

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305  
(A-24)

Introduced by: Oklahoma

Subject: Public Service Loan Forgiveness Reform

Referred to: Reference Committee C

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1 Whereas, there is a physician shortage across all specialties, locations, and practice types in  
2 the United States<sup>1</sup>; and  
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4 Whereas, the federal government is responsible for direct healthcare services through the  
5 Veteran's Health Administration (VHA) and Indian Health Service (IHS); and  
6

7 Whereas, the VHA and IHS both experience chronic, nationwide physician shortages (12.9% at  
8 VHA as of 2022<sup>2</sup>, 25% at IHS as of 2018<sup>3</sup>), paralleling the nation's physician shortage; and  
9

10 Whereas, the VHA loan repayment program offers up to \$200,000 in relief to physicians over  
11 five years, with no service commitment, while the IHS loan repayment program offers up to  
12 \$50,000 in relief to physicians, with a two-year service commitment<sup>4,5</sup>; and  
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14 Whereas, the VHA has bolstered physician retention and reduced physician burnout by offering  
15 competitive financial relief to physicians and making improvements in workload, organizational  
16 satisfaction, and psychological safety<sup>6,7</sup>; and  
17

18 Whereas, the VHA compensates physicians using Title 38 pay scales, which provides special  
19 authority to recruit and retain employees in certain health care occupations, and also allows the  
20 agency to be competitive with other healthcare facilities in the area<sup>8,9</sup>; and  
21

22 Whereas, the IHS compensates physicians using Title 5 pay scales, which are generally less  
23 than Title 38 pay scales<sup>10,11</sup>; and  
24

25 Whereas, the Partnership for Public Service and Boston Consulting Group (PPS-BCG) reported  
26 that the IHS ranked in the bottom-quartile of agencies within the U.S. Department of Health and  
27 Human Services for employee engagement and satisfaction (332 of 432) in 2022<sup>12</sup>; and  
28

29 Whereas, the PPS-BCG reported that nearly half of IHS physicians and other employees were  
30 not satisfied with their pay and nearly a third were not satisfied with their work-life balance in  
31 2022<sup>12</sup>; and  
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33 Whereas, the AMA recommends that compensation for IHS physicians be increased to a level  
34 competitive with other federal agencies and non-governmental service (H-350.977); and  
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36 Whereas, physicians employed by the federal government may be eligible for the Public Service  
37 Loan Forgiveness Program, which forgives qualifying federal loans after a standard ten-year  
38 repayment plan<sup>13</sup>; and

1 Whereas, loan repayment can address physician retention and decrease physician burnout in  
2 facilities that may not provide competitive pay or are in geographically remote locations<sup>14,15,16</sup>;  
3 and  
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5 Whereas, the AMA has stated that reducing physician burnout should be an urgent priority<sup>17</sup>;  
6 and  
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8 Whereas, the AMA already supports immediate changes in the Public Service Loan  
9 Forgiveness Program to allow physicians to receive immediate loan forgiveness when they  
10 practice in a Veteran's Health Administration facility (D-510.990) due to the VA physician  
11 shortage; therefore be it  
12

13 RESOLVED, that our American Medical Association amend Indian Health Service H-350.977 by  
14 addition and deletion as follows:  
15

16 Indian Health Service H-350.977

17 The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to  
18 meet its obligation to bring American Indian health up to the general population level. The AMA  
19 specifically recommends: (1) Indian Population: (a) In current education programs, and in the  
20 expansion of educational activities suggested below, special consideration be given to involving  
21 the American Indian and Alaska native population in training for the various health professions,  
22 in the expectation that such professionals, if provided with adequate professional resources,  
23 facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration  
24 with American Indian leaders of the possibility of increased numbers of nonfederal American  
25 Indian health centers, under tribal sponsorship, to expand the American Indian role in its own  
26 health care; (c) Increased involvement of private practitioners and facilities in American Indian  
27 care, through such mechanisms as agreements with tribal leaders or Indian Health Service  
28 contracts, as well as normal private practice relationships; and (d) Improvement in  
29 transportation to make access to existing private care easier for the American Indian population.  
30 (2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities  
31 and roads, and the availability of alternative nonfederal resources, the AMA recommends that  
32 those Indian Health Service facilities currently necessary for American Indian care be identified  
33 and that an immediate construction and modernization program be initiated to bring these  
34 facilities up to current standards of practice and accreditation.

35 (3) Personnel Manpower: (a) Compensation scales for Indian Health Service physicians be  
36 increased to a level competitive with other Federal agencies and nongovernmental service; (b)  
37 Consideration should be given to increased compensation for specialty and primary care service  
38 in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made  
39 to establish closer ties with teaching centers and other federal health agencies, thus increasing  
40 both the available staffing manpower and the level of professional expertise available for  
41 consultation; (d) Allied health professional staffing of Service facilities should be maintained at a  
42 level appropriate to the special needs of the population served without detracting from physician  
43 compensation; (e) Continuing education opportunities should be provided for those health  
44 professionals serving these communities, and especially those in remote areas, and, increased  
45 peer contact, both to maintain the quality of care and to avert professional isolation and burnout;  
46 and (f) Consideration should be given to a federal statement of policy supporting continuation of  
47 the Public Health Service to reduce the great uncertainty now felt by many career officers of the  
48 corps.

49 (4) Medical Societies: In those states where Indian Health Service facilities are located, and in  
50 counties containing or adjacent to Service facilities, that the appropriate medical societies  
51 should explore the possibility of increased formal liaison with local Indian Health Service  
52 physicians. Increased support from organized medicine for improvement of health care provided

1 under their direction, including professional consultation and involvement in society activities  
2 should be pursued.

3 (5) Our AMA also support the removal of any requirement for competitive bidding in the Indian  
4 Health Service that compromises proper care for the American Indian population.

5 (6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic  
6 Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical  
7 schools and ACGME-accredited residency programs.

8 (7) Our AMA will encourage the development of funding streams to promote rotations and  
9 learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.

10 (8) Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program  
11 to allow physicians to receive immediate loan forgiveness when they practice in an Indian  
12 Health Service, Tribal, or Urban Indian Health Program. (Modify Current HOD Policy)  
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Fiscal Note: Modest - between \$1,000 - \$5,000

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## RELEVANT AMA POLICY

### Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

(6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.

(7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.

### Fixing the VA Physician Shortage with Physicians D-510.990

1. Our AMA will work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities.
2. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility.
3. Our AMA will work with the Veterans Administration to minimize the administrative burdens that discourage or prevent non-VA physicians without compensation (WOCs) from volunteering their time to care for veterans.
4. Our AMA will: (a) continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions; and (b) collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process.
5. Our AMA supports postgraduate medical education service obligations through programs where the

expectation for service, such as military service, is reasonable and explicitly delineated in the contract with the trainee.

6. Our AMA opposes the blanket imposition of service obligations through any program where physician trainees rotate through the facility as one of many sites for their training.

#### **Physician Burnout D-405.972**

Our AMA will work with: (1) Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians; and (2) hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications.

#### **Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925**

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/20 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish

collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for

PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

23. Continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt.

24. Encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels.

25. Support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including educational and cost of attendance debt.

26. Support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services or are determined to have financial need through another formal mechanism.

### **Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953**

In the setting of the COVID-19 pandemic, our AMA will advocate for additional financial relief for physicians to reduce medical school educational debt.