AMA
AMERICAN MEDICAL ASSOCIATION

AMA House of Delegates Handbook

2025 Annual Meeting
Hyatt Regency Chicago
June 6–11

Access the handbook online at ama-assn.org/hod-business.

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@AmerMedicalAssn

ANNUAL
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MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

- **All Delegates, Alternate Delegates and others receiving this material are reminded that it refers only to items to be considered by the House.**

- **No action has been taken on anything herein contained, and it is informational only.**

- **Only those items that have been acted on finally by the House can be considered official.**

- **REMINDER*: Only the Resolve portions of the resolutions are considered by the House of Delegates. The Whereas portions or preambles are informational and explanatory only.***

AMA
AMERICAN MEDICAL ASSOCIATION

UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

Current American Medical Association (AMA) policy is catalogued in PolicyFinder, an electronic database that is updated after each AMA House of Delegates (HOD) meeting and available online. Each policy is assigned to a topical or subject category. Those category headings are alphabetical, starting with "abortion" and running to "women"; the former topic was assigned the number 5, and "women" was assigned 525. Within a category, policies are assigned a 3 digit number, descending from 999, meaning that older policies will *generally* have higher numbers within a category (eg, 35.999 was initially adopted before 35.984). A policy number is not affected when it is modified, however, so a higher number may have been altered more recently than a lower number. Numbers are deleted and not reused when policies are rescinded.

AMA policy is further categorized into one of four types, indicated by a prefix:

- "H" – for statements that one would consider positional or philosophical on an issue
- "D" – for statements that direct some specific activity or action. There can be considerable overlap between H and D statements, with the assignment made on the basis of the core nature of the statement.
- "G" – for statements related to AMA governance
- "E" – for ethical opinions, which are the recommendations put forward in reports prepared by the Council on Ethical and Judicial Affairs and adopted by the AMA-HOD

AMA policy can be accessed at https://policysearch.ama-assn.org/policyfinder.

The actions of the AMA-HOD in developing policy are recorded in the *Proceedings*, which are available online as well. Annotations at the end of each policy statement trace its development, from initial adoption through any changes. If based on a report, the annotation includes the following abbreviations:

BOT – Board of Trustees
CCB – Council on Constitution and Bylaws
CEJA – Council on Ethical and Judicial Affairs
CLRPD – Council on Long Range Planning and Development
CME – Council on Medical Education
CMS – Council on Medical Service
CSAPH – Council on Science and Public Health

If a resolution was involved, "Res" is indicated. The number of the report or resolution and meeting (A for Annual; I for Interim) and year (two digits) are also included (eg, BOT Rep. 1, A-14 or Res. 319, I-12).

AMA policy is recorded in the following categories, and any particular policy is recorded in only a single category.

5.000 Abortion	10.000 Accident Prevention/Unintentional Injuries
15.000 Accident Prevention: Motor Vehicles	20.000 Acquired Immunodeficiency Syndrome
25.000 Aging	30.000 Alcohol and Alcoholism
35.000 Allied Health Professions	40.000 Armed Forces
45.000 Aviation Medicine	50.000 Blood
55.000 Cancer	60.000 Children and Youth
65.000 Civil and Human Rights	70.000 Coding and Nomenclature
75.000 Contraception	80.000 Crime
85.000 Death and Vital Records	90.000 Disabled
95.000 Drug Abuse	100.000 Drugs
105.000 Drugs: Advertising	110.000 Drugs: Cost
115.000 Drugs: Labeling and Packaging	120.000 Drugs: Prescribing and Dispensing
125.000 Drugs: Substitution	130.000 Emergency Medical Services
135.000 Environmental Health	140.000 Ethics
145.000 Firearms: Safety and Regulation	150.000 Foods and Nutrition

155.000 Health Care Costs	160.000 Health Care Delivery
165.000 Health Care/System Reform	170.000 Health Education
175.000 Health Fraud	180.000 Health Insurance
185.000 Health Insurance: Benefits and Coverage	190.000 Health Insurance: Claim Forms and Claims Processing
195.000 Health Maintenance Organizations	200.000 Health Workforce
205.000 Health Planning	210.000 Home Health Services
215.000 Hospitals	220.000 Hospitals: Accreditation Standards
225.000 Hospitals: Medical Staff	230.000 Hospitals: Medical Staff - Credentialing and Privileges
235.000 Hospitals: Medical Staff - Organization	240.000 Hospitals: Reimbursement
245.000 Infant Health	250.000 International Health
255.000 International Medical Graduates	260.000 Laboratories
265.000 Legal Medicine	270.000 Legislation and Regulation
275.000 Licensure and Discipline	280.000 Long-Term Care
285.000 Managed Care	290.000 Medicaid and State Children's Health Insurance Programs
295.000 Medical Education	300.000 Medical Education: Continuing
305.000 Medical Education: Financing and Support	310.000 Medical Education: Graduate
315.000 Medical Records and Patient Privacy	320.000 Medical Review
330.000 Medicare	335.000 Medicare: Carrier Review
340.000 Medicare: PRO	345.000 Mental Health
350.000 Minorities	355.000 National Practitioner Data Bank
360.000 Nurses and Nursing	365.000 Occupational Health
370.000 Organ Donation and Transplantation	373.000 Patients
375.000 Peer Review	380.000 Physician Fees
383.000 Physician Negotiation	385.000 Physician Payment
390.000 Physician Payment: Medicare	400.000 Physician Payment: Medicare - RBRVS
405.000 Physicians	406.000 Physician-Specific Health Care Data
410.000 Practice Parameters	415.000 Preferred Provider Arrangements
420.000 Pregnancy and Childbirth	425.000 Preventive Medicine
430.000 Prisons	435.000 Professional Liability
440.000 Public Health	445.000 Public Relations
450.000 Quality of Care	455.000 Radiation and Radiology
460.000 Research	465.000 Rural Health
470.000 Sports and Physical Fitness	475.000 Surgery
478.000 Technology - Computer	480.000 Technology - Medical
485.000 Television	490.000 Tobacco Use, Prevention and Cessation
495.000 Tobacco Products	500.000 Tobacco: AMA Corporate Policies and Activities
505.000 Tobacco: Federal and International Policies	510.000 Veterans Medical Care
515.000 Violence and Abuse	520.000 War
525.000 Women	600.000 Governance: AMA House of Delegates
605.000 Governance: AMA Board of Trustees and Officers	610.000 Governance: Nominations, Elections, and Appointments
615.000 Governance: AMA Councils, Sections, and Committees	620.000 Governance: Federation of Medicine
625.000 Governance: Strategic Planning	630.000 Governance: AMA Administration and Programs
635.000 Governance: Membership	640.000 Governance: Advocacy and Political Action

LIST OF MATERIALS INCLUDED IN THIS HANDBOOK (A-25)

Resolutions and reports have been collated by referral according to reference committee assignment. In the listing below, referral is indicated by letter following the title of the report. Resolutions have been numbered according to referrals (i.e., those referred to the Reference Committee on Ethics and Bylaws begin with 001, Reference Committee B begins with 201, etc.).

The informational reports contain no recommendations and will be filed on Saturday, June 7, unless a request is received for referral and consideration by a Reference Committee (similar to the use of a consent calendar).

1. **Memorandum from the Speaker**

2. **Understanding the Recording of American Medical Association Policy**

3. **Declaration of Professional Responsibility - Medicine's Social Contract with Humanity**

4. **Delegate / Alternate Delegate Job Description, Roles, and Responsibilities**

5. **Seating Allocation and Seating Chart for the House of Delegates**

6. **Hotel Maps**

7. **Official Call to the Officers and Members of the AMA**
   - **Officials of the Association and AMA Councils**
   - **Ex Officio Members of the HOD**
   - **SSS Representatives**
   - **Listing of Delegates and Alternate Delegates**

8. **Reference Committee Schedule and Room Assignments**

9. **Note on Order of Business**

10. **Summary of Fiscal Notes**

11. **List of Resolutions by Sponsor**

FOLLOWING COLLATED BY REFERRAL

12. **Report(s) of the Board of Trustees - Michael Suk, MD, JD, MPH, MBA, Chair**

01	Annual Report	F
02	New Specialty Organizations Representation in the House of Delegates	E&B
03	2024 Grants and Donations	Info. Report
04	AMA 2026 Dues	F
05	Update on Corporate Relationships	Info. Report
06	Transparency and Accountability of Hospitals and Hospital Systems	G
07	AMA Performance, Activities and Status in 2024	Info. Report

08	Annual Update on Activities and Progress in Tobacco Control: March 2024 through February 2025	Info. Report
09	Council on Legislation Sunset Review of 2015 House Policies	B
10	American Medical Association Health Equity Annual Report	Info. Report
11	AMA Efforts on Medicare Payment Reform	Info. Report
12	Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted	Info. Report
13	The Uniform Health-Care Decisions Act	B
14	A Public Health-Centered Criminal Justice System	B
15	Physician Assistants and Nurse Practitioner Movement Between Specialties	Info. Report
16	Research Correcting Political Misinformation and Disinformation on Scope of Practice	B
17	Antidiscrimination Protections for LGBTQ+ Youth in Foster Care	B
18	Physician Assisted Suicide	E&B
19	Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout	G
20	Guardianship and Conservatorship Reform	D
21	Advocacy for More Stringent Regulations / Restrictions on Distribution of Cannabis	B
22	Ranked Choice Voting	F
23	Financial Assistance to Facilitate Attendance at MSS Meetings	F
24	Creation of an AMA Council with a Focus on Digital Health Technologies and AI	F
25	AMA Public Health Strategy Update	Info. Report
26	Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout	E&B
27	AMA Reimbursement of Necessary HOD Business Expenses for Delegates and Alternates	Info. Report

13. Report(s) of the Council on Constitution and Bylaws - Jerry P. Abraham, MD, MPH, Chair

01	Bylaws Review Report	E&B
02	Concurrent Service on Councils and Section Governing Councils	E&B
03	Clarifying Bylaw Language	E&B

14. Report(s) of the Council on Ethical and Judicial Affairs - Jeremy A. Lazarus, MD, Chair

01	The AMA Code of Medical Ethics Evolving to Provide Health Care Systems Ethics Guidance	E&B
02	Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	E&B
03	Reconsidering Terminology to Describe Physician Assisted Suicide	Info. Report
04	Reconsideration of Physician Assisted Suicide	Info. Report
05	Protecting Physicians Who Engage in Contracts to Deliver Health Care Services	E&B
06	Amendment to Opinion 1.1.1 “Patient-Physician Relationships”	E&B
07	Guidelines on Chaperones for Sensitive Exams	E&B

08	Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blinded Model for Organ Procurement and Transplantation	E&B
09	Ethical Impetus for Research in Pregnant and Lactating Individuals	E&B
10	The Preservation of the Primary Care Relationship	E&B
11	CEJA Sunset Review of 2015 House Policies	E&B
12	Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report	Info. Report
13	Presumed Consent & Mandated Choice for Organs from Deceased Donors	E&B

15. Opinion(s) of the Council on Ethical and Judicial Affairs - Jeremy A. Lazarus, MD, Chair

01	Palliative Care	Info. Report

16. Report(s) of the Council on Long Range Planning and Development - Michelle Berger, MD, Chair

01	International Medical Graduates Section Five-Year Review	F
02	Organized Medical Staff Section Five-Year Review	F
03	Demographic Characteristics of the House of Delegates and AMA Leadership	Info. Report

17. Report(s) of the Council on Medical Education - Krystal Tomei, MD, MPH, Chair

01	Council on Medical Education Sunset Review of 2015 House of Delegates' Policies	C
02	International Applicants to U.S. Medical Schools	C
03	Unmatched Graduating Physicians	C
04	Access to Restricted Health Services When Completing Physician Certification Exams	C
05	Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine (Res. 309-A-24)	C
06	Reporting of Total Attempts of USMLE Step 1 and COMLEX-USA Level 1 Examinations	C
07	Designation of Descendants of Enslaved Africans in America	C
08	Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes	C

18. Report(s) of the Council on Medical Service - Stephen Epstein, MD, MPP, Chair

01	Council on Medical Service Sunset Review of 2015 House Policies	G
02	Reconsidering the Affordable Care Act (ACA) Eligibility Firewall	A
03	Regulation of Corporate Investment in the Health Care Sector	G
04	Requiring Payment for Physician Signatures	G
05	Medicaid Estate Recovery Reform	A
06	Prescription Medication Price Negotiation	A
07	Impact of Patient Non-adherence on Quality Scores	G
08	Prescription Drug Affordability Boards	Info. Report
09	Minimum Requirements for Medication Formularies	A

19. Report(s) of the Council on Science and Public Health - John T. Carlo, MD, Chair

01	Council on Science and Public Health Sunset Review of 2015 House Policies	E
02	Addressing Social Determinants of Health Through Closed Loop Referral Systems	D
03	Protections Against Surgical Smoke Exposure	D
04	Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals	D
05	Screening for Image Manipulation in Research Publications	E
06	Fragrance Regulation (Resolution 501-A-24)	D
07	Addressing the Health Issues Unique to Minority Communities in Rural Areas	D
08	Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms	E
09	Rare Disease Advisory Councils	E

20. Report(s) of the HOD Committee on Compensation of the Officers - Evelyn Lewis, MD, Chair

01	Report of the House of Delegates Committee on Compensation of the Officers	F

21. Resolutions

001	Opposition to Censuring Medical Societies or Organizations Based on Politics or Policies of Governments	E&B
002	Physician Disclosures of Relationships in Private Equity Held Organizations	E&B
003	Opposition to Censorship in Public Libraries	E&B
004	Reducing the Harmful Impacts of Immigration Status on Health	E&B
005	Dedicated Interfaith Prayer and Reflection Spaces in Medical Schools and Healthcare Facilities	E&B
006	Military Deception as a Threat to Physician Ethics	E&B
007	Use of Inclusive Language in AMA Policy	E&B
008	Humanism in Anatomical Medical Education	E&B
009	Patient centered health care as a Determinant of Health	E&B
010	Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure	E&B
011	Opposition of Health Care Entities from Reporting Individual Patient Immigration Status	E&B
012	Carceral Systems and Practices in Behavioral Health Emergency Care	E&B
013	Continued Support of World Health Organization (WHO) & United States Agency for International Development (USAID)	E&B
101	Uniform Adoption of Service Intensity Tools to Support Medical Decision-making and Service Gap Analysis	A
102	Access to Single Maintenance and Reliever Therapy for Asthma	A
103	Inadequate Reimbursement for Biosimilars	A
104	Study of Whether the HSA Model Could Become an Option for Medicaid Beneficiaries	A

105	Development of an Educational Resource on Opting Out of Medicare for Physicians	A
106	Advocating for All Payer Coverage for Custom Breast Prostheses for Patients with History of Mastectomy Secondary to Breast Cancer Treatment	A
107	Advocating for All Payer Coverage of Reconstructive and Cosmetic Surgical Care Related to Cleft Lip and Palate	A
108	Firearm Storage Diagnosis and Counseling Reimbursement	A
109	Medicare Advantage Plans Double Standard	A
110	Study of the Federal Employee Health Benefit Plan (FEHBP)	A
111	New Reimbursement System Needed for Rural Hospital Survival	A
112	Continuation of Affordable Connectivity Program	A
113	Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts	A
114	An Assessment of Physician Support for Value-Based Payment Models and its Impact on Healthcare to Inform AMA Advocacy Efforts—A Survey	A
115	Supporting Legislative Efforts to Remove Certain High-Cost Supplies and Equipment from the Medicare Physician Fee Schedule	A
116	Medicare Coverage of Registered Dietitian (RD) and Certified Nutrition Support Specialist (CNSS) Visits Beyond Type 2 Diabetes and Renal Disease	A
117	Liberalized Remorse Period for Medicare Advantage Plan Insureds	A
118	Improving Access to Peripartum Pelvic Floor Physical Therapy	A
119	Cancer Survivorship Program Coverage	A
120	Medigap, Pre-Existing Conditions, and Medicare Coverage Education	A
201	Inclusion of DICOM Imaging in Federal Interoperability Standards	B
202	Preservation of the CDC Epilepsy Program Workforce and Infrastructure	B
203	Supporting SUPPORT Act modifications to enhance care of patients with chronic pain	B
204	Protecting the Prescriptive Authority of Plenary Licensed Physicians	B
205	AMA Support for Continuance of the Section 1115 - Social Security Act, Medicaid Waiver Program	B
206	AMA Support for Renewal of Section 1115 - Social Security Act, Medicaid Waiver Demonstration Projects Supporting Food and Nutrition Services	B
207	Abolishing Venue Shopping	B
208	Binding Arbitration in Health Insurance Contracts	B
209	Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Addiction Medications for Legitimate Medical Purposes	B
210	Impact of Tariffs on Healthcare Access and Costs	B
211	Support for State Provider and Managed Care Organization Taxes to Sustain Federal Medicaid Matching Funding	B
212	Setting Standards for Forensic Toxicology Laboratories Used in Litigation	B
213	Emergency Department Designation Requires Physician on Site	B
214	United Health Care and InterQual Monopoly	B

215	Support for Changing Standards for Minors Working in Agriculture	B
216	Support for Aging-Out Foster Youth with Mental Health and Psychotropic Needs	B
217	Regulation and Oversight of the Troubled Teen Industry	B
218	Distribution of Resident Slots Commensurate with Shortages	B
219	Opposing Unwarranted National Institutes of Health Research Institute Restructuring	B
220	Strengthening AMA Policy on Noncompete Clauses in Ownership Transitions	B
221	Preservation of Medicaid	B
222	Need for Separate H1B Pathway for IMG Doctors in the USA	B
223	Preservation of Medicaid	B
224	Support SAVE Plan and Public Service Loan Forgiveness (PLSF) Applications	B
225	The Private Practice Physicians in the Community	B
226	Regulations for Algorithmic-Based Health Insurance Utilization Review	B
227	Payment Recoupment—Let Sanity Prevail	B
228	CHIP Coverage of OTC Medications	B
229	Guaranteeing Timely Delivery and Accessibility of Federal Health Data	B
230	Advocating to expand private insurance coverage of anti-obesity medications (AOM)	B
231	Preventing Venue Shopping in Medical Liability to Protect Physician Practices and Access to Care	B
232	Preservation of Medicaid	B
233	Increasing Transparency of AMA Medicare Payment Reform Strategy	B
234	Protection for International Medical Graduates	B
235	CMS Payment Monitoring Following Government Staff Reductions	B
301	Examining ABMS Processes for New Boards	C
302	AMA Study of Lifestyle Medicine and Culinary Electives to Reduce Burnout and Bolster Career Satisfaction in Trainees	C
303	Support for the Establishment of an Indigenous-Led Medical School in the United States	C
304	Addressing Professionalism Standards in Medical Training	C
305	Curricular Structure Reform to Support Physician and Trainee Well-Being	C
306	Innovation and Reform of Medical Education	C
307	Disclosure of Individual Physician Volunteers Participation in Committee Decision-making to other Organizations, Stakeholders and Joint Providers	C
308	Streamlining Annual Compliance Training Requirements for Physicians	C
309	Increasing Education on Physician-Led Care and Advocacy in Residency Training	C
310	Protections for Trainees Experiencing Retaliation in Medical Education	C

311	Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter	C
312	Selection of IMG Residents Based on Merit	C
401	Reducing Pickleball-Related Ocular Injuries	D
402	Protecting In-Person Prison Visitations to Reduce Recidivism	D
403	Promoting Evidence-Based Responses to Measles and Misuse of Vitamin A	D
404	Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers	D
405	Health Warning Labels on Alcoholic Beverage Containers	D
406	Call for Study: Should Petroleum-Powered Emergency Medical Services (EMS) Vehicles in Urban Service Areas be Replaced by Renewably-Powered Electric Vehicles?	D
407	Sleep Deprivation as a Public Health Crisis	D
408	Removing Artificial Turf in Schools, Parks, and Public Places	D
409	Guidelines for Restricting Cell Phones in K-12 Schools	D
410	Hate Speech is a Public Health Concern	D
411	Protecting Access to mRNA Vaccines	D
412	Supporting inclusive long-term care facilities	D
413	Preservation of Public Funding for Physicians and Hospitals Providing LGBTQ+ Care	D
414	Expanding Sexually Transmitted Infection Care for Persons with Unstable or No Housing	D
415	Promoting Child Welfare and Communication Rights in Immigration Detention	D
416	Culturally and Religiously Inclusive Food Options	D
417	Updating Alcohol Health Warning Labels to Reflect Evidence-Based Health Risks and Supporting National Labeling and Signage Policy Reform	D
418	AMA Study on Plastic Pollution Reduction	D
419	Advocating for Universal Summer Electronic Benefit Transfer Program for Children (SEBTC)	D
420	Study of Plant-Based & Lab-Grown Meat	D
421	Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities	D
422	Protecting the Integrity of the U.S. Healthcare System from Misinformation and Policy	D
423	Requiring Universal Vaccine reporting to a National Immunization Registry and Access to a National Immunization Information System	D
424	Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records	D
425	Alcohol Consumption and Health	D
426	Addressing Patient Safety and Environmental Stewardship of Single-Use and Reusable Medical Devices	D

427	Elevate Obesity as a Strategic Objective	D
428	Public Health Implications of US Food Subsidies	D
429	Addressing the Health Consequences of Microplastics in Humans	D
430	Addressing the Health Impacts of Ultraprocessed Foods	D
431	Alcohol & Breast Cancer Risk	D
432	Support for Long-Term Sequelae of Pregnancy	D
433	Clinical Lactation Care	D
434	Breast Cancer Risk Reduction	D
501	Safer Button / Coin Batteries	E
502	NIH Grant Funding for Medical Research	E
503	Safeguarding Neural Data Collected by Neurotechnologies	E
504	Physician Performed Microscopy Designation for Synovial Fluid Crystal Exam: Modify the Clinical Laboratory Amendment of 1988	E
505	Mandating Properly Fitting Lead Aprons in Hospitals	E
506	Opposing the use of harm reduction items as evidence of commercial sex work	E
507	Clinical and Public Safety Implications of AI-Generated Content and Symbolic Compliance Infrastructure	E
508	Standardizing Safety Requirements for Traditional and Rideshare-Based Non-Emergency Medical Transportation	E
509	Allergen Labeling for Spices and Herbs	E
510	Improving Cybersecurity Standards for Healthcare Entities	E
511	Increased Transparency Among Psychotropic Drug Administration in Prisons	E
512	Preventing Drug-Facilitated Sexual Assault in Drinking Establishments	E
513	Transparency on Comparative Effectiveness in Direct-to-Consumer Advertising	E
514	Support for a Nicotine Free Generation	E
515	Nitrous Oxide Abuse	E
516	Creating a Registry of Potential Side Effects of GIP & GLP-1 Medications	E
517	In Support of a National Drug Checking Registry	E
518	Mandatory Accreditation and Regular Inspections of Hyperbaric Chambers	E
519	Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making	E
520	Study of Grading Systems in AMA Board Reports	E
521	Warning labels on OTC sleep aids	E
522	Access to Important and Essential Drugs	E
601	AMA To Develop Patient Educational Materials Regarding Ultra-processed Foods for Distribution by AMA members	F
602	Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations	
603	Renaming the Minority Affairs Section to the Underrepresented in Medicine Advocacy Section	F
604	Advisory Committee on Tribal Affairs	F

701	Electronic Health Records Contract Termination	G
702	Strengthening Health Plan Accountability for Physician Satisfaction	G
703	Appropriate Use of Data from Surgical Practices	G
704	Mitigating the Impact of Excessive Prior Authorization Processes	G
705	Elimination of Transaction Fees for Electronic Healthcare Payments	G
706	Increasing Transparency Surrounding Medicare Advantage Plans	G
707	Simplifying Correspondence from Health Insurers	G
708	Advocating Against Prior Authorization for In-Person Visits with Physicians	G
709	Allowing Timely Access to Pain Medications in Discharged Hospital and Ambulatory Surgery Patients	G
710	Requiring Insurances to apply discounted cost medication to the patient's deductible	G
711	Study of Practice Models for Physicians Working Across State Lines	G
712	Billings and Collections Transparency	G
713	Aiding Members of Medical Staffs	G
714	Root Cause Analysis of the Causes of the Decline of Private Medical Practice	G
715	Grace Period for Timely Filing Due to Technology Failures Regardless of Cause	G
716	Minimum Payer Communication Quality Standards	G
717	Promoting Medication Continuity and Reducing Prior Authorization Burdens	G

DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE'S SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well-being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well-being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to:

1. Respect human life and the dignity of every individual.

2. Refrain from supporting or committing crimes against humanity and condemn all such acts.

3. Treat the sick and injured with competence and compassion and without prejudice.

4. Apply our knowledge and skills when needed, though doing so may put us at risk.

5. Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.

6. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.

7. Educate the public and polity about present and future threats to the health of humanity.

8. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.

9. Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.

Adopted by the House of Delegates of the American Medical Association
in San Francisco, California on December 4, 2001

Delegate/Alternate Delegate Job Description, Roles and Responsibilities

At the 1999 Interim Meeting, the House of Delegates adopted as amended Recommendation 16 of the final report of the Special Advisory Committee to the Speaker of the House of Delegates. This recommendation included a job description and roles and responsibilities for delegates and alternate delegates. The description and roles and responsibilities were modified at the 2002 Annual Meeting by Recommendation 3 of the Joint Report of the Board of Trustees and Council on Long Range Planning and Development. The modified job description, qualifications, and responsibilities are listed below.

Delegates and Alternate Delegates should meet the following job description and roles and responsibilities:

Job Description and Roles and Responsibilities of AMA Delegates/Alternate Delegates

Members of the AMA House of Delegates serve as an important communications, policy, and membership link between the AMA and grassroots physicians. The delegate/alternate delegate is a key source of information on activities, programs, and policies of the AMA. The delegate/alternate delegate is also a direct contact for the individual member to communicate with and contribute to the formulation of AMA policy positions, the identification of situations that might be addressed through policy implementation efforts, and the implementation of AMA policies. Delegates and alternate delegates to the AMA are expected to foster a positive and useful two-way relationship between grassroots physicians and the AMA leadership. To fulfill these roles, AMA delegates and alternate delegates are expected to make themselves readily accessible to individual members by providing the AMA with their addresses, telephone numbers, and e-mail addresses so that the AMA can make the information accessible to individual members through the AMA web site and through other communication mechanisms. The qualifications and responsibilities of this role are as follows:

A. Qualifications
- AMA member.
- Elected or selected by the principal governing body or the membership of the sponsoring organization.
- The AMA encourages that at least one member of each delegation be involved in the governance of their sponsoring organization.

B. Responsibilities
- Regularly communicate AMA policy, information, activities, and programs to constituents so he/she will be recognized as the representative of the AMA.
- Relate constituent views and suggestions, particularly those related to implementation of AMA policy positions, to the appropriate AMA leadership, governing body, or executive staff.
- Advocate constituent views within the House of Delegates or other governance unit, including the executive staff.
- Attend and report highlights of House of Delegates meetings to constituents, for example, at hospital medical staff, county, state, and specialty society meetings.
- Serve as an advocate for patients to improve the health of the public and the health care system.
- Cultivate promising leaders for all levels of organized medicine and help them gain leadership positions.
- Actively recruit new AMA members and help retain current members.
- Participate in the AMA Membership Outreach Program.

SEATING ALLOCATION – 2025 ANNUAL MEETING

ADDICTION MEDICINE - 3
American Society of Addiction Medicine (ASAM) – 3
Trustee (Levin) – 1
Delegates - 2

AMGA - 1
American Medical Group Association (AMGA) - 1

ANESTHESIOLOGY - 11
American Society of Anesthesiologists (ASA) - 9
Delegates - 8
Resident and Fellow Section Delegate - 1
American Society of Regional Anesthesia and Pain Medicine (ASRAPM) - 2

ARS – 1
American Rhinologic Society (ARS) - 1

CARDIOLOGY - 18
American College of Cardiology (ACC) - 9
American Society of Echocardiography (ASE) - 2
American Society of Nuclear Cardiology (ASNC) - 2
Heart Rhythm Society (HRS) - 1
Society for Cardiovascular Angiography and Interventions (SCAI) - 2
Society for Cardiovascular Magnetic Resonance (SCMR) - 1
Society of Cardiovascular Computed Tomography (SCCT) - 1

CHEST PHYSICIANS - 2
American College of Chest Physicians (CHEST) (ACCP) - 2

CRITICAL CARE MEDICINE- 2
Society of Critical Care Medicine (SCCM) - 2

DERMATOLOGY - 15
American Academy of Dermatology Association (AAD) – 6
Former President (Resneck) - 1
Delegates - 5
American College of Mohs Surgery (ACMS) - 1
American Contact Dermatitis Society (ACDS) - 1
American Society for Dermatologic Surgery Association (ASDSA) - 3
American Society for Laser Medicine and Surgery, Inc. (ASLMS) - 1
American Society of Dermatopathology (ASD) - 1
Society for Investigative Dermatology (SID) - 1
Society for Pediatric Dermatology (SPD) - 1

EMERGENCY MEDICINE - 14
American Academy of Emergency Medicine (AAEM) - 3
American College of Emergency Physicians (ACEP) - 11
Delegates - 9
Resident and Fellow Section Delegates - 2

ENDOCRINOLOGY - 3
American Assn of Clinical Endocrinology (AACE) - 1
The Endocrine Society (ES) - 2

FAMILY PHYSICIANS - 27
American Academy of Family Physicians (AAFP) - 27
Former Board Chair (Langston) - 1
Delegates - 26

GASTROENTEROLOGY - 7
American College of Gastroenterology (ACG) - 3
American Gastroenterological Association (AGA) - 2
American Society for Gastrointestinal Endoscopy (ASGE) - 2

GERIATRIC MEDICINE - 2
American Geriatrics Society (AGS) – 2

GREAT LAKES - 64
Illinois - 19
Trustee (Siddiqui) - 1
Delegates - 12
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegate - 1
American College of Legal Medicine (ACLM) - 1
American Medical Women's Association (AMWA) - 1
American Osteopathic Association (AOA) – 1
Society of Nuclear Medicine and Molecular Imaging (SNMMI) - 1
Indiana - 7
Trustee (Welsh) - 1
Delegates – 5
Medical Student Regional Delegate - 1
Michigan - 15
Delegates - 14
Resident and Fellow Section Delegate - 1
Ohio - 15
Delegates (minus Speaker @ dais) - 11
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegates - 3
Wisconsin - 8
Delegates - 5
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegate - 1
Undersea & Hyperbaric Medical Society (UHMS) - 1

HEART OF AMERICA - 11
Kansas - 4
Delegates - 3
Medical Student Regional Delegate - 1
Missouri – 7
Former President (Barbe) - 1
Delegates - 6

HEMATOLOGY - 2
American Society of Hematology (ASH) - 2

HOSPITAL MEDICINE - 3
Society of Hospital Medicine (SHM) - 3

INFECTIOUS DISEASE - 2
Infectious Diseases Society of America (IDSA) - 2

INTERNAL MEDICINE - 38
American College of Lifestyle Medicine (ACLsM) - 2
American College of Physicians (ACP) – 35
Trustee (Fryhofer) - 1
Delegates - 34
Former President (Wilson)
Renal Physicians Association (RPA) - 1

MOBILITY CAUCUS - 12
American Acad of Orthopaedic Surgeons (AAOS) – 4
Delegates - 4
Former President (Gurman)
American Association for Hand Surgery (AAHS) - 1
American Orthopaedic Association (AOrA) - 1
American Orthopaedic Foot and Ankle Society (AOFAS) - 1
American Society for Surgery of the Hand (ASSH) - 1
American Society of Interventional Pain Physicians (ASIPP) - 1
International Soc for the Advancement of Spine Surgery (ISASS) -1
North American Spine Society (NASS) - 2

