 future issues. The results of this analysis are forthcoming.

## 21 22 SSP

23  
24 Related to diversity of applicants or honorees, SSP staff indicate that such data are not tracked at  
25 the national level, but that meetings with chapter presidents and review of the lists of graduating  
26 seniors indicate an appropriate level of diversity. Staff added, "At this point we see no problems  
27 with the selection process. This has not been an issue or a problem with our organization, but if this  
28 is brought up and becomes a concern, we are ready to do whatever needs to be done to address this  
29 situation."

30  
31 That said, it is important to provide context and note that DO schools report even lower levels of  
32 diversity than allopathic schools. Data from the AAMC and the American Association of Colleges  
33 of Osteopathic Medicine Application Services (AACOMAS) show a medical school matriculation  
34 rate of 16.9 percent for URM individuals entering allopathic programs<sup>19</sup> versus 12.1 percent for  
35 osteopathic programs.<sup>20</sup> In short, the "appropriate" level of diversity may be proportionate to the  
36 overall level of diversity in a given field, but that does not mitigate the core issue of inequity.

## 37 38 ATTEMPTS TO OPTIMIZE THE RESIDENCY SELECTION PROCESS

### 39 40 *Standardized Tools*

41  
42 In 2018, the AAMC piloted a standardized video interview (SVI) for emergency medicine  
43 programs, with the intent of providing a useful supplementary tool for selecting applicants to  
44 interview. Its intent was to measure knowledge of professional behaviors along with interpersonal  
45 skills and communication. The SVI, however, was discontinued after three cycles due to lack of  
46 interest among both applicants and program directors. A letter from key stakeholders in emergency  
47 medicine to the AAMC delineated three reasons for the program's dissolution: "lack of evidence to  
48 support the SVI as an assessment tool, uncertainty around the cost of the program, and student  
49 perceptions."<sup>21</sup>



1 In addition to helping program directors decide which applicants to interview, it was hoped that use  
2 of the SVI would reduce bias in the selection process, as the interviews were scored by trained  
3 reviewers not associated with the programs, and the performance of those reviewers was subject to  
4 quality control. During the pilot phase, however, this standardized approach was subverted, in that  
5 the videos were shared with programs in addition to the scores.

6  
7 Other standardized approaches to ranking applicants include CASPer (Computer-based Assessment  
8 for Sampling Personal characteristics (<https://takealtus.com/casper/>), an online, open-response  
9 situational judgment test. CASPer is used by some medical schools in the application process and  
10 has seen limited but increasing use in the residency selection process as well. For the 2022-23  
11 application cycle, ophthalmology<sup>22</sup> is piloting the use of the Altus Suite for Graduate Medical  
12 Education,<sup>23</sup> comprising supplemental applications that include CASPer and two other tests:

- 13 • Snapshot, a one-way video interview designed to assess communication skills, self-  
14 reflection, and motivation for the profession, and
- 15 • Duet, designed to assess alignment of values between an applicant and a program.

16  
17 One article notes the use of CASPer in some general surgery residency programs led to a greater  
18 number of interview offers to applicants from minoritized populations.<sup>24</sup> With growing interest in  
19 ensuring professionalism, communication skills, and emotional intelligence among the physician  
20 workforce, the use of this and similar tools may grow. Currently, these are either used too  
21 infrequently or by so few programs that evidence is lacking to support or refute their use, especially  
22 in the context of equity.

23  
24 Another tool, described in a 2017 study, “validates a process for selecting and weighting  
25 components of the ERAS application and interview day to create a customizable, institution-  
26 specific tool for ranking candidates to postgraduate medical education programs.”<sup>25</sup> The authors do  
27 not discuss whether this tool might have any impact on equity or diversity of applicants.

