AAMC
655 K Street, NW, Suite 100
Washington, DC 20001-2399
T 202-828-0400
aamc.org

Association of American Medical Colleges
Statement for the Record
before the
House Ways and Means Health Subcommittee
"Advancing the Next Generation of America's Health Care Workforce"
February 24, 2026

The AAMC (Association of American Medical Colleges)[1] appreciates the opportunity to submit this statement for the record regarding the "Advancing the Next Generation of America's Health Care Workforce" hearing on February 24, 2026. The AAMC welcomes the chance to share the perspective of academic medicine and to work with you as you discuss the health care workforce.

Working in partnership with the nation's medical schools, AAMC member health systems and teaching hospitals represent only 5% of all inpatient U.S. hospitals – and yet they train 69% of residents nationwide.[2] Our member teaching health systems and hospitals, despite being a small percentage of hospitals, operate 100% of comprehensive cancer centers, 68% of burn unit beds, 56% of level-one trauma centers, and 65% of pediatric intensive care unit (ICU) beds.[3] Our members also provide 32% of hospital charity care nationwide, and receive approximately 60% of the National Institutes of Health's (NIH) extramural research funding.[4] Our institutions are dedicated to their missions of patient care, education, research, and community collaboration, and serve as pillars of the communities in which they are located.

The AAMC shares the Subcommittee's goals of ensuring that the physician workforce of tomorrow is equipped to serve patients in every community, including rural and underserved areas, with the tools and knowledge that modern medicine demands. In this statement, we address four areas of particular relevance to the Subcommittee's work: first, the urgent need to expand Medicare-supported GME residency positions, which remains a foundational bottleneck for physician workforce development; second, the targeted programs and policy fixes needed to ensure that new slots and training opportunities reach rural and underserved communities; third, our strong opposition to conditioning Medicare payments on residency programs' use of specific licensing examinations; and fourth, the concrete steps the academic medicine community is already taking to integrate nutrition, artificial intelligence, and telehealth into

[1] The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 163 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 Canadian medical schools accredited by the Committee on Accreditation of Canadian Medical Schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe.
[2] AAMC analysis of FY2024 American Hospital Association Annual Survey Database, and the National Cancer Institute's Office of Cancer Centers, 2024. AAMC membership data, December 2025
[3] Ibid.
[4] https://www.aamc.org/media/75056/download

physician education and training. The AAMC is a committed partner in advancing a health care workforce that meets the needs of every patient, in every community, across the United States.

The Need to Expand Medicare-Supported Graduate Medical Education (GME)
The United States faces a projected shortage of up to 86,000 physicians, including both primary care and specialty physicians, by 2036.[5] Medical schools have done their part by increasing enrollment by nearly 40% since 2002, and by opening more than 30 new MD-granting schools in that time. But increasing the number of medical school graduates alone cannot solve the physician shortage. Every one of those graduates must complete a residency training program before they can independently practice medicine, and the number of Medicare-supported residency positions has been effectively frozen since Congress capped GME through the Balanced Budget Act of 1997.

The Consolidated Appropriations Acts of 2021 and 2023 provided the first new investments in Medicare-supported GME since 1997. While the AAMC is greatly appreciative of those bipartisan investments, totaling 1,200 positions, additional investment is needed to make an impact due to the magnitude of the physician shortage. Unless Congress acts to significantly expand Medicare-supported GME positions, the pathway for new physicians will remain artificially constrained regardless of how many students enroll in medical school.

Medicare supports graduate medical education (GME) through payments that offset a portion of teaching institutions' training-related expenditures, including resident stipends and benefits, faculty compensation, and institutional overhead. However, it is important to bear in mind that one GME slot does not equal one new physician. Because residency programs span multiple years, ranging from three years for primary care to seven or more for surgical specialties, programs must "backfill" positions each year as residents advance. Training a single primary care physician requires three slots over three years. The real-world yield of new physicians from any slot expansion is therefore smaller than the headline number suggests, reinforcing the need for a robust investment.

AAMC-member teaching health systems and hospitals train over 78,000 residents annually across the country. Medicare contributes to approximately 56,000 of those trainees, meaning the remainder of the institutions are fully funding the training of over 22,000 residents out of their own budgets. Because Medicare only pays for the percentage of time that residents care for Medicare patients, the program only reimburses hospitals about $6.26 billion (about 24%) of the $26.49 billion that teaching health systems and hospitals spend on physician training.[6] That is more than $20 billion in direct, unreimbursed training costs absorbed by teaching hospitals each year. Despite this immense financial burden, **90% of AAMC member health systems and teaching hospitals continue to train residents above and beyond their caps** to meet their commitment to their educational missions and the communities they serve.