NEUROSCIENCES - 35
Academy of Consultation-Liaison Psychiatry (ACLP) - 1
American Academy of Addiction Psychiatry (AAAP) - 1
American Academy of Child and Adolescent Psychiatry (AACAP) - 2
American Academy of Hospice and Palliative Medicine (AAHPM) - 2
American Academy of Neurology (AAN) - 7
Delegates - 3
Resident and Fellow Section Delegates - 4
American Academy of Pain Medicine (AAPM) - 1
American Acad of Psychiatry and the Law (AAPL) - 1
American Assoc for Geriatric Psychiatry (AAGP) - 1
American Association of Neurological Surgeons (AANS) - 3
Former President (Carmel) - 1
Delegates – 2
American Psychiatric Association (APA) - 11
Former President (Harris) - 1
Delegates - 8
Resident and Fellow Section Delegates – 2
Congress of Neurological Surgeons (CNS) - 2
GLMA: Health Professionals Advancing LGBTQ+ Equality – 1
North American Neuromodulation Society (NANS) - 1
International Pain and Spine Intervention Society (IPSIS) - 1

NEW ENGLAND - 32
Connecticut - 8
Trustee (Breig) - 1
Delegates - 4
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegates - 2
Maine - 2
Massachusetts - 17
Delegates - 13
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegates – 2
Amer Assn of Neuromuscular & Electrodiagnostic Med (AANEM)- 1
New Hampshire - 1
Rhode Island - 3
Delegates - 2
Resident and Fellow Section Delegates – 1
Vermont – 1

NEW YORK - 30
Former President (Nielsen) - 1
Delegates - 23
Medical Student Regional Delegates - 2
Resident and Fellow Section Delegate – 1
American College of Nuclear Medicine (ACNM) - 1
American Society of Neuroradiology (ASN) - 2

NORTH CENTRAL - 20
Iowa - 6
Delegates - 4
Medical Student Regional Delegate - 1
Outpatient Endovascular and Interventional Society (OEIS) - 1
Minnesota – 7
Delegates - 5
Resident and Fellow Section Delegate – 1
American Hernia Society (AHS) - 1
Nebraska – 2
North Dakota - 3
Delegates - 2
Medical Student Regional Delegate - 1
South Dakota - 2

OBSTETRICIANS AND GYNECOLOGISTS - 20
American Association of Gynecologic Laparoscopists (AAGL) - 2
American College of Medical Genetics and Genomics (ACMGG) -1
American College of Obstetricians and Gynecologists (ACOG) - 16
Trustee (Koirala) -1
Delegates - 14
Former President (Wah)
Resident and Fellow Section Delegate - 1
American Society for Reproductive Medicine (ASRM) - 1

ONCOLOGY - 6
Association for Clinical Oncology (ASCO) – 6
Delegates - 5
Former President (McAneny)
Resident and Fellow Section Delegate - 1

PACWEST CONFERENCE - 91
Alaska - 1
Arizona - 8
Delegates - 5
American College of Radiation Oncology (ACRO) - 1
American Institute of Ultrasound in Medicine (AIUM) - 2
California - 48
Trustees (Ding) - 1
Former Presidents (Plested) - 1
Delegates - 37
Medical Student Regional Delegates - 2
Resident and Fellow Section Delegates - 3
American Clinical Neurophysiology Soc (ACNS) – 1
American Soc for Radiation Oncology (ASRO) – 2
North American Neuro-Ophthalmology Society (NANOS) - 1
Colorado -10
Delegates - 6
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegates - 2
Obesity Medicine Association (OMA) - 1

PACWEST CONFERENCE (cont'd)
Hawaii - 2
Idaho - 1
Montana - 1
Nevada – 2
New Mexico - 3
Delegates - 2
American Academy of Allergy, Asthma & Immunology (AAAAI) – 1
Oregon - 4
Utah - 4
Former President (J. Nelson) - 1
Delegates - 3
Washington - 6
Wyoming – 1

PALTmed –1
Post-Acute and Long-Term Care Medical Association (PALTmed) – 1

PATHOLOGY - 9
American Society for Clinical Pathology (ASCP) – 3
American Society of Cytopathology (ASC) - 1
College of American Pathologists (CAP) – 4
National Association of Medical Examiners (NAME) - 1

PEDIATRICS - 7
American Academy of Pediatrics (AAP) - 7
Trustee (Garretson) - 1
Delegates - 5
Resident and Fellow Section Delegate - 1

PENNSYLVANIA - 19
Trustee (Heine) – 1
Delegates - 15
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
American Assn of Physicians of Indian Origin (AAPIO) - 1

PHYSICAL MEDICINE AND REHABILITATION - 5
American Acad of Physical Med & Rehabilitation (AAPMR) - 4
Delegates - 3
Resident and Fellow Section Delegate - 1
Association of Academic Physiatrists (AACP) - 1

PREVENTIVE MEDICINE - 7
Aerospace Medical Association (AsMA) - 1
American Academy of Insurance Medicine (AAIM) - 1
American Association of Public Health Physicians (AAPHP) – 2
Delegate - 1
Resident and Fellow Section Delegate - 1
American College of Medical Quality (ACMQ) - 1
American College of Occup & Environmental Med (ACOEM) -1
American College of Preventive Medicine (ACPM) - 1

RADIOLOGY - 16
American College of Radiology (ACR) – 8
Delegates – 8
Former President (Johnson)
American Roentgen Ray Society (ARRS) – 3
Association of Academic Radiology (AAR) - 1
Radiological Society of North America (RSNA) – 3
Society of Interventional Radiology (SIR) - 1

RHEUMATOLOGY - 2
American College of Rheumatology (ACRh) - 2

SECTIONS - 12
Academic Physicians Section (APS) - 1
Integrated Physician Practice Section (IPPS) - 1
International Medical Graduates Section (IMG) - 1
LGBTQ+ Section - 1
Medical Student Section (MSS) - 1
Minority Affairs Section (MAS) - 1
Organized Medical Staff Section (OMSS) - 1
Private Practice Physicians Section (PPPS) - 1
Resident and Fellow Section (RFS) – 1
Senior Physicians Section (SPS) - 1
Women Physicians Section (WPS) -1
Young Physicians Section (YPS) - 1

SERVICES - 6
Air Force - 1
Army - 1
AMSUS - Society of Federal Health Professionals - 1
Navy - 1
Public Health Service - 1
Veterans Affairs - 1

SLEEP MEDICINE – 2
American Academy of Sleep Medicine (AASM) - 2

SOUTHEASTERN - 118
Alabama - 4
Arkansas -3
Trustee (Ferguson) - 1
Delegates - 2
Delaware - 2
Former Board Chair (Permut) – 1
Delegate - 1
District of Columbia - 2
Florida - 21
Trustee (Butler) - 1
Delegates - 17
Medical Student Regional Delegate- 1
National Medical Association (NMA) - 1
The Triological Society (TS) - 1
Georgia - 9
Delegates - 7
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
Kentucky - 6
Former President (Hoven) - 1
Delegates - 5
Louisiana -7
Maryland - 7
Delegates - 6
Acad of Physicians in Clinical Research (APCR) - 1
Mississippi - 5
Former President (Hill) - 1
Delegates - 3
Medical Student Regional Delegate- 1
New Jersey - 10
Delegates - 9
Medical Student Regional Delegate- 1

SOUTHEASTERN (cont'd)
North Carolina - 6
Oklahoma - 8
Delegates - 4
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegates - 3
Puerto Rico - 2
South Carolina – 7
Former Presidents (Harmon, Smoak) - 2
Delegates - 4
Medical Student Regional Delegate - 1
Tennessee - 8
Delegates - 6
Medical Student Regional Delegate - 1
American Vein and Lymphatic Society (AVLS) - 1
Virginia - 8
Delegates - 7
Medical Student Regional Delegate- 1
West Virginia – 3
Delegates - 2
Medical Student Regional Delegate- 1

SURGEONS - 45
American Academy of Cosmetic Surgery (AACS) - 1
American Acad of Facial Plastic and Reconstructive Surg (AAFPRS) -1
American Academy of Ophthalmology (AAO) – 4
American Acad of Otolaryngic Allergy (AAOA) - 1
Amer Acad of Oto-Head & Neck Surgery (AAOHNS) -3
American Association for Thoracic Surgery (AATS) - 1
American Association of Plastic Surgeons (AAPS) - 1
American College of Surgeons (ACS) - 9
Delegates (minus Vice Speaker @ dais) - 7
Resident and Fellow Section Delegates – 2
American Society for Aesthetic Plastic Surgery (ASAPS) - 1
American Soc for Metabolic and Bariatric Surgery (ASMBS) - 1
American Soc for Reconstructive Microsurgery (ASRMS) - 1
American Soc of Cataract and Refractive Surgery (ASCTRS) - 2
American Soc of Colon and Rectal Surgeons (ASCRS) - 2
American Soc of Maxillofacial Surgeons (ASMS) - 1
Amer Soc of Ophthalmic Plastic & Reconstructive Surg (ASOPRS) -1
American Soc of Plastic Surgeons (ASPS) - 4
Trustee (Jeffers) - 1
Delegates - 3
American Soc of Retina Specialists (ASRS) - 1
American Soc of Transplant Surgeons (ASTS) - 1
American Venous Forum (AVF) - 1
International Coll of Surgeons-US Section (ICS-US) - 1
Society for Vascular Surgery (SVS) - 1
Soc of Amer Gastrointestinal Endo Surgeons (SAGES) -2
The American Soc of Breast Surgeons (ASBS) - 1
The Soc of Laparoscopic and Robotic Surgeons (SLRS) - 1
Society of Thoracic Surgeons (STS) - 2

TERRITORIES - 2
Guam - 1
Virgin Islands - 1

TEXAS - 31
Former Presidents (Bailey, Dickey, Rohack) - 3
Former Board Chair (Kridel) - 1
Delegates - 22
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegates - 2
American College of Allergy, Ashtma & Immunology (ACAAI) - 1
International Society of Hair Restoration Surgery (ISHRS) – 1

THORACIC MEDICINE - 2
American Thoracic Society (ATS) - 2

UROLOGY - 5
American Assoc of Clinical Urologists (AACU) - 2
American Urological Association (AUA) – 3
Trustee (Underwood) - 1
Delegates - 2

OFFICIAL OBSERVERS - 30
Accreditation Association for Ambulatory Health Care
Alliance for Continuing Education in the Health Professions
Alliance for Regenerative Medicine
Ambulatory Surgery Center Association
American Academy of Physician Associates
American Association of Medical Assistants
American Board of Medical Specialties
American Dental Association
American Health Quality Association
American Hospital Association
American Nurses Association
American Podiatric Medical Association
American Public Health Association
Association of periOperative Registered Nurses
Association of State and Territorial Health Officials
Commission on Graduates of Foreign Nursing Schools
Council of Medical Specialty Societies
Federation of State Medical Boards
Federation of State Physician Health Programs
Intealth (ECFMG)
Medical Group Management Association
Medical Professional Liability Association
National Association of County and City Health Officials
National Commission on Correctional Health Care
National Council of State Boards of Nursing
National Indian Health Board
Society for Academic Continuing Medical Education
US Pharmacopeia
United States Professional Association for Transgender Health
World Medical Association

TELLERS - 5

HOUSE OF DELEGATES · HYATT REGENCY CHICAGO (A-25)

Audience Left — STAGE — **Audience Right**

SPEAKER — VICE SPEAKER

	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1
1				NEW YORK - 30							INTERNAL MEDICINE - 38						
										NY STUDENT							RPA
2				NEW YORK							INTERNAL MEDICINE						
										NY RESIDENT							
3				NEW YORK							INTERNAL MEDICINE						
										NY STUDENT							
4				NEW YORK							INTERNAL MEDICINE						
									NIELSEN	ACNM							
5				PENNSYLVANIA - 19					NEW YORK		INTERNAL MEDICINE						
								AAPIO	ASN	ASN	ACP WILSON					ACLsM	ACLsM
6				PENNSYLVANIA							INTERNAL MEDICINE			PEDIATRICS - 7			
									PA RESIDENT	HEINE	FRYHOFER			AAP RESIDENT			
7				PENNSYLVANIA							FAMILY PHYSICIANS - 27				PEDIATRICS		
										PA STUDENT					GARRETSON		
8				MOBILITY - 12							FAMILY PHYSICIANS						
				AAOS	AAOS	AAOS	AAOS GURMAN	AAHS	AOFAS	ASSH							
9				MOBILITY					X		FAMILY PHYSICIANS						
				AOrA	ASIPP	ISASS	NASS	NASS									
10				CARDIOLOGY - 18							FAMILY PHYSICIANS						
	SCCT	SCMR	SCAI	SCAI	HRS	ASNC	ASNC	ASE	ASE	LANGSTON							
11				CARDIOLOGY							DERMATOLOGY - 15				ADDICTION MEDICINE - 3		
	ACC	ACC	ACC	ACC	ACC	ACC	ACC	ACC	ACC	ASLMS	ASD	SID	SPD	ACDS	LEVIN		
12				NEUROSCIENCES - 35							DERMATOLOGY						
	AAAP	AACAP	AACAP	AAPL	AAGP	ACLP	GLMA	AAHPM	AAHPM	AAPM	RESNECK	AAD	AAD	AAD	AAD	AAD	ACMS
13				NEUROSCIENCES							DERMATOLOGY			CRITICAL CARE MED - 2	CHEST PHYSICIANS-2		
	APA	APA	APA	APA	APA	APA RESIDENT	IPSIS	NANS	AAN RESIDENT	AAN RESIDENT	ASDSA	ASDSA	ASDSA				
14				NEUROSCIENCES							GASTROENTEROLOGY - 7						
	APA	APA	APA	APA RESIDENT	HARRIS	AAN	AAN	AAN	AAN RESIDENT	AAN RESIDENT	ACG	ACG	ACG	AGA	AGA	ASGE	ASGE
15				NEUROSCIENCES			WISCONSIN - 8				SOUTH DAKOTA - 2		IOWA - 6				
	CARMEL	AANS	AANS	CNS	CNS				WI RESIDENT				OEIS	IA STUDENT			
16				MICHIGAN - 15			WISCONSIN		NEBRASKA - 2		MINNESOTA - 7						
							WI STUDENT	UHMS			AHS	MN RESIDENT					
17				MICHIGAN					NORTH DAKOTA - 3		ONCOLOGY - 6						
										ND STUDENT		ASCO RESIDENT	ASCO MCANENY				
18				ILLINOIS - 19			MICHIGAN		PATHOLOGY - 9								
					IL RESIDENT			MI RESIDENT	ASCP	ASCP	ASCP	ASC	CAP	CAP	CAP	CAP	NAME
19				ILLINOIS					RADIOLOGY - 16								
							IL STUDENT	SIDDIQUI	ACR JOHNSON	ACR	ACR	ACR	ACR	ACR	ACR	ACR	AAR
20			INDIANA - 7		ILLINOIS				RHEUMATOLOGY - 2		RADIOLOGY						
				SNMMI	AOA	AMWA	ACLM				ARRS	ARRS	ARRS	SIR	RSNA	RSNA	RSNA
21				INDIANA			OHIO - 15		X	PALT - 1	THORACIC MED - 2		UROLOGY - 5				
					IN STUDENT	WELSH							UNDERWOOD	AUA	AUA	AACU	AACU
22				OHIO					VT - 1	RHODE ISLAND - 3			NH - 1	MASSACHUSETTS - 17			
							OH RESIDENT	OH RESIDENT		RI RESIDENT				MA STUDENT			
23				OHIO		SECTIONS - 12			MASSACHUSETTS								
					IPPS	WPS	YPS	RFS	MA RESIDENT								
24				SECTIONS					MASSACHUSETTS				MAINE - 2		CONNECTICUT - 8		
	MAS	APS	LGBTQ+	IMG	OMSS	PPPS	SPS	MSS	MA RESIDENT			AANEM			CT RESIDENT		
25				PREVENTIVE MEDICINE - 7				AMGA - 1	GERIATRIC MEDICINE - 2		HEMATOLOGY - 2		CONNECTICUT				
	ACPM	ACOEM	ACMQ	AAPHP	AAPHP RESIDENT	AAIM	ASMA						BREIG	CT RESIDENT	CT STUDENT		

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1				SURGEONS - 45					WASHINGTON - 6								
	T	T	T	ACS	ACS	ACS	ACS	ACS RESIDENT									
2				SURGEONS					NEW MEXICO - 3		UTAH - 4						
	SVS	AVF	ASBS	ACS	ACS	ACS	ACS RESIDENT	AAAAI			J. NELSON						
3				SURGEONS					COLORADO - 10		ID - 1	MT - 1	NEVADA - 2				
	ASCRS	ASCRS	ASMBS	ASMS	ICS-US	SAGES	SAGES	CO RESIDENT									
4				SURGEONS					COLORADO								
	ASOPRS	ASRS	AATS	ASTS	STS	STS	SLRS	OMA	CO STUDENT	CO RESIDENT							
5				SURGEONS					ARIZONA - 8				HAWAII - 2				
	ASCTRS	ASCTRS	AAO	AAO	AAO	AAO	ASRMS										
6				SURGEONS					ARIZONA		OREGON - 4						
	ASAPS	AAPS	AACS	ASPS	ASPS	ASPS	JEFFERS	AIUM	AIUM	ACRO							
7				SURGEONS			ARS - 1	AK - 1	WY - 1	CALIFORNIA - 48							
	AAO-HNS	AAO-HNS	AAO-HNS	AAOA	AAFPRS				CA RESIDENT								
8				KENTUCKY - 6					CALIFORNIA								
			HOVEN				DING	CA STUDENT									
9		DC - 2		DE - 2					CALIFORNIA								
				PERMUT	PLESTED												
10				MARYLAND - 7					CALIFORNIA								
					APCR			CA RESIDENT									
11				ALABAMA - 4		PR - 2			CALIFORNIA								
							CA RESIDENT										
12				OKLAHOMA - 8					CALIFORNIA								
				OK RESIDENT	OK STUDENT	OK RESIDENT	OK RESIDENT		CA STUDENT					NANOS	ACNS	ASRO	ASRO
13				LOUISIANA - 7				X	ENDOCRINOLOGY - 3		SERVICES - 6						
									ES	ES	AACE	AF	PHS	NAVY	ARMY	AMSUS	VA
14				TENNESSEE - 8					EMERGENCY MEDICINE - 14								
				TN STUDENT		AVLS			ACEP RESIDENT	ACEP RESIDENT	ACEP	ACEP	ACEP	ACEP	ACEP	ACEP	ACEP
15				VIRGINIA - 8					X	EMERGENCY MEDICINE					HOSPITAL MED - 3		
				VA STUDENT						AAEM	AAEM	AAEM	ACEP	ACEP			
16				NORTH CAROLINA - 6			WEST VIRGINIA - 3		PHYSICAL MEDICINE & REHABILITATION - 5					TEXAS - 31			
								WV STUDENT		AACP	AAPMR RESIDENT	AAPMR	AAPMR	AAPRM	KRIDEL		
17				FLORIDA - 21					TEXAS								
			BUTLER	FL STUDENT				DICKEY	TX STUDENT								
18				FLORIDA					TEXAS								
				NMA				ROHACK	TX RESIDENT								
19				FLORIDA					TEXAS						SLEEP MED - 2		
				TS				ISHRS	ACAAI	BAILEY	TX RESIDENT						
20			HARMON	SC STUDENT	SMOAK			KOIRALA	OBSTETRICIANS & GYNECOLOGISTS - 20								
									ACOG	ACOG	ACOG	ACOG	ACOG	ACOG	ACOG	ACOG	ACOG
21				GEORGIA - 9					OBSTETRICIANS & GYNECOLOGISTS								
				GA STUDENT	GA RESIDENT				ACMGG	ASRM	ACOG RESIDENT	ACOG WAH	ACOG	ACOG	ACOG	ACOG	
22				ARKANSAS - 3			NEW JERSEY - 10			OBGYN		MISSOURI - 7		KANSAS - 4			
			FERGUSON				NJ STUDENT			AAGL	AAGL			KS STUDENT			
23				MISSISSIPPI - 5			NEW JERSEY		X	INFECTIOUS DIS - 2		MISSOURI					
			HILL	MS STUDENT									BARBE				
24				ANESTHESIOLOGY - 11							GU - 1	VI - 1					
	ASA	ASA	ASA	ASA	ASA	ASA	ASA	ASA	ASA RESIDENT	ASRAPM	ASRAPM						

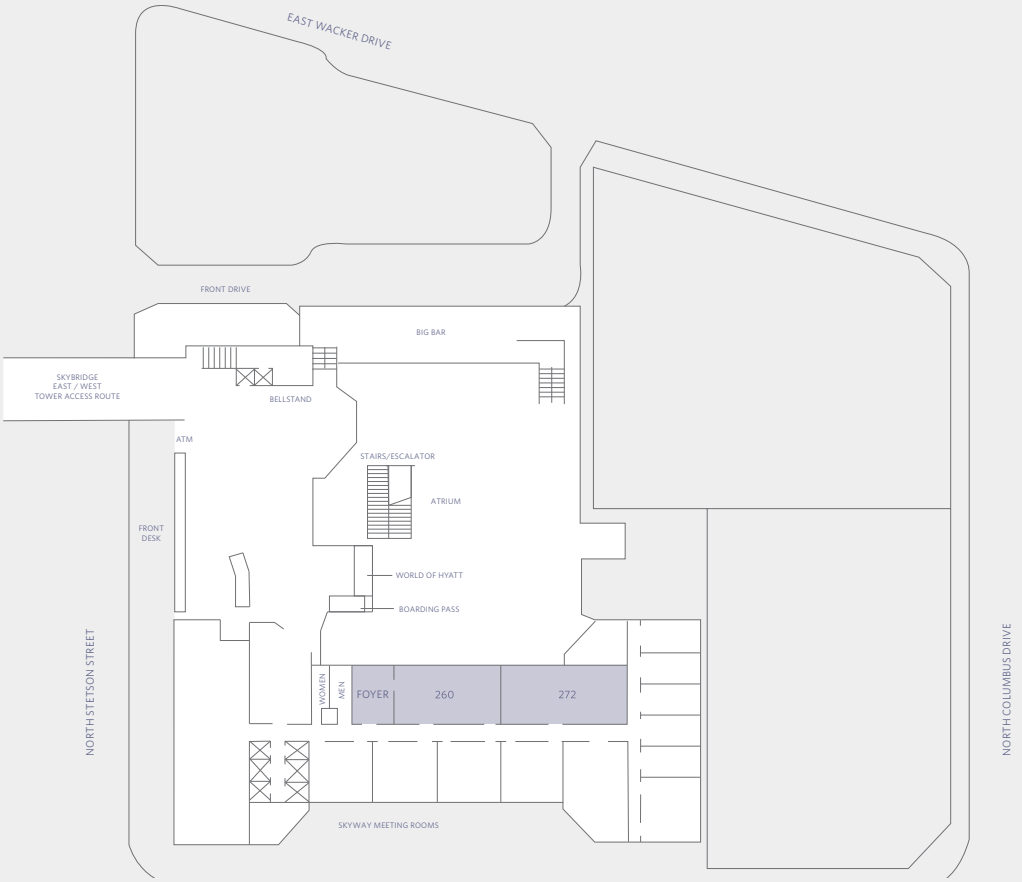
HYATT REGENCY CHICAGO
151 East Wacker Drive
Chicago, Illinois 60601, USA
T +1 312 565 1234
F +1 312 239 4541
hyattregencychicago.com



CAPACITY CHART

Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Skyway Level (East Tower)										
SKYWAY MEETING ROOMS										
Skyway Foyer	27'9" x 21'4" x 9'	507	—	40	—	—	6	—	—	—
Skyway 260	23'3" x 43'1" x 9'	961	40	100	51	36	30	—	—	—
Skyway 272	23'3" x 41'2" x 9'	811	40	70	45	36	28	—	—	—

FLOOR PLAN



Note: Above setups are tables and chairs ONLY without space left for other equipment such as staging, AV, display tables, registration tables or coffee breaks.

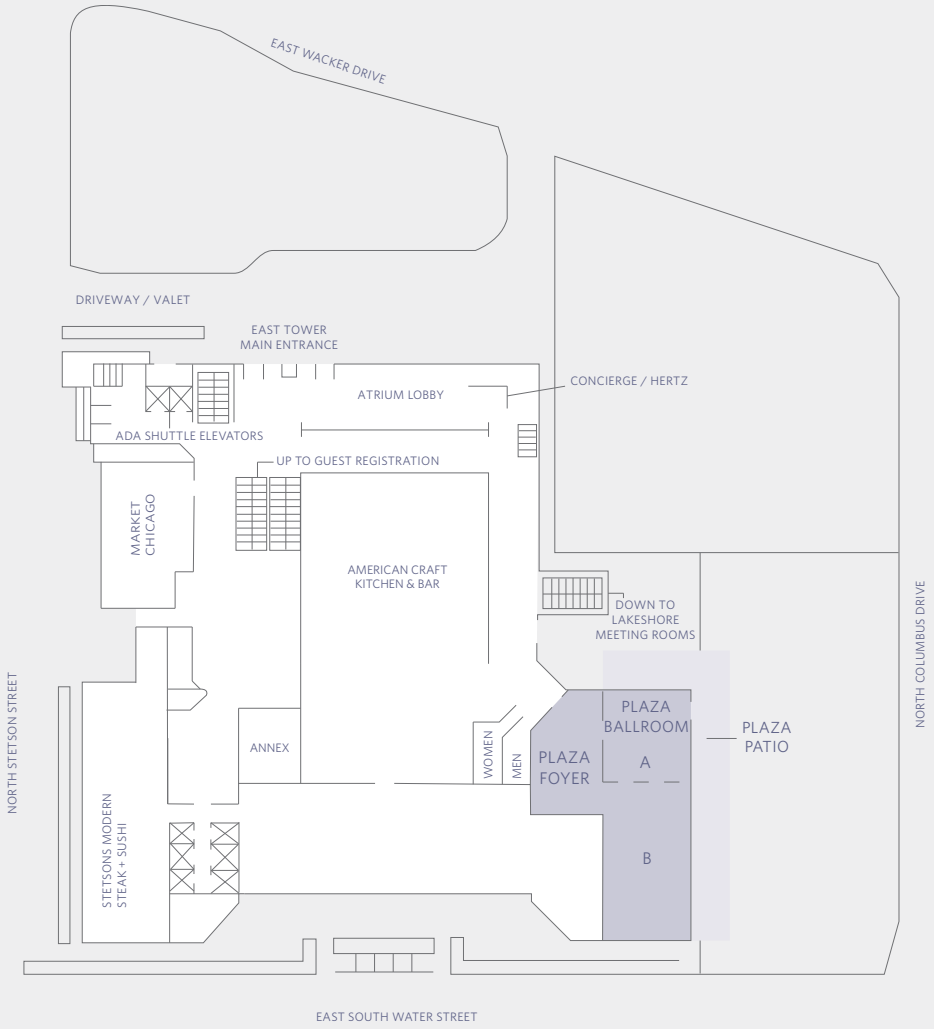
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CAPACITY CHART

Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Lobby Level (East Tower)										
PLAZA BALLROOM	92'9" x 28'9" x 10'6"	2,652	140	250	200	159	60	70	72	—
Plaza A	39'3" x 28'9"" x 10'6"	1,128	60	130	70	63	24	30	32	—
Plaza B	53' x 28'9" x 10'6"	1,524	80	150	130	96	36	40	40	—
Plaza Patio	34'5" x 115'3" x 9"	1,925	—	—	—	—	—	—	—	—
Plaza Park	— x — x —	—	—	—	—	—	—	—	—	—

FLOOR PLAN



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CAPACITY CHART

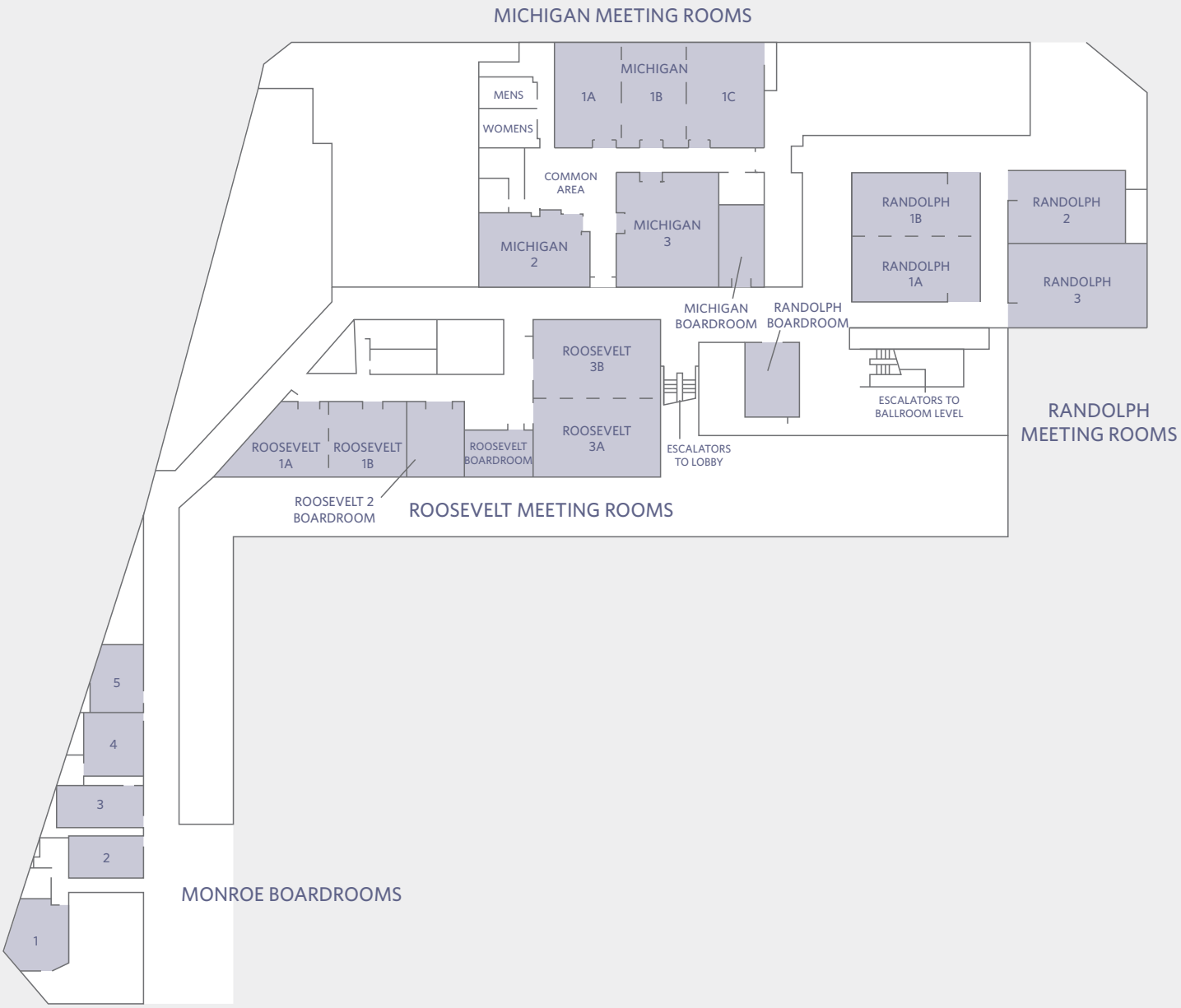
Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Concourse Level (East Tower)										
LAKESHORE MEETING ROOMS										
Michigan 1A, 1B, 1C	33'4" x 74'5" x 8'6"	2,475	140	250	270	135	40/50*	69	78	—
Michigan 1A	33'4" x 25' x 8'6"	825	50	80	66	42	22	21	24	—
Michigan 1B	33'4" x 24.5' x 8'6"	760	50	75	66	42	22	21	24	—
Michigan 1C	33'4" x 25.5' x 8'6"	841	50	80	66	42	22	21	24	—
Michigan 2	26.5' x 39' x 8'6"	1,033	50	100	80	50	28	24	30	—
Michigan 3	41.5' x 34' x 8'6"	1,390	60	135	90	60	34	30	36	—
Michigan Boardroom	26' x 15' x 8'6"	390	—	—	—	—	12	—	—	—
Randolph 1A & 1B	33' x 46' x 8'6"	1,767	100	175	108	60	40	40	48	—
Randolph 1A	33' x 23' x 8'6"	819	50	80	50	27	28	21	24	—
Randolph 1B	33' x 23' x 8'6"	819	50	80	50	27	28	21	24	—
Randolph 2	36' x 26'9" x 8'6"	922	50	90	60	30	28	24	30	—
Randolph 3	42' x 29'10" x 8'6"	1,192	70	120	84	48	34	30	36	—
Randolph Boardroom	23' x 16' x 8'6"	368	—	—	—	—	10	—	—	—
Roosevelt 1A & 1B	27'6" x 42' x 8'6"	1,186	60	125	70	42	40	39	42	—
Roosevelt 1A	27'6" x 26'/16' x 8'6"	599	30	50	28	18	28	18	21	—
Roosevelt 1B	27'6" x 26' x 8'6"	587	30	70	32	18	28	15	18	—
Roosevelt 2 Boardroom	25' x 17' x 8'6"	425	—	—	—	—	12	—	—	—
Roosevelt Boardroom	17' x 21' x 8'6"	357	—	—	—	—	8	—	—	—
Roosevelt 3A & 3B	30' x 55' x 8'6"	1,650	100	165	132	78	52	54	60	9
Roosevelt 3A	30' x 28' x 8'6"	840	40	80	60	42	28	24	36	—
Roosevelt 3B	30' x 27' x 8'6"	810	40	80	60	42	28	24	36	—
Monroe 1 Boardroom	24'6" x 19'9" x 8'6"	400	—	—	—	—	10	—	—	—
Monroe 2 Boardroom	20'6" x 15' x 8'6"	307	—	—	—	—	8	—	—	—
Monroe 3 Boardroom	24'6" x 15' x 8'6"	367	—	—	—	—	12	—	—	—
Monroe 4 Boardroom	18' x 22'6 x 8'6"	405	—	—	—	—	10	—	—	—
Monroe 5 Boardroom	16' x 21' x 8'6"	336	—	—	—	—	14	—	—	—