### 28 29 *Holistic Review*

30  
31 Holistic review of applicants to medical school has been defined as “a flexible, individualized way  
32 of assessing an applicant’s capabilities by which balanced consideration is given to experiences,  
33 attributes, and academic metrics... and, when considered in combination, how the individual might  
34 contribute value as a medical student and future physician.”<sup>26</sup> The authors of a 2021 *NEJM*  
35 Perspective note that holistic review “has been shown to enhance diversity without affecting the  
36 average grade-point average or exam scores for the entering class.”<sup>27</sup> Extending this process,  
37 holistic review has been encouraged to mitigate biases in the residency selection process and shift  
38 focus to factors associated with success in residency

39  
40 While holistic review is viewed favorably by most, its practical use continues to face significant  
41 barriers. Widespread adoption is hampered by the growing number of residency applications,  
42 which exacerbates the administrative burden of reviewing a large volume of applications per open  
43 residency slot and can lead to the use of objective metrics to filter applications. One experiment  
44 seeks to use augmented intelligence and “big data” as tools for holistic screening of applicants to  
45 improve the process at the medical school admissions level. Research at New York University  
46 Grossman School of Medicine used clustering and other statistical techniques to develop profiles or  
47 “signatures” that charted the academic success and trajectory of four different types of applicants—  
48 “risers,” “improvers,” “solids,” and “statics.” Using this approach “can more sensitively uncover  
49 success potential since it takes into account the inherent heterogeneity within the student  
50 population.”<sup>28</sup>

### 1 *Supplemental ERAS Application and Preference Signaling*

2  
3 A recent effort by the AAMC, the Supplemental ERAS Application, seeks to empower applicants  
4 to share more information about themselves using a fair process and driving holistic review in the  
5 context of a high volume of applications. A list of FAQs on the AAMC website (see  
6 <https://students-residents.aamc.org/applying-residencies-eras/supplemental-eras-application-faq>)  
7 indicates that the application is “intended to help programs better identify applicants who are  
8 genuinely interested in their program, and whose interests and experience align well with the  
9 program’s setting, mission, and goals.” The supplemental application comprises three sections: past  
10 experiences about the applicant’s most meaningful work, volunteer or research experiences;  
11 geographic information (by region and by urban/rural setting); and preference signals for specific  
12 programs. It shows promise as a vehicle to communicate information more relevant to residency  
13 selection in these early pilots, but its impact on equity is still unknown. Use of the supplemental  
14 application is growing, from the three fields of dermatology, general surgery, and internal medicine  
15 in 2021 to 16 specialties planning to use it for the 2023 ERAS season, representing more than  
16 2,900 programs.

### 17 *Interview capping*

18  
19  
20 In response to the COVID-19 pandemic, ophthalmology, which participates in the San Francisco  
21 Match and thus has a different match timeline compared to most other specialties, has placed caps  
22 on the number of programs to which a student can apply.<sup>29</sup> This cap is currently at 15 programs for  
23 the 2022-23 application cycle.

### 24 *AMA ChangeMedEd Initiative*

25  
26  
27 The AMA funds a number of collaborative projects to address the transition from medical school to  
28 residency. During its ChangeMedEd<sup>®</sup> 2021 conference, for example, the AMA funded three  
29 submissions out of an initial pool of 135 applicants from institutions or collaborations related to  
30 improving EDB in medical education. One program looks to view medical student evaluation and  
31 assessment through an equity lens to make needed changes that support increased diversity. The  
32 other two aim to help future physicians representing first-generation college attendees and students  
33 from socioeconomically disadvantaged backgrounds make the transition from community college  
34 to medical school in an expeditious and cost-effective way and to provide mentorship and  
35 physician role models to young people considering a career in medicine.<sup>30</sup>

### 36 37 RELEVANT AMA POLICY

38  
39 The AMA has a number of policies related to increased diversity in medical education and  
40 (ultimately) practice, as shown in Appendix B. In particular, edits to D-200.985, “Strategies for  
41 Enhancing Diversity in the Physician Workforce,” are noted in this report’s recommendations, to  
42 extend policy in favor of holistic review from solely medical school admissions to encompass  
43 residency/fellowship program application as well.

### 44 45 CONCLUSION

46  
47 A 2020 article describes the opportunity for reform in the program application, interview, and  
48 matching process occasioned by the pandemic and the potential for positive impact related to EDB:  
49 “This transformation to virtual interviews may allow us to reconsider how our present systems  
50 perpetuate sociocultural biases.” The article also notes, “In the current social climate, it is

1 incumbent on program leaders to consider their own processes to minimize bias—both at a  
2 personal level for their interviewers, but also at a systemic level within the systems we use.<sup>31</sup>~~[REDACTED]~~

3  
4 A related article from the same authors, in a three-part series on recruiting, interviewing, and  
5 ranking residency program applicants, calls on program leadership to “deliberately incorporate  
6 procedures that ensure equity.”<sup>32</sup> When considering equity, virtual interviews have both pros and  
7 cons. On the plus side, students with less means, who were not as able as their more affluent peers  
8 to travel to multiple interviews, had greater access via virtual interviews. On the other hand,  
9 candidates and programs may not attain a true sense of each other, making ranking difficult and  
10 likely defaulting to familiarity and certainty, as opposed to choosing the best “fit.” This may  
11 perpetuate existing bias. A secondary concern is the potential for a digital divide, with some  
12 candidates lacking the technology and/or expertise with visual rhetoric to ensure a professionally  
13 enhancing video image; this may also exacerbate existing inequities.