The AAMC strongly supports the bipartisan Resident Physician Shortage Reduction Act (H.R. 4731/S. 2439), which would gradually provide 14,000 new Medicare-supported GME positions over seven years. Slots authorized by this legislation would be prioritized to hospitals in rural areas, hospitals serving patients in Health Professional Shortage Areas (HPSAs), hospitals in states with new medical schools, and hospitals operating over their caps. When fully enacted, this legislation would produce an additional

[5] The Complexities of Physician Supply and Demand: Projections From 2021 to 2036: https://www.aamc.org/media/75236/download?attachment
[6] AAMC Analysis of FY2023 Hospital Cost Reporting Information System (HCRIS) data, July 2025 release. If FY2023 data is not available, FY2022 data is used.

3,500 new doctors every year. The demand for additional GME support is clear: hundreds of hospitals applied for the limited slots in prior CAA distributions, many knowing their chances of an award were slim.

Distribution of GME Slots and Expanding Rural Physician Training

As noted repeatedly throughout the hearing, the number of Medicare-supported GME positions has been effectively frozen since a cap was imposed on the program in 1997. As a result, the distribution of slots has not kept pace with and does not necessarily reflect the growing and shifting US population. In 1997, the population of the United States was about 272 million people; today, the population is over 340 million, a more than 20 percent increase.[7] Though new residency programs have helped expand training opportunities across the country, it is clear that additional GME positions are needed to help ameliorate the physician shortage. Proposals to redistribute existing training slots according to population migration ignore the central problem – there are not enough slots to begin with.

The AAMC also urges the Subcommittee to acknowledge that **the true universe of eligible rural teaching hospitals is quite limited**. According to the most recent CMS data, there are only 69 rural teaching hospitals in the U.S. that are paid under the IPPS and therefore eligible to receive new GME slots. Of those, only 22 are over their cap, meaning **the majority of eligible rural teaching hospitals may have unused cap slots and are not eligible for additional Section 126 distributions**.[8] For context, there are nearly 1,200 teaching hospitals in the U.S. overall, more than 883 of which are over their caps. The modest number of applications from geographically rural teaching hospitals in prior slot distributions reflects this constrained universe of eligible institutions, not a lack of interest.

The AAMC continues to be concerned about CMS's distribution methodology, which super-prioritizes HPSA scores to the exclusion of other statutory factors. Congress established four categories of qualifying hospitals for Section 126 distributions: hospitals in rural areas, hospitals over their cap, hospitals in states with new medical schools, and hospitals serving geographic HPSAs; with a requirement that no fewer than 10% of slots be distributed to each category. CMS's approach to distribution potentially disadvantaged rural teaching hospitals with low or no HPSA scores, and likely had a chilling effect on their applications. While some have suggested that an unintended definition of "rural teaching hospital" in Sec. 126 was the primary reason for low rural teaching hospital applications, we believe it is clear that HPSA super-prioritization, limited eligibility numbers, and limited resources to expand residency programs are the real issues.

For future slot distributions, the AAMC urges the Subcommittee to include explicit statutory language requiring CMS to distribute slots consistent with all four statutory categories.

GME investments alone, however, cannot fully resolve physician workforce challenges in rural and underserved areas. In fact, **the AAMC urges the Subcommittee to consider that many maldistribution issues in the program could be resolved by additional positions and increased investment in Health Resources and Services Administration (HRSA) workforce programs.** The AAMC is strongly supportive of programs such as Children's Hospitals Graduate Medical Education (CHGME), Teaching Health Center Graduate Medical Education (THCGME), and the Title VII health professions workforce

[7] https://www.census.gov/popclock/
[8] AAMC's analysis of FY2022 Medicare cost report data, HCRIS July 2024 release. If FY2022 isn't available, FY2021 data is used. AAMC membership as of September 2024.

development programs – all of which play key roles in increasing the number of physicians and need increased investment. Additionally, international health care professionals in the U.S. under the temporary nonimmigrant J-1 "exchange visitor" or H-1B "specialty occupation" visa programs are essential to addressing health care workforce shortages, advancing medical breakthroughs, and delivering care to communities in need. Far from displacing U.S. workers, these highly educated, and extensively vetted visa holders serve as an important complement within our health workforce, helping to fill gaps in the shortage. Finally, new annual and aggregate loan limits coupled with the elimination of Grad PLUS could create challenges for some medical students to finance their education due to the credit-based nature of private loans, resulting in an additional financial barrier to attending medical school. This added barrier could deter qualified candidates, particularly those from low-income, rural, and non-traditional backgrounds, from pursuing a medical degree altogether. Without access to this critical source of funding, aspiring physicians may find it increasingly difficult to finance medical school.