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F +1 312 239 4541
hyattregencychicago.com



FLOOR PLAN
Concourse Level (East Tower)



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CAPACITY CHART

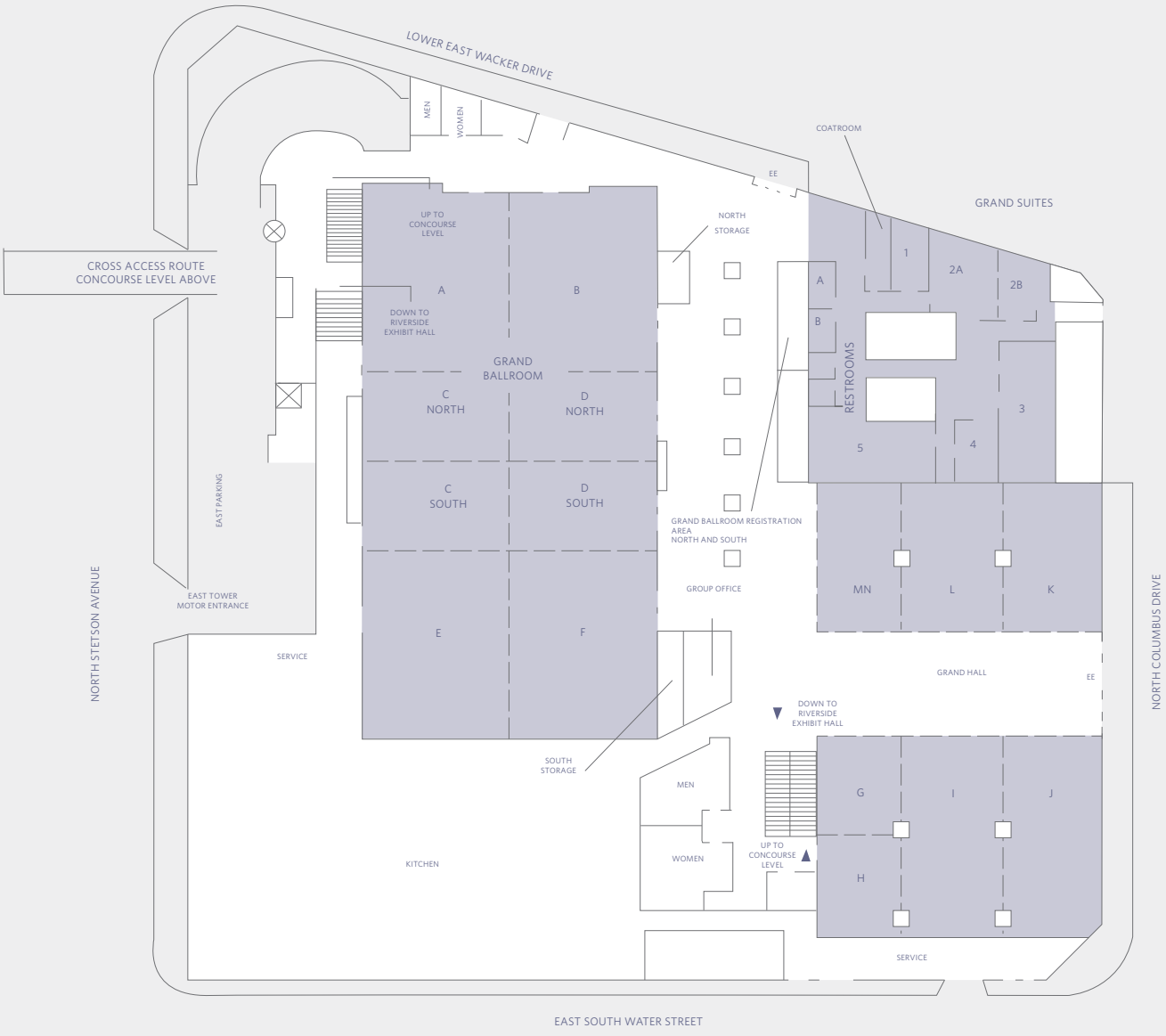
Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Ballroom Level (East Tower)										
GRAND BALLROOM	213' x 114' x 17'	24,282	1,800	3,000	2,400	1,250	—	—	—	137
Grand A or B	71' x 57' x 17'	4,047	240	400	400	250	74	80	100	20
Grand AB	71' x 114' x 17'	8,094	500	800	800	500	—	—	—	45
Grand C or D	71' x 57' x 17'	4,047	240	400	400	250	74	80	100	20
Grand CD	71' x 114' x 17'	8,094	500	800	800	500	—	—	—	51
Grand C or D North	36' x 57' x 17'	2,052	110	200	200	110	36	40	50	—
Grand C or D South	36' x 57' x 17'	2,052	110	200	200	110	36	40	50	—
Grand CD North or South	36' x 114' x 17'	4,047	280	400	400	250	74	80	100	25
Grand E or F	71' x 57' x 17'	4,047	240	400	400	250	74	80	100	20
Grand EF	71' x 114' x 17'	8,094	500	800	800	500	—	—	—	45
GRAND HALL	110'4" x 169'5" x 9'6"	17,628	1,250	1,800	—	—	—	—	—	93
Grand Hall G or H	37'8" x 34'6" x 9'6"	1,263	50	115	80	34	34	34	40	—
Grand Hall GH	76'8" x 34'6" x 9'6"	2,551	150	250	210	129	62	70	80	12
Grand Hall I	76'8" x 36'11" x 9'6"	2,798	170	250	225	144	70	70	80	12
Grand Hall J	76'8" x 36'11" x 9'6"	2,873	170	250	225	144	70	70	80	12
Grand Hall K	60'3" x 37'7" x 9'6"	2,310	120	225	180	108	58	60	65	12
Grand Hall L	60'3" x 37'7" x 9'6"	2,243	120	200	180	108	58	55	60	12
Grand Hall MN	60'3" x 37'7" x 9'6"	1,951	120	200	180	108	52	55	60	12
GRAND SUITES	38'5" x 9'6"									
Grand Suite 1	14' x 19' x 11'	264	10	25	16	—	8	—	—	—
Grand Suite 2A	20'9" x 25'9" x 11'	523	30	35	30	24	10	6	12	—
Grand Suite 2B	16'3" x 14' x 11'	238	10	15	15	9	8	—	—	—
Grand Suite 2AB	42'5" x 20'9" x 11'	764	40	75	60	30	14	12	18	—
Grand Suite 3	25' x 57' x 9'	1,425	80	130	120	60	40	32	36	—
Grand Suite 4	14' x 23' x 9'	322	—	—	—	—	8	—	—	—
Grand Suite 5	23' x 49' x 11'	1,127	70	100	96	60	30	22	25	—

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FLOOR PLAN
Ballroom Level (East Tower)



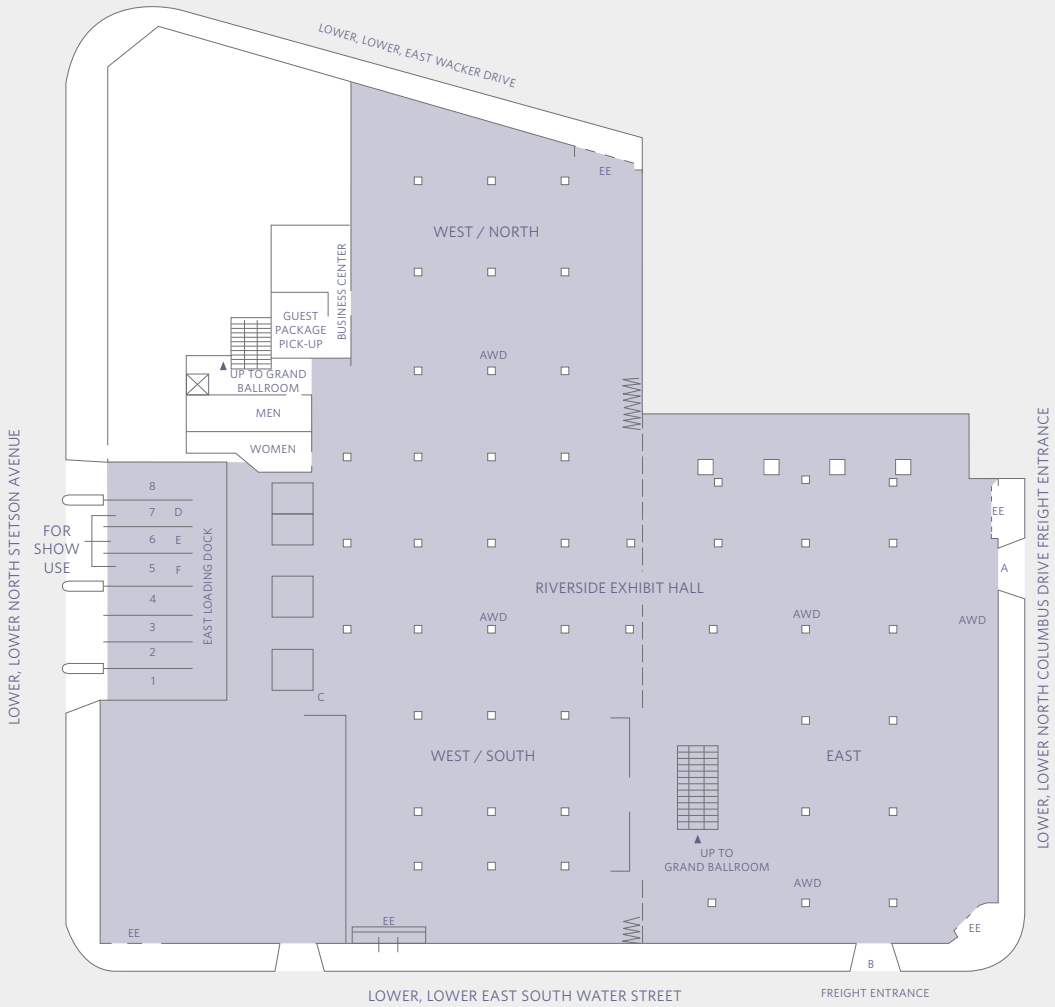
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CAPACITY CHART

Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Exhibit Level (East Tower)										
RIVERSIDE EXHIBIT HALL										
HALL	CEILING HEIGHT 12'	70,000	2,330	7,000	—	—	—	—	—	355
EAST	—	30,000	870	2,500	2,400	—	—	—	—	151
WEST	—	40,000	1,330	4,500	3,300	—	—	—	—	204
EAST DOCK (D, E, F)	—	3 Bays	—	—	—	—	—	—	—	—

FLOOR PLAN



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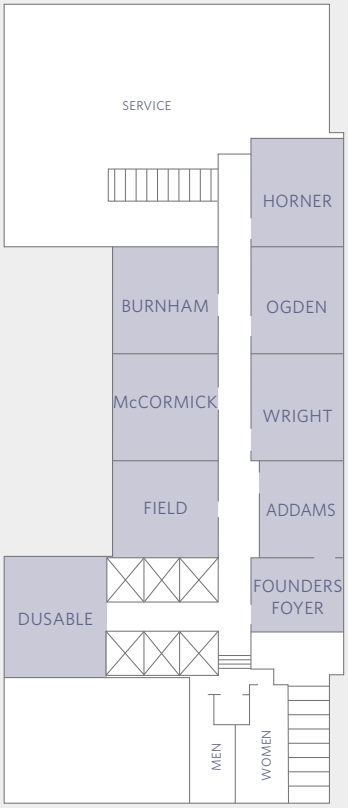
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CAPACITY CHART

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Third Floor (West Tower)										
FOUNDERS SUITES										
Dusable	26'5" x 26'7" x 9'	677	40	60	50	27	28	18	30	—
Field	25'5" x 26'3" x 9'	688	40	60	50	27	28	18	30	—
McCormick	25'5" x 26'3" x 9'	688	40	60	50	27	28	18	30	—
Burnham	25'5" x 24' x 10'	688	40	60	50	27	28	18	30	—
Addams	22' x 24'10" x 9'	556	40	50	32	18	20	15	18	—
Wright	23'8" x 26'3" x 9'	628	40	60	40	24	24	18	24	—
Ogden	23'8" x 26'3" x 9'	628	40	60	40	24	24	18	24	—
Horner	23'8" x 26'3" x 9'	628	40	60	40	24	24	18	24	—
Founders Foyer	16' x 23'10" x 9'	446	—	—	—	—	8	—	—	—

FLOOR PLAN



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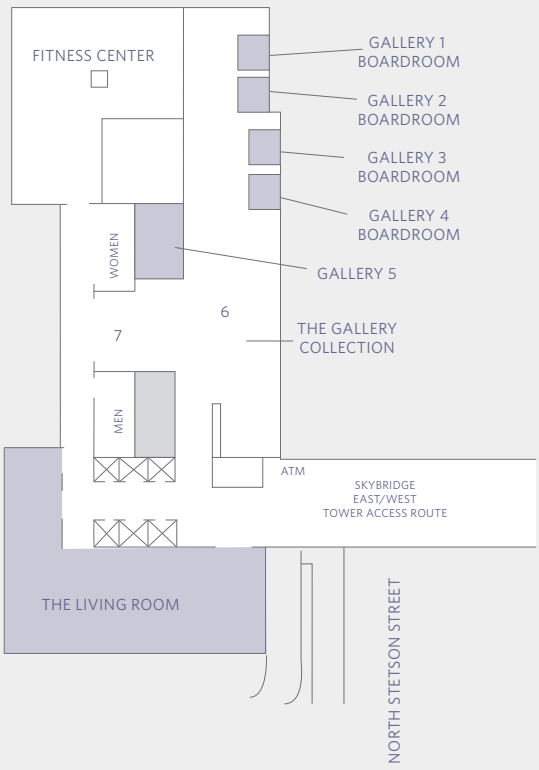
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Skyway Level (West Tower)										
THE LIVING ROOM	—	—	—	—	—	—	—	—	—	—
GALLERY COLLECTION										
The Gallery Lounge 6	23' x 52'10"	1,206	—	—	—	—	—	—	—	—
The Gallery Lounge 7	32'2" x 24'2"	759	—	—	—	—	—	—	—	—
Gallery 1 Boardroom	21'4" x 10'4"	223	—	—	—	—	10	—	—	—
Gallery 2 Boardroom	21'4" x 11'4"	251	—	—	—	—	10	—	—	—
Gallery 3 Boardroom	21'4" x 12'2"	258	—	—	—	—	10	—	—	—
Gallery 4 Boardroom	21'4" x 11'10"	284	—	—	—	—	10	—	—	—
Gallery 5	17'9" x 28'4"	470	20	40	30	24	18	—	—	—

FLOOR PLAN



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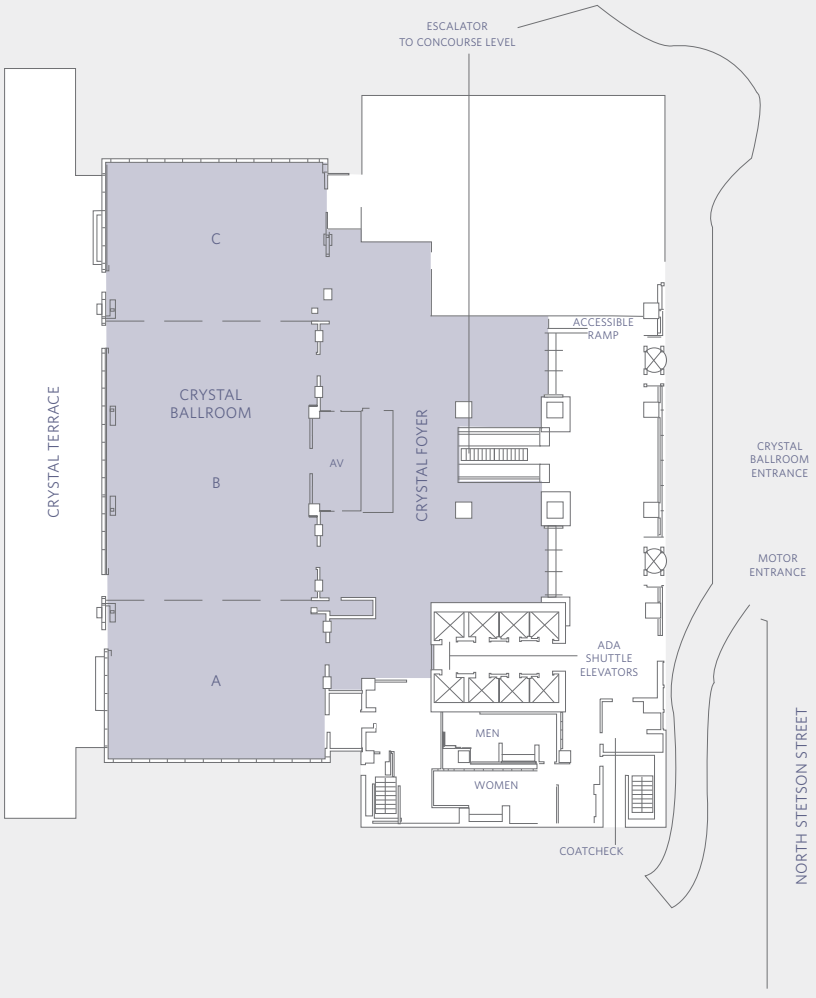
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CAPACITY CHART

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Lobby Level (West Tower)										
CRYSTAL BALLROOM	167' x 59' x 19'	9,853	700	1,000	950	500	—	—	—	40
Crystal A	43' x 59' x 19'	2,584	160	250	280	125	50	56	66	—
Crystal B	80' x 56' x 19'	4,559	320	500	450	240	100	70	82	—
Crystal C	43' x 59' x 19'	2,586	160	250	280	125	50	56	66	—
Crystal AB or BC	123' x 59' x 19'	7,198	480	750	870	380	120	129	150	—
CRYSTAL FOYER	—	5,120	—	400	—	—	—	—	—	—

FLOOR PLAN



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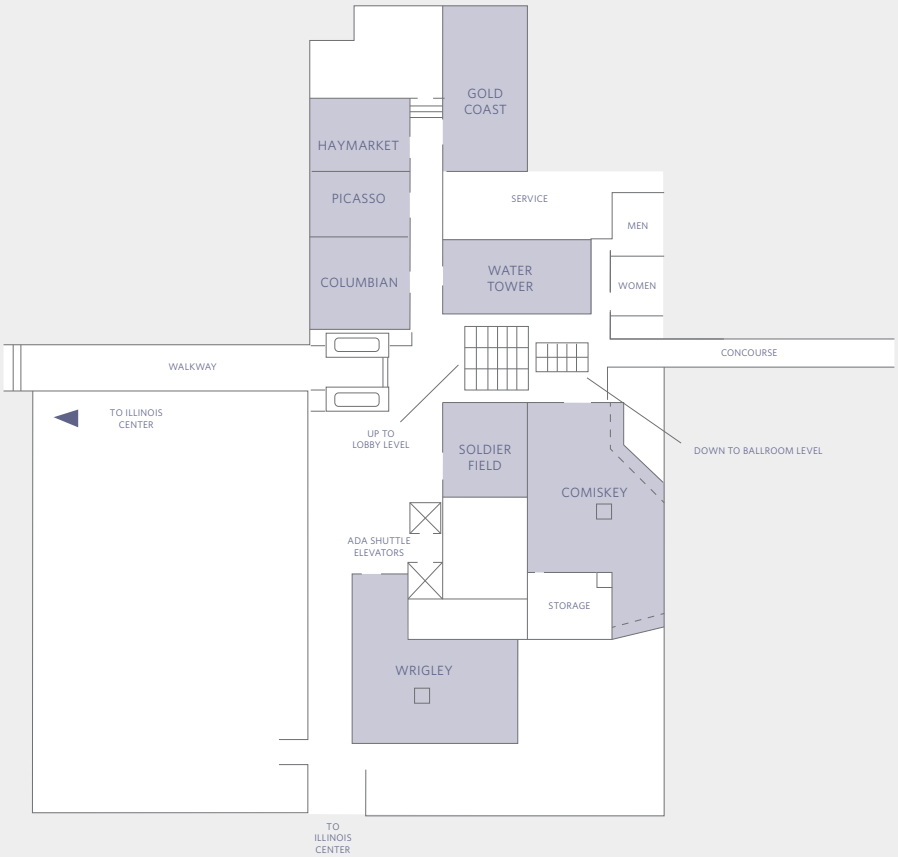
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Concourse Level (West Tower)										
LANDMARK SUITES										
Comiskey	40' x 62' x 9'	1,982	70	200	90	84	40	36	42	—
Water Tower	45'3"' x 25' x 9'	1,143	80	120	120	54	28	26	36	—
Gold Coast	47'6" x 25' x 9'	1,178	80	120	120	54	28	26	36	—
Haymarket	29'6" x 19'6" x 9'	562	40	60	30	24	24	20	25	—
Picasso	29'6" x 22' x 9'	599	40	60	30	30	24	18	24	—
Columbian	27'3' x 25' x 9'	681	40	60	60	33	26	25	30	—
Soldier Field	34' x 25'8 x 9'	789	40	70	45	30	24	25	30	—
Wrigley	43' x 52' x 9'	1,540	70	140	60	48	30	25	30	—

FLOOR PLAN



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Ballroom Level (West Tower)										
REGENCY BALLROOM	72' x 230' x 11'8"	16,560	1,000	1,600	1,600	750	—	—	—	90
Regency A, B, C or D	72' x 58' x 11'8"	4,176	240	400	400	220	70	72	100	20
Regency AB, BC or CD	72' x 117' x 11'8"	8,424	480	800	800	450	140	144	200	40
Regency ABC or BCD	72' x 174' x 11'8"	12,528	750	1,200	1,200	675	—	—	—	60
INTERNATIONAL SUITES	59'6" x 81'3" x 7'6"	3,936	240	350	—	—	—	—	—	22
Toronto	59'6" x 26'6" x 8'5"	1,558	100	150	120	96	55	55	60	10
Hong Kong	28' x 27' x 8'5"	808	40	50	60	36	30	23	28	3
Acapulco	59'6" x 27' x 8'5"	1,558	100	150	120	96	55	55	60	10
CITY SUITES										
Atlanta	24' x 32' x 7'9"	768	40	60	60	36	24	18	24	—
San Francisco	25' x 26' x 7'9"	650	40	60	55	27	24	29	32	—
New Orleans	28' x 33' x 7'9"	906	50	70	65	45	30	24	30	—
West Tower (36th Floor)										
BOARD OF TRADE	23' x 27'	621	—	—	—	—	16	—	—	—

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FLOOR PLAN

Ballroom Level (West Tower)



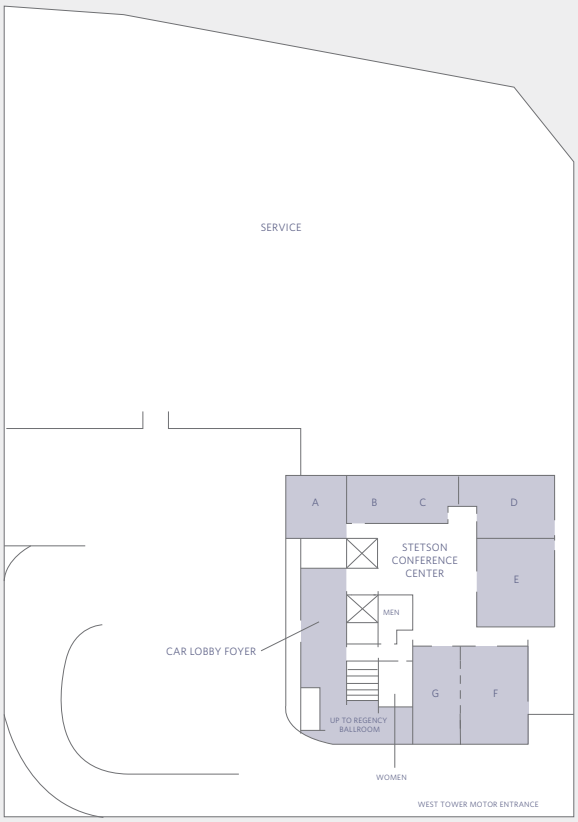
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Exhibit Level (West Tower)										
STETSON CONFERENCE CENTER										
Stetson Suite A	9' x 19' x 8'	378	10	25	24	15	12	—	—	—
Stetson Suite BC	30' x 17' x 8'	510	30	40	45	18	24	27	30	—
Stetson Suite D	18' x 24' x 8'	432	10	25	30	18	20	10	12	—
Stetson Suite E	30' x 27' x 8'	810	40	55	50	21	26	14	16	—
Stetson Suite F	36' x 25' x 8'	900	50	60	70	45	34	18	20	—
Stetson Suite G	36' x 14' x 8'	504	30	40	48	27	14	14	14	—
Stetson Suite F-G	36' x 39' x 8'	1,404	80	90	—	—	—	—	—	—

FLOOR PLAN



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2025 ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Official Call to the Officers and Members of the American Medical Association to attend the June 2025 Annual Meeting of the House of Delegates in Chicago, Illinois, June 6 – 11, 2025.

The House of Delegates will convene at 6:00 p.m., on June 6 at the Hyatt Regency Chicago.

STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

Alabama 4	Guam 1	Massachusetts 13	New York 23	Tennessee 6
Alaska 1	Hawaii 2	Michigan 14	North Carolina 6	Texas 22
Arizona 5	Idaho 1	Minnesota 5	North Dakota 2	Utah 3
Arkansas 2	Illinois 12	Mississippi 3	Ohio 12	Vermont 1
California 37	Indiana 5	Missouri 6	Oklahoma 4	Virgin Islands 1
Colorado 6	Iowa 4	Montana 1	Oregon 4	Virginia 7
Connecticut 4	Kansas 3	Nebraska 2	Pennsylvania 15	Washington 6
Delaware 1	Kentucky 5	Nevada 2	Puerto Rico 2	West Virginia 2
District of Columbia 2	Louisiana 7	New Hampshire 1	Rhode Island 2	Wisconsin 5
Florida 17	Maine 2	New Jersey 9	South Carolina 4	Wyoming 1
Georgia 7	Maryland 6	New Mexico 2	South Dakota 2	

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

American Academy of Child and Adolescent Psychiatry 2
American Academy of Dermatology 5
American Academy of Emergency Medicine 3
American Academy of Family Physicians 26
American Academy of Hospice and Palliative Medicine 2
American Academy of Neurology 3
American Academy of Ophthalmology 4
American Academy of Orthopaedic Surgeons 4
American Academy of Otolaryngology-Head and Neck Surgery 3
American Academy of Pediatrics 5
American Academy of Physical Medicine and Rehabilitation 3
American Academy of Sleep Medicine 2
American Association of Clinical Urology, Inc. 2
American Association of Gynecologic Laparoscopists 2
American Association of Neurological Surgeons 2
American College of Cardiology 9
American College of Chest Physicians (CHEST) 2
American College of Emergency Physicians 9
American College of Gastroenterology 3
American College of Lifestyle Medicine – 2
American College of Obstetricians and Gynecologists 14
American College of Physicians 34
American College of Radiology 8
American College of Rheumatology 2
American College of Surgeons 8
American Gastroenterological Association 2
American Geriatrics Society 2
American Institute of Ultrasound in Medicine 2
American Psychiatric Association 8
American Roentgen Ray Society 3
American Society for Clinical Pathology 3
American Society for Dermatologic Surgery 3
American Society for Gastrointestinal Endoscopy 2
American Society for Radiation Oncology 2
American Society of Addiction Medicine 2
American Society of Anesthesiologists 8
American Society of Cataract and Refractive Surgery 2
American Society of Colon and Rectal Surgeons 2
American Society of Echocardiography 2
American Society of Hematology 2
American Society of Neuroradiology 2
American Society of Nuclear Cardiology – 2
American Society of Plastic Surgeons 3
American Society of Regional Anesthesia and Pain Medicine 2
American Thoracic Society 2
American Urological Association 2
Association for Clinical Oncology 5
College of American Pathologists 4
Congress of Neurological Surgeons 2
Infectious Diseases Society of America 2
North American Spine Society 2
Radiological Society of North America 3
Society for Cardiovascular Angiography and Interventions 2
Society of American Gastrointestinal Endoscopic Surgeons 2
Society of Critical Care Medicine 2
Society of Hospital Medicine 3
Society of Thoracic Surgeons 2
The Endocrine Society 2

Remaining eligible national medical specialty societies (74) are entitled to one delegate each.

The Academic Physicians Section, Integrated Physician Practice Section, International Medical Graduates Section, LGBTQ+ Section, Medical Student Section, Minority Affairs Section, Organized Medical Staff Section, Private Practice Physicians Section, Resident and Fellow Section, Senior Physicians Section, Women Physicians Section, Young Physicians Section, Army, Navy, Air Force, Public Health Service, Department of Veterans Affairs, Professional Interest Medical Associations, AMWA, AOA and NMA are entitled to one delegate each.

State Medical Associations	322
National Medical Specialty Societies	322
Professional Interest Medical Associations	3
Other National Societies (AMWA, AOA, NMA)	3
Medical Student Regional Delegates	25
Resident and Fellow Delegate Representatives	41
Sections	12
Services	5
Total Delegates	**733**

Registration facilities will be maintained at the Hyatt Regency Chicago Foyer.