14  
15 In their 2020 article, Lucey et al. classify equity in medical assessment and advancement as a  
16 “wicked problem”—in other words, one that is multilayered, complex, complicated, and rife with  
17 inherent conflict and dynamic tensions.<sup>33</sup> Addressing this problem will require continued  
18 innovation and sustained attention.

## 19 20 SUMMARY AND RECOMMENDATIONS

21  
22 The current pressures related to the residency selection process contributed to the use of readily  
23 accessible comparative metrics (e.g., membership in one or more medical honor societies) when  
24 determining which applicants to interview. Overreliance on these “objective” measures can  
25 unintentionally perpetuate inequities and inhibit diversity in medical education. The current  
26 pressures related to the residency selection process contributed to the use of readily accessible  
27 comparative metrics (e.g., membership in one or more medical honor societies) when determining  
28 which applicants to interview. However, measures once viewed as objective can unintentionally  
29 perpetuate inequities and inhibit diversity in medical education. Numerous projects are underway  
30 to optimize the residency selection process, including several sponsored by our AMA. Moving  
31 forward, the profession must develop a resident selection process that is mutually beneficial for  
32 applicants as well as program directors and institutions, while ensuring a commitment to a diverse,  
33 equitable, and inclusive workforce.

34  
35 The Council on Medical Education therefore recommends that the following recommendations be  
36 adopted and the remainder of this report be filed:

- 37  
38 1. That our AMA encourage medical schools, medical honor societies, and  
39 residency/fellowship programs to work toward ethical, equitable, and transparent recruiting  
40 processes, which are made available to all applicants. (New HOD Policy)  
41  
42 2. That AMA Policy D-200.985, “Strategies for Enhancing Diversity in the Physician  
43 Workforce,” be amended by addition and deletion, to read as follows:

44  
45 Our AMA will recommend that medical school admissions committees and  
46 residency/fellowship programs use holistic assessments of applicants that take into account  
47 the diversity of preparation and the variety of talents that applicants bring to their  
48 education with the goal of improving health care for all communities. (Modify Current  
49 HOD Policy)

- 1       3. That our AMA advocate for residency and fellowship programs to avoid using objective  
2 criteria available in the Electronic Residency Application Service (ERAS) application  
3 process as the sole determinant for deciding which applicants to offer interviews.  
4 (Directive to Take Action)  
5
- 6       4. That our AMA advocate to remove membership in medical honor societies as a mandated  
7 field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting  
8 its use as an automated screening mechanism—and encourage applicants to share this  
9 information within other aspects of the ERAS application. (Directive to Take Action)  
10
- 11       5. That our AMA advocate for and support innovation in the undergraduate medical  
12 education to graduate medical education transition, especially focusing on the efforts of the  
13 Accelerating Change in Medical Education initiative, to include pilot efforts to optimize  
14 the residency/fellowship application and matching process and encourage the study of the  
15 impact of using filters in the Electronic Residency Application Service (ERAS) by  
16 program directors on the diversity of entrants into residency. (New HOD Policy)  
17
- 18       6. That our AMA encourage caution among medical schools and residency/fellowship  
19 programs when utilizing novel online assessments for sampling personal characteristics for  
20 the purpose of admissions or selection and monitor use and validity of these tools. (New  
21 HOD Policy)  
22
- 23       7. That AMA Policy D-295.963(5), “Continued Support for Diversity in Medical Education,”  
24 be rescinded, as having been fulfilled through this report. (Rescind HOD Policy)

Fiscal note:     \$1,000.

APPENDIX A: MEMORANDUM FROM THE ARNOLD P. GOLD FOUNDATION TO THE AMA, FEBRUARY 7, 2022

This briefing by The Arnold P. Gold Foundation (Gold Foundation) is in response to the request from the American Medical Association (AMA) for information on honor societies in American medical schools as they relate to equity and diversity in medical education and practice.