Rural Residency Planning and Development (RRPD) Grants
The AAMC strongly supports the codification of Rural Residency Planning and Development (RRPD) Grants. This program directly addresses the start-up infrastructure barrier that is often decisive for rural hospitals considering a new or expanded residency program. New training programs require significant resources: accreditation, supervisory faculty, equipment, and administrative infrastructure, costs that can run into the millions and take years to build. Rural hospitals operating on thin margins rarely have these additional resources. RRPD grants address this structural barrier, and their codification would ensure rural hospitals have the sustained Medicare support needed to build lasting training programs. The AAMC is supportive of the bipartisan Rural Residency Planning and Development Grant Act of 2025 (H.R. 6468), which would codify this crucial program.

Rural Training Programs (RTPs)
The significant changes to the RTP through Section 127 of the CAA, 2021 greatly increased the utility and appeal of the program. RTPs represent an important development for rural training, capitalizing on the strengths of urban academic medical centers and rural clinical training sites. Three prospective policy changes would be to (1) allow RTPs with established RTP caps before October 1, 2022 a new cap building window, which would allow for the expansion of proven rural training programs, (2) to remove RTP residents altogether from a hospital's GME cap, and (3) statutorily reduce the rural training time required to participate in an RTP from greater than 50% to 30% or more. Many programs are unable to meet the greater than 50% requirement to the detriment of the development of rural training rotations. Reducing the training requirement would increase the number of programs and specialties that can participate in RTPs and increase rural training nationally.

Residency programs are inherently resource intensive. They require dedicated faculty supervision, robust clinical training infrastructure to ensure safe and effective patient care, and sufficient patient volume to meet accreditation and educational requirements. As a result, infrastructure capacity is often the primary limiting factor in the development of new RTPs.

Ensuring Integrity in the Residency Application Process
The AAMC continues to oppose efforts to condition Medicare IME or DGME payments on the use of specific licensing examinations in the residency application process. Both MD and DO graduates seek positions through the same unified matching process and match at high rates. Program directors are best positioned to determine the criteria most relevant to their programs and patients.

The AAMC has worked collaboratively with the American Association of Colleges of Osteopathic Medicine, the American Osteopathic Association, and the National Board of Osteopathic Medical Examiners toward a non-legislative solution to concerns about COMLEX[9] recognition since 2021. That work is producing measurable results: the share of programs excluding COMLEX has dropped from 38% in 2015 to 26% in 2024, and eleven primary care specialties have committed to recognizing COMLEX as equivalent to USMLE.[10,11] The medical education community is addressing these concerns; legislative mandates, such as those proposed in the Fair Access in Residency Act (H.R. 2314), are unnecessary and counterproductive.

The AAMC strongly cautions the Subcommittee against conditioning Medicare Indirect Medical Education (IME) payments on residency program compliance with examination-related requirements. IME payments are patient care payments that offset the higher costs of caring for complex patients at teaching hospitals. Misguided efforts targeting IME payments would harm patient care, disproportionately affect vulnerable populations, and destabilize the institutions that train the next generation of physicians. Instead, the Subcommittee should support off-the-Hill solutions and encourage all groups involved to continue to explore promising partnerships and initiatives that would address stated concerns about the residency application process.

Innovations in Medical Education: Nutrition, AI, and Telehealth

Over the last two decades, shifts in demographics, science, and federal policies have had a major impact on health care, a phenomenon that will persist. Accordingly, the education and training of physicians and other health professionals have changed significantly and continue to change. The structure, content, and delivery of medical education continue to be refined as medicine improves, new public health challenges emerge, learning and teaching are better understood, and educators strive to ensure more seamless transitions between the phases of medical education. These and other developments reflect the dynamic nature of health care and the corresponding commitment of medical education to prepare physicians who can adapt and respond to an ever-changing environment.

The structure of medical school is changing, with themes such as earlier patient and community experiences, longitudinal integration of foundational with clinical and health system sciences, and a focus on outcomes or competencies. Learners are exposed to a wide variety of health care settings and instructional modalities, capitalizing on new technologies and capabilities. Increasingly, they are expected to achieve competence in multiple domains rather than merely amassing a litany of facts. Schools are also reporting innovative approaches to advancing their specific missions, such as requiring students to complete community service, establishing dedicated tracks in primary care and rural health, promoting medical research experiences, or founding regional medical campuses at sites distant from the main campus.