Bruce A. Scott, MD
President

Lisa Bohman Egbert, MD
Speaker, House of Delegates

Toluwalase A. Ajayi, MD
Secretary

2024 - 2025

OFFICIALS OF THE ASSOCIATION

BOARD OF TRUSTEES (OFFICERS)

President – Bruce A. Scott ..... Louisville, Kentucky
President-Elect - Bobby Mukkamala ..... Flint, Michigan
Immediate Past President – Jesse M. Ehrenfeld ..... Milwaukee, Wisconsin
Secretary – Toluwalase A. Ajayi ..... San Diego, California
Speaker, House of Delegates - Lisa Bohman Egbert ..... Dayton, Ohio
Vice Speaker, House of Delegates - John H. Armstrong ..... Ocala, Florida

David H. Aizuss (2028), *Chair-Elect* ..... Encino, California
Geralyn R. Breig (2028) ..... West Port, Connecticut
Madelyn E. Butler (2025) ..... Tampa, Florida
Alexander Ding (2026) ..... Louisville, Kentucky
Scott Ferguson (2026) ..... West Memphis, Arkansas
Sandra Adamson Fryhofer (2026) ..... Atlanta, Georgia
Melissa Garretson (2028) ..... Fort Worth, Texas
Marilyn J. Heine (2026) ..... Dresher, Pennsylvania
Lynne Jeffers (2028) ..... Oxnard, California
Pratistha Koirala (2025) ..... Danbury, Connecticut
Ilse R. Levin (2028) ..... Silver Spring, Maryland
Aliya Siddiqui (2025) ..... Milwaukee, Wisconsin
Michael Suk (2027), *Chair* ..... Danville, Pennsylvania
Willie Underwood, III (2027) ..... Buffalo, New York
David Welsh (2028) ..... Batesville Indiana

COUNCILS OF THE AMA

COUNCIL ON CONSTITUTION AND BYLAWS
Jerry P. Abraham, Los Angeles, California, Chair (2025); John H. Armstrong, Ocala, Florida, Vice Speaker: Ex Officio (2025); Mark N. Bair, Highland, Utah (2027); Adrina Kocharian, Minneapolis, Minnesota, (Student) (2025); Mary Ann Contogiannis, Greensboro, North Carolina, Vice Chair, (2025); Lisa Bohman Egbert, Dayton, Ohio, Speaker: Ex Officio (2025); Christopher E. Gribbin, Princeton, New Jersey (2028); Daniel O. Pfeifle, Indianapolis, Indiana (Resident) (2025); Kevin C. Reilly, Sr., Grovetown, Georgia (2026); Steven C. Thornquist, Bethany, Connecticut (2026).
Secretary: Janice Robertson, Chicago, Illinois.

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
Rebecca W. Brendel, Boston, Massachusetts, Vice Chair, (2026); Arthur R. Derse, Shorewood, Wisconsin (2030); Sophia A. Doerr, Madison, Wisconsin, (Student) (2025); Charles J. Hickey, Mechanicsburg, Ohio (2031); Michael G. Knight, Washington, District of Columbia (2029); Jeremy A. Lazarus, Greenwood Village, Colorado, Chair (2025); Kelsey C. Mumford, Pflugerville, Texas, (Resident) (2026); Larry E. Reaves, Fort Worth, Texas (2027); Daniel P. Sulmasy, Washington, District of Columbia (2028).
Secretary: Amber Comer, Chicago, Illinois.

COUNCIL ON LEGISLATION
Vijaya L. Appareddy, Chattanooga, Tennessee (2025); Maryanne C. Bombaugh, Falmouth, Massachusetts (2025); Claude D. Brunson, Ridgeland, Mississippi (2025); Michael D. Chafty, Kalamazoo, Michigan (2025); Hilary E. Fairbrother, Houston, TX (2025); Gary W. Floyd, Corpus Christi, Texas (2025); Merrilee Aynes Gober, Atlanta, Georgia (Alliance Rep) (2025); Ross F. Goldberg, Miami, Florida (2025); Tripti C. Kataria, Chicago, Illinois, Vice Chair, (2025); Laurie L. Lapp, Madison, Wisconsin (Student) (2025); Sion Roy, Malibu, CA (AMPAC Liaison) (2025); Sophia E. Spadafore, New York, New York (Resident) (2025); Ann Rosemarie Stroink, Heyworth, Illinois (2025); Marta J. Van Beek, Iowa City, Iowa, Chair (2025).
Secretary: George Cox, Washington, District of Columbia.

COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
Edmond B. Cabbabe, St. Louis, Missouri (2025); Erin K. Harnish, Longview, Washington (2028); Moudi K. Hubeishy, Chicago, Illinois (Resident) (2026); Gary R. Katz, Dublin, OH (2027); G. Sealy Massingill, Fort Worth, Texas (2027); Gary D. Thal, Chicago, Illinois (2025); Michelle A. Berger, Austin, Texas, Chair (2026); Jan M. Kief, Merritt Island, Florida, Vice Chair (2027); Shilpen A. Patel, San Francisco, California (2028); Dhruv Puri, Pleasanton, California (Student) (2025).
Secretary: Susan Close, Chicago, Illinois.

COUNCIL ON MEDICAL EDUCATION
Suja M. Mathew, Hinsdale, Illinois (2026); Sherri S. Baker, Edmond, Oklahoma (2025); Kelly J. Caverzagie, Omaha, Nebraska, Vice Chair (2027); Ricardo R. Correa Marquez, Phoenix, Arizona (2027); Louito C. Edje, Cincinnati, Ohio (2025); Robert B. Goldberg, Morristown, New York (2025); Shannon M. Kilgore, Los Altos, California (2027); Daniel C. Lee, Mobile, Alabama (Resident) (2025); Radhika B. Patel, Sugarland, Texas (Student) (2025); Seema Sidhu, Morgan Hill California (2028); Krystal L. Tomei, Lyndhurst, Ohio, Chair (2025); Daniel M. Young, Vestal, New York (2027).
Secretary: Tanya Lopez, Chicago, Illinois.

COUNCIL ON MEDICAL SERVICE
A. Patrice Burgess, Boise, Idaho (2027); Alain A. Chaoui, Peabody, Massachusetts (2025); Steven L. Chen, San Diego, California (2028); Betty S. Chu, Detroit, Michigan, Chair-Elect (2026); Alice Coombs, Richmond, Virginia (2027); Erick A. Eiting, New York, New York (2028); Stephen K. Epstein, Needham, Massachusetts, Chair (2026); Ravi Goel, Cherry Hill, New Jersey (2026); Hari S. Iyer Detroit, Michigan (Resident) (2025); Justin W. Magrath New Orleans, Louisiana (Student) (2025); Sheila Rege, Pasco, Washington (2026); Ezequiel Silva, III, San Antonio, Texas (2028).
Secretary: Linda Walsh, Chicago, Illinois.

COUNCIL ON SCIENCE AND PUBLIC HEALTH
Ankush K. Bansal, Loxahatchee, Florida (2027); Joanna Bisgrove, Evanston, Illinois (2026);John T. Carlo, Dallas, Texas, Chair (2025); Joshua M. Cohen, New York, New York (2026); David R. Cundiff, Ilwaco, Washington (2026); Rachel Ekaireb, Sacramento, California (Resident) (2026); Mary E. LaPlante, Broadview Heights, OH (2025); Marc Mendelsohn, St. Louis, MO (2027); Tamaan K. Osbourne-Roberts, Denver, Colorado (2027); Padmini D. Ranasinghe, Baltimore, Maryland, Chair-Elet (2026); Rajadhar T. Reddy, Round Rock, Texas (Student) (2025); Raymond K. Tu, Washington, DC (2028).
Secretary: Andrea Garcia, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE
Elie C. Azrak, St. Louis, Missouri; Brooke M. Buckley, Bloomfield Hills, Michigan, Chair; Paul J. Carniol, Summit, New Jersey; Juliana Cobb, Lousiville, Kentucky (Student); Benjamin Z. Galper, McLean, Virginia (COL Liaison); Victoria Gordon, Houston, Texas (Resident); Bruce A. MacLeod, Pittsburgh, Pennsylvania; L. Elizabeth Peterson, Spokane, Washington, Secretary; Stephen J. Rockower, Bethesda, Maryland; Theresa M. Rohr-Kirchgraber, Athens, Georgia; Sion K. Roy, Malibu, California; Janice E. Tildon-Burton, Wilmington, Delaware.
Executive Director and Treasurer: Rob Jordan, Washington, District of Columbia.

EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES

The Former Presidents and Former Trustees of the Association, the Chairs of the Councils of the AMA and the current General Officers, with the exception of the Speaker and Vice Speaker of the House of Delegates, are ex officio, nonvoting members of the House of Delegates.

FORMER PRESIDENTS

Susan R. Bailey	2020-2021	Patrice A. Harris	2019-2020	William G. Plested, III	2006-2007
David O. Barbe	2017-2018	J. Edward Hill	2005-2006	Jack Resneck, Jr	2022-2023
Lonnie R. Bristow	1995-1996	Ardis D. Hoven	2013-2014	J. James Rohack	2009-2010
Peter W. Carmel	2011-2012	Daniel H. Johnson, Jr.	1996-1997	Randolph D. Smoak, Jr.	2000-2001
Yank D. Coble, Jr.	2002-2003	Jeremy A. Lazarus	2012-2013	Steven J. Stack	2015-2016
Richard F. Corlin	2001-2002	Barbara L. McAneny	2018-2019	Robert M. Wah	2014-2015
Nancy W. Dickey	1998-1999	Alan R. Nelson	1989-1990	Cecil B. Wilson	2010-2011
Andrew W. Gurman	2016-2017	John C. Nelson	2004-2005	Percy Wootton	1997-1998
Gerald E. Harmon	2021-2022	Nancy H. Nielsen	2008-2009		

FORMER TRUSTEES

Herman I. Abromowitz	1997-2005	Alan C. Hartford	1989-1990	Harris Pastides	2020-2024
Susan Hershberg Adelman	1998-2002	Drayton Charles Harvey	2020-2023	Rebecca J. Patchin	1988-1989
Kendall S. Allred	2008-2009	William A. Hazel, Jr	2004-2009	Rebecca J. Patchin	2003-2011
Raj S. Ambay	2009-2011	Cyril M. Hetsko	2003-2011	Stephen R. Permut	2010-2018
Joseph P. Annis	2006-2014	J. Edward Hill	1996-2004	Pamela Petersen-Crair	1996-1998
Grayson W. Armstrong	2019-2021	Ardis D. Hoven	2005-2012	Dina Marie Pitta	2015-2016
John H. Armstrong	2002-2006	William E. Jacott	1989-1998	William G. Plested, III	1998-2005
Maya A. Babu	2013-2017	Hillary D. Johnson	2001-2002	Stephen Pool	1995-1996
Susan R. Bailey	2011-2018	Matthew D. Kagan	1999-2000	Liana Puscas	1999-2001
Timothy E. Baldwin	1987-1989	Christopher K. Kay	2008-2012	Kevin C. Reilly	2003-2005
David O. Barbe	2009-2016	William E. Kobler	2012-2020	Ryan J. Ribeira	2013-2014
Regina M. Benjamin	1995-1998	Russell W.H. Kridel	2014-2022	J. James Rohack	2001-2008
Scott L. Bernstein	1991-1992	Edward L. Langston	2003-2011	David A. Rosman	2002-2004
Stefano M. Bertozzi	1986-1988	Matthew C. Lawyer	2004-2005	Samantha L. Rosman	2005-2009
David J. Brailer	1985-1986	Jeremy A. Lazarus	2005-2011	Raymond Scalettar	1985-1994
Lonnie R. Bristow	1985-1994	W. J. Lewis	1979-1984	Bruce A. Scott	1998-2002
Peter Carmel	2002-2010	Audrey J. Ludwig	1990-1991	Carl A. Sirio	2010-2018
Alice A. Chenault	1984-1985	Thomas J. Madejski	2020-2024	Sarah Mae Smith	2019-2020
Yank D. Coble	1994-2001	Justin B. Mahida	2009-2010	Randolph D. Smoak, Jr.	1992-1999
David S. Cockrum	1993-1994	Omar Z. Maniya	2016-2017	Steven J. Stack	2006-2014
MaryAnn Contogiannis	1989-1993	Barbara L. McAneny	2010-2017	Michael Suk	1994-1995
Malini Daniel	2012-2013	William A. McDade	2016-2020	Andrew M. Thomas	1997-1999
Christopher M. DeRienzo	2006-2008	Mary Anne McCaffree	2008-2016	Jeffrey A. Towson	1998-1999
Nancy W. Dickey	1989-1997	Joe T. McDonald	2005-2006	Georgia A. Tuttle	2011-2019
Alexander Ding	2011-2013	Samuel J. Mackenzie	2014-2015	Jordan M. VanLare	2011-2012
William A. Dolan	2007-2011	Sandeep “Sunny” Mistry	2000-2001	Robert M. Wah	2005-2013
Willarda Edwards	2016-2024	Mario Motta	2018-2022	Peter Y. Watson	2001-2003
Melissa J. Garretson	1992-1993	Elizabeth Blake Murphy	2020-2021	Monica C. Wehby	2011-2013
Michael S. Goldrich	1993-1997	Alan R. Nelson	1980-1988	Kevin W. Williams	2016-2020
Julie K. Goonewardene	2012-2016	John C. Nelson	1994-2003	Meredith C. Williams	2010-2011
Andrew W. Gurman	2007-2015	Nancy H. Nielsen	2005-2007	Cecil B. Wilson	2002-2009
Patrice A. Harris	2011-2018	Albert J. Osbahr, III	2011-2019	Percy Wootton	1991-1996

SPECIALTY AND SERVICE SOCIETY REPRESENTATIVES
2025 Annual Meeting of the AMA House of Delegates

(The following are representatives of the following societies which are represented in the SSS but are not members of the House of Delegates.)

American Association of Endocrine Surgeons	Dina Elaraj, MD
American Association of Hip and Knee Surgeons	Beau Kildow, MD
American College of Correctional Physicians	Charles Lee, MD
American Dermatological Association	Murad Alam, MD
American Epilepsy Society	David M. Labiner, MD
American Foregut Society	Jonathan A. Levy, MD
American Society of Nephrology	Jeffrey S. Berns, MD
American Society of Neuroimaging	Ryan Hakimi, MD
American Urogynecologic Society	Jennifer Wu, MD
Association of Professors of Dermatology	Christopher R. Shea, MD
International Academy of Independent Medical Evaluators	Gary Pushkin, MD
Korean American Medical Association	Jennifer Inhae Lee, MD
Society for Maternal-Fetal Medicine	Andrea L. (Fick) Greiner, MD
United States and Canadian Academy of Pathology	Nicole Riddle, MD
Urgent Care College of Physicians	Lindsey Fish, MD

MEMBERS OF THE HOUSE OF DELEGATES - JUNE 2025
The following is a list of credentialed delegates and alternate delegates to the House of Delegates as reported to the Executive Vice President

Medical Association of the State of Alabama
Delegates
B Jerry Harrison, MD, Haleyville, AL
John Meigs Jr, MD, Brent, AL
William Schneider, MD, Huntsville, AL
George C. Smith, Jr MD, Lineville, AL
Alternate Delegates
Mark H. LeQuire, MD, Montgomery, AL
Alexis Mason, MD, Tuscaloosa, AL
Jane Weida, MD, Tuscaloosa, AL
Tom Weida, MD, Tuscaloosa, AL

Alaska State Medical Association
Delegate
Alex Malter, MD MPH, Juneau, AK
Alternate Delegate
Rhene Merkouris, MD, Anchorage, AK

Arizona Medical Association
Delegates
Veronica K. Dowling, MD, Lakeside, AZ
Timothy Fagan, MD, Tucson, AZ
Gary R. Figge, MD, Tucson, AZ
M Zuhdi Jasser, MD, Phoenix, AZ
Marc Leib, MD, Phoenix, AZ
Alternate Delegates
Ilana Addis, MD, Tucson, AZ
David Baltazer, DO, Scottsdale, AZ
Stewart Goldman, MD, Phoenix, AZ
Nadeem Kazi, MD, Casa Grande, AZ

Arkansas Medical Society
Delegates
Amy Cahill, MD, White Hall, AR
Stephen Magie, MD, Conway, AR
Alternate Delegates
Danny Wilkerson, MD, Little Rock, AR
Alan Wilson, MD, Monticello, AR

California Medical Association
Delegates
Jerry P Abraham, MD MPH, Los Angeles, CA
Barbara J. Arnold, MD, Sacramento, CA
Patricia L. Austin, MD, Alamo, CA
Dirk Stephen Baumann, MD, Burlingame, CA
Peter N. Bretan, Jr MD, Novato, CA
J Brennan Cassidy, MD, Newport Beach, CA
Maisha Draves, MD, Fairfield, CA
Suparna Dutta, MD, Oakland, CA
Kyle P. Edmonds, MD, San Diego, CA
Sergio Flores, MD, San Diego, CA
George Fouras, MD, Los Angeles, CA
Anjalee Galion, MD, Santa Ana, CA
Dev A. GnanaDev, MD, Upland, CA
Brian Grady, MD, San Francisco, CA
Donaldo Hernandez, MD, Seaside, CA
Robert Hertzka, MD, Rancho Santa Fe, CA
Jennifer Hone, MD, Santa Barbara, CA
Samuel Huang, MD, Los Angeles, CA
Jeff Klingman, MD, Orinda, CA
Raymond Ko, Walnut Creek, CA
Terence Lin, MD, Fremont, CA
John Maa, MD, San Francisco, CA
Ramin Manshadi, MD, Stockton, CA
Theodore Mazer, MD, Fort Myers, FL
Kelly McCue, MD, Davis, CA
Mihir Parikh, MD, La Jolla, CA
Stephen Parodi, MD, Oakland, CA
Albert Ray, MD, San Diego, CA
Daniel Resnick, Pomona, OR
Ryan J. Ribeira, MD, Mountain View, CA
Katrina Saba, MD, Oakland, CA
Illan Shapiro-Strygler, MD, Commerce, CA
Seema Sidhu, MD, Fremont, CA
Tatiana W. Spirtos, MD, Redwood City, CA
James J. Strebig, MD, Irvine, CA
Shannon Udovic-Constant, MD, San Francisco, CA
Holly Yang, MD, San Diego, CA
Alternate Delegates
Ameena Ahmed, MD, Oakland, CA
Alpesh Amin, MD, Anaheim, CA
Jack Chou, MD, Baldwin Park, CA
Duc Chung, MD, Los Angeles, CA
James Cotter, MD, Napa, CA
Michele Evans, MD, Rocklin, CA
David Friscia, MD, San Diego, CA
Liliane Gibbs, MD, Anaheim, CA
Douglas Gibson, MD, Folsom, CA
Raminder Gill, MD, Sacramento, CA
Catherine Gutfreund, MD, Santa Rosa, CA
Eric Hansen, DO, Oak Hills, CA
Janet Jacobson, MD, Anaheim, CA
Scott Richard Karlan, MD, West Hollywood, CA
Mark H. Kogan, MD, San Pablo, CA
Sudeep Kukreja, MD, Orange, CA
Mehzabin Lala, Pomona, CA
Man Kit Leung, MD, San Francisco, CA
Stacey Ludwig, MD, Los Angeles, CA
Debbie Lupeika, MD, Redding, CA
Lindsay Mazotti, MD, Danville, CA
Linda Mirdamadi, MD, Los Angeles, CA
Chang Na, MD, Bakersfield, CA
Smita Rouillard, MD, Fresno, CA
Sion Roy, MD, Malibu, CA
Shivani Ruben, MD, Sacramento, CA
Samuel Santoro, DO, Vacaville, CA
Shireen Saxena, MD, Los Angeles, CA
Ryan Shanahan, MD, Ventura, CA
Raymond Tsai, MD, Lost Hills, CA
William Tseng, MD, San Diego, CA

Valencia Walker, MD, Los Angeles, CA
Christina Wang, MD, San Francisco, CA
Patricia Wang, MD, Antioch, CA
Barbara Weissman, MD, Pacifica, CA
Anna Yap, MD, Carmichael, CA

Colorado Medical Society
Delegates
David Downs, MD, Denver, CO
Jan Kief, MD, Merritt Island, FL
Rachelle M. Klammer, MD, Denver, CO
A. "Lee" Morgan, MD, Denver, CO
Tamaan Osbourne-Roberts, MD FAAFP, Denver, CO
Lynn Parry, MD, Littleton, CO
Alternate Delegates
Amy Duckro, DO, Lafayette, CO
Carolynn Francavilla, MD, Lakewood, CO
Brigitta J. Robinson, MD, Centennial, CO
Michael Volz, MD, Englewood, CO
Kimberly Warner, MD, Denver, CO
Patricia Weber, MD, Grand Jct, CO

Connecticut State Medical Society
Delegates
Katherine L. Harvey, MD, Canton, CT
Kathleen A. LaVorgna, MD, Norwalk, CT
Bollepalli Subbarao, MD, Middletown, CT
Steven C. Thornquist, MD, Bethany, CT
Alternate Delegates
M. Natalie Achong, MD, Unionville, CT
Raymond Lorenzoni, MD, Woodbridge, CT
Stacy Taylor, MD, New Hartford, CT
Michael Virata, MD, Woodbridge, CT

Medical Society of Delaware
Delegate
Janice Tildon-Burton, MD, Newark, DE
Alternate Delegate
Matthew Burday, DO, Wilmington, DE

Medical Society of the District of Columbia
Delegates
Peter E. Lavine, MD, Washington, DC
Raymond K. Tu, MD, Washington, DC
Alternate Delegates
Neal D Barnard, MD, Washington, DC
Susanne Bathgate, MD, Arlington, VA

Florida Medical Association
Delegates
Ankush Bansal, MD, Westlake, FL
Rebekah Bernard, MD, Fort Myers, FL
Charles J. Chase, DO, Winter Park, FL
Andrew Cooke, MD, Mount Dora, FL
Lisa Cosgrove, MD, Jacksonville, FL
Eva Crooke, MD, Tampa, FL
Mark Dobbertien, DO, Orange Park, FL
Michelle Falcone, MD, Miami, FL
Shelley C. Glover, MD, Clermont, FL
Tra'Chella Johnson Foy, MD, Jacksonville, FL
John Montgomery, MD MPH, Fleming Island, FL
Ralph Jacinto Nobo, Jr MD, Bartow, FL
Michael L. Patete, MD, Venice, FL
Sanjay Pattani, MD, Windermere, FL
Alan B. Pillersdorf, MD, Lake Worth, FL
Mark Rubenstein, MD, Jupiter, FL
Michael Andrew Zimmer, MD, St Petersburg, FL
Alternate Delegates
Shawn Baca, MD, Boca Raton, FL
Rose Berkun, MD, Williamsville, NY
Michael Cromer, MD, Tampa, FL
Aaron Elkin, MD, Hollywood, FL
Vania Fernandez, MD, Miami, FL
Ronald Frederic Giffler, MD, Davie, FL
Raphael C. Haciski, MD, Naples, FL
Ryan Hall, MD, Lake Mary, FL
Karen Harris, MD, Gainesville, FL
Marc J. Hirsh, MD, Delray Beach, FL
Rebecca Lynn Johnson, MD, Tampa, FL
Deborah Mulligan, MD, Coral Springs, FL
Vicki Norton, MD, Boca Raton, FL
Arthur E. Palamara, MD, Hollywood, FL
Thomas G. Peters, MD, Jacksonville, FL
Sergio B. Seoane, MD, Lakeland, FL
Natalia Solenkova, MD, Aventura, FL

Medical Association of Georgia
Delegates
John S. Antalis, MD, Dalton, GA
S William Clark III, MD, Waycross, GA
Shamie Das, MD, Atlanta, GA
Billie Luke Jackson, MD, Macon, GA
Zachary Lopater, MD, Macon, GA
Ali R Rahimi, MD MPH FACC, Atlanta, GA
Charles Wilmer, MD, Atlanta, GA
Alternate Delegates
Lethenia Baker, MD, Lagrange, GA
Keisha Callins, MD, Macon, GA
Samuel Church, MD, Hiawassee, GA
Phillip Coule, MD, Augusta, GA
Andrea Juliao, MD, Tucker, GA
Jin Lee, MD, Lawrenceville, GA
Fonda A. Mitchell, MD, Atlanta, GA

Hawaii Medical Association
Delegates
Elizabeth A. Ignacio, MD, Kahului, HI
Jerry Van Meter, MD, Honolulu, HI

Idaho Medical Association
Delegate
A. Patrice Burgess, MD, Boise, ID
Alternate Delegate
Zachary Warnock, MD, Pocatello, ID

Illinois State Medical Society

Delegates

Rodney Alford, MD, Watseka, IL
Howard Axe, MD, Grayslake, IL
Joseph Ballard, MD, Chicago, IL
Christine Bishof, MD, Elmhurst, IL
Howard Chodash, MD, Springfield, IL
Scott A. Cooper, MD, Chicago, IL
Niva Lubin-Johnson, MD, Chicago, IL
James L. Milam, MD, Grayslake, FL
Robert Panton, MD, Elmwood Park, IL
Shastri Swaminathan, MD, Westmont, IL
Piyush Vyas, MD, Lake Forest, IL
Steven D. Williams, MD, Bourbonnais, IL

Alternate Delegates

Aadil Ahmed, MD, Forest Park, IL
Richard C Anderson, MD, Peoria, IL
Thomas M. Anderson, Jr MD, Chicago, IL
Smitha Arekapudi, MD, Chicago, IL
Nancy Church, MD, Chicago, IL
Richard A. Geline, MD, Glenview, IL
Anne Langguth, MD, Hindsdale, IL
Christopher Martinez, Chicago, IL
Martha Menchaca, MD, Brookfield, IL
Vikram B. Patel, MD, South Barrington, IL
Holly Rosencranz, MD, Champaign, IL
Judith G Savage, MD, Tinley Park, IL

Indiana State Medical Association

Delegates

Heidi Dunniway, MD, Evansville, IN
Vidya S. Kora, MD, Michigan City, IN
William Mohr, MD, Kokomo, IN
Rhonda Sharp, MD, Lagrange, IN
Thomas Vidic, MD, Elkhart, IN

Alternate Delegates

Deepak Azad, MD, Floyds Knobs, IN
Roberto Darroca, MD, Muncie, IN
Lisa Hatcher, MD, Columbia City, IN
Tashera Perry, MD, Bloomington, IN

Iowa Medical Society

Delegates

Thomas Evans, MD, Johnston, IA
Douglas Martin, MD, Dakota Dunes, SD
Douglas Peters, MD, W Burlington, IA
Victoria Sharp, MD, Iowa City, IA

Alternate Delegates

Cynthia Hoque, DO, Des Moines, IA
Brian Privett, MD, Cedar Rapids, IA

Kansas Medical Society

Delegates

Gerhard A. Fast, MD, Hesston, KS
Robert Gibbs, MD, Parsons, KS
Arthur D. Snow, Jr MD, Shawnee Mission, KS

Alternate Delegates

Tessa Rohrberg, MD, Andover, KS
Kimberly Swan, MD, Overland Park, KS
Estephan Zayat, MD, Wichita, KS

Kentucky Medical Association

Delegates

David J. Bensema, MD, Lexington, KY
J Gregory Cooper, MD, Cynthiana, KY
Shawn C. Jones, MD, Paducah, KY
John L. Roberts, MD, Louisville, KY
Donald J. Swikert, MD, Edgewood, KY

Alternate Delegates

Evelyn M. Jones, MD, Paducah, KY
Neal J. Moser, MD, Taylor Mill, KY
Nancy Swikert, MD, Union, KY
Monalisa Tailor, MD, Louisville, KY
R. Brent Wright, MD, Glasgow, KY

Louisiana State Medical Society

Delegates

Luis M. Alvarado, MD, Mandeville, LA
Kamel Brakta, MD, Shreveport, LA
George Ellis, MD, New Orleans, LA
Deborah Fletcher, MD, Shreveport, LA
William Freeman, MD, Prairieville, LA
Clayton Runfalo, MD, Prairieville, LA

Alternate Delegates

Donnie Batie, MD, Baton Rouge, LA
Kristin Lynch Grimes, DO, Baton Rouge, LA
Smita Prasad, MD, Springfield, LA

Maine Medical Association

Delegates

Richard A. Evans, MD, Dover Foxcroft, ME
Maroulla S. Gleaton, MD, Augusta, ME

Alternate Delegates

R. Scott Hanson, MD, Lewiston, ME
Dieter Kreckel, MD, Rumford, ME

MedChi: The Maryland State Medical Society

Delegates

Harbhajan Ajrawat, MD, Annapolis, MD
Karen Dionesotes, MD MPH, Baltimore, MD
Loralie Dawn Ma, MD, Fulton, MD
Gary Pushkin, MD, Baltimore, MD
Padmini Ranasinghe, MD, Baltimore, MD
Stephen J. Rockower, MD, Bethesda, MD

Alternate Delegates

Renee Bovelle, MD, Silver Spring, MD
Anuradha Reddy, MD, Ellicott City, MD
Manna Varghese, MD, Gainesville, FL
Bruce Wollman, MD, Potomac, MD
James J. York, MD, Millersville, MD

Massachusetts Medical Society

Delegates

Maryanne C. Bombaugh, MD, Mashpee, MA
Theodore A Calianos II, MD, Mashpee, MA
Alain A. Chaoui, MD, Boxford, MA
Dennis Dimitri, MD, Worcester, MA
Henry Dorkin, MD, Newton, MA
Ronald Dunlap, MD, Weymouth, MA
Christopher Garofalo, MD, N Attleboro, MA
Michael Medlock, MD, Lexington, MA
David A. Rosman, MD MBA, Stoneham, MA
Kenath Shamir, MD, Fall River, MA
Spiro Spanakis, MD, Shrewsbury, MA
Barbara A. Spivak, MD, Watertown, MA
Lynda M. Young, MD, Worcester, MA

Alternate Delegates

Tiffany Bellomo, MD, Boston, MA
Eli Freiman, MD, Watertown, MA
Matthew Gold, MD, Winchester, MA
Afareen Jaleel, Lexington, MA
Olivia Liao, MD, Weston, MA
Mario E. Motta, MD, Salem, MA
Maximilian J. Pany, MD PhD, Brookline, MA

Michigan State Medical Society

Delegates

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Mason Tuttle, Kansas City, MO (Endorsed by Missouri State Medical Association)
Michael C. Shukis, Cincinnati, OH (Endorsed by Ohio State Medical Association)
Jessy Silfer, Cleveland, OH (Endorsed by Ohio State Medical Association)
Denise Ocampo, Hummelstown, PA (Endorsed by Pennsylvania Medical Society)
Kayla Jernigan, Greenville, SC (Endorsed by South Carolina Medical Association)
Paneeta Mohapatra, Memphis, TN (Endorsed by Tennessee Medical Association)
Andrew Ibrahim, Lubbock, TX (Endorsed by Texas Medical Association)
Lyiba Malik, Franklin, WI (Endorsed by Wisconsin Medical Society)

Reference Committee Hearing Room Assignments
Saturday, June 7

15 minutes after HOD second session close	**Room**
Ethics & Bylaws	Regency Ballroom A/B
B Advocacy	Crystal Ballroom A & B
C Medical Education	Regency C/D
D Public Health	Grand Hall G/J
F AMA Governance and Finance	Grand Ballroom
G Medical Practice	Grand Hall K/N

Reference Committee Hearing Room Assignments
Sunday, June 8

8:00am	**Room**
A Medical Service	Regency Ballroom A/B
E Science and Technology	Regency Ballroom C/D

AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES

2025 Annual Meeting
Notes on Orders of Business
Grand Ballroom, Hyatt Regency Chicago

FIRST SESSION, Friday, June 6, 6:00 – 8:00 pm

SECOND SESSION, Saturday, June 7, 12:30 – 1:00 pm

THIRD SESSION, Monday, June 9, 10:00 am

FOURTH SESSION, Tuesday, June 10, 9 am (or 10 minutes after Election Session) – 3:00 pm

Note: The Inauguration of Bobby Mukkamala, MD, as the 180th President of the American Medical Association, will be held at 5:00 pm in the Crystal Ballroom of the Hyatt Regency Chicago.