The Gold Foundation was founded in 1988 to preserve and elevate the tradition of humanism in healthcare (see <https://www.gold-foundation.org/>). As a means to focus and enhance the foundation's efforts, we created the Gold Humanism Honor Society (GHHS) in 2002 (<https://www.gold-foundation.org/programs/ghhs/>), and it now is an international program with 180 chapters and close to 45,000 members.

As an expression of the Gold Foundation itself, and as described below, the GHHS identifies medical student exemplars of humanism using a validated, peer-nomination system (McCormack et al., 2007). In the past 23 months, the foundation and the GHHS have pivoted to respond vigorously to the challenges of COVID-19 and have redoubled our efforts to address DEI in response to the racial reckoning following George Floyd's murder to support healthcare in which human interests, values, and dignity predominate.

We appreciate that AMA is also working on ensuring diversity and equity in medical education and practice, and we are pleased to share these updates on our work with the AMA House of Delegates. Should you have any questions regarding this response, please let us know.

*Response to AMA regarding the GHHS in American Medical Education and Practice*

The Gold Foundation established the Gold Humanism Honor Society (GHHS) twenty years ago as a signature program to recognize exemplary medical students, residents, and faculty who practice patient-centered care by modeling the qualities of integrity, excellence, compassion, respect, and empathy.

What began in 2002 at only a few medical schools now includes 180 chapters, with more than 3,000 students inducted each year and a total membership that numbers close to 45,000. The GHHS is an active society promoting humanism within medical schools and hospitals. Chapters participate in annual programs such as Thank a Resident Day and Solidarity Week for Compassionate Patient Care, and also undertake individual chapter-initiated projects on their campuses and within their communities. GHHS members are expected to be leaders of humanism on their campus and throughout their careers.

The GHHS leadership structure includes a national Advisory Council of 23 members comprising both the career stages and the broad functions represented in healthcare and academic medicine. The Advisory Council provides guidance and support to the society with committees and working groups, and the GHHS Advisory Council Chair and the Chair-Elect sit on the Gold Foundation Board of Trustees. Medical schools wishing to start a GHHS chapter apply and are thoroughly vetted. As noted, student selection into a GHHS chapter is based on peer nomination using a validated tool (McCormack et al., 2007). The initial group of peer-nominated students is then typically evaluated by a selection committee that considers academic eligibility, program director evaluations, an additional essay, interview, or other indication of the nominee's demonstrated humanism. While GHHS allows for some flexibility, all selection processes are vetted and approved when a medical school applies for a chapter and then reviewed periodically thereafter.

The Gold Foundation has long understood that equity, diversity, and inclusion are part of the very fabric of humanism. This was further spurred by the pandemics of COVID-19 and racism, which have highlighted inequalities and disparities, and compelled a closer look at flaws within our healthcare system. Within this broad context, the Gold Foundation reviewed all its programming through the lens of diversity, equity, inclusion, and anti-racism and has placed explicit emphasis on these issues within our work and strategic plan. (Click to read [Gold Foundation statement on diversity, equity, inclusion and anti-racism](#))

The GHHS has specifically addressed this topic throughout the past two years in a number of ways, including:

1. Engaging a researcher to assess the demographics of GHHS
2. Establishing a National Initiative in 2020-21 for chapters on the impact of structural racism in medicine, which concluded with a large international conference in May 2021 to share what had been learned, as well as steps that schools and systems could take to begin addressing racism in medicine
3. Engaging in a continuous improvement project to determine best practices in diversity and inclusivity through work with the AAMC and individual GHHS chapters.

*Research on GHHS Demographics*

While racial/ethnic disparities in Alpha Omega Alpha (ΑΩΑ) membership have been documented (Boatright et al., 2017) and formally responded to by the ΑΩΑ (Byyny et al., 2020), less is known about how the demographic composition of GHHS reflects the diversity of medical schools nationally. One study of GHHS published in *Academic Medicine* in 2019 demonstrated no difference in the likelihood of Black or African-American medical students being inducted into GHHS compared to white medical students (Wijesekera, et al., 2019).