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[9] The Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) is a three-level, national standardized exam series required for licensure to practice as a Doctor of Osteopathic Medicine (DO)

[10] Data were retrieved from a GME Track special report as of March 26, 2025. The GME Track is a national secure data collection system designed to track and report information about residents and fellows throughout their graduate medical education (GME) training. The data collected through GME Track plays a crucial role in informing public policy, supporting workforce planning, and enhancing the quality of medical education in the United States. https://www.aamc.org/data-reports/students-residents/report/gme-track

[11] https://www.nbome.org/what-we-do/education-advocacy/

Medical school graduates then must enter GME or residency training if they seek medical licensure and/or board certification in a medical specialty or subspecialty. This phase is conducted in clinical settings, with AAMC-member health systems and teaching hospitals training 69 percent of all residents.[12] In GME, too, innovations abound. Educational experts are designing curricula and programs in response to community health needs. They are exploring opportunities to optimize the duration of GME by, for example, shortening educational pathways. According to data from the Accreditation Council for Graduate Medical Education (ACGME), which includes the AAMC and four other organizations in its not-for-profit membership corporation, 88 percent of pathway programs in both primary and nonprimary care specialties place residents in nonhospital and ambulatory settings for some of their training.

Aside from innovations in medical education, academic medicine is also at the forefront of leading innovations in medical discovery and health care delivery. Medical schools' and teaching hospitals' leadership in propelling such innovations goes hand in hand with the educational experience for the next generation of physicians. No environment is better suited and more committed to preparing the physician workforce for the health care system of the future than the very institutions pioneering such transformations. As new performance metrics are created, tested, and evaluated, these data will demonstrate the increasing ability of new physicians to work in teams, facilitate system changes to improve population health, and foster continuous quality improvement in care delivery.

Enhancing Medical Education Content on Nutrition
Educators must remain nimble to ensure that the future physician workforce is equipped to address public health challenges as they emerge. One current example of how the academic medicine community is adapting to the public's changing needs is work underway to enhance content on disease prevention, health promotion, and specifically, nutrition. Nutrition is central to preventing, managing, and treating many of the chronic diseases that continue to drive morbidity, mortality, and health care costs in the United States—including cardiovascular disease, Type 2 diabetes, obesity, hypertension, and certain cancers. Physicians must be adequately prepared with the competencies to address their patients' nutrition-related health needs, including collaborative, team-based approaches that engage nurses, registered dietitians, nutritionists, social workers, and other health professionals.

The AAMC has engaged in strategic efforts to improve nutrition education for many years. As a result, there have been significant increases in schools integrating this content within their educational programs. **Specifically, in 2024, 94% of schools reported having nutrition content required in the curricula beyond that related to the basic sciences (metabolism, macro and micronutrients, up from just 38% in 2014).**[13]

Our ongoing work in this area is grounded in competency-based medical education. While some past critiques of nutrition education predate our most recent efforts and have relied on outdated measures—such as counting hours of instruction—medical education has shifted toward embedding nutrition within the skills, behaviors, and professional attitudes expected of all medical graduates. This longitudinal integration is consistent with the educational approach AAMC is recommending to our member medical schools across all high-priority topics, to prioritize meaningful uptake among learners over symbolic gestures (such as counting hours of instruction) that may not lead to significant improvements.

[12] AAMC analysis of FY2024 American Hospital Association Annual Survey Database. AAMC membership data, December 2025
[13] Howley LD, Bannuru A. Nutrition in Medical Education Curricula: A Recipe for Increased Competency Based Teaching and Learning. AAMC Data Snapshot. AAMC; 2025.

While it is important to note that we strongly support the ability of each medical school to retain the flexibility to design local curricula aligned with its mission and accreditation standards, we work regularly to equip educators with national frameworks, shared resources, and evidence-based guidance to guide their work, including through national convenings and professional development opportunities, competency-based frameworks and curricular guidance, and dissemination of evidence-based educational resources. With respect to nutrition specifically, some recent efforts that AAMC led, co-led, or participated in include:

National convening of medical education leaders: The 2023 National Summit on Nutrition Education—co-hosted by AAMC with the ACGME and American Association of Colleges of Osteopathic Medicine (AACOM)—brought together a diverse group of stakeholders from across the medical education continuum, including residents, undergraduate medical education (UME) and graduate medical education (GME) educators, learners, specialty societies, certifying boards, nutrition experts, and registered dietitians. The summit underscored three key insights: (1) nutrition knowledge is relevant to every specialty and a vital component of physician training; (2) nutrition education is most effective when integrated into existing curricula rather than added as a separate requirement in an already crowded system; and (3) physician learners must gain a clear understanding of the roles of all health care team members, particularly registered dietitians (RDs/RDNs), and how to engage community agencies and resources in patient care.