FIFTH SESSION, Wednesday, June 11, 8:30 am – completion of business

Summary of Fiscal Notes (A-25)

Report(s) of the Board of Trustees

01	Annual Report	Minimal
02	New Specialty Organizations Representation in the House of Delegates	Minimal
03	2024 Grants and Donations	Info. Report
04	AMA 2026 Dues	None
05	Update on Corporate Relationships	Info. Report
06	Transparency and Accountability of Hospitals and Hospital Systems	Minimal
07	AMA Performance, Activities and Status in 2024	Info. Report
08	Annual Update on Activities and Progress in Tobacco Control: March 2024 through February 2025	Info. Report
09	Council on Legislation Sunset Review of 2015 House Policies	
10	American Medical Association Health Equity Annual Report	Info. Report
11	AMA Efforts on Medicare Payment Reform	Info. Report
12	Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted	Info. Report
13	The Uniform Health-Care Decisions Act	Minimal
14	A Public Health-Centered Criminal Justice System	Minimal
15	Physician Assistants and Nurse Practitioner Movement Between Specialties	Info. Report
16	Research Correcting Political Misinformation and Disinformation on Scope of Practice	Minimal
17	Antidiscrimination Protections for LGBTQ+ Youth in Foster Care	TBD
18	Physician Assisted Suicide	Minimal
19	Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout	Modest
20	Guardianship and Conservatorship Reform	Minimal
21	Advocacy for More Stringent Regulations / Restrictions on Distribution of Cannabis	Minimal
22	Ranked Choice Voting	Minimal
23	Financial Assistance to Facilitate Attendance at MSS Meetings	Modest
24	Creation of an AMA Council with a Focus on Digital Health Technologies and AI	$330,000
25	AMA Public Health Strategy Update	Info. Report
26	Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout	Minimal
27	AMA Reimbursement of Necessary HOD Business Expenses for Delegates and Alternates	Info. Report

Summary of Fiscal Notes (A-25)

Report(s) of the Council on Constitution and Bylaws and

01	Bylaws Review Report	
02	Concurrent Service on Councils and Section Governing Councils	
03	Clarifying Bylaw Language	

Report(s) of the Council on Constitution and Bylaws and the Council on Long Range Planning and Development

01	Joint Council Sunset Review of 2015 House Policies	

Report(s) of the Council on Ethical and Judicial Affairs

01	The AMA Code of Medical Ethics Evolving to Provide Health Care Systems Ethics Guidance	Minimal
02	Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	Minimal
03	Reconsidering Terminology to Describe Physician Assisted Suicide	Minimal
04	Reconsideration of Physician Assisted Suicide	Minimal
05	Protecting Physicians Who Engage in Contracts to Deliver Health Care Services	Minimal
06	Amendment to Opinion 1.1.1 “Patient-Physician Relationships”	Minimal
07	Guidelines on Chaperones for Sensitive Exams	Minimal
08	Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blinded Model for Organ Procurement and Transplantation	Minimal
09	Ethical Impetus for Research in Pregnant and Lactating Individuals	Minimal
10	The Preservation of the Primary Care Relationship	Minimal
11	CEJA Sunset Review of 2015 House Policies	Minimal
12	Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report	
13	Presumed Consent & Mandated Choice for Organs from Deceased Donors	Minimal

Opinion(s) of the Council on Ethical and Judicial Affairs

01	Palliative Care	

Summary of Fiscal Notes (A-25)

Report(s) of the Council on Long Range Planning and Development

01	International Medical Graduates Section Five-Year Review	Minimal
02	Organized Medical Staff Section Five-Year Review	Minimal
03	Demographic Characteristics of the House of Delegates and AMA Leadership	

Report(s) of the Council on Medical Education

01	Council on Medical Education Sunset Review of 2015 House of Delegates' Policies	Modest
02	International Applicants to U.S. Medical Schools	Modest
03	Unmatched Graduating Physicians	Modest
04	Access to Restricted Health Services When Completing Physician Certification Exams	Modest
05	Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine (Res. 309-A-24)	Modest
06	Reporting of Total Attempts of USMLE Step 1 and COMLEX-USA Level 1 Examinations	Modest
07	Designation of Descendants of Enslaved Africans in America	Modest
08	Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes	Modest

Report(s) of the Council on Medical Service

01	Council on Medical Service Sunset Review of 2015 House Policies	
02	Reconsidering the Affordable Care Act (ACA) Eligibility Firewall	Minimal
03	Regulation of Corporate Investment in the Health Care Sector	Minimal
04	Requiring Payment for Physician Signatures	Minimal
05	Medicaid Estate Recovery Reform	Minimal
06	Prescription Medication Price Negotiation	Minimal
07	Impact of Patient Non-adherence on Quality Scores	Minimal
08	Prescription Drug Affordability Boards	
09	Minimum Requirements for Medication Formularies	Minimal

Report(s) of the Council on Science and Public Health

01	Council on Science and Public Health Sunset Review of 2015 House Policies	Modest
02	Addressing Social Determinants of Health Through Closed Loop Referral Systems	Modest
03	Protections Against Surgical Smoke Exposure	Minimal
04	Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals	Minimal

Summary of Fiscal Notes (A-25)

05	Screening for Image Manipulation in Research Publications	Minimal
06	Fragrance Regulation (Resolution 501-A-24)	Minimal
07	Addressing the Health Issues Unique to Minority Communities in Rural Areas	Minimal
08	Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms	
09	Rare Disease Advisory Councils	

Report(s) of the HOD Committee on Compensation of the Officers

01	Report of the House of Delegates Committee on Compensation of the Officers	

Resolutions

001	Opposition to Censuring Medical Societies or Organizations Based on Politics or Policies of Governments	Modest
002	Physician Disclosures of Relationships in Private Equity Held Organizations	Minimal
003	Opposition to Censorship in Public Libraries	Minimal
004	Reducing the Harmful Impacts of Immigration Status on Health	Minimal
005	Dedicated Interfaith Prayer and Reflection Spaces in Medical Schools and Healthcare Facilities	Moderate
006	Military Deception as a Threat to Physician Ethics	Minimal
007	Use of Inclusive Language in AMA Policy	Modest
008	Humanism in Anatomical Medical Education	Minimal
009	Patient centered health care as a Determinant of Health	Minimal
010	Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure	Modest
011	Opposition of Health Care Entities from Reporting Individual Patient Immigration Status	Minimal
012	Carceral Systems and Practices in Behavioral Health Emergency Care	Moderate
013	Continued Support of World Health Organization (WHO) & United States Agency for International Development (USAID)	Modest
101	Uniform Adoption of Service Intensity Tools to Support Medical Decision-making and Service Gap Analysis	Modest
102	Access to Single Maintenance and Reliever Therapy for Asthma	Modest
103	Inadequate Reimbursement for Biosimilars	Modest
104	Study of Whether the HSA Model Could Become an Option for Medicaid Beneficiaries	Modest
105	Development of an Educational Resource on Opting Out of Medicare for Physicians	Moderate

Summary of Fiscal Notes (A-25)

106	Advocating for All Payer Coverage for Custom Breast Prostheses for Patients with History of Mastectomy Secondary to Breast Cancer Treatment	Modest
107	Advocating for All Payer Coverage of Reconstructive and Cosmetic Surgical Care Related to Cleft Lip and Palate	Modest
108	Firearm Storage Diagnosis and Counseling Reimbursement	Modest
109	Medicare Advantage Plans Double Standard	Modest
110	Study of the Federal Employee Health Benefit Plan (FEHBP)	Modest
111	New Reimbursement System Needed for Rural Hospital Survival	Modest
112	Continuation of Affordable Connectivity Program	Modest
113	Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts	Modest
114	An Assessment of Physician Support for Value-Based Payment Models and its Impact on Healthcare to Inform AMA Advocacy Efforts—A Survey	$594,118 contract to survey physicians
115	Supporting Legislative Efforts to Remove Certain High-Cost Supplies and Equipment from the Medicare Physician Fee Schedule	Minimal
116	Medicare Coverage of Registered Dietitian (RD) and Certified Nutrition Support Specialist (CNSS) Visits Beyond Type 2 Diabetes and Renal Disease	Modest
117	Liberalized Remorse Period for Medicare Advantage Plan Insureds	Moderate
118	Improving Access to Peripartum Pelvic Floor Physical Therapy	Modest
119	Cancer Survivorship Program Coverage	Modest
120	Medigap, Pre-Existing Conditions, and Medicare Coverage Education	Moderate
201	Inclusion of DICOM Imaging in Federal Interoperability Standards	Modest
202	Preservation of the CDC Epilepsy Program Workforce and Infrastructure	Modest
203	Supporting SUPPORT Act modifications to enhance care of patients with chronic pain	Modest
204	Protecting the Prescriptive Authority of Plenary Licensed Physicians	Moderate
205	AMA Support for Continuance of the Section 1115 - Social Security Act, Medicaid Waiver Program	Modest
206	AMA Support for Renewal of Section 1115 - Social Security Act, Medicaid Waiver Demonstration Projects Supporting Food and Nutrition Services	Modest
207	Abolishing Venue Shopping	Moderate
208	Binding Arbitration in Health Insurance Contracts	Modest
209	Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Addiction Medications for Legitimate Medical Purposes	Minimal
210	Impact of Tariffs on Healthcare Access and Costs	Moderate
211	Support for State Provider and Managed Care Organization Taxes to Sustain Federal Medicaid Matching Funding	Moderate

Summary of Fiscal Notes (A-25)

212	Setting Standards for Forensic Toxicology Laboratories Used in Litigation	Modest
213	Emergency Department Designation Requires Physician on Site	Modest
214	United Health Care and InterQual Monopoly	Modest
215	Support for Changing Standards for Minors Working in Agriculture	Minimal
216	Support for Aging-Out Foster Youth with Mental Health and Psychotropic Needs	Minimal
217	Regulation and Oversight of the Troubled Teen Industry	Minimal
218	Distribution of Resident Slots Commensurate with Shortages	Minimal
219	Opposing Unwarranted National Institutes of Health Research Institute Restructuring	Minimal
220	Strengthening AMA Policy on Noncompete Clauses in Ownership Transitions	Modest
221	Preservation of Medicaid	Moderate
222	Need for Separate H1B Pathway for IMG Doctors in the USA	Modest
223	Preservation of Medicaid	Moderate
224	Support SAVE Plan and Public Service Loan Forgiveness (PLSF) Applications	Modest
225	The Private Practice Physicians in the Community	Moderate
226	Regulations for Algorithmic-Based Health Insurance Utilization Review	Modest
227	Payment Recoupment—Let Sanity Prevail	Modest
228	CHIP Coverage of OTC Medications	Moderate
229	Guaranteeing Timely Delivery and Accessibility of Federal Health Data	Modest
230	Advocating to expand private insurance coverage of anti-obesity medications (AOM)	Minimal
231	Preventing Venue Shopping in Medical Liability to Protect Physician Practices and Access to Care	Moderate
232	Preservation of Medicaid	Moderate
233	Increasing Transparency of AMA Medicare Payment Reform Strategy	$108,308 hire consultants to conduct research and prepare reports
234	Protection for International Medical Graduates	Moderate
235	CMS Payment Monitoring Following Government Staff Reductions	Moderate
301	Examining ABMS Processes for New Boards	Minimal
302	AMA Study of Lifestyle Medicine and Culinary Electives to Reduce Burnout and Bolster Career Satisfaction in Trainees	Minimal
303	Support for the Establishment of an Indigenous-Led Medical School in the United States	Moderate
304	Addressing Professionalism Standards in Medical Training	Minimal

Summary of Fiscal Notes (A-25)

305	Curricular Structure Reform to Support Physician and Trainee Well-Being	Minimal
306	Innovation and Reform of Medical Education	Minimal
307	Disclosure of Individual Physician Volunteers Participation in Committee Decision-making to other Organizations, Stakeholders and Joint Providers	Minimal
308	Streamlining Annual Compliance Training Requirements for Physicians	Modest
309	Increasing Education on Physician-Led Care and Advocacy in Residency Training	Moderate
310	Protections for Trainees Experiencing Retaliation in Medical Education	Minimal
311	Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter	Minimal
312	Selection of IMG Residents Based on Merit	Modest
401	Reducing Pickleball-Related Ocular Injuries	Minimal
402	Protecting In-Person Prison Visitations to Reduce Recidivism	Minimal
403	Promoting Evidence-Based Responses to Measles and Misuse of Vitamin A	$102,954 contract to develop educational content
404	Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers	$43,166 initiate a public health campaign
405	Health Warning Labels on Alcoholic Beverage Containers	Minimal
406	Call for Study: Should Petroleum-Powered Emergency Medical Services (EMS) Vehicles in Urban Service Areas be Replaced by Renewably-Powered Electric Vehicles?	Modest
407	Sleep Deprivation as a Public Health Crisis	Modest
408	Removing Artificial Turf in Schools, Parks, and Public Places	Minimal
409	Guidelines for Restricting Cell Phones in K-12 Schools	Minimal
410	Hate Speech is a Public Health Concern	Minimal
411	Protecting Access to mRNA Vaccines	Moderate
412	Supporting inclusive long-term care facilities	Minimal
413	Preservation of Public Funding for Physicians and Hospitals Providing LGBTQ+ Care	Minimal
414	Expanding Sexually Transmitted Infection Care for Persons with Unstable or No Housing	Minimal
415	Promoting Child Welfare and Communication Rights in Immigration Detention	Modest
416	Culturally and Religiously Inclusive Food Options	Minimal
417	Updating Alcohol Health Warning Labels to Reflect Evidence-Based Health Risks and Supporting National Labeling and Signage Policy Reform	Minimal
418	AMA Study on Plastic Pollution Reduction	Modest

Summary of Fiscal Notes (A-25)

419	Advocating for Universal Summer Electronic Benefit Transfer Program for Children (SEBTC)	Modest
420	Study of Plant-Based & Lab-Grown Meat	Modest
421	Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities	Modest
422	Protecting the Integrity of the U.S. Healthcare System from Misinformation and Policy	$102,954 contract to develop educational content
423	Requiring Universal Vaccine reporting to a National Immunization Registry and Access to a National Immunization Information System	Modest
424	Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records	Minimal
425	Alcohol Consumption and Health	Minimal
426	Addressing Patient Safety and Environmental Stewardship of Single-Use and Reusable Medical Devices	Modest
427	Elevate Obesity as a Strategic Objective	$293,127 adopt strategic objective
428	Public Health Implications of US Food Subsidies	Modest
429	Addressing the Health Consequences of Microplastics in Humans	Modest
430	Addressing the Health Impacts of Ultraprocessed Foods	Modest
431	Alcohol & Breast Cancer Risk	$70,454 contract to develop educational content
432	Support for Long-Term Sequelae of Pregnancy	Moderate
433	Clinical Lactation Care	Minimal
434	Breast Cancer Risk Reduction	Minimal
501	Safer Button / Coin Batteries	Modest
502	NIH Grant Funding for Medical Research	Moderate
503	Safeguarding Neural Data Collected by Neurotechnologies	Minimal
504	Physician Performed Microscopy Designation for Synovial Fluid Crystal Exam: Modify the Clinical Laboratory Amendment of 1988	Minimal
505	Mandating Properly Fitting Lead Aprons in Hospitals	Moderate
506	Opposing the use of harm reduction items as evidence of commercial sex work	Minimal
507	Clinical and Public Safety Implications of AI-Generated Content and Symbolic Compliance Infrastructure	Modest
508	Standardizing Safety Requirements for Traditional and Rideshare-Based Non-Emergency Medical Transportation	Modest
509	Allergen Labeling for Spices and Herbs	Minimal
510	Improving Cybersecurity Standards for Healthcare Entities	Minimal

Summary of Fiscal Notes (A-25)

511	Increased Transparency Among Psychotropic Drug Administration in Prisons	Modest
512	Preventing Drug-Facilitated Sexual Assault in Drinking Establishments	Minimal
513	Transparency on Comparative Effectiveness in Direct-to-Consumer Advertising	Minimal
514	Support for a Nicotine Free Generation	Resolve 1 - Modest Resolve 2 - Minimal
515	Nitrous Oxide Abuse	Minimal
516	Creating a Registry of Potential Side Effects of GIP & GLP-1 Medications	Minimal
517	In Support of a National Drug Checking Registry	Modest
518	Mandatory Accreditation and Regular Inspections of Hyperbaric Chambers	Modest
519	Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making	Modest
520	Study of Grading Systems in AMA Board Reports	Modest
521	Warning labels on OTC sleep aids	Modest
522	Access to Important and Essential Drugs	Moderate
601	AMA To Develop Patient Educational Materials Regarding Ultra-processed Foods for Distribution by AMA members	$65,179 annually to develop educational materials
602	Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations	Minimal
603	Renaming the Minority Affairs Section to the Underrepresented in Medicine Advocacy Section	Minimal
604	Advisory Committee on Tribal Affairs	$74,321 annually for advisory committee
701	Electronic Health Records Contract Termination	Modest
702	Strengthening Health Plan Accountability for Physician Satisfaction	Minimal
703	Appropriate Use of Data from Surgical Practices	Minimal
704	Mitigating the Impact of Excessive Prior Authorization Processes	$545,376 database research and legal analysis
705	Elimination of Transaction Fees for Electronic Healthcare Payments	Minimal
706	Increasing Transparency Surrounding Medicare Advantage Plans	Minimal
707	Simplifying Correspondence from Health Insurers	Modest
708	Advocating Against Prior Authorization for In-Person Visits with Physicians	Modest
709	Allowing Timely Access to Pain Medications in Discharged Hospital and Ambulatory Surgery Patients	Modest
710	Requiring Insurances to apply discounted cost medication to the patient’s deductible	Modest

Summary of Fiscal Notes (A-25)

711	Study of Practice Models for Physicians Working Across State Lines	Moderate
712	Billings and Collections Transparency	Resolve 1 - Modest Resolve 2 - Moderate
713	Aiding Members of Medical Staffs	Moderate
714	Root Cause Analysis of the Causes of the Decline of Private Medical Practice	Moderate
715	Grace Period for Timely Filing Due to Technology Failures Regardless of Cause	Modest
716	Minimum Payer Communication Quality Standards	Modest
717	Promoting Medication Continuity and Reducing Prior Authorization Burdens	Modest

RESOLUTIONS – BY SPONSOR (A-25)

SPONSOR	Reso #	TITLE
Academic Physicians Section	406	Call for Study: Should Petroleum-Powered Emergency Medical Services (EMS) Vehicles in Urban Service Areas be Replaced by Renewably-Powered Electric Vehicles?
American Academy of Child and Adolescent Psychiatry	101	Uniform Adoption of Service Intensity Tools to Support Medical Decision-making and Service Gap Analysis
American Academy of Ophthalmology	204	Protecting the Prescriptive Authority of Plenary Licensed Physicians
American Academy of Ophthalmology	401	Reducing Pickleball-Related Ocular Injuries
American Academy of Otolaryngology	501	Safer Button / Coin Batteries
American Association of Clinical Urologists	701	Electronic Health Records Contract Termination
American Association of Gynecologic Laparoscopists	703	Appropriate Use of Data from Surgical Practices
American Association of Neurological Surgeons	201	Inclusion of DICOM Imaging in Federal Interoperability Standards
American Association of Neurological Surgeons	202	Preservation of the CDC Epilepsy Program Workforce and Infrastructure
American Association of Neurological Surgeons	203	Supporting SUPPORT Act modifications to enhance care of patients with chronic pain
American Association of Public Health Physicians	006	Military Deception as a Threat to Physician Ethics
American Association of Public Health Physicians	402	Protecting In-Person Prison Visitations to Reduce Recidivism
American Association of Public Health Physicians	403	Promoting Evidence-Based Responses to Measles and Misuse of Vitamin A
American College of Cardiology	301	Examining ABMS Processes for New Boards
American College of Cardiology	404	Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers
American College of Chest Physicians	102	Access to Single Maintenance and Reliever Therapy for Asthma
American College of Lifestyle Medicine	205	AMA Support for Continuance of the Section 1115 - Social Security Act, Medicaid Waiver Program
American College of Lifestyle Medicine	206	AMA Support for Renewal of Section 1115 - Social Security Act, Medicaid Waiver Demonstration Projects Supporting Food and Nutrition Services
American College of Lifestyle Medicine	302	AMA Study of Lifestyle Medicine and Culinary Electives to Reduce Burnout and Bolster Career Satisfaction in Trainees
American College of Lifestyle Medicine	601	AMA To Develop Patient Educational Materials Regarding Ultra-processed Foods for Distribution by AMA members
American College of Preventive Medicine	405	Health Warning Labels on Alcoholic Beverage Containers
American College of Rheumatology	502	NIH Grant Funding for Medical Research
American College of Surgeons	207	Abolishing Venue Shopping
American Psychiatric Association	208	Binding Arbitration in Health Insurance Contracts
American Society for Gastrointestinal Endoscopy	103	Inadequate Reimbursement for Biosimilars
American Society for Gastrointestinal Endoscopy	210	Impact of Tariffs on Healthcare Access and Costs

SPONSOR	Reso #	TITLE
American Society of Addiction Medicine	209	Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Addiction Medications for Legitimate Medical Purposes
American Thoracic Society	407	Sleep Deprivation as a Public Health Crisis
American Thoracic Society	602	Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations
Association for Clinical Oncology	120	Medigap, Pre-Existing Conditions, and Medicare Coverage Education
Association for Clinical Oncology	235	CMS Payment Monitoring Following Government Staff Reductions
Association for Clinical Oncology	522	Access to Important and Essential Drugs
California	211	Support for State Provider and Managed Care Organization Taxes to Sustain Federal Medicaid Matching Funding
California	408	Removing Artificial Turf in Schools, Parks, and Public Places
California	409	Guidelines for Restricting Cell Phones in K-12 Schools
California	410	Hate Speech is a Public Health Concern
Colorado	411	Protecting Access to mRNA Vaccines
Colorado	503	Safeguarding Neural Data Collected by Neurotechnologies
Daniel H. Johnson, Jr, MD	104	Study of Whether the HSA Model Could Become an Option for Medicaid Beneficiaries
Florida	105	Development of an Educational Resource on Opting Out of Medicare for Physicians
Florida	704	Mitigating the Impact of Excessive Prior Authorization Processes
Georgia	504	Physician Performed Microscopy Designation for Synovial Fluid Crystal Exam: Modify the Clinical Laboratory Amendment of 1988
Georgia	705	Elimination of Transaction Fees for Electronic Healthcare Payments
Illinois	001	Opposition to Censuring Medical Societies or Organizations Based on Politics or Policies of Governments
Illinois	106	Advocating for All Payer Coverage for Custom Breast Prostheses for Patients with History of Mastectomy Secondary to Breast Cancer Treatment
Illinois	107	Advocating for All Payer Coverage of Reconstructive and Cosmetic Surgical Care Related to Cleft Lip and Palate
Illinois	212	Setting Standards for Forensic Toxicology Laboratories Used in Litigation
Illinois	706	Increasing Transparency Surrounding Medicare Advantage Plans
Indiana	002	Physician Disclosures of Relationships in Private Equity Held Organizations
Indiana	108	Firearm Storage Diagnosis and Counseling Reimbursement
Indiana	109	Medicare Advantage Plans Double Standard
Indiana	213	Emergency Department Designation Requires Physician on Site
Indiana	214	United Health Care and InterQual Monopoly
Indiana	505	Mandating Properly Fitting Lead Aprons in Hospitals

International Medical Graduates Section	234	Protection for International Medical Graduates
International Medical Graduates Section	312	Selection of IMG Residents Based on Merit
LGBTQ+ Section	003	Opposition to Censorship in Public Libraries
LGBTQ+ Section	412	Supporting inclusive long-term care facilities
LGBTQ+ Section	413	Preservation of Public Funding for Physicians and Hospitals Providing LGBTQ+ Care
LGBTQ+ Section	414	Expanding Sexually Transmitted Infection Care for Persons with Unstable or No Housing
LGBTQ+ Section	506	Opposing the use of harm reduction items as evidence of commercial sex work
Louisiana	110	Study of the Federal Employee Health Benefit Plan (FEHBP)
Medical Society of the District of Columbia	434	Breast Cancer Risk Reduction
Medical Student Section	007	Use of Inclusive Language in AMA Policy
Medical Student Section	008	Humanism in Anatomical Medical Education
Medical Student Section	216	Support for Aging-Out Foster Youth with Mental Health and Psychotropic Needs
Medical Student Section	217	Regulation and Oversight of the Troubled Teen Industry
Medical Student Section	218	Distribution of Resident Slots Commensurate with Shortages
Medical Student Section	219	Opposing Unwarranted National Institutes of Health Research Institute Restructuring
Medical Student Section	304	Addressing Professionalism Standards in Medical Training
Medical Student Section	305	Curricular Structure Reform to Support Physician and Trainee Well-Being
Medical Student Section	306	Innovation and Reform of Medical Education
Medical Student Section	418	AMA Study on Plastic Pollution Reduction
Medical Student Section	419	Advocating for Universal Summer Electronic Benefit Transfer Program for Children (SEBTC)
Medical Student Section	420	Study of Plant-Based & Lab-Grown Meat
Medical Student Section	508	Standardizing Safety Requirements for Traditional and Rideshare-Based Non-Emergency Medical Transportation
Medical Student Section	509	Allergen Labeling for Spices and Herbs
Medical Student Section	510	Improving Cybersecurity Standards for Healthcare Entities
Medical Student Section	511	Increased Transparency Among Psychotropic Drug Administration in Prisons
Medical Student Section	512	Preventing Drug-Facilitated Sexual Assault in Drinking Establishments
Medical Student Section	513	Transparency on Comparative Effectiveness in Direct-to-Consumer Advertising
Medical Student Section	604	Advisory Committee on Tribal Affairs
Minority Affairs Section	004	Reducing the Harmful Impacts of Immigration Status on Health
Minority Affairs Section	005	Dedicated Interfaith Prayer and Reflection Spaces in Medical Schools and Healthcare Facilities
Minority Affairs Section	215	Support for Changing Standards for Minors Working in Agriculture
Minority Affairs Section	303	Support for the Establishment of an Indigenous-Led Medical School in the United States
Minority Affairs Section	415	Promoting Child Welfare and Communication Rights in Immigration Detention
Minority Affairs Section	416	Culturally and Religiously Inclusive Food Options

Minority Affairs Section	417	Updating Alcohol Health Warning Labels to Reflect Evidence-Based Health Risks and Supporting National Labeling and Signage Policy Reform
Minority Affairs Section	603	Renaming the Minority Affairs Section to the Underrepresented in Medicine Advocacy Section
Mississippi	111	New Reimbursement System Needed for Rural Hospital Survival
Mississippi	117	Liberalized Remorse Period for Medicare Advantage Plan Insureds
Mississippi	507	Clinical and Public Safety Implications of AI-Generated Content and Symbolic Compliance Infrastructure
Mississippi	707	Simplifying Correspondence from Health Insurers
Mississippi	708	Advocating Against Prior Authorization for In-Person Visits with Physicians
New England	009	Patient centered health care as a Determinant of Health
New England	220	Strengthening AMA Policy on Noncompete Clauses in Ownership Transitions
New England	221	Preservation of Medicaid
New England	514	Support for a Nicotine Free Generation
New York	112	Continuation of Affordable Connectivity Program
New York	222	Need for Separate H1B Pathway for IMG Doctors in the USA
New York	223	Preservation of Medicaid
New York	224	Support SAVE Plan and Public Service Loan Forgiveness (PLSF) Applications
New York	225	The Private Practice Physicians in the Community
New York	307	Disclosure of Individual Physician Volunteers Participation in Committee Decision-making to other Organizations, Stakeholders and Joint Providers
New York	421	Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities
New York	422	Protecting the Integrity of the U.S. Healthcare System from Misinformation and Policy
New York	423	Requiring Universal Vaccine reporting to a National Immunization Registry and Access to a National Immunization Information System
New York	515	Nitrous Oxide Abuse
New York	521	Warning labels on OTC sleep aids
New York	709	Allowing Timely Access to Pain Medications in Discharged Hospital and Ambulatory Surgery Patients
New York	710	Requiring Insurances to apply discounted cost medication to the patient’s deductible
Obesity Medicine Association	427	Elevate Obesity as a Strategic Objective
Ohio	113	Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts
Ohio	308	Streamlining Annual Compliance Training Requirements for Physicians
Ohio	424	Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 02-A-25

Subject: New Specialty Organizations Representation in the House of Delegates

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee on Ethics and Bylaws

The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the applications of the American Academy of Emergency Medicine and American Society for Laser Medicine and Surgery, Inc. for national medical specialty organization representation in the American Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by the AMA SSS Rules Committee and presented to the SSS Assembly for consideration. The applications were considered using criteria developed by the Council on Long Range Planning and Development and adopted by the HOD (Policy G-600.020). (Exhibit A)

Organizations seeking admission were asked to provide appropriate membership information to the AMA. That information was analyzed to determine AMA membership, as required under criterion three. A summary of this information is attached to this report as Exhibit B.

In addition, organizations must submit a letter of application in a designated format. This format lists the above-mentioned guidelines followed by each organization's explanation of how it meets each of the criteria.

Before a society is eligible for admission to the HOD, it must participate in the SSS for three years. These organizations have actively participated in the SSS for more than three years.

Review of the materials and discussion during the SSS meeting at the November 2024 Interim Meeting indicated that the American Academy of Emergency Medicine and American Society for Laser Medicine and Surgery, Inc. meet the criteria for representation in the HOD.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the American Academy of Emergency Medicine and American Society for Laser Medicine and Surgery, Inc. be granted representation in the AMA House of Delegates and that the remainder of the report be filed. (Directive to Take Action)

Fiscal Note: Less than $500

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APPENDIX
Exhibit A

GUIDELINES FOR REPRESENTATION IN & ADMISSION TO THE HOUSE OF DELEGATES:

National Medical Specialty Societies

1) The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.

2) The organization must (a) represent a field of medicine that has recognized scientific validity; and (b) not have board certification as its primary focus, and (c) not require membership in the specialty organization as a requisite for board certification.

3) The organization must meet one of the following criteria:

   - 1,000 or more AMA members;
   - At least 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   - Have been represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.

4) The organization must be established and stable; therefore, it must have been in existence for at least 5 years prior to submitting its application.

5) Physicians should comprise the majority of the voting membership of the organization.

6) The organization must have a voluntary membership and must report as members only those who are current in payment of applicable dues are eligible to participate on committees and the governing body.

7) The organization must be active within its field of medicine and hold at least one meeting of its members per year.

8) The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.

9) The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.

10) If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS

1. To cooperate with the AMA in increasing its AMA membership.

2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.

3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.

4. To disseminate to its membership information to the actions taken by the House of Delegates at each meeting.

5. To provide information and data to the AMA when requested.

Exhibit B - Summary Membership Information

Organization	**AMA Membership of Organization's Total Eligible Membership**
American Academy of Emergency Medicine*	1,727 of 6,270 (28%)
American Society for Laser Medicine and Surgery, Inc.	323 of 1,156 (28%)

* *Represented in the House of Delegates at the 1990 Annual Meeting*

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-A-25

Subject: Physician Assisted Suicide

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2023 Interim Meeting, the House of Delegates (HOD) referred Resolution 004, "Study of Physician Assisted Suicide and Medical Aid in Dying," which was introduced by the Medical Student Section. This resolution asked our American Medical Association (AMA) to:

> Oppose criminalization of physicians and health professionals who engage in medical aid in dying at a patient's request and with their informed consent, and oppose civil or criminal legal action against patients who engage or attempt to engage in medical aid in dying
>
> Use the term "medical aid in dying" instead of the term "physician assisted suicide" and accordingly amend HOD policies and directives, excluding Code of Medical Ethics opinions
>
> Rescind our HOD policies on physician assisted suicide, H-270.965 "Physician Assisted Suicide" and H-140.952 "Physician Assisted Suicide," while retaining our Code of Medical Ethics opinion on this issue
>
> Amend H-140.966 "Decisions Near the End of Life" by deletion as follows, while retaining our Code of Medical Ethics opinions on these issues:
>
> > Our AMA believes that:
> >
> > (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.
> >
> > (2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.
> >
> > (3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.
> >
> > ~~(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient~~

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~~autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.~~

(5) Our AMA supports continued research into and education concerning pain management

Study changing our existing position on medical aid in dying, including reviewing government data, health services research, and clinical practices in domestic and international jurisdictions where it is legal

BACKGROUND

Physician assisted suicide occurs when "a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform a life-ending act" [1]. This act is sometimes referred to using other terminology such as medical aid in dying. Currently, there is no federal law governing physician assisted suicide; therefore, individual states are permitted to determine their own legal stance. At this time, 10 states and the District of Columbia permit this practice; however, most states have legislation banning this practice [2]. Furthermore, two states have removed their residency requirement, effectively opening the practice of physician assisted suicide more broadly to patients throughout the US.

Our AMA has a long-standing policy (H-270.965) opposing the legalization of physician assisted suicide. That said, our AMA is also opposed to the criminalization of physician medical judgement and the regulation of medical practice through criminal penalties (H-160.954, D-160.911, D-275.944, H-5.980, D-5.999). Additionally, our AMA has policy preserving a physician's right to exercise their autonomy (H-405.958, *Code of Medical Ethics* Opinion 1.1.7).

