1 **C7**
2 **American Medical Student Association**
3 **House of Delegates 2022**
4 **Resolution:**
5
6 **INTRODUCED BY:** Amanda Huff; Coco Victoria Gomez Tirambulo; David Schaub; Emily
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8
9 **SCHOOL:** University of Arizona College of Medicine Tucson
10
11 **SUBJECT:** Principles Regarding Medical Education – Curriculum Content
12
13 **TYPE OF RESOLUTION:** Resolution of Principles
14

15
16 WHEREAS AMSA recognizes the issue and challenges of sustaining the healthcare workforce
17 especially due to the COVID-19 pandemic (Fact Sheet, 2022) and
18
19 WHEREAS AMSA acknowledges the benefit of training medical students to act and serve in
20 times of public health crises and healthcare worker shortages (Lazarus, 2021) and
21
22 WHEREAS AMSA condemns the perpetration of microaggressions, especially in through
23 pimping, against medical students (Chisholm, 2020; Anderson, 2021)
24
25 WHEREAS AMSA recognizes that burnout and drop off rates for medical students are a concern
26 (Chisholm, 2020; Anderson, 2021) and
27
28 WHEREAS microaggression education and prevention is essential for building resiliency in
29 healthcare curriculum (White-Davis, 20218; Sandoval, 2021).
30
31 **THEREFORE BE IT RESOLVED** that the Principles regarding medical education –
32 curriculum content (pg. 18) BE AMENDED to state:
33
34 1. SUPPORTS a medical school curriculum that:
35 a. Provides formal instruction about the pharmaceutical and medical products
36 industry, including:
37 i. critical evaluation of the issues of pharmaceutical development incentives
38 and cost, research quality and independence, regulation, and
39 communication;
40 ii. the decision-making process for prescribing medications, as it relates to
41 the economics and bioequivalence of using brand name versus generic
42 drugs;
43 iii. the impact and ethics of direct-to-consumer and direct-to-physician
44 marketing practices employed by the pharmaceutical industry, as they
45 relate to the physician-patient relationship;

46 iv. studies on medical prescriber-drug company interactions and the effects of
47 marketing on prescribing habits.
48 v. how to critically evaluate clinical trials.
49 vi. how to critically evaluate pharmaceutical marketing.
50 vii. principles of evidence-based prescribing.
51 b. provides full disclosure about commercial sources of sponsorship of any medical
52 education program, whether Grand Rounds or CME;
53 c. establishes pharmacy and therapeutics committees in all teaching hospitals to
54 encourage the following:
55 i. active team practice (joint bedside rounds, pharmacy chart reviews, etc.)
56 involving clinical pharmacists and physicians in drug use decision-
57 making;
58 ii. establishment of oversight and evaluation mechanisms for prescribing
59 practices of students, housestaff, and physicians; these mechanisms to
60 include guidelines for interaction with industry representatives in teaching
61 institutions;
62 iii. establishment of hospital formularies which specify drugs, their
63 indications, mode and cost of administration, and complications;
64 d. PROHIBITS pharmaceutical industry representatives from marketing to medical
65 students, including, but not limited to, distributing paraphernalia advertising
66 pharmaceuticals or pharmaceutical companies to students, detailing students
67 about a particular prescription drug, and inviting students to pharmaceutical
68 industry-sponsored meals.
69 e. PREPARES students to act and serve in times of public health emergencies
70 through the introduction of relevant courses as their role can provide significant
71 beneficial impact during healthcare personnel shortages (Lazarus, 2021) (2022).
72
73 2. In regard to social media:
74 a. RECOGNIZES the importance of training students on both the professional
75 promises and perils of social media.
76 b. URGES the incorporation of comprehensive social media education into medical
77 school curricula.
78 c. SUPPORTS social media pages that foster a healthy community of pre-medical
79 students, medical students, and physicians who support one another. (2021)
80 d. OPPOSES harassment and bullying through social media medical-related pages.
81 (2021)
82
83 3. In regards to medical misuse and overuse:
84 a. RECOGNIZES the importance of physicians-in-training to be aware of misuse
85 and overuse in medical practice; (2015)
86 b. RECOGNIZES the right to health care is also a claim on common wealth and thus
87 should not extend to ineffective treatments; (2015)
88 c. RECOGNIZES that medical training should provide the ethical grounding for
89 clinicians to be transparent about the basis of their decision-making and explicit
90 training in how to communicate different options and to involve patients in
91 decisions regarding diagnostic strategies; (2015)