Competency frameworks: The AAMC has led efforts to define and integrate nutrition-related competencies into education frameworks. Following the 2023 Summit, new nutrition competencies were embedded into the annual AAMC SCOPE Curriculum Survey, which is the gold standard curriculum inventory across all M.D. and D.O. granting medical schools in the U.S. The 2024 Foundational Competencies for UME, developed jointly by AAMC, AACOM, and ACGME, along with proposed nutrition competencies published in *JAMA*, provide actionable pathways for consistent integration across institutions.[14] By embedding nutrition into competency frameworks, the AAMC supports individualized learning and prepares learners to deliver high-quality, team-based patient care.

Dissemination of resources: Disseminating evidence-based resources is a strategic approach to strengthening nutrition education. *MedEdPORTAL*, the AAMC's peer-reviewed, open-access journal, curates high-quality curricula and teaching tools that faculty can readily adopt and adapt across undergraduate and graduate medical education (as well as other health professions education programs). These resources enable schools and residency programs to integrate nutrition into their teaching without relying on outdated and symbolic metrics, such as tracking instructional hours. In addition, the AAMC has contributed to scholarship on lifestyle medicine and nutrition education, including a 2024 *American College of Lifestyle Medicine* keynote on curricular innovation. By curating, developing, and sharing such resources, the AAMC ensures that medical educators have access to innovative materials that support the preparation of future physicians.

While we have made tremendous progress, we also recognize that much work remains, and the medical education community, along with other health professions, has a role to play in promoting greater awareness and advancing education in nutrition. We are committed to supporting our members as they

[14] Eisenberg DM, Cole A, Maile EJ, et al. Proposed Nutrition Competencies for Medical Students and Physician Trainees: A Consensus Statement. JAMA Network Open. 2024;7(9):e2435425. doi:10.1001/jamanetworkopen.2024.35425

continue to further integrate targeted and longitudinal training opportunities in this area throughout the medical education continuum. Recently, the AAMC announced the following actions, which demonstrate our ongoing commitment to equipping future physicians with the knowledge, skills, and attitudes needed to address all patients' nutrition-related health needs effectively:

The AAMC issued a **position statement and call to action** in November 2025, affirming the responsibility of academic medicine to address nutrition in the context of chronic disease. Through this call to action, we have urged all member medical school Deans to appraise current practices, strengthen, and expand nutrition education within their curricula. The AAMC's recent **Data Snapshot on Nutrition in Medical Education** includes concrete curricular recommendations and strategies for integration. Historically, such publications from the AAMC have had a galvanizing effect on the medical education community, and we expect this communication will serve as both a call to action and a practical resource to guide schools in enhancing nutrition training for future physicians.

The AAMC is integrating nutrition education at meetings by intentionally weaving the topic into sessions across our annual and regional gatherings, which reach thousands of educators across academic medicine. These sessions serve to raise the visibility of nutrition as a core component of medical education and practice, encourage new research and scholarship in the field, and provide faculty with professional development opportunities to enhance their teaching. By showcasing innovative curricula, sharing emerging evidence, and facilitating cross-disciplinary dialogue, we will continue to build momentum within the academic medicine community. This commitment ensures that nutrition is not only recognized as a vital contributor to health outcomes but also positioned as a strategic educational priority for medical schools and teaching hospitals, and health systems nationwide.

We will host a first-of-its-kind event for medical educators, "**Convening on Best Practices in Medical Nutrition Education**," which will take place at the AAMC headquarters in April 2026. This collaborative event will be offered by the Teaching Kitchen Collaborative, the National Board of Medical Examiners, and others, and will identify and summarize effective strategies for competency-based education in nutrition. Additionally, we co-sponsored the **Teaching Kitchen Collaborative Annual Conference** in fall 2025 and joined the **Academy of Integrative Health and Medicine** for a 2025 Leadership Summit.