DISCUSSION

The referred resolution addresses several issues encompassed within the broad context of physician-assisted suicide: terminology, opposition to the legalization and practice of physician assisted suicide, and opposition to the criminalization of physician participation in assisted suicide. This report addresses these topics in the context of our AMA's current HOD policies and Code of Medical Ethics guidance. In addition, the Council on Ethical and Judicial Affairs has produced two informational reports to further discuss the ethical complexity of these topics as they relate to physician assisted suicide and the practice of medicine.

Terminology

The terminology used in the AMA Code of Medical Ethics and HOD policy to describe this practice offers a clear delineation of intent and action. The use of other terminology to describe this practice has the potential to confuse patients and unduly influence decision making [5]. Descriptors such as Medical Aid in Dying (MAID), physician aid-in-dying, and death with dignity could apply to palliative care practices and compassionate care near the end of life that do not include intending the death of patients. In CEJA Report 2-A-19, "Physician Assisted Suicide," the Council determined that PAS was the terminology which described the practice best. The report supported this supposition with the following analysis which remains valid:

The Council recognizes that choosing one term of art over others can carry multiple, and not always intended messages. However, in the absence of a perfect option, CEJA believes ethical deliberation and debate is best served by using plainly descriptive language. In the Council's view, despite its negative connotations, the term "physician assisted suicide" describes the practice with the greatest precision. Most importantly, it clearly distinguishes the practice from euthanasia. The terms "aid in dying" or "death with dignity" could be used to describe either euthanasia or palliative/hospice care at the end of life and this degree of ambiguity is unacceptable for providing ethical guidance.

Opposition to the legalization and practice of physician assisted suicide

AMA policy opposes the legalization and practice of physician assisted suicide stating that it is "fundamentally incompatible with the physician's role as a healer" [1]. In developing CEJA Report 2 (A-19) which informed our AMA's current ethics standards on physician assisted suicide, the Council on Ethical and Judicial Affairs analysis and deliberations were informed by available data and research. However, its decision was not an empirically dictated one, but rather, it was driven by the core values of medicine preserved within the Code of Medical Ethics.

Although legislative developments since 2019 have occurred, recent empirical data reviewing physician assisted suicide practices in US and international jurisdictions where PAS and/or euthanasia are legal are subject to varied interpretations. As a matter of ethical reasoning, the data does not settle the ethical issue. Additionally, the relevant core ethical values at stake have not changed since the adoption of CEJA Report 2 (A-19). As such, the AMA's position on physician assisted suicide should remain unchanged.

Of note, the AMA's position on physician assisted suicide is not a position of neutrality and establishes that the profession of medicine should not support the legalization or practice of physician assisted suicide or see it as part of a physician's role.

Opposition to the criminalization of physician participation in assisted suicide

While AMA policy opposes the legalization of or participation in physician assisted suicide, this stance must also be balanced with AMA policies opposing criminalization of physician medical judgement within the confines of the law and the use of criminal penalties to regulate medical practice. As a physician's choice to engage in the practice of physician assisted suicide is considered by many to be a medical judgement, failing to oppose criminalization of physicians who engage in physician assisted suicide may be contrary to the AMA's long-standing opposition to interference with physician medical judgement. To wit, the AMA's recognition that physicians may have differing aspects of conscience is upheld in the *Code of Medical Ethics,* which states that "morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician assisted suicide." Additionally, the *Code* Appendix to the opinion on physician assisted suicide notes that the AMA *Code* preserves the opportunity for individual physicians "to act (or refrain from acting) in accordance with the dictates of conscience in their professional practice." [2]. In essence, if after due moral consideration, a physician decides to participate in the practice, they will be judged to have acted conscientiously, consistent with the AMA *Code* [3].

If after due moral consideration, a physician exercises their autonomy, conscience, and medical judgement to participate in physician assisted suicide, our AMA should uphold its long-standing opposition to the criminalization of physician medical judgement and the imposition of criminal penalties on medical practice. Opposing criminalization of physicians who engage in physician

assisted suicide, while simultaneously not supporting the legalization of this practice, will allow our AMA to uphold its existing core values including not supporting the legalization of the practice of physician assisted suicide (H-270.965, *Code of Medical Ethics* Opinion 5.7), opposing criminalization of physician medical judgement and health care decisions (H-160.954, D-160.911, D-275.944, H-5.980, D-5.999, D-160.999), and allowing physicians to uphold their conscience (H-405.958, *Code of Medical Ethics* Opinion 1.1.7).

It is important to distinguish between opposing the legalization of physician assisted suicide and opposing the criminalization of physicians who engage in the practice within the confines of the law in the jurisdiction in which they practice as an exercise of their medical judgement. Opposing legalization refers to our AMA organizational stance against the *practice* of physician assisted suicide, whereas criminalization refers to our AMA organizational stance regarding the *consequences* to physicians for engaging in the practice of physician assisted suicide. Additionally, criminalization is different from a civil penalty in that criminalization has a potential consequence of incarceration, whereas a civil penalty only carries a financial consequence.

Additionally, in keeping with AMA policy of protecting the patient-physician relationship, including protecting patients who engage in shared-medical decision making with their physician and patient exercise of autonomous medical decision making and information consent (H-165.837, *Code* 2.1.1, and 1.1.3), it follows that our AMA should oppose the criminalization of patients engaging or attempting to engage in physician assisted suicide at their request, with their informed consent.

CONCLUSION

While AMA policy opposes legalization of physician assisted suicide, it also upholds the principles that medical judgement should not be subject to criminal penalties and remains committed to protecting the integrity of the patient-physician relationship.

RECOMMENDATIONS

The Board of Trustees recommends adoption of the following in lieu of the Resolution 004-I-23, "Study of Physician Assisted Suicide and Medical Aid in Dying" and the remainder of this report be filed:

Our American Medical Association opposes:

(1) Civil or criminal legal action against physicians and health professionals who legally engage in physician assisted suicide at a patient's request and with their informed consent.

(2) Civil or criminal legal action against patients who engage or attempt to engage in physician assisted suicide.

Fiscal Note: Minimal – Less than $500

REFERENCEES

1. American Medical Association. *Code of Medical Ethics* Opinion 5.7 Physician Assisted Suicide. Physician-Assisted Suicide | AMA-*Code* (ama-assn.org)
2. States Where Medical Aid in Dying is Authorized. Compassion & Choices. Accessed August 21, 2024. https://compassionandchoices.org/resource/states-or-territories-where-medical-aid-in-dying-is-authorized.
3. American Medical Association. *Code of Medical Ethics*. Opinion 1.1.7 Physician Exercise of Conscience. Physician Exercise of Conscience | AMA-*Code* (ama-assn.org).

REPORT OF THE BOARD OF TRUSTEES

B of T Report 26-A-25

Subject:	Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee on Ethics and Bylaws

At the 2024 Annual Meeting, the House of Delegates (HOD) adopted Resolution 001, Resolved 2, "Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout," resulting in policy D-460.962, which directs our AMA to: "develop ethical guidelines on the collection, use, and protection of personal and biological data obtained to improve professional workforce wellbeing." This report is in fulfillment of this second directive from D-460.962.

BACKGROUND

Burnout represents a serious health crisis for physicians and other health care practitioners. Burnout compromises physician well-being and can negatively impact the quality of care that physicians provide to their patients [1]. The COVID-19 pandemic greatly exacerbated rates of burnout, with prevalence among physicians rising from 38.2 percent in 2020 to 62.8 percent in 2021 [2]. Drivers of burnout include increasing administrative burdens, lack of support from physicians' institutions and health care systems, changing political and legal landscapes, and other disruptions to the patient-physician relationship.

Since the height of the pandemic, the rate of burnout has trended downward, reaching below 50% in 2023 for the first time in four years [3]. Contributing to this decline are various health systems' initiatives to promote professional well-being, including hiring more staff, creating opportunities for coaching and leadership development, appointing wellness officers, and attempts to afford physicians greater flexibility and autonomy [4].

Though burnout is widespread throughout the medical profession, it is highly contextual and can manifest in different ways and to different extents depending on the individual and on the practice, institution, or health system in which the physician works. As such, health systems have increasingly turned to data to help guide and tailor their resources and efforts to support physician well-being, including using physician personal health information and biological data to inform interventions to reduce burnout [5]. However, how such physician information is collected and used raises ethical concerns.

The collection and use of physicians' personal health information and/or biological data raises ethical issues related to consent, privacy, confidentiality, and data security. Additionally, the collection and use of such data to help reduce burnout raises questions of accountability regarding who is ultimately responsible for implementing changes to reduce burnout, and risks shifting the focus of burnout reduction interventions from organizational strategies to individual physician behavioral changes, placing the burden of reducing burnout directly on physicians themselves.

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DISCUSSION

There is general agreement within the medical profession that more needs to be done to reduce burnout and improve physician well-being. Because individual personal health information and biological data can provide valuable insights into physical and mental health, the collection and use of such data offer potential avenues to support the well-being of healthcare professionals, including the early identification of burnout and the development of evidence-based prevention strategies. The Internet of Things (IoT), which, in relation to health data, refers to a network of connected medical devices, such as wearable sensors that continuously capture various health metrics, including heart rate, blood pressure, sleep levels, and blood glucose levels, and transmit this information wirelessly in real time to a health care platform, has made it easier than ever to collect and monitor personal health information and has been promoted as a potential tool for combating physician burnout. Many physicians already use such wearable technologies as tools for self-monitoring and behavioral modification to promote well-being. However, while the collection and use of physicians' personal health information may help to identify and reduce burnout, doing so also poses serious concerns regarding efficacy, privacy, ethical data collection, and accountability.

Validity and Relevance of Collected Data

A primary concern raised with respect to relying on personal health information and/or biological data to reduce burnout is whether the observable data can accurately reflect the underlying subjective sense of well-being and mental health associated with burnout [6]. There are numerous factors associated with burnout, and the relationships between these factors are complex; furthermore, failure to accurately model this dynamic will inevitably result in a failure to adequately capture burnout. While substantive research has been done on physician burnout, there is no clear consensus on the definition or on how to assess it [7].

In their critique of the bio-psycho-social model of burnout (a framework that emphasizes the interconnectedness of biology, psychology, and social factors in human health and illness), Listopad et al identify a total of 40 factors related to burnout and conclude that the bio-psycho-social model is insufficient to identify all the factors and explain the pathogenesis of burnout; they propose extending the model to include spiritual and work culture dimensions that also impact burnout [8]. In addition to biological and psychological factors, which might be more readily detected via personal health information, Listopad et al show that socio-environmental factors, spirituality, and work culture also play an important role in the onset of burnout, which poses a problem for any data-based detection of burnout that fails to include these dimensions [8]. As Adler et al explain:

> Unlike illnesses solidly grounded in biological mechanisms, mental health and well-being is so fluid, psychosocial, and personal a construct that its indicators are necessarily up to individual interpretation—to monitor sleep and sociality in a potentially depressed person is not to monitor blood glucose in a person with diabetes. Removing a patient's ability to provide interpretation—their "right to self-presentation"—risks endorsing a fully data-centric perspective on well-being, one that might flatten necessary subjectivity [6].

Questions thus remain regarding what data best represents physician well-being and burnout, and how that data should be utilized.

Privacy and Confidentiality of Collected Data

Additional concerns regarding the collection and use of personal health information and/or biological data to reduce burnout center around issues related to privacy, confidentiality, data security, consent, and autonomy. There is general agreement among scholars that collecting and analyzing personal sensing data, the kind recorded by IoT technologies, poses real challenges to current norms around privacy, especially regarding the relationship between physicians and their supervisors [9]. Such challenges include concerns that personal data used to enhance professional well-being might blur the boundaries between work and life contexts, might recast physicians as patients, and that anonymity might be functionally impossible [6].

A central issue that emerges is how to balance respect for privacy with program utility. The challenge that arises is that anonymizing data is generally recognized as decreasing the utility of that data for improving individual-level well-being [6]. Research using protected health information (PHI) generally requires stricter privacy protections than de-identified data used for quality assessment (QI) or quality improvement (QI). However, even de-identified data risks re-identification, and it is highly likely that at small health care institutions anonymity of physician data would be impossible. Furthermore, even if anonymity were possible, reporting on average values derived from de-identified datasets defeats the purpose of identifying individuals struggling with burnout.

While informed consent has been considered the key tool to remediate concerns regarding data privacy and confidentiality, Adler et al note with respect to personal sensing data, consent is not the same thing as an ongoing data use agreement [6]. An ongoing data use agreement (DUA) is a legal contract that outlines how specific data can be used and shared between parties, essentially governing the access and usage of sensitive information once it has been collected, whereas informed consent is a process in which individuals are given detailed information about a medical intervention or data collection activity before agreeing to participate. While an informed consent agreement primarily focuses on an individual's understanding of a medical intervention and their right to participate in it, a DUA focuses on the restrictions and permitted uses of collected data once it is shared. Such data sharing by physicians raises related concerns including who owns the data, how it is to be protected, and assurance that it will only be used to improve physician well-being.

Ethical Data Collection

Sharing personal health information, which could be collected even during non-working hours, potentially blurs the boundaries between physicians' work and personal lives and could be considered a violation of their privacy. Passive data collection and sharing also violates physicians' control over disclosure and may violate their autonomy. Any data collection program aimed at improving physician well-being would thus require an opt-out option, though it should be noted that opting out could negatively impact the overall quality of the data captured and negate any individual-level burn-out interventions. Relatedly, physicians should recognize that they have a duty to promote occupational health, though meeting this obligation should not come at the cost of violating their own individual rights.

To limit or reduce the risk of violations to physicians' privacy and autonomy, a crucial aspect of any such burnout reduction program would be a requirement to obtain the informed consent of any participating physicians, and would likely require the implementation of a DUA as well. In determining whether such a program would allow physicians to voluntarily opt-in or require them to voluntarily opt-out, it is important to acknowledge that, while opt-in policies may reduce the

likelihood of participation and thus decrease the quality of any datasets obtained, opt-in policies do preserve the autonomy of physicians more than opt-out policies. Furthermore, it is imperative that anyone developing such programs recognize that the more data that is collected, the more personal the data is, and the more identifiable the information is all contribute to increasingly higher standards of physician protections that need to be in place.

Accountability

Current practices of physician performance profiling should be considered a warning sign about the likelihood that physician personal and/or biological data will be used only to improve physician well-being. The two main types of physician profiling in the US are clinical profiling and economic profiling, which examine a physician's treatments and outcomes of care or their financial performance (including cost and utilization of services), respectively. While, ideally, profiling should provide physicians with meaningful information on their clinical performance to help improve the quality of the services they provide, such profiling has largely become a tool for hospitals and other health care entities to control costs rather than as a method of measuring and improving quality of care [9]. Such developments raise questions about whether programs that use physician personal and/or biological data will actually use that data to serve physicians' best interests.

The focus on individual physician data also raises concerns regarding who may be seen as accountable for making improvements. The collection of individual physician data places an emphasis on individual behaviors rather than on institutional changes, which the consensus of researchers believe is necessary to significantly reduce burnout [10]. As Olson et al note, ameliorating burnout requires a systems approach and that organization-level interventions are far more effective at reducing burnout than individual-based interventions [10]. Rather than focusing only on programs aimed at promoting individual physician resiliency, Olson et al suggest that health care entities can reduce burnout by promoting workplace efficiency, supporting work-life integration, and granting greater physician control and autonomy over clinical decision-making and practice management in conjunction with promoting personal resilience [10].

Ultimately, collecting and using physician personal health information and/or biological data to improve physician well-being should only be implemented if the data is used solely to ameliorate stress-causing working conditions with clear accountability within the program regarding who is responsible for instituting those improvements. Any use of physician personal health information or biological data for other ends, such as improving operational efficiency, especially any ends that could be perceived as retaliatory or perpetuating unjust biases, should be avoided.

RELEVANT AMA POLICY AND RESOURCES

It deserves to be noted that all physicians are at times likely to also be patients and suffer their own illnesses and injuries that require medical attention. In their capacity as patients, physicians enjoy the same rights as any other patient as outlined in the AMA *Code of Medical Ethics* (see Opinion 1.1.3, "Patient Rights") [11]. Like any patient, they are entitled to receive quality care (Opinion 1.1.6), to informed consent (Opinion 2.1.1), to have their privacy respected (Opinion 3.1.1), and to have their de-identified data handled with care (Opinion 3.3.4) [12-15].

In their capacity as physicians, they also have obligations to practice continual self-awareness and self-observation to ensure that they are competent to practice medicine (Opinion 8.13), to strive to promote their own health and wellness (Opinion 9.3.1), and to intervene with respect and compassion in the event that they discover a colleague is not able to practice safely (Opinion 9.3.2)

[16-18]. Any programmatic collection and use of physician data, especially that which might be considered private health information, must adhere to the ethics guidance outlined in the AMA *Code of Medical Ethics*.

The collection and use of physician data raises several concerns, including issues related to privacy and consent, access and appropriate use, and the potential for coercion and discrimination. To protect physicians whose data is collected and used to improve physician well-being, it is therefore crucial that, in addition to the AMA *Code of Medical Ethics*, the AMA Privacy Principles be followed [19]. These principles, derived primarily from AMA HOD policy, were developed to provide individuals with data rights and protections from data holders other than HIPAA-covered entities. These guidelines provide broad guardrails to address individual rights, equity, data stewardship and related entity responsibilities, appropriate applicability, and enforcement. Any programmatic collection and use of physician data to improve well-being must also recognize that different specialties will likely require custom solutions, that different sized institutions will likely require tailored solutions, and that, generally, one-size-fits-all interventions are likely to be ineffective. Lastly, the collection of physician data is likely to be insufficient on its own to reduce burnout—physician engagement and collaboration will be crucial to successfully operationalize the collection and use of physician data to reduce burnout and improve physician well-being.

CONCLUSION

As technologies advance, the workplace is becoming increasingly quantified, with data analytics being used to identify opportunities for optimization and to improve productivity. The implementation of new tools for the collection and use of data is remaking the boundaries of appropriate information flows and will continue to have a growing impact on physicians and the practice of medicine. The collection and use of physicians' personal health information and/or biological data has the potential to help reduce burnout and improve physician well-being; however, the practice also creates several ethical dilemmas and should not be viewed as a panacea.

Further research is needed to better capture and define the lived experiences of burnout and well-being. Prior to implementation, policy protections should be developed to hold supervisors and administrators accountable and ensure that such programs are truly physician-centered and do not place the onus of preventing burnout on those suffering from it. Additionally, new policies and relational norms will need to be developed to protect physician data, prevent abuse of the power differential between data subjects and the data recipients, and ensure that such data is used solely for improving physician well-being and not in any way that could be perceived as retaliatory [6].

In light of these observations, the medical profession may consider collecting physician data to improve well-being but should do so with extreme caution. Furthermore, when collecting physician data, it is imperative that the AMA *Code of Medical Ethics* and AMA Privacy Principles be followed.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and the remainder of the report be filed.

1. With the aim of promoting physician well-being in the workplace, physician personal health information and/or biological data should be:

a. Collected only if evidence supports that the specific data being collected is minimized to only that which is relevant and necessary to the development of interventions which promote physician well-being and reduce professional burnout;

b. Collected only if physicians are informed whether the data is directly or indirectly identifiable;

c. Collected only if physicians have the ability to opt-in or opt-out without retribution, penalty, or direct or indirect coercion;

d. Collected only if physicians are able to provide informed consent prior to data acquisition and use;

e. Collected only if physicians retain the option to opt-out at any time;

f. Used only to ameliorate burnout-inducing working conditions. (New HOD Policy)

2. Any use of physician personal health information or biological data that is retaliatory or that perpetuates unjust biases should be avoided and prohibited. (New HOD Policy)

3. The second directive of Policy D-460.962 be rescinded having been accomplished by this report.

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-A-25

Subject: Bylaws Review Report

Presented by: Jerry Abraham, MD, MPH, Chair

Referred to: Reference Committee on Ethics and Bylaws

Per AMA Bylaw 6.1.1, the Council on Constitution and Bylaws is responsible for recommending changes in the Bylaws as it deems appropriate for action by the House of Delegates. The Council focuses its fact-finding review and proposed bylaw amendments on provisions that are internally inconsistent, incomplete or inaccurate.

In this report, the Council notes that the Bylaw language associated with the process of filling a Medical Student Trustee position is not only inconsistent with language regarding the initial election of the Medical Student Trustee but inconsistent with language about filling other Board vacancies. Also, the Council finds that other language is inaccurate in describing how the medical student members of Councils are appointed and incomplete as to how and when student vacancies may be filled.

The Council has proposed some bylaw amendments to provide consistency, clarity and accuracy.

BACKGROUND

Bylaw 3.5.6 and its subprovisions provide for the election of the Medical Student Trustee by the Medical Student Section and detail the position's term, ability for reelection and the filling of vacancies as follows:

> 3.5.6 Medical Student Trustee. The Medical Student Section shall elect the medical student trustee annually. The medical student trustee shall have all of the rights of a trustee to participate fully in meetings of the Board, including the right to make motions and to vote on policy issues, intra-Board elections or other elections, appointments or nominations conducted by the Board of Trustees.
>
> 3.5.6.1 Term. The medical student trustee shall be elected at the Business Meeting of the Medical Student Section prior to the Interim Meeting for a term of one year beginning at the close of the next Annual Meeting and concluding at the close of the second Annual Meeting following the meeting at which the trustee was elected.
>
> 3.5.6.2 Re-election. The medical student trustee shall be eligible for re-election as long as the trustee remains eligible for medical student membership in AMA.
>
> 3.5.6.3 Cessation of Enrollment. The term of the medical student trustee shall terminate and the position shall be declared vacant if the medical student

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trustee should cease to be eligible for medical student membership in the AMA by virtue of the termination of the trustee's enrollment in an educational program. If the medical student trustee graduates from an educational program during their term, the trustee shall be permitted to continue to serve on the Board of Trustees for up to 200 days after graduation but not extending past the Annual Meeting following graduation.

Bylaw 3.6 sets forth the process for filling any vacancy on the Board, including that of the Medical Student Trustee:

3.6 Vacancies.

3.6.1 Appointment. The Board of Trustees may, by appointment, fill any vacancy in the office of Speaker, Vice Speaker or Trustee, except the public trustee, to serve until the next meeting of the House of Delegates. A vacancy in the office of medical student trustee shall be filled by appointment by the Board of Trustees from 2 or more nominations provided by the Medical Student Section Governing Council. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

The Council notes that the filling of some but not all Board vacancies is permissive rather than mandatory, and supports consistent language throughout.

The Council also found that there is inconsistent language across the AMA Councils with respect to appointed members. AMA Policy G-610.090 speaks to the need to make "every effort to have two or more candidates for each vacancy." Policy also directs the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity. The Council supports consistency between the Bylaws and policy.

Furthermore, the Council notes that there is explicit bylaw language regarding the role of the Medical Student Section (MSS) Governing Council vis-a-vis the appointed student members of the AMA Councils. However, the Council, including the Speakers, know it is ultimately the Board's responsibility to make all appointments and believes the Bylaw language should be accurate. Conversely, the Bylaws do not address the role of the Resident and Fellow Section in submitting the names of potential candidates for various appointed Councils as the Board considers not only those physicians nominated by the Resident and Fellow Section, but other residents/fellows who are self-nominated or nominated by a Federation entity.

Lastly, the Council also believes that there should be consistent language across the Councils to permit the Board to fill a vacancy in the medical student position, with the lone exception of the Council on Ethical and Judicial Affairs which does not permit any vacancy to be filled by appointment.

6.5 Council on Ethical and Judicial Affairs.

6.5.5 Membership.

6.5.5.1 Nine active members of the AMA, one of whom shall be a resident/fellow physician and one of whom shall be a medical student. Members elected to

the Council on Ethical and Judicial Affairs shall resign all other positions held by them in the AMA upon their election to the Council. No member, while serving on the Council on Ethical and Judicial Affairs, shall be a delegate or an alternate delegate to the House of Delegates, or an Officer of the AMA, or serve on any other council, committee, or as representative to or Governing Council member of an AMA Section, with the exception of service on the Committee on Conduct at AMA Meetings (CCAM) as specified in AMA Policy.

6.5.6 Nomination and Election. The members of the Council shall be elected by the House of Delegates on nomination by the President-Elect who assumes the office of President at the conclusion of the meeting. State associations, national medical specialty societies, Sections, and other organizations represented in the House of Delegates, and members of the Board of Trustees may submit the names and qualifications of candidates for consideration by the President-Elect.

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6.5.9 Vacancies.

6.5.9.1 Members other than the Resident/Fellow Physician Member. Any vacancy among the members of the Council other than the resident/fellow physician member shall be filled at the next meeting of the House of Delegates. The new member shall be elected by the House of Delegates, on nomination by the President, for the remainder of the unexpired term.

6.5.9.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates at the next Annual Meeting, on nomination by the President, for a 2-year term.

6.6 Council on Long Range Planning and Development.

6.6.2 Membership.

6.6.2.1 Ten active members of the AMA. Five members shall be appointed by the Speaker of the House of Delegates as follows: Two members shall be appointed from the membership of the House of Delegates, 2 members shall be appointed from the membership of the House of Delegates or from the AMA membership at-large, and one member appointed shall be a resident/fellow physician. Four members shall be appointed by the Board of Trustees from the membership of the House of Delegates or from the AMA membership at-large. One member appointed shall be a medical student member appointed by the Governing Council of the Medical Student Section with the concurrence of the Board of Trustees.

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6.6.5 Vacancies.

6.6.5.1 Members Other than the Resident/Fellow Physician and Medical Student Member. Any vacancy among the members of the Council other than the resident/fellow physician and the medical student member shall be filled by appointment by either the Speaker of the House of Delegates or by the Board of Trustees as provided in Bylaw 6.6.2. The new member shall be appointed for a 4-year term.

6.6.5.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which appointed, the remainder of the term shall be deemed to have expired. The successor shall be appointed by the Speaker of the House of Delegates for a 2-year term.

6.7 Council on Legislation.

6.7.2 Membership.

6.7.2.1 Twelve active members of the AMA, one of whom shall be a resident/fellow physician, and one of whom shall be a medical student. These members of the Council shall be appointed by the Board of Trustees. The medical student member shall be appointed from nominations submitted by the Medical Student Section.

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6.7.5 Vacancies. Any vacancy occurring on the Council shall be filled for the remainder of the unexpired term at the next meeting of the Board of Trustees. Completion of an unexpired term shall not count toward maximum tenure on the Council.

6.8 Election - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.8.1 Nomination and Election. Members of these Councils, except the medical student member, shall be elected by the House of Delegates. The Chair of the Board of Trustees will present announced candidates, who shall be entered into nomination by the Speaker at the opening session of the meeting at which elections take place. Nominations may also be made from the floor by a member of the House of Delegates at the opening session of the meeting at which elections take place.

6.8.2 Medical Student Member. Medical student members of these Councils shall be appointed by the Governing Council of the Medical Student Section with the concurrence of the Board of Trustees.

6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.9.1 Term.

6.9.1.1 Members other than the Resident/Fellow Physician Member and Medical Student Member. Members of these Councils other than the

resident/fellow physician and medical student member shall be elected for terms of 4 years.

6.9.1.2 Resident/Fellow Physician Member. The resident/fellow physician member of these Councils shall be elected for a term of 2 years. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to /be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.9.1.3 Medical Student Member. The medical student member of these Councils shall be appointed for a term of one year. Except as provided in Bylaw 6.11, if the medical student member ceases to be enrolled in an educational program at any time prior to the expiration of the term for which elected, the service of such medical student member on the Council shall thereupon terminate, and the position shall be declared vacant.

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6.9.3 Vacancies.

6.9.3.1 Members other than the Resident/Fellow Physician and Medical Student Member. Any vacancy among the members of these Councils other than the resident/fellow physician and medical student member shall be filled at the next Annual Meeting of the House of Delegates. The successor shall be elected by the House of Delegates for a 4-year term.

6.9.3.2 Resident/Fellow Physician Member. If the resident/fellow physician member of these Councils ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates for a 2-year term.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments (highlighted in RED) to the Bylaws be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

3--Officers

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3.6 Vacancies.

3.6.1 Appointment. The Board of Trustees may, by appointment, fill any vacancy in the office of Speaker, Vice Speaker or Trustee, except the public trustee, to serve until the next meeting of the House of Delegates. A vacancy in the office of medical student trustee ~~shall~~ may be filled by appointment by the Board of Trustees from a minimum of two ~~2 or more nominations~~ nominees submitted ~~provided~~ by the Medical Student

Section Governing Council. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

6--Councils

6.6 Council on Long Range Planning and Development.

6.6.2 Membership.

6.6.2.1 Ten active members of the AMA. Five members shall be appointed by the Speaker of the House of Delegates as follows: Two members shall be appointed from the membership of the House of Delegates, ~~2~~ two members shall be appointed from the membership of the House of Delegates or from the AMA membership at-large, and one member appointed shall be a resident/fellow physician. Four members shall be appointed by the Board of Trustees from the membership of the House of Delegates or from the AMA membership at-large. One member ~~appointed~~ shall be a medical student member-appointed by the Board of Trustees from a minimum of two-nominees submitted by the Medical Student Section Governing Council ~~of the Medical Student Section with the concurrence of the Board of Trustees~~. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

6.6.5 Vacancies.

6.6.5.1 Members Other than the Resident/Fellow Physician and Medical Student Member. Any vacancy among the members of the Council other than the resident/fellow physician member and the medical student member shall be filled by appointment by either the Speaker of the House of Delegates or by the Board of Trustees as provided in Bylaw 6.6.2. The new member shall be appointed for a ~~4~~four-year term.

6.6.5.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which appointed, the remainder of the term shall be deemed to have expired. The successor shall be appointed by the Speaker of the House of Delegates for a ~~2~~two-year term.

6.6.5.3 Medical Student Member. If the medical student member of the Council ceases to complete the term for which appointed, the Board of Trustees may appoint a successor to fill the remainder of the unexpired term from a minimum of two nominees submitted by the Medical Student Section Governing Council. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

6.7 Council on Legislation.

6.7.2 Membership.

6.7.2.1 Twelve active members of the AMA, one of whom shall be a resident/fellow physician, and one of whom shall be a medical student. These members of the Council shall be appointed by the Board of Trustees. The medical student member shall be appointed by the Board of Trustees from a minimum of two nominees ~~nominations~~ submitted by the Medical Student Section Governing Council. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

6.7.3 Term.

6.7.3.1 Members of the Council on Legislation shall be appointed for terms of one year, beginning at the conclusion of the Annual Meeting. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which appointed, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant. Except as provided in Bylaw 6.11, if the medical student member ceases to be enrolled in an educational program the service of such medical student member on the Council shall thereupon terminate, and the position shall be declared vacant.

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6.7.5 Vacancies. Any vacancy occurring on the Council ~~shall~~ may be filled for the remainder of the unexpired term at the next meeting of the Board of Trustees. Completion of an unexpired term shall not count toward maximum tenure on the Council.

6.8 Election - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.8.1 Nomination and Election. Members of these Councils, except the medical student member, shall be elected by the House of Delegates. The Chair of the Board of Trustees will present announced candidates, who shall be entered into nomination by the Speaker at the opening session of the meeting at which elections take place. Nominations may also be made from the floor by a member of the House of Delegates at the opening session of the meeting at which elections take place.

6.8.2 Medical Student Member. Medical student members of these Councils shall be appointed by the Board of Trustees from a minimum of two nominees submitted by the Medical Student Section Governing Council ~~of the Medical Student Section with the concurrence of the Board of Trustees~~. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointments.

6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.9.1 Term.

6.9.1.3 Medical Student Member. The medical student member of these Councils shall be appointed for a term of one year. Except as provided in Bylaw 6.11, if the medical student member ceases to be enrolled in an educational program at any time prior to the expiration of the term for which elected, the service of such medical student member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.9.2 Tenure. Members of these Councils may serve no more than ~~8~~eight years. The limitation on tenure shall take priority over a term length for which the member was elected. Medical student members who are appointed shall assume office at the close of the Annual Meeting with the exception of a medical student who is appointed to fill a vacancy.