Recognizing the importance of more deeply understanding the demographic composition of our members, the Gold Foundation decided in 2020 to reach out to an academic researcher to examine this issue. With the assistance of a Gold Foundation Board of Trustees advisory committee, Dr. Dowin Boatright, MD, MBA, MHS, Assistant Professor of Emergency Medicine and Officer for Diversity and Inclusion at Yale School of Medicine, was identified and agreed to include GHHS in his work.

Dr. Boatright and his research team are examining the association between GHHS membership and several aspects of student identity including race/ethnicity, sex, sexual orientation, and socioeconomic status (SES) in a national cohort of medical students. Although the results are preliminary and currently unpublished, per Dr. Boatright, *so far, they are finding no disparities by sex, sexual orientation, or SES. Additionally, they are finding no difference in the likelihood of membership between Black, Hispanic, and Native American students and white students, but they are seeing some differences between white and Asian students favoring white students. The cause of this disparity is unknown and warrants further examination* (D. Boatright, personal communication, January 19, 2022). Dr. Boatright expects to finalize his analysis and publish later this year, and the Gold Foundation has committed to supporting open access publication of this research.

The Gold Foundation is committed to continuing to transparently assess, understand, and address inequities. To that end, Dr. Boatright notes:

*“Disparities in honor society membership are important to acknowledge and address. Nevertheless, it is unclear if removing honor societies from the ERAS application will solve the underlying problem contributing to these disparities nor ameliorate the downstream implication of these disparities on the physician workforce as medical students could always self-report honor society membership on the ERAS application.*

*Instead, it is likely more important for honor societies, like GHHS, to continuously examine honor society membership for systematic disparities and investigate evidence-based interventions to ensure equity in membership. Moreover, honor societies should be transparent in their findings and make data concerning disparities public. Additionally, as GHHS is committed to doing, the national honor societies should work with local chapters to promote equity and inclusion in membership selection.”* (D. Boatright, personal communication, January 19, 2022)

*GHHS Programmatic Focus on Diversity, Equity, Inclusion and Anti-Racism*

GHHS chapters have undertaken many projects dedicated to serving populations most in need. Recent projects include: Engagement in Justice in Middle Tennessee and the Nation (Vanderbilt), Chicago Street Medicine (University of Chicago, Illinois), The Invisible Minority: Healthcare Disparities in Appalachia (West Virginia University), How We Heal: Applying Structural Competency to Care for Immigrant Communities (UC Riverside), and many others.

The events of 2020 compelled GHHS leadership to create a focused National Initiative for 2020-2021 titled “Humanism and Healing: Structural Racism and its Impact on Medicine.” Chapters were encouraged to use their leadership roles to start or extend conversations about racism and its impact on healthcare in their local communities and beyond, to create space for grieving, processing, and bearing witness around this topic, or to take action in one of many powerful ways that humanism can begin to heal. Chapter projects included such activities as:

- Creation of an anti-racism library collection (Cooper Medical School)
- Video Vignettes of Bias and Racism workshop (Central Michigan University)
- Panel discussion titled “A Calculated Risk: Engaging with Black Patients in Discussion About the Covid-19 Vaccine” (Emory University)
- Panel discussion titled “Fad-vocacy Armchair Empathy: Maintaining Social Justice Momentum” (joint project with Howard University and University of Michigan)
- Panel discussion titled “The Dismissal of Black Suffering” (University of California Irvine)
- Panel discussion titled “Medical Students Partner and Learn from Women Who are Incarcerated” (GHHS member Michelle Harper, MD, and the Ohio State University)

The National Initiative concluded with a large virtual conference on May 6-8, 2021. The conference, hosted by GHHS, included presentations from GHHS members (including panel discussions, workshops, and poster sessions) as well as many other Gold Foundation partners. Keynote presentations included:

- “The Ultimate ‘Anti-Racism Statement’ that Medicine Can Make is to Diversify Our Ranks” (Quinn Capers, MD, Associate Dean for Faculty Diversity and Vice Chair for Diversity and Inclusion, Department of Internal Medicine, UT Southwestern)
- “Partnership with HBCUs: Challenging Systemic Racism in Health Education, A Nursing Story” (Dr. Gina S. Brown, Dean, College of Nursing and Allied Health Sciences at Howard University; Dr. Eileen Sullivan-Marx, Dean of the New York University Rory Meyers College of Nursing; Dr. George Thibault (Ignitor), Immediate Past President of the Josiah Macy Junior Foundation)
- “COVID-19 and the Racial Reckoning” (Dr. Richard I. Levin, President and CEO of the Gold Foundation; Dr. Wayne Riley, President of SUNY Downstate Health Sciences University)

Many insightful and thought-provoking sessions encouraging participants to work toward increased health equity and racial equality were part of the conference, including a panel discussion on advocacy and grassroots change, a film screening of *Black Men in White Coats*, a panel on vaccine deliberation, and many more. The 2021-23 GHHS International Initiative expands on this work, titled “Healing the Heart of Healthcare: Reimagining How We Listen, Connect and Collaborate.” GHHS members are leaders in humanism and will, with Gold Foundation support, continue to work toward greater diversity, equity, and inclusion within healthcare for years to come.



*Continuous Improvement Project to Determine Best Practices in Diversity and Inclusivity*

The Gold Foundation is continually working with GHHS chapters to provide guidance and determine best practices for ensuring that membership is inclusive and diverse. Currently, the GHHS leadership is nearing the conclusion of a biennial check-in with chapters. The 2021 check-in added questions to gather information regarding how each chapter is working to ensure and improve diversity and inclusion within its selection process, including members of the selection committee. The Gold Foundation is concurrently working with the AAMC to consider URM medical student representation within chapters as it compares with each chapter's medical school at large. These efforts will be used to create best practice strategies for GHHS chapters to ensure inclusivity and diversity.

*Summary*

The Gold Foundation established the Gold Humanism Honor Society (GHHS) twenty years ago as a signature program to recognize exemplary medical students, residents, and faculty who practice patient-centered care by modeling the qualities of integrity, excellence, compassion, respect, and empathy. What began in 2002 at only a few medical schools now includes 180 chapters, with more than 3,000 students inducted each year, and a membership that numbers close to 45,000. The Gold Foundation is committed to ensuring that the society is diverse and inclusive.

- Research on GHHS demographic makeup is underway by a Yale research team led by Dr. Dowin Boatright. Publication is expected shortly.
- The 2020-2021 GHHS National Initiative, "Humanism and Healing: Structural Racism and its Impact on Medicine," was followed by a virtual conference of the same name hosted by GHHS.
- The Gold Foundation is engaged in a continuous improvement project to determine best practices in diversity and inclusivity through work with the AAMC and individual GHHS chapters.

APPENDIX B: RELEVANT AMA POLICY

*D-200.985, "Strategies for Enhancing Diversity in the Physician Workforce"*

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups.
  2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
  3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
  4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
  5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
  6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
  7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
  8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
  9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
  10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
  11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
  12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
  13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
- (CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21)

*D-295.963, "Continued Support for Diversity in Medical Education"*

Our AMA will: (1) publicly state and reaffirm its stance on diversity in medical education; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; and (5) work with appropriate stakeholders to study reforms to mitigate demographic and socioeconomic inequities in the residency and fellowship selection process, including but not limited to the selection and reporting of honor society membership and the use of standardized tools to rank applicants, with report back to the House of Delegates.

(Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13; Appended: CME Rep. 5, A-21)

*H-350.960, "Underrepresented Student Access to US Medical Schools"*

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

(Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15)

*D-295.963, "Continued Support for Diversity in Medical Education"*

1. Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education.
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.

(Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13)

*H-295.888, "Progress in Medical Education: the Medical School Admission Process"*

1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges.

2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities

in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school.

(CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11)

*H-65.952, "Racism as a Public Health Threat"*

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

(Res. 5, I-20)

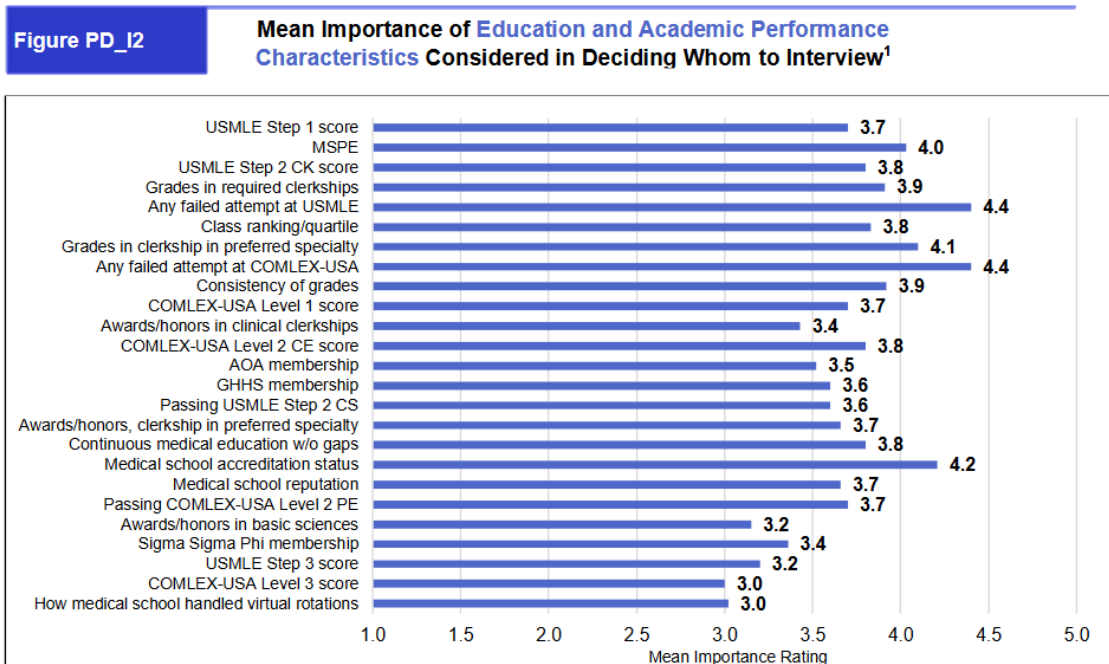
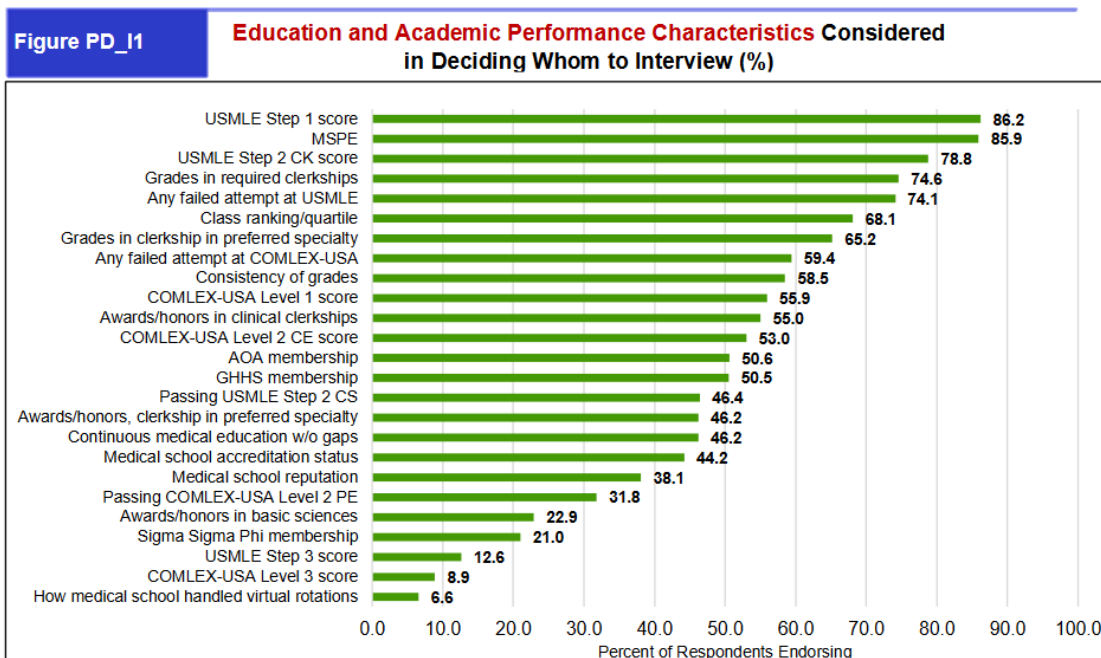
APPENDIX C – NRMP PROGRAM DIRECTOR SURVEY RESULTS

Source:

Results of the 2021 NRMP Program Director Survey.

National Resident Matching Program, August 2021.