Our community is eager to continue its progress in this area, and the commitments we have outlined above reflect strategic opportunities to advance that interest. It is important to note that the AAMC strongly believes that the LCME and the Commission on Osteopathic College Accreditation, which are the recognized accreditation authorities, are the appropriate bodies to set standards with respect to the medical education curriculum. The medical accreditation process is a critical mechanism designed to promote the highest quality medical education and patient safety. To protect learners and patients most effectively, it must be experts in medicine and education who, through their thorough, extensive, and ongoing review of the evidence, determine the content and structure of medical education to ensure that medical education and subsequent practice are guided by evidence rather than political priorities. The LCME requirements are carefully designed and regularly updated to ensure all programs prepare graduates to possess the general professional competencies required for proficient medical care, while recognizing "the existence and appropriateness of diverse institutional missions and educational objectives" in carrying those requirements out.

We strongly believe that the most effective approach to promoting change in medical education is working with the community to equip medical educators with the necessary tools and resources to address

pervasive public health challenges as they emerge. Such efforts should rely on medical and educational expertise and not one-size-fits-all or government-mandated approaches. The AAMC has a long history of facilitating such work and stands ready to work with policymakers toward this goal as it relates to continuing to integrate evidence-based content on nutrition into the curriculum and ensuring patient safety remains at the forefront of any effort.

We must also recognize that interventions beyond the classroom directly shape the clinical learning environment. Supporting interprofessional, team-based care models—where physicians, nurses, registered dietitian nutritionists, social workers, and other professionals collaborate seamlessly—by providing appropriate incentives for nutrition and lifestyle-related clinical interventions, all contribute to better patient outcomes. When care teams are empowered and supported through these systemic changes, they model effective, equitable practice for learners—helping to ensure the next generation of physicians and health professionals deliver unbiased, high-quality care that reduces suffering for patients and families.

Telehealth in Medical Education
The AAMC has advanced telehealth education through national competency development, curricular guidance, and targeted grant funding for curricular innovations. Through the *New and Emerging Areas in Medicine* initiative, the AAMC created a set of telehealth competencies across six domains, including patient safety, access and equity, communication, technology, and ethical/legal practice, to guide integration across undergraduate, graduate, and continuing medical education. Evidence shows telehealth is now widely embedded in training: more than half of U.S. medical schools reported telehealth content in their curricula even before the COVID-19 pandemic, and nearly 90% incorporated telemedicine education by the 2020–2021 academic year. Adoption was accelerated, in part, due to an AAMC Competency-Based Education in Telehealth Challenge Grant Program, supporting institutions in developing and disseminating interprofessional telehealth curricula and assessment strategies across the learning continuum.[15] Collectively, these efforts position telehealth not as an isolated skill but as a core component of competency-based medical education, preparing learners to deliver safe, equitable, and effective virtual care within modern health systems.

Artificial Intelligence in Medical Education
Medical schools are integrating artificial intelligence (AI) across the medical education continuum, and the AAMC is supporting these efforts through national competency development, community engagement, and curricular innovation. Building on its *New and Emerging Areas in Medicine* work, the AAMC is currently leading a multi-stakeholder initiative to develop AI competencies in medicine, outlining progressive expectations for learners and physicians in areas such as clinical reasoning with AI, ethical and safe use, data literacy, human–AI collaboration, communication with patients about AI, and systems-level stewardship. These competencies are designed to align with competency-based education frameworks and support integration across undergraduate, graduate, and continuing professional development.

Evidence shows rapid curricular uptake: surveys indicate that a growing majority of U.S. medical schools are introducing AI-related content through health systems science, clinical informatics, and digital health curricula, with increasing emphasis on applied learning rather than stand-alone coursework. In one year (2023-2024), there was a 24% increase in MD and DO-granting medical schools in the US and Canada reporting AI within the required curriculum (77% reported the AI in the curriculum in 2024). Medical

[15] https://www.sciencedirect.com/science/article/abs/pii/S2213076421000051

schools, residency, and continuing education programs are translating emerging AI capabilities into educational practice while promoting professionalism, ethics, and patient safety. Collectively, this work positions AI not only as a technological innovation but as a core domain of modern medical education, preparing learners to use AI thoughtfully to enhance care, learning, and health system performance.

We appreciate the opportunity to offer our perspective and look forward to working with the Subcommittee as it considers policies that affect the nation's health care system, medical education, and public health. For further questions, please contact Len Marquez, AAMC senior director, government relations and legislative advocacy, at lmarquez@aamc.org, or Ally Perleoni, AAMC director, government relations, at aperleoni@aamc.org.