6.9.3 Vacancies.

6.9.3.1 Members other than the Resident/Fellow Physician and Medical Student Member. Any vacancy among the members of these Councils other than the resident/fellow physician and medical student member shall be filled at the next Annual Meeting of the House of Delegates. The successor shall be elected by the House of Delegates for a ~~4~~four-year term.

6.9.3.2 Resident/Fellow Physician Member. If the resident/fellow physician member of these Councils cease~~s~~ to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates for a ~~2~~two-year term.

6.9.3.3 Medical Student Member. If the medical student member of these Councils ceases to complete the term for which appointed, the Board may appoint a medical student member from a minimum of two nominees submitted by the Medical Student Section Governing Council to fill the remainder of the one-year term. The Board of Trustees may request additional nominations from the Medical Student Section Governing Council before making the appointment.

6.11 Term of Resident/Fellow Physician or Medical Student Member. A resident/fellow physician member of a Council who completes residency or fellowship within 90 days prior to an Annual Meeting shall be permitted to serve on the Council until the completion of the Annual Meeting. A medical student member of a Council who graduates from an educational program during their term shall be permitted to serve on the Council for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation. Service on a Council as a resident/fellow physician and/or medical student member shall not be counted in determining maximum Council tenure.

(Modify Bylaws)

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-A-25

Subject: Concurrent Service on Councils and Section Governing Councils

Presented by: Jerry P. Abraham, MD, MPH, Chair

Referred to: Reference Committee on Ethics and Bylaws

Our AMA's parliamentary authority, the American Institute of Parliamentarians Standard Code of Parliamentary Procedure (AIPSC), states that no member can hold two incompatible offices, and recommends that if it is unclear whether certain offices are incompatible, an organization should clarify the compatibility or lack thereof in its bylaws. Per AIPSC (2nd ed.) 26.26, "Incompatibility not only consists of practical impossibility to perform the duties of both offices but also includes a conflict between the duties of the two offices." AIPSC (2nd ed.) further clarifies that unless the bylaws provide otherwise, a member who holds an office may be a candidate for another office without first giving up the current office, but if the member is elected to and accepts an incompatible office, the former office is forfeited. The Council, as part of its responsibilities embodied in Bylaw 6.1.1, examined the AMA Bylaws, Council rules and section Internal Operating Procedures for existing language regarding concurrent service.

AMA Bylaw 3.2.1.1 states, "Trustees shall resign all other positions held by them in the AMA upon their election and/or appointment," with a few exceptions: 1) The Speaker and Vice Speaker, under Bylaw 6.1.2.2, are ex officio members of the Council on Constitution and Bylaws without the right to vote, and 2) the House of Delegates' Selection Committee for the Public Member of the Board of Trustees (Bylaw 2.15.5) includes two appointed trustees; and 3) Bylaws 2.13.6 whereby the membership of Special Committees of the House of Delegates are in accordance with the motions authorizing their appointment and ***may*** include Board members. The Council recognizes that there also are several task forces or committees in which Board and/or Council members have a role, notably the AMA Foundation Board, Search Committee for the AMA Executive Vice President, Task Force on Digital Health and AI, and Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted. The Council also knows that each AMA Council, each AMA Section and the AMPAC Board has one or more trustees who are designated as Board liaisons.

AMA Bylaw 6.5.1.1 states, "No member, while serving on the Council on Ethical and Judicial Affairs, shall be a delegate or an alternate delegate to the House of Delegates, or an Officer of the AMA, or serve on any other council, committee, or as representative to or Governing Council member of an AMA Section, with the exception of service on the Committee on Conduct at AMA Meetings (CCAM) as specified in AMA Policy." Beyond that, the AMA Bylaws are silent on concurrent service on more than one Council or Section Governing Councils or concurrent service on an AMA Council and a Section Governing Council. While rare, there have been instances over the years where concurrent service has occurred.

The Council found that some but not all Sections have language in their Rules (known as Internal Operating Procedures) prohibiting concurrent service on a Section Governing Council and an AMA Council.

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To bring our AMA Bylaws into compliance with AIPSC (2nd ed.), the Council believes it is appropriate that there be AMA Bylaw language specifically prohibiting concurrent service as a voting member on multiple Councils, multiple Section Governing Councils or on a Council and a Section Governing Council. Codifying such language is especially important since most Councils and Section Governing Councils meet in conjunction with the HOD meetings. Council/Section meetings often overlap, as do member responsibilities. Lastly, the Council believes such an explicit prohibition in our AMA Bylaws will eliminate potential conflicts of interest that can occur when holding two leadership positions simultaneously, provide consistency across Councils, and expand a finite number of leadership opportunities to more members.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments (highlighted in RED) to the Bylaws be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

6 Councils

6.0.1 Responsibilities

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6.0.1.4 Concurrent Service. A Council member may not serve concurrently as a voting member of more than one Council or on a Council and a Section Governing Council.

7 Sections

7.0.3 Governing Council. There shall be a Governing Council for each Section to direct the programs and the activities of the Section. The programs and activities shall be subject to the approval of the Board of Trustees or the House of Delegates.

7.0.3.1 Qualifications. Members of each Section Governing Council must be members of the AMA and of the Section. A Section Governing Council member may not serve concurrently as a voting member of more than one Section Governing Council or on an AMA Council while a voting member of a Section Governing Council.

(Modify Bylaws)

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 3-A-25

Subject: Clarifying Bylaw Language

Presented by: Jerry P. Abraham, MD, MPH, Chair

Referred to: Reference Committee on Ethics and Bylaws

The Council on Constitution and Bylaws has responsibility per AMA Bylaw 6.1.1 for recommending changes in the Bylaws as it deems appropriate for action by the House of Delegates. In this report, the Council focuses its fact-finding review and proposed bylaw amendments on various provisions relating to membership and representation that are no longer accurate or relevant.

BACKGROUND

Membership Categories (Bylaw Section 1). Our AMA Constitution Article III states, "The American Medical Association is composed of physician members who are represented in the House of Delegates through state associations and other constituent associations, national medical specialty societies and other entities, as specified in the Bylaws." The Bylaws further define constituent associations as "recognized medical associations of states, commonwealths, districts, territories, or possessions of the United States of America."

The Council is aware that current Bylaw language may be confusing as AMA members are defined by how they pay their dues. At one time, some but not all constituent medical societies sent a single dues invoice to physicians and medical students for dues associated with the constituent medical society, the county medical society and AMA, and the constituent society subsequently transmitted the AMA dues to the AMA along with a list of their AMA dues-paying and dues-exempt members. Those who joined via this mechanism were known as Active Constituent Members. Those physicians and medical students who paid their dues directly to the AMA were categorized as Active Direct Members.

Additional language identifies the other categories of membership (Affiliate Members, Honorary Members and International Members) and specifies the rights and privileges of those members. The Council noted that while these membership categories comprehensively define the rights and privileges of members, the current language for Active and Direct Members does not, and provides only for receipt of the *Journal of the American Medical Association* and such other publications as the Board of Trustees may authorize.

Lastly, the Constitution Article VIII states that "Funds may be raised by annual dues or by assessment on the active members of the Association on recommendation by the Board of Trustees and after approval by the House of Delegates." Bylaw 1.1.1.5 states that active members are liable for such dues as are determined and fixed by the House of Delegates, and Bylaw 1.1.1.5.4 states that "active members are delinquent if their dues and assessments are not received by the House of Delegates." The Council notes the latter is inaccurate as it is the Board of Trustees, not the House of Delegates, which establishes the dues delinquency date.

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House of Delegates (Bylaw Section 2). This section identifies the types of entities represented in the HOD, and sets forth the apportionment of the constituent medical societies and the national medical specialty societies. The Bylaws for constituent medical societies and the national medical specialty societies grant an extra delegate to those societies that are 'unified' (require all its members to also be AMA members). The Council learned that there have been no unified societies since 2007.

Another bylaw awards an additional delegate to those constituent societies who are not unified but where 75 percent or more of their members are AMA members. The Council learned that it has been many years since any constituent society had such a large percentage of AMA members.

Young Physicians Section (Bylaws Section 7.5) Similarly, in Section 7, unified societies receive additional delegates to the Young Physicians Section.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments (highlighted in RED) to the Bylaws be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

1—Membership

1.1.1 Categories.

Categories of membership in the American Medical Association (AMA) are: Active ~~Constituent, Active Direct,~~ Members, Affiliate Members, Honorary Members, and International Members.

1.1.1 Active Member~~ship~~.

~~**1.1.1.1 Active Constituent.** Constituent associations are recognized medical associations of states, commonwealths, districts, territories, or possessions of the United States of America. Active constituent members are members of constituent associations who are entitled to exercise the rights of membership in their constituent associations, including the right to vote and hold office, as determined by their respective constituent associations and who meet one of the following requirements:~~

~~a. Possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent.~~

~~b. Are medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical.~~

~~1.1.1.1.1 **Admission.** Active constituent members are admitted to membership upon certification by the constituent association to the AMA, provided there is no disapproval by the Council on Ethical and Judicial Affairs.~~

1.1.1.1 Active Members.

~~1.1.1.1 **Active Direct.** Active direct members are those who apply for membership in the AMA directly. Applicants residing in states where the constituent association requires all of its members to be members of the AMA are not eligible for this category of membership unless the applicant is serving full time in the Federal Services that have been granted representation in the House of Delegates.~~

Active ~~direct~~ members must meet one of the following requirements:

a. Possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent.

b. Are medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical.

1.1.1.1.1

~~1.1.1.2.1~~ **Admission.** Active ~~direct~~ members are admitted to membership upon application to the AMA or through a constituent association, provided that there is no disapproval by the Council on Ethical and Judicial Affairs or an objection to membership from a society represented in the House of Delegates.

1.1.1.1.1.1

~~1.1.1.2.1.1~~ **Notice.** The AMA shall notify each constituent association of the name and address of those applicants for ~~active direct~~ membership residing within its jurisdiction.

1.1.1.1.1.2

~~1.1.1.2.1.2 **Objections.** Objections to applicants for active direct membership must be received by the Executive Vice President of the AMA within 45 days of receipt by the constituent association of the notice of the application for such membership.~~ All objections to membership will immediately be referred to the Council on Ethical and Judicial Affairs for prompt disposition

pursuant to the rules of the Council on Ethical and Judicial Affairs.

1.1.1.2
~~1.1.1.3~~ **Council on Ethical and Judicial Affairs Review.** The Council on Ethical and Judicial Affairs may consider information pertaining to the character, ethics, professional status and professional activities of the applicant for membership. The Council shall provide by rule for an appropriate hearing procedure to be provided to the applicant.

1.1.1.3
~~1.1.1.4~~ **Rights and Privileges.** Active members may attend AMA meetings, hold office, and are entitled to receive the *Journal of the American Medical Association* and such other publications as the Board of Trustees may authorize.

1.1.1.4
~~1.1.1.5~~ **Dues and Assessments.** Active members are liable for such dues and assessments as are determined and fixed by the House of Delegates.

~~1.1.1.5.1 **Active Constituent Members.** Active constituent members shall pay their annual dues to the constituent associations for transmittal to the AMA, except as may be otherwise arranged by the Board of Trustees.~~

~~1.1.1.5.2 **Active Direct Members.** Active direct members shall pay their annual dues directly to the AMA.~~

1.1.1.4.1
~~1.1.1.5.3~~ **Exemptions.** On request, active members may be exempt from the payment of dues on January 1 following their sixty-fifth birthday, provided they are fully retired from the practice of medicine. Additionally, the Board of Trustees may exempt members from payment of dues to alleviate financial hardship or because of retirement from medical practice due to medical disability. The Board of Trustees shall establish appropriate standards and procedures for granting all dues exemptions. Members who were exempt from payment of dues based on age and retirement under Bylaw provisions applicable in prior years shall be entitled to maintain their dues-exempt status in all subsequent years. Dues exemptions for financial hardship or medical disability shall be reviewed annually.

1.1.1.4.2
~~1.1.1.5.4~~ **Delinquency.** Active members are delinquent if their dues and assessments are not received by the date determined by the Board of Trustees ~~House of Delegates~~, and shall forfeit their membership in the AMA if such delinquent dues and assessments are not received by the AMA within

30 days after a notification to the delinquent member has been made on or following the delinquency date.

1.1.2 Affiliate Members.

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1.1.3 Honorary Members.

***

1.1.4 International Members.

Physicians who have graduated from medical schools located outside the United States and its territories and are ineligible to be ~~for~~ Active Members ~~Constituent or Active Direct membership~~ and who can fulfill and document the following requirements:

a. Graduation from a medical school listed in the World Health Organization Directory.

b. Possession of a valid license in good standing in the country of graduation or practice location documented by one of the following:

(i) verification that the applicant is an international member of a national medical specialty society seated in the House of Delegates that has a procedure to verify the applicant's educational credentials;

(ii) certification from the national medical association in the country of practice attesting to the applicant's valid authorization to practice medicine without limitation; or

(iii) certification from the registry or licensing authority of the country of practice attesting to the applicant's valid license in good standing.

1.1.4.1 Admission. International members are admitted to membership by providing a completed application accompanied by the required documentation. The Council on Ethical and Judicial Affairs shall provide by rule for an appropriate hearing procedure to be provided to the applicant should denial of membership be based on information pertaining to the applicant's character, ethical conduct, or professional status.

****

1.2 Maintenance of Membership.

A member may hold only one category of membership in the AMA at any one time. Membership may be retained as long as the member complies with the provisions of the Constitution and Bylaws and Principles of Medical Ethics of the AMA.

~~1.3 Transfer of Membership.~~

~~Members of the AMA, except members serving full time in the Federal Services, who move to a jurisdiction in which the constituent association requires that all members of the constituent association be members of the AMA, must apply for membership in the constituent association within one year after moving into the jurisdiction to continue membership in the AMA. Unless membership in the constituent association has been granted within 2 years after application, membership in the AMA shall cease.~~

1.3
~~1.4~~ **Discrimination.**

Membership in the AMA or in any constituent association, national medical specialty society or professional interest medical association represented in the House of Delegates, shall not be denied or abridged because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities.

1.4.
~~1.5~~ **Termination of Membership or Other Discipline.**

The Council on Ethical and Judicial Affairs, after due notice and hearing may censure, suspend, expel, or place on probation any member of the AMA for an infraction of the Constitution or these Bylaws, for a violation of the Principles of Medical Ethics, or for unethical or illegal conduct.

2—House of Delegates

2.0.1 **Composition and Representation.** The House of Delegates is composed of delegates selected by recognized constituent associations and specialty societies, and other delegates as provided in this bylaw.

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2.1 **Constituent Associations.** Constituent associations are recognized medical associations of states, commonwealths, districts, territories, or possessions of the United States. Each recognized constituent association granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment~~, and such additional delegate seats as may be provided under Bylaw 2.1.1.2~~. Only one constituent association from each U.S. state, commonwealth, territory, or possession shall be granted representation in the House of Delegates.

2.1.1 **Apportionment.** The apportionment of delegates from each constituent association is one delegate for each 1,000, or fraction thereof, active constituent and active direct members of the AMA within the jurisdiction of each constituent association, as recorded by the AMA as of December 31 of each year.

2.1.1.1 **Effective Date.** Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.1.1.1.1 Retention of Delegate. If the membership information as recorded by the AMA as of December 31 warrants a decrease in the number of delegates representing a constituent association, the constituent association shall be permitted to retain the same number of delegates, without decrease, for one additional year, if it promptly files with the AMA a written plan of intensified AMA membership development activities among its members. At the end of the one year grace period, any applicable decrease will be implemented.

~~**2.1.1.2 Unified Membership.** A constituent association that adopts bylaw provisions requiring all members of the constituent association to be members of the AMA shall not suffer a reduction in the number of delegates allocated to it by apportionment during the first 2 years in which the unified membership bylaw provisions are implemented.~~

~~**2.1.2 Additional Delegates.** A constituent association meeting the following criteria shall be entitled to the specified number of additional delegates.~~

~~**2.1.2.1 Unified Membership.** A constituent association shall be entitled to 2 additional delegates if all of its members are also members of the AMA. If during any calendar year a constituent association adopts bylaw provisions requiring unified membership, and such unified membership is to be fully implemented within the following calendar year, the constituent association shall be entitled to the 2 additional delegates. The constituent association shall retain the 2 additional delegates only if the membership information as recorded by the AMA as of each subsequent December 31 confirms that all of the constituent association's members are members of the AMA.~~

~~**2.1.2.2 Minimum 75% Membership.** A constituent association shall be entitled to one additional delegate if 75% or more of its members, but not all of its members, are members of the AMA. The constituent association shall retain the additional delegate only if the membership information as recorded by the AMA as of each subsequent December 31 confirms that 75% or more of the constituent association's members are members of the AMA. If the membership information indicates that less than 75% of the constituent association's members are members of the AMA, the constituent association shall be permitted to retain the additional delegate for one additional year if it promptly files with the AMA a written plan of intensified AMA membership development activities among its members. If the membership information for the constituent association, as recorded by the AMA as of the following December 31 indicates that for the second successive year less than 75% of the constituent association's members are members of the AMA, the constituent association shall not be entitled to retain the additional delegate.~~

~~**2.1.2.3 Maximum Additional Delegates.** No constituent association shall be entitled to more than 2 additional delegates under Bylaw 2.1.2.~~

~~2.1.2.3.1 **Effective Date.** The additional delegates provided for under this bylaw shall be based upon membership information recorded by the AMA as of December 31 of each year. Allocation of these seats shall take effect on January 1 of the following year.~~

2.2 National Medical Specialty Societies. The number of delegates representing national medical specialty societies shall equal the number of delegates representing the constituent societies. Each national medical specialty society granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment~~, and such additional delegate seat as may be provided under Bylaw 2.2.2~~. The total number of delegates apportioned to national medical specialty societies under Bylaw 2.2.1 shall be adjusted to be equal to the total number of delegates apportioned to constituent societies under sections 2.1.1 ~~and 2.1.2~~ using methods specified in AMA policy.

2.2.1 Apportionment. The apportionment of delegates from each specialty society represented in the AMA House of Delegates is one delegate for each 1,000, or fraction thereof, physician specialty society members as of December 31 of each year who are eligible to serve on committees or the governing body, are active members of the AMA and are members in good standing and current in payment of applicable dues of both the specialty society and the AMA. ~~The delegates eligible for seating in the House of Delegates by apportionment are in addition to the additional delegate and alternate delegate authorized for unified specialty societies meeting the requirements of Bylaw 2.2.2.~~

2.2.1.1 Effective Date. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

~~2.2.2 **Additional Delegate.** A specialty society that has adopted and implemented bylaw provisions requiring unified membership is entitled to one additional delegate. If during any calendar year the specialty society adopts bylaw provisions requiring unified membership, and such unified membership is to be fully implemented within the following calendar year, the specialty society shall be entitled to the additional delegate. The specialty society shall retain the additional delegate only if the membership information recorded by the AMA as of each subsequent December 31 confirms that all of the specialty society's members are members of the AMA.~~

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6—Councils

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6.5 Council on Ethical and Judicial Affairs.

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6.5.3 Original Jurisdiction. The Council on Ethical and Judicial Affairs shall have original jurisdiction in:

6.5.3.1 All questions involving membership as provided in Bylaws 1.1.1.1.1, 1.1.4.1 and 1.4 ~~1.1.1.1, 1.1.1.2, 1.1.2, 1.1.4, and 1.5~~.

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7—Sections

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7.5 Young Physicians Section.

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7.5.3 Representatives to the Business Meeting. The Business Meeting shall consist of representatives from constituent associations, Federal Services, and national medical specialty societies represented in the House of Delegates. There shall be no alternate representatives.

7.5.3.1 Constituent Associations, National Medical Specialty Societies, and Federal Services. Each constituent association and Federal Service shall be entitled to representation based on the number of seats allocated to it by apportionment. Each national medical specialty society granted representation in the House of Delegates shall be entitled to representation based on the number of seats allocated to it by apportionment. ~~In addition, unified constituent associations and specialty societies that are entitled to additional representation pursuant to Bylaw 2.1.1.2 or Bylaw 2.2.1 shall be entitled to 2 additional representatives.~~

(Modify Bylaws)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 01-A-25

Subject: The AMA *Code of Medical Ethics* Evolving to Provide Health Care Systems Ethics Guidance

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

BACKGROUND

In 1847, the AMA established the world's first national code of ethics for physicians [1-2]. Stewarded by the Council on Ethical and Judicial Affairs (and its predecessors), the AMA *Code of Medical Ethics* is continually updated to help physicians meet their ethical obligations to patients in an ever changing scientific and practice environment [3]. As a living document, the *Code* has gone through major updates. In 1957, a major revision of the *Code* distinguished medical etiquette from medical ethics. In 1980, the *Code* was updated to address the tension between ethical standards and legal requirements [4]. More recently, the *Code* modernization project, completed in 2016, worked to ensure that Ethical Opinions in the *Code* were internally consistent, used modern terminology, and provided sound ethical guidance to physicians [5].

While the *Code* remains focused on the ethical duties of physicians, today's practitioners interact with many health care-related organizations, whether they be hospitals, insurers, or pharmaceutical companies. One major structural change in the practice environment is that most physicians are no longer self-employed (or their own bosses) and are now employees of hospitals, group practices, or other corporate entities. For example, the trend towards employed physicians accelerated within recent years, and the number of physicians in private practices dropped below 50 percent for the first time in 2020 [6]. Consequently, the decisions that physicians make in service to their patients are increasingly shaped, influenced, and sometimes dictated by organizational actors.

ETHICAL ISSUE

When organizational actors shape, influence, or dictate decisions that physicians make in service to their patients, it can create moral tension and ethical conflict between physicians and the health care organizations with whom they are interacting. For the *Code* to serve its purpose in this rapidly changing practice environment, its ethics opinions should speak to how health care organizations can support physicians in meeting their ethical obligations to patients, or what will be referred to as "health system ethics" for the remainder of this report.

Up to now, the *Code* has addressed health system ethics indirectly by speaking to the ethical responsibilities of physicians in organizational leadership positions and a case-by-case basis such

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as in Opinion 11.2.7, Responsibilities to Promote Equitable Care. Therefore, the issue is whether the *Code* should again evolve so that its opinions also provide ethics guidance to health care organizations regarding how they can support physicians in upholding their ethical obligations to patients.

ETHICAL ANALYSIS

The purpose of the *Code* addressing health systems ethics is to provide guidance regarding actions health care organizations ought to take to create environments that will support and enable physicians to abide by and uphold their individual ethical obligations and duties. As this is a new way of approaching the development of ethics opinions within the *Code*, the Council on Ethical and Judicial Affairs sought feedback from various stakeholders as follows:

- CEJA Open Forum at I-23 entitled "Should the AMA *Code* Speak to Health Care Systems." Invited panelists included Drs. Michael Suk, Jessie Ehrenfeld, and Michael Tutty of our AMA leadership.
- A virtual meeting in October of 2024, with physician leadership from key AMA Sections and Councils. Attendees included Dr. Nancy Church from the Organized Medical Staff Section, Dr. Stephen Parodi from the Integrated Physician Practices Section, and Drs. Betty Chu and Steve Epstein from the Council on Medical Service.
- CEJA Open Forum at I-24 entitled "Evolving the AMA *Code* to Speak to Health Care Organizations." Invited panelists included Dr. Christopher DeRienzo, Chief Physician Executive, at the American Hospital Association and Julie Wagner, Head of Global Ethics, Compliance, and Enforcement Legal Policy, at the Pharmaceutical Research and Manufacturers of America.

During these above engagements, there was broad support expressed for the *Code* to address health system ethics. The ethics logic for moving toward providing health system ethics guidance is premised on the understanding that when health care organizations are acting ethically, physicians are better able to provide high quality patient care. Additionally, when any party to patient care fails to act ethically, patients' trust in the medical profession and of health care organizations can be undermined, contributing to greater moral distress and burnout among physicians, as well as damaged organizational reputation and market position for health care organizations.

RECOMMENDATION

In the light of the above, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of the report be filed:

That our AMA supports the continued evolution of the *Code of Medical Ethics* in addressing how health care organizations and physicians can work together in meeting their mutual obligations to serve patients and the public.

Fiscal Note: Less than $500

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REPORT 02 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-25)
Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization (Res 016-A-23)

EXECUTIVE SUMMARY

In adopting Policy H-405.946, "Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization," the House of Delegates requested that the Council on Ethical and Judicial Affairs (CEJA) "review the advisory restricting collective action in section 1.2.10 of its Code of Medical Ethics to allow for more flexibility on the part of physicians who have exhausted other non-disruptive methods for reform."

Although not all collective actions by physicians may impact clinical practice, the practical issue for consideration is whether disruptive collection actions by physicians, such as but not limited to strikes, may be permissible. The ethical dilemma is whether physicians can prioritize patient welfare over their own self-interest while engaging in tactics that have the potential to harm patients in the short term, even if the ultimate goal of the action is proposed to be long-term patient benefit. To respond to these issues, CEJA recommends amending Opinion 1.2.10, "Political Action by Physicians," to more clearly articulate that disruptive collective actions that create the potential for harm to patients, even minimally, and even if undertaken for the purpose of improving the care of other patients in the future, are to be avoided; however, this does not mean that all forms of disruptive collective action must be avoided. Disruptive actions should, though, only be undertaken as a last resort when good faith negotiations have broken down and the aim of the action is to improve patient care.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 02-A-25

Subject: Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

Policy H-405.946, "Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization," was adopted at the 2023 Annual Meeting and asks that the Council on Ethical and Judicial Affairs (CEJA) "review the advisory restricting collective action in section 1.2.10 of its *Code of Medical Ethics* to allow for more flexibility on the part of physicians who have exhausted other non-disruptive methods for reform."

BACKGROUND

The consolidation of hospitals and physician practices in recent years has led to a shift in the practice of medicine away from the independent practice model to one in which physicians increasingly find themselves working as employees. In 2012, only 5.6 percent of physicians were directly employed by hospitals, with 23.4 percent of physician-owned practices having some hospital ownership; however, by 2022, a total of 74 percent of practicing physicians were employed, including 52.1 percent of physicians employed by hospitals or health systems and 21.8 percent employed by other corporate entities [1]. Paralleling this increase in corporate intrusion into medicine has been the rise of unionization within the profession. While the number of physicians who are members of a union is relatively small, and mostly among house officers, their ranks saw an approximately 26 percent increase in just five years from 2014–2019 [2]. As of 2021, an estimated 5.9 percent of practicing physicians were union members, with union contracts covering 8.1 percent of practicing physicians [1]. Currently, two of the main physician unions are the Federation of Physicians and Dentists and the Union of American Physicians and Dentists.

As the financing, organization, and leadership of the health care system change, the practice environment increasingly makes it challenging for physicians to provide the kind of care patients want and deserve. Physicians are now increasingly held to strict performance metrics that many feel are more about meeting corporate financial goals than they are about providing quality patient care. As a recent New York Times article puts it, "longer-term consolidation of health care companies has left workers feeling powerless in big bureaucracies. They say the trend has left them with little room to exercise their professional judgment" [3]. There is a growing sense among physicians that current working conditions are increasingly compromising the patient–physician relationship, physicians' health, and medical professionalism, driving burnout, moral injury, and retirement from medicine.

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Unions are seen by some as a mechanism for physicians to exert influence on corporate health systems where physicians have less autonomy than in private practices [4]. Unions' power for collective bargaining comes from their ability to organize members to take collective action. Unionization, however, is not the only means by which physicians can organize and take collective action. Hospitals' organized medical staff has been a means by which physicians have exercised authority over decision making and culture, but the authority and scope of responsibility of the organized medical staff has been limited [5]. While employed physicians in large systems have not explored re-invigorating the organized medial staff, this remains an alternative means by which physicians can reclaim lost authority and exercise collective action.

Physicians may undertake many forms of collective action, both in the public arena and within health care institutions. Public actions include, but are not limited to, public advocacy, media campaigns, lobbying, negotiation, and litigation. Collective actions in the clinical setting increasingly are being considered as additional forms of collective action, particularly to effect change in specific clinical environments. Some of these are not disruptive, such as negotiation with administrators. Disruptive actions are also being considered, such as picketing, refusal to comply with corporate directives deemed unethical, withholding billing, work slowdowns, or striking. A primary concern surrounding the use of these disruptive collective actions by physicians in the clinical setting is that some of these actions may impact patient care and thus be in direct conflict with physicians' professional and ethical duties to not abandon patients and to prioritize patient care above self-interest [6].

Relevant Laws

In 1935, Congress passed the National Labor Relations Act (NLRA), amended in 1947 through the Taft-Hartley Act, which guarantees private sector employees the right to unionize, engage in collective bargaining, and take collective actions such as strikes [1]. The NLRA covers most private sector employees but does not cover independent contractors, supervisors, or managers. Part-time physicians working as independent contractors, physicians in private practice, and physicians considered to serve a supervisory role, such as medical directors or tenured medical faculty, are currently excluded [2].

When Congress passed the 1974 amendments to the NLRA, which extended coverage to nonprofit hospitals, it added Section 8(g), requiring health care employee unions to give at least a ten-day notice before engaging in any strike or picketing to ensure that hospitals have sufficient time to make appropriate arrangements for the continuity of patient care in the event of a work stoppage [2].

Laws prohibiting the corporate practice of medicine are an under-appreciated mechanism for physicians to use in reclaiming clinical authority. Most states have had laws dating to the 1880s that prohibit the corporate practice of medicine, but little attention has been paid to the potential use of such laws to prevent health care institutions from infringing upon the clinical decision-making authority that properly belongs to physicians [7].

Relevant AMA Policy Provisions

In 2019, the AMA modified two relevant policies: H-385.973 "Collective Negotiations" and H-385.976 "Physician Collective Bargaining" [8,9]. Both support the right of physicians to engage in collective bargaining and express the AMA's commitment to work for the expansion of which physicians are eligible for that right under federal law. This includes supporting efforts to narrow the definition of supervisors such that more physicians are protected under the NLRA.

Though not policy, the AMA's Advocacy Resource Center has also issued a recent Issue Brief: "Collective bargaining for physicians and physicians in training" that outlines AMA policy on physician unions and collective bargaining, including the interpretation that the AMA's position is that "physicians should refrain from the use of the strike as a bargaining tactic, although in rare circumstances, individual or grassroots actions, such as brief limitations of personal availability, may be appropriate as a means of calling attention to needed changes in patient care" [2].

Relevant Code *Provisions*

The AMA *Code of Medical Ethics* Opinion 1.1.1, "Patient-Physician Relationships," states that the core tenets of the clinical encounter for the physician are "to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare." This foundational opinion emphasizes the primary ethical duties of physicians to prioritize patient care and regard their responsibility to the patient as paramount. The Principles enumerated in the Code also indicate that such duties extend beyond the bedside and that physicians have a responsibility to seek changes to laws that are contrary to the best interests of the patient.

Opinion 1.2.10, "Political Action by Physicians," currently states that not only *can* physicians seek to change policies or laws that they find contrary to the best interest of patients but they in fact *have* an ethical duty to do so, though they also "have a responsibility to do so in ways that are not disruptive to patient care" [10]. While the opinion states that "[s]trikes and other collective actions […] should not be used as a bargaining tactic", it also adds that "[i]n rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care" [10]. However, this permissibility must be balanced by the opinion's first directive that physicians participating in advocacy activities should "[e]nsure that the health of patients is not jeopardized and that patient care is not compromised" [10].

This is in line with Opinion 1.1.6, "Quality," which states that "[a]s professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable" [11]. Taken together, by stating that "physicians have an ethical responsibility to seek change" at times (Opinion 1.2.10) and that they also have an "obligation to ensure" quality care (Opinion 1.1.6), these opinions highlight the fact that certain conditions may arise that actually demand action be taken by physicians to improve patient care.

Opinion 9.3.1, "Physician Health & Wellness," similarly outlines that physicians have a responsibility to take action when their own health or wellness is compromised [12]. The opinion stipulates that physicians have a responsibility both individually and collectively to ensure and promote health and wellness among physicians, and that when their health or wellness is compromised, individual physicians should fulfill this responsibility by "taking measures to mitigate the problem" [12]. Physician health and wellness is necessary for effective healing and the provision of quality care, and collective action may be an appropriate means of securing institutional conditions that are conducive to patient health and well-being.