<https://www.nrmp.org/wp-content/uploads/2021/11/2021-PD-Survey-Report-for-WWW.pdf>



<sup>1</sup> Rated on a scale of 1 (not at all important) to 5 (very important)

Figure PD\_13

**Personal Characteristics and Other Knowledge of Applicants Considered in Deciding Whom to Interview (%)**

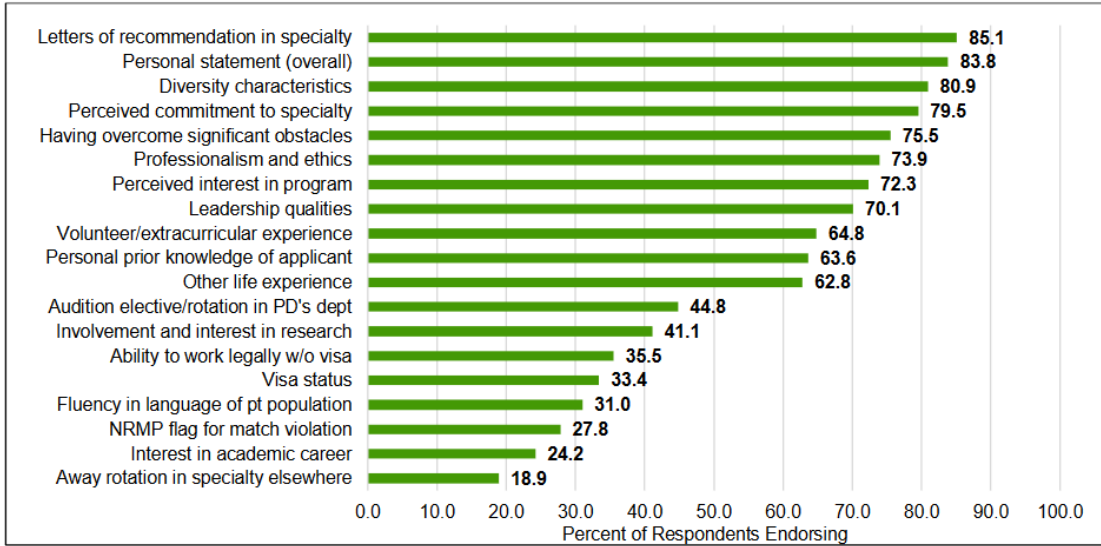
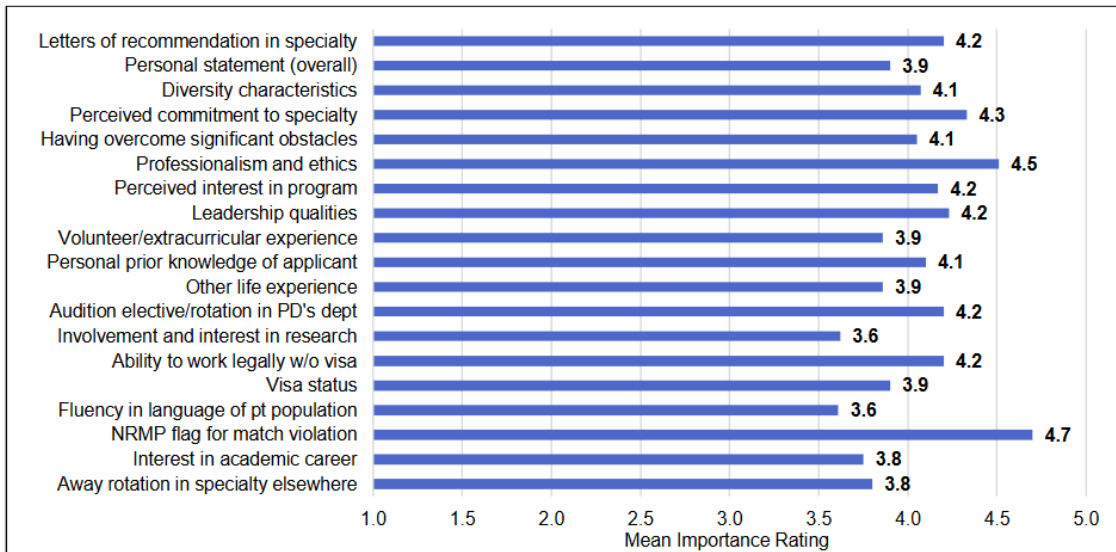


Figure PD\_14

**Mean Importance of Personal Characteristics and Other Knowledge of Applicants Considered in Deciding Whom to Interview<sup>1</sup>**



<sup>1</sup> Rated on a scale of 1 (not at all important) to 5 (very important)

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