92 d. STRONGLY ENCOURAGES medical schools to develop a formal curricula that
93 teaches medical students about the risks of overuse, the risks of misuse, and the
94 actual cost of diagnostic tests, promote the principles of good stewardship, and
95 evaluate trainees in their delivery of high-value care; (2015)
96 e. STRONGLY ENCOURAGES that medical trainees must be taught that overuse is
97 unethical - besides risking harm, it undermines the ability to extend coverage to
98 all and fund other societal needs that can improve health; (2015)
99 f. URGES medical trainees to learn about embracing and accepting uncertainty and
100 the human and financial costs that come with pursuing unnecessary testing;
101 (2015) g. URGES that medical education foster humility, empathy, patience,
102 service, courage, and restraint (2015)
103 4. In regard to nutrition education:
104 a. URGES the integration of at least 25 hours of comprehensive nutrition education
105 into medical school curricula; (2015)
106 b. URGES that medical schools incorporate nutrition curricula with other healthcare
107 professional programs and interprofessional courses and experiences. (2015)
108
109 5. In regard to racism and education, specifically health-science academia, and health-
110 science workforce
111 a. RECOGNIZES that racism may be found within, amongst others, the labor
112 market, education, housing, employment, and income. (2021)
113 b. RECOGNIZES that poorer academic achievement is associated with the
114 psychological and biological stress response of perceiving racial discrimination as
115 a racially/ethnically minoritized individual (2021)
116 c. RECOGNIZES that this attrition contributes to the lack of underrepresentation of
117 minoritized individuals within higher education, including health science
118 academia, and the health science workforce. Therefore, academia must improve
119 its efforts to understand the factors underlying attrition and remedy them such that
120 higher education fulfills its mission of providing equal opportunities for everyone.
121 (2021)
122 d. RECOGNIZES that informal housing segregation still exists. (2021)
123 e. RECOGNIZES that admission committee members of higher education have a
124 sizable influence on the students that are admitted, and that the graduate
125 admission process has inherent biases, such as excluding minoritized individuals,
126 albeit unintentionally, thereby impacting the composition of the workforce and
127 thus the health outcomes of current and future populations. (2021)
128 f. RECOGNIZES that within health science academia, and specifically medicine,
129 minorities are underrepresented. (2021)
130 g. RECOGNIZES that an increased composition of underrepresented minoritized
131 individuals underrepresented in the health workforce is vital for better serving
132 marginalized populations, decreasing racial health inequities, and improving the
133 efficiency of teams and institutions. (2021)
134 h. STRONGLY SUPPORTS racially minoritized individuals in health-science
135 academia, health-science workforce, and in organizational power positions, such
136 as leadership. (2021)

137 i. STRONGLY ENCOURAGES institutions, such as health science centers and
138 hospitals, to examine, evaluate, and continuously re-evaluate their admission
139 processes, curriculum, hiring practices, culture, and finances for racist practices
140 and content, and once found, rectifying it. (2021)
141 j. STRONGLY ENCOURAGES institutions, especially health science academia, to
142 teach race as a sociopolitical construct rather than a biological construct. (2021)
143 k. STRONGLY ENCOURAGES institutions, especially health science academia, to
144 incorporate teachings of historical and ongoing racism with examples of medical
145 neglect, mistreatment, and non-consensual, non-informed testing of patients by
146 the medical profession. (2021)
147 l. STRONGLY ENCOURAGES health science centers to have standardized
148 patients and cases that have nonwhite patients. (2021)
149 m. ENCOURAGES institutions, especially health science academia, to refrain from
150 using deficit-oriented language and approaches when referring to racial and ethnic
151 minoritized individuals to instead using assets-based language and approaches.
152 (2021)
153 n. STRONGLY OPPOSES microaggressions perpetrated against medical students
154 during training to prevent burnout and withdrawal from training (Chisholm, 2020;
155 Anderson, 2021). (2022)
156 o. ENCOURAGES institutions to provide students and faculty with workshops on
157 tools and strategies on how to respond to microaggressions and discrimination.
158 (White-Davis, 20218; Sandoval, 2021) (2022)
159
160 **FISCAL Note**: none
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162 Citations:
163
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