Additional Relevant Policy

The World Medical Association recommends that physicians adopt the following guidelines regarding collective action:

1. Physicians who take part in collective action are not exempt from their ethical or professional obligations to patients.
2. Even when the action taken is not organized by or associated with the Constituent Member, the Constituent Member should ensure that the individual physician is aware of and abides by their ethical obligations.
3. Whenever possible, physicians should press for reforms through non-violent public demonstrations, lobbying and publicity or informational campaigns, and/or through negotiation or mediation.
4. If involved in collective action, Constituent Members should act to minimize the harm to the public and ensure that essential and emergency health services, and the continuity of care, are provided throughout a strike. Further, Constituent Members should advocate for measures to review exceptional cases. If involved in collective action, Constituent Members should provide continuous and up-to-date information to their patients and the general public with regard to the demands of the conflict and the actions being undertaken. The general public must be kept informed in a timely manner about any strike actions and the restrictions they may have on health care [13].

ETHICAL ISSUE

What are the ethical considerations regarding participation in collective labor action by physicians? Since certain collective actions can be disruptive, they present a potential risk to patient care and thus create a dilemma for physicians, particularly when collective actions may create immediate risks to patients, even if intended as a means to improve patient care in the long term. What collective actions by physicians are ethically permissible must be examined to ensure that the primacy and quality of patient care are protected. The core ethical issue is whether physicians who embrace tactics used by organized labor will also still be able to embrace their role as professionals.

RELEVANT PRACTICAL MATTERS FOR CLINICAL PRACTICE

While not all collective actions by physicians may impact clinical practice, disruptive actions such as strikes result in practical challenges to clinical care. This report defines a disruptive collective action by physicians as any collective action that disrupts the day-to-day workflow of physicians within the health care systems in which they practice. Some of these actions may have the potential to decrease quality of care and cause patient harm.

REVIEW OF RELEVANT LITERATURE

The normative ethics literature on the use of collective actions by physicians is generally cautious about collective actions that present a risk to patients, such as striking. A common stance is that, provided adequate precautions are taken to minimize the risk to patients, the primary goal of the collective action is to improve patient care, and the disruptive action is considered only as a last resort after all other means have been exhausted, physician strikes may be ethically justifiable [6,13,18,19,20]. However, strikes and other disruptive collective actions become ethically problematic when they are done for any reason other than for improving patient care, such as for increasing physicians' income [6,18].

One line of argument in favor of permitting disruptive collective actions that might harm patients, such as strikes, is to suggest that physicians are, and have always been, workers like any other set of workers, and that claims of professionalism that would place physicians in a special position of privilege in recognition of a higher set of ethical standards have always been a mere pretense. On

this view, there is nothing intrinsically "special" about medicine as opposed to any other form of work. There are some limits on what forms of collective action may be undertaken that are due to the critical nature of the service physicians provide, but there is no reason to maintain the fiction that they cannot engage in strikes or job actions because they are professionals called to put patient interest ahead of self-interest. The ethical question thus becomes how to draw limits on the scope of permissible collective action that recognizes physicians as laborers with all the rights of laborers, while drawing limits that protect the public from harm.

A second line of argument is a variation on this first line of argument—asserting that while medicine is ideally construed as a profession with intrinsically special rights and obligations, one must now, however reluctantly, accept the de-professionalization of physicians as a socioeconomic and historical fact. On this view, physicians have been forced out of their professional status by changes in the financing and organization of health care and the only available means of asserting power now is through unionization and the means of negotiation that have been used for the last two centuries by other workers in resolving disputes with their employers. Again, the operative ethical question becomes one of setting limits on these actions in accord with the vital nature of the service physicians provide.

A third line of argument attempts to reconcile a conception of physicians as professionals, obligated to place patient interest above self-interest, with an understanding that, under certain circumstances (such as those experienced by house officers and, increasingly, physicians employed in large health care systems), there is a *de facto* imbalance in power between the administrators and the employed physicians. They argue on consequentialist grounds that if impediments to good patient care are sufficiently serious, and the goal of a disruptive collective action (such as a strike) is to improve patient care in the long run, then if potential harm to patients in the short-run is minimized, the action is undertaken only as a last resort, and the goal of improving patient care through the action is foreseeably achievable, such an action could be justified [6,19]. These commentators reject the idea that a disruptive collective action with the potential to harm patients could be ethically and justifiably undertaken solely to advance the welfare of physicians. However, they generally recognize that the motives for such actions will often be mixed, and admit that the argument that physician welfare could be sought as the primary (or even secondary) goal of a strike but justified as a necessary means for achieving patient welfare in the long run might either be self-deceived, or, at least, difficult for the public to believe [6,19,21].

Others have held that strikes by physicians are almost never justifiable [22-24]. Strikes by physicians raise serious questions at the heart of what it means to be a physician. As Pellegrino has written:

> Whatever justification they may have, strikes or "slow downs" by segments of the profession have seriously damaged the image of medicine as a profession dedicated to service above its own interests. One of the distinguishing features of the medical profession has thus been compromised by physicians themselves. Those who choose to pursue self-interest, as union members may, cannot at the same time demand a superior moral position in society [22].

Contrary to the arguments favoring physicians strikes, opponents have appealed to the principle that the duty to promote the good of the patient is always paramount, and that strikes will always harm patients, at least to a modest degree. In fact, they argue, this is the point of the strike—to disrupt care, inconvenience, or possibly harm patients, even if minimally, in order to pressure administrators into acceding to the demands of the striking physicians. Even granting that the

ultimate aim of the strike is to improve patient care in the long run, patients will be harmed in the short run, and this conflicts with the profession's ancient duty to protect patients from harm.

Moreover, opponents take issue with the consequentialist argument that some patients could justifiably be exposed to potential harms now for the sure benefit of others in the future. They argue that a primary principle of ethics is that persons should always be treated as ends in themselves and never as means only. Physician strikes, by their nature, instrumentalize some patients, using their potential harm as means of achieving physicians' ends, even if those ends are justifiable and good.

Additionally, the effect of strikes on public trust in the profession must be considered. Trust is the glue that holds the patient-physician relationship together. The sense that one's own health as a patient could in any way be jeopardized or used as a bargaining tool might lead to public distrust in the profession.

While there is not a substantive body of empirical research on the effects of physician strikes on patient outcomes, there are some data. Although the majority of available empirical evidence shows that strikes have minimal impact on patient care [25-28], much of the data are of relatively poor quality, are at risk of bias, and suffer from a lack of generalizability [26,27]. Furthermore, most studies examine patient mortality as the primary outcome of interest, which has limitations as an indicator of deleterious change in patient health outcomes [25]. Importantly, a 2019 study found a slight increase in 30-day readmission rates for Black patients on strike days in the UK, suggesting that the ways in which strikes impact staffing are unlikely to affect all patient groups equally, with minority groups more likely to experience worse care when hospital systems are under strain [28]. This observation has critical importance in determining care for vulnerable populations when considering collective actions. Additionally, there is a lack of crucial research on how collective actions by physicians impact patient perceptions of and trust in both the medical profession and health care institutions. Reports of strongly negative public perceptions during a recent physicians' strike in Korea, while not systematic, suggest a note of caution [29].

ETHICAL ANALYSIS

In its review of Opinion 1.2.10, "Political Action by Physicians," CEJA has examined the ethics of collective actions by physicians. While the practical issue for consideration is whether disruptive collection actions by physicians, such as but not limited to strikes, may be permissible, the ethical dilemma is whether physicians can, in fact, fully understand themselves as professionals called to prioritize patient welfare over their own self-interest while engaging in tactics that have the potential to harm patients in the short term, even if the ultimate goal of the action is proposed to be long-term patient benefit.

Historically, physicians retained strong independence in clinical practice, and self-regulation permitted this professionalism to flourish. However, the growth of the health care sector has seen an increase in the complexity of health care systems, the transition to a majority physician employment structure, and as a result, a loss of physician independence and control in clinical practice. This bureaucratization has led physicians to seek other non-physicians to run the administrative aspects of their practices, and decreasing margins has led physicians to seek capital infusions and buyouts from private equity firms and venture capitalists, further driving the financialization of medicine and the employment of physicians.

The result is a general loss of control over practice conditions that have driven dissatisfaction, burnout, and early retirement from the profession. However, the issue is not necessarily

employment itself, but the associated loss of independence of clinical practice and control over the clinical environment, which many today see as the de-professionalization of medicine.

For those seeking to maintain and restore physician authority and independence, the primary avenue has been to pursue legal and political actions, such as lobbying (either independently or through specialty associations). However, with the change towards physician employment, physicians are now considering the use of tools that laborers have historically relied on for negotiating, such as legally permissible collective actions, in their attempts to improve patient care. This acceptance of the tools of organized labor, however, is in tension with medicine's self-understanding and public representation of itself as a profession with distinct privileges granted by society in recognition of its commitment to a distinctive set of ethical duties. Certainly, some forms of collective action are not likely to violate the norms of medical professionalism [30]. Disruptive collective actions, however, which have the potential to disrupt the day-to-day workflow of physicians, decrease quality of care, and cause harm to patients, seem prima facie to violate the medical profession's fundamental duty to do no harm and care for patients. Any disruptive collective action that causes harm to patients is inherently inconsistent with the responsibilities and duties of physicians.

Disruptive collective actions that create the potential for harm to patients, even minimally, and even if undertaken for the purpose of improving the care of other patients in the future, are therefore to be avoided. This does not mean, however, that all forms of disruptive collective action must be avoided. Certain forms of disruptive action, such as collective refusal to comply with administrative directives that are understood as antithetical to good patient care or otherwise incompatible with the norms of professional ethics, may be ethically justified. Other forms of disruptive action that are aimed at disrupting administrative processes such as billing but do not disrupt service to patients, might also be justified. Disruptive actions should only be undertaken, however, as a last resort when good faith negotiations have broken down and the aim of the action is to improve patient care.

CONCLUSION

Physicians must uphold their central ethical and professional responsibilities to patients when considering collective actions. When considering disruptive collective actions, physicians should take into account that the care of current patients must be continued and not compromised; urgent, emergent and otherwise needed medical care must still be provided; and all other non-disruptive actions that do not negatively impact patients must first be exhausted. Additionally, the primary goal of the action must be to improve patient care and not solely physician self-interest. To protect the integrity of the profession, patients and the public should also be informed well in advance and be continuously updated with respect to the demands being made and the actions being undertaken, with the terms for resolving disruptive actions made public and open to scrutiny and discussion. Whether all these conditions can ever be met in a physician strike or work slowdown remains an open question.

Physicians thinking about participating in disruptive collective actions therefore must first consider their professional responsibilities and obligations.

RECOMMENDATIONS

The Council on Ethical and Judicial Affairs recommends that the following recommendations be adopted and the remainder of the report be filed:

1. That Opinion 1.2.10 be amended by addition and deletion with a change in title as follows:

Advocacy and Collective Actions by Physicians ~~Political Action by Physicians~~

Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law, ~~or~~ policy, or practice are contrary to the best interests of patients. However, advocacy actions should not put the wellbeing of patients in jeopardy.

Collective action is one means by which physicians can advocate for patients, the health of communities, the profession, and their own health. Physicians have a responsibility to avoid disruption to patient care when engaging in any collective action. When considering collective actions that have the potential to be disruptive, whether aimed at changing the policies of government, the private sector, or their own institutions, there are additional considerations that should be addressed. These include avoiding harm to patients, minimizing the impact of actions on patient access to care, maintaining trust in the patient-physician relationship, fulfilling the responsibility to improve patient care, avoiding mental and physical harms to physicians, promoting physician wellbeing, upholding the values and integrity of the profession, and considering alternative measures that could reasonably be expected to achieve similar results with less potential effect on patient and physician wellbeing.

When considering participation ~~Physicians who participate~~ in advocacy activities, including collective actions:

(a) ~~Ensure that the health of patients is not jeopardized, and that patient care is not compromised.~~ Physicians should recognize that, in pursuing their primary commitment to patients, physicians can, and at times may have an obligation to, engage in collective political action to advocate for changes in law and institutional policy aimed at promoting patient care and wellbeing.

(b) ~~Avoid using disruptive means to press for reform. Strikes and other collective actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.~~ Physicians may also engage in collective action to advocate for changes within their institutions, including changes in patient care practices, physician work conditions, health and wellbeing, and/or institutional culture that negatively affect patient care.

(c) Physicians should refrain from collective action that could jeopardize the health of patients or compromise patient care.

(d) Physicians may consider engaging in disruptive forms of collective action that do not compromise patient care only as a last resort, with the primary objective to improve patient care and outcomes by calling attention to and/or making needed changes in practices, protocols, incentives, expectations, structures, and/or institutional culture.

(e) Disruptive actions, including strikes, that could directly compromise patient care should be avoided and should not be used solely for physician self-interest.

(f) Physicians should avoid forming workplace or other alliances, such as unions, with ~~workers~~ colleagues and others who do not share physicians' primary and overriding commitment to patients.

(g) Physicians should refrain from using ~~undue influence or pressure colleagues~~ punitive or coercive means to force others to participate in advocacy activities or collective actions, or to penalize others ~~and should not punish colleagues, overtly or covertly,~~ for deciding not to participate in such activities.

2. That Policy H-405.946(2) be rescinded as having been accomplished by this report. (Rescind AMA Policy)

Fiscal Note: Less than $500

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REPORT 05 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-25)
"Protecting Physicians Who Engage in Contracts to Deliver Health Care Services"
(D-140.951)

EXECUTIVE SUMMARY

Policy D-140.951, "Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices," asks that the Council on Ethical and Judicial Affairs (CEJA) to "study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership".

Increasing investments by private equity firms in health care raise ethical concerns regarding dual loyalties of physicians and competing interests between profits and patients. The ethical concerns raised by private equity firms' incursion into health care warrant extreme caution. To respond to these issues, CEJA recommends amending Opinion 11.2.3, "Contracts to Deliver Health Care Services" to more clearly encompass partnerships with private equity firms and the ethical dilemmas and obligations that they raise for both physicians seeking capital to support their private practice as well as physicians entering into employment contracts with private equity-owned health care entities.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 05-A-25

Subject: Protecting Physicians Who Engage in Contracts to Deliver Health Care Services

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

Policy D-140.951, "Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices," asks our American Medical Association (AMA) to "study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership", the Council on Ethical and Judicial Affairs (CEJA) presented Report 02-A-23, Report 03-A-24, and Report 02-I-24, which offered recommendations on amending Opinion 11.2.3, "Contracts to Deliver Health Care Services." The last report was referred back to CEJA at the 2024 Interim Meeting, with testimony expressing a desire that a stronger stance be taken against private equity's (PE) involvement in health care, noting that the report placed too high of a bar on physicians contracting with private equity and needs stronger language to guide physicians working for private equity investors. CEJA acknowledges that private equity investment in health care raises pressing, complex issues, which will ultimately require multiple avenues to address, such as the related Council on Medical Service report (CMS 03-A-25) on private equity and the corporate practice of medicine as well as work currently being done by our AMA's Advocacy unit to promote physician-led care and reduce burnout. The present report has been revised in light of the valuable comments proffered at the last meeting, and offers specific ethics analysis and guidance for physicians impacted by private equity's involvement in medicine.

BACKGROUND

The past several decades have seen an increase in the corporatization, financialization, and commercialization of health care [1,2]. Since 2018, more physicians now work as employees of hospitals or health care systems rather than in private practice [3,4]. Our AMA reports that this trend is continuing: "[e]mployed physicians were 50.2 percent of all patient care physicians in 2020, up from 47.4 percent in 2018 and 41.8 percent in 2012. In contrast, self-employed physicians were 44 percent of all patient care physicians in 2020, down from 45.9 percent in 2018 and 53.2 percent in 2012" [4]. A major factor in these trends has been the incursion of private equity into health care. It is estimated that private equity capital investment between 2000 and 2018 grew from $5 billion to $100 billion [1]. Between 2016 and 2017 alone, the global value of private equity deals in health care increased 17 percent, with health care deals compromising 18 percent of all private equity deals in 2017 [5].

Private equity firms use capital from institutional investors to purchase private practices, typically utilizing a leveraged buy-out model that finances the majority of the purchase through loans for

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which the physician practice serves as security, with the goal of selling the investment within three to seven years and yielding a return of 20-30 percent [1,5,6]. However, private equity investment broadly encompasses many types of investors and strategies, including venture capital firms that primarily invest in early-stage companies for a minority ownership, growth equity firms that tend to partner with promising later-stage ventures, and traditional private equity firms that borrow money through a leveraged buyout to take a controlling stake of mature companies [7]. Private equity firms represent a unique business model within health care due to their primary focus, not on goods or services, but on quick returns on financial investment, emphasis on fulfilling promises to investors, and treatment of health care entities as not substantially different from non-health related investments.

When ownership shifts from physicians to private equity firms, the firms typically seek to invest resources to expand market share, increase revenue, and decrease costs to make the practice more profitable before selling it to a large health care system, insurance company, another private equity firm (as a secondary buyout), or the public via an initial public offering (IPO) [8]. To expand market share, private equity typically employs a "platform and add-on" or "roll-up" approach in which smaller add-ons are acquired after the initial purchase of a large, established practice, allowing private equity firms to gain market power in a specific health care segment or sub-segment [1,9]. These practices by private equity appear to be driving mergers and acquisitions within health care, significantly contributing to the consolidation of the health care industry that has dramatically increased over the past decade [9].

Proponents of private equity investments in health care claim that private equity provides access to capital infusions, which may facilitate practice innovation and aid in the adoption of new technological infrastructure [6,8]. Proponents also advocate that private equity can bring "valuable managerial expertise, reduce operational inefficiencies, leverage economies of scale, and increase healthcare access by synergistically aligning profit incentives with high quality care provision" [10].

Critics argue that private equity's focus on generating large, short-term profits likely establishes an emphasis on profitability over patient care, which creates dual loyalties for physicians working as employees at private equity-owned practices [5,6]. Critics further assert that prioritizing profits likely jeopardizes patient outcomes, overburdens health care companies with debt, leads to an over-emphasis on profitable services, limits access to care for certain patient populations (such as uninsured individuals or individuals with lower rates of reimbursement such as Medicaid or Medicare patients), and fundamentally limits physician control over the practice and clinical decision making [5,8,10].

While more empirical research is needed on the impacts of private equity investment in health care, there is a growing accumulation of evidence that private equity investment results in negative outcomes, including increases in costs, decreases in the quality of patient care, and decreases in patient satisfaction [10-13]. This is particularly worrisome as private equity firms are emerging to be major employers of physicians. Currently, it is estimated that 8 percent of all private hospitals in the U.S. and 22 percent of all proprietary for-profit hospitals are owned by private equity firms [14].

Relevant Laws

Fuse Brown and Hall write that despite the market consolidation that results from private equity acquisitions within health care, these acquisitions generally go unreported and unreviewed since they do not exceed the mandatory reporting threshold under the Hart-Scott-Rodino (HSR) Act and

that there are currently no legal guidelines for assessing the collective market effects of add-on acquisitions. However, they do note:

> Under Section 7 of the Clayton Act, federal antitrust authorities—the Federal Trade Commission (FTC) and the Department of Justice —can sue to block mergers and acquisitions where the effect of the transaction may be "substantially to lessen competition, or to tend to create a monopoly." To determine whether a transaction may threaten competition, antitrust agencies analyze whether the transaction will enhance the market power of the transacting parties in a given geographic and product market. […] Typically, the FTC oversees health care acquisitions (other than insurance).[1]

To protect patients from harmful billing practices, the federal government has passed the No Surprise Act, the False Claims Act, Anti-Kickback Statute, and Stark Law. Additionally, most states have similar laws, such as those barring fee-splitting and self-referral, and several states have passed laws regulating or restricting the use of gag clauses in physician contracts [1]. In 2024, the FTC also issued a final rule banning noncompete clauses in all employment contracts; while a district court issued an order stopping the FTC from enforcing the rule, the FTC has appealed that decision [15].

The federal Emergency Medical Treatment and Labor Act ensures that hospitals with an emergency department provide all patients access to emergency services regardless of their ability to pay. Similarly, federal law requires nonprofit hospitals, which account for 58 percent of community hospitals, provide some level of charity care as a condition for their tax-exempt status, which the Internal Revenue Service defines as "free or discounted health services provided to persons who meet the organization's eligibility criteria for financial assistance and are unable to pay for all or a portion of the services" [16].

While there is no federal law banning the corporate practice of medicine (CPOM), most states do have CPOM laws that prohibit corporations from owning or operating medical practices. However, these state laws typically include exceptions that allow corporate investors, such as private equity firms, to invest in health care entities through a physician management company or management services organization, and which also provide potential avenues for corporate investors to circumvent stringent limits on their operational authority.

Relevant AMA Policy Provisions

Council on Medical Service Report 11-A-19 reviewed the scope and impact of private equity and venture capital investment in health care, and its recommendations were adopted as Policy H-160.891, "Corporate Investors." This policy delineates 11 factors that physicians should consider before entering into partnership with corporate investors, including alignment of mission, vision, and goals; the degree to which corporate partners may require physicians to cede control over practice decision making; process for staff representation on the board of directors and medical leadership selection; and retaining medical authority in patient care and supervision of nonphysician practitioners.

Our AMA further developed and published materials to assist physicians contemplating partnering with private equity and venture capital firms:

- Venture Capital and Private Equity: How to Evaluate Contractual Agreements
- Model Checklist: Venture Capital and Private Equity Investments
- Snapshot: Venture Capital and Private Equity Investments

Policy H-310.901, "The Impact of Private Equity on Medical Training," encourages GME training institutions and programs to "demonstrate transparency on mergers and closures, especially as it relates to private equity acquisition" and asserts that our AMA will "[s]upport publicly funded independent research on the impact that private equity has on graduate medical education."

Policy H-385.926, "Physician Choice of Practice," states that "[o]ur AMA supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.)." While this policy upholds physician autonomy and supports the freedom of physicians to choose where and how they practice, the right to choose a method of earning a living is not unbounded, as the policy also states that physicians should charge their patients fair fees and provide "adequate fee information prior to the provision of services" whenever possible.

Additionally, policy H-215.981, "Corporate Practice of Medicine," states, "[o]ur AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups." This policy recognizes the attendant risks that the corporate practice of medicine represents to both patients and the practice of medicine.

Relevant AMA *Code Provisions*

Opinion 10.1.1, "Ethical Obligations of Medical Directors," states that physicians in administrative positions must uphold their core professional obligations to patients. The opinion mandates that physicians in their role as medical directors should help develop guidelines and policies that are fair and equitable, and that they should always "[p]ut patient interests over personal interests (financial or other) created by the nonclinical role."

Opinion 11.2.1, "Professionalism in Health Care Systems," acknowledges that "[p]ayment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians" and offers recommendations for physicians within leadership positions regarding the ethical use of payment models that influence where and by whom care is delivered. Key elements include the need for transparency, fairness, a primary commitment to patient care, and avoiding overreliance on financial incentives that may undermine physician professionalism.

Opinion 11.2.2, "Conflicts of Interest in Patient Care," clearly states: "[t]he primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. […] When the economic interests of the hospital, health care organization, or other entity are in conflict with patient welfare, patient welfare takes priority."

Opinion 11.2.3, "Contracts to Deliver Health Care Services," stipulates that physicians' fundamental ethical obligation to patient welfare requires physicians to carefully consider any contract to deliver health care services they may enter into to ensure they do not create untenable conflicts of interest. The opinion states that physicians should negotiate or remove "any terms that unduly compromise physicians' ability to uphold ethical standards." However, it should be acknowledged that physicians have little leverage in changing entire payment structures or reimbursement mechanisms when negotiating their contracts with hospitals. Similarly, physicians in private practice often feel that they have little leverage in negotiating the sale of their practice; they simply receive an offer and are told they can take it or leave it.

Opinion 11.2.3.1, "Restrictive Covenants," states: "[c]ovenants-not-to-compete restrict competition, can disrupt patient care, and may limit access to care" and that physicians should not enter into covenants that "[u]nreasonably restrict the right of a physician to practice medicine for a

specified period of time or in a specified geographic area on termination of a contractual relationship". However, many hospitals and hospital systems today now routinely include noncompete clauses as part of their physician contracts. These clauses put physicians at risk of violation of professional obligations and their widespread use has the potential to undermine the integrity of the profession as a whole. While the FTC issued a rule in April 2024 banning most noncompete agreements, a Texas District Judge issued a preliminary injunction on July 3, 2024, halting the enforcement of the ban.

ETHICAL ANALYSIS

The increasing corporatization and financialization of health care have generated legitimate concerns over ethical dilemmas they raise regarding a focus on profits at the expense of patient care. Prioritizing profits over patients is incompatible with physicians' ethical obligations. In other words, because it is unethical for physicians to place profit motives above commitments to patient care and well-being, when private equity firms invest in health care, their business model is prima facie ethically problematic for physicians. Private equity's primary objective of fast profit-making in order to uphold their promises to investors is at odds with physicians' primary obligation of acting in the patient's best interest.

However, although private equity-owned health care entities are different in their ownership structure and oversight compared to other traditional health care investors, private equity-acquired health care entities may not be substantively different from other for-profit and non-profit health care entities in terms of their stated goals of both solvency and patient care. Zhu and Polsky argue that private equity is not inherently unethical and that there are likely good and bad actors as is the case in many sectors [6]. They add: "physicians should be aware that private equity's growth is emblematic of broader disruptions in the physician-practice ecosystem and is a symptom of medicine's transformation into a corporate enterprise" [6].

The corporatization of medicine comes with ethical and professional risks that are perhaps best exemplified by private equity but are not unique to private equity alone. One only needs to turn to the systemic failure of nonprofit hospitals to provide adequate charity care or how for-profit hospitals often reduce access to care (particularly for Medicaid recipients) to see examples of how the corporatization and financialization of medicine has increasingly come to treat health care as a mere commodity [17,18]. This is despite the fact that health care is inherently different from normal market goods because the demand for health care is substantially inelastic and nonfungible, and medical knowledge is a social good collectively produced by the work of generations of physicians, researchers, and patients. The real problem with private equity's involvement in health care is that it blatantly reveals that as a society, we have increasingly moved towards treating health care as a commodity when as a profession, we know this should not be the case.

While business ethics and medical ethics are not inherently antithetical, differences do clearly exist [19]. Many physicians are thus justly concerned about any removal of professional control that may accompany the increasing commercialization of the physician's role. Veatch points out that paradoxically, despite being open to the profit motive in the practice of medicine, the profession as a whole has shown strong resistance to the commercialization of medical practice. For Veatch, the crux of the issue is whether people perceive health care as a fundamental right or a commodity like any other, adding that the notion of health care as a right jeopardizes any profit motive in health care including traditional private practitioner fee-for-service models [19].

Pellegrino offers a similar analysis, arguing that health care is not a commodity but rather a human good that society has an obligation to provide in some measure to all citizens [20]. Pellegrino

argues that health care is substantively different from traditional market goods—it is not fungible, cannot be proprietary because medical knowledge is possible only due to collective achievements, is realized in part through the patient's own body, and requires an intensely personal relationship—and thus cannot be a commodity. Pellegrino warns that the commodification of health and medicine turns any interaction between the patient and physician into a commercial transaction subject to the laws and ethics of business rather than to medical and professional ethics. "In this view," Pellegrino writes, "inequities are unfortunate but not unjust […]. In this view of health care, physicians and patients become commodities too" [20].

As health care has become increasingly commodified, the ethical risks to patients and physicians are being realized as physicians find themselves increasingly working as employees and worrying about the impact commercial enterprises—such as private equity investments—may be having on patients.

Private equity represents the latest and most extreme form of health care commercialization that has escalated over the past few decades. This is the very reason why private equity firms became interested in health care in the first place—they recognized that health care as a market was already ripe for investment and future profitability. Private equity firms use the same investment models in health care that they do in other industries—invest in fragmented markets, acquire the most promising targets as a platform, expand through add-on acquisitions, and exit the market once a significant consolidation of market share can secure a sale, secondary buyout, or IPO [9]. Each individual acquisition is typically too small to require review by anti-trust regulators at the FTC; at the same time, however, this practice is driving the trend of mergers and acquisitions in the health care sector [9].

Fuse Brown and Hall explain, "[private equity] functions as a divining rod for finding market failures—where PE has penetrated, there is likely a profit motive ripe for exploitation" [1]. They continue that private equity investments pose three primary risks:

> First, PE investment spurs health care consolidation, which increases prices and potentially reduces quality and access. Second, the pressure from PE investors to increase revenue can lead to exploitation of billing loopholes, overutilization, upcoding, aggressive risk-coding, harming patients through unnecessary care, excessive bills, and increasing overall health spending. Third, physicians acquired by PE companies may be subject to onerous employment terms and lose autonomy over clinical decisions [1].

While the profit motive of private equity firms may drive them to take part in less than scrupulous practices, such as private equity's exploitation of out-of-network surprise billing, there is also potential for private equity to play a more positive role in transforming health care practices [1,21]. Powers et al write:

> Ultimately, private equity—a financing mechanism—is not inherently good or bad. Instead, it acts to amplify the response to extant financial incentives. Within a fee-for-service construct, this is intrinsically problematic. But value-based payment models can serve as an important guardrail, helping to ensure that financial return to private equity investors are appropriately aligned with system goals of access, quality, equity, and affordability [21].

Private equity firms could help accelerate changes in health care payment and delivery towards value-based models. With such models, where financial performance is tied to quality and value, private equity may be incentivized to invest in changes that support better health and lower costs [21].

While more research is needed on the impacts of private equity investments in health care and on de-investment, when private equity firms ultimately pull out of a health care sector, private equity firms' involvement in health care does not appear to be exceptional within the current corporate transformation of the profession. As Fuse Brown and Hall point out, "PE investment in health care is just the latest manifestation of the long trend of increasing commercialization of medicine. And so long as the U.S. treats health care as a market commodity, profit-seeking will persist" [1]. Any financing model of health care that ignores patient care or puts profits over patient care should be considered unethical by physicians and the public.

Concerns over private equity's incursion into health care are clearly warranted. However, the financial and investment landscape of health care continues to evolve, and while private equity may be the latest trend it will not be the last version that emerges within the health care marketplace. Health care spending in the US continues to rise each year, with health spending increasing by 4.1 percent in 2022 for a total of $4.5 trillion and accounting for roughly 17 percent of total GDP [22]. With so much money involved in health care, it is bound to draw in investors; the involvement of investors from outside of health care, who may treat it as merely a market commodity and do not share physicians' overriding commitment to patient care and well-being, should be concerning. Such involvement by outside investors is likely to further transform health care, driving consolidation, commercialization, and de-professionalization.

In a practical approach to the current financial health care landscape, Ikrum et al offer some realistic recommendations for partnering with private equity in health care:

> While PE involvement in health care delivery invokes inherent concerns, it has provided much-needed capital for many primary care practices to mitigate the effects of the pandemic and to potentially undertake care delivery innovations such as population health management under value-based payment models. To make partnerships with private investors work, providers need to select the right investors, establish strategies upfront to address misaligned objectives, and define a successful partnership by setting goals for and transparently reporting on indicators that reflect both financial and clinical performance. Safeguards and regulations on sales may also protect patients and providers [7].

While private equity's overriding profit motive may be unethical in many instances, the reality is that private equity is already a large player in health care and physicians urgently need guidance on how to interact with private equity firms and private equity-owned health care entities. Keeping within its purview, the *Code* should offer guidance to physicians and to the practice of medicine on how to best interact with private equity and other outside forces that increasingly impact health care today. To support physicians as private equity continues to increase its market share of health care entities, practical guidance is needed related to both the sale of physician-owned practices to private equity as well as to those seeking employment by private equity-owned health care entities to help physicians navigate today's evolving financial health care landscape. Guidance is also needed for physicians employed by corporate entities that interact with the health care profession, including by private equity firms, management service organizations (MSOs), professional services corporations (PCs), insurance companies, and pharmaceutical benefit managers (PBMs).

CONCLUSION

The ethical concerns raised by private equity investments in health care are not unique but instead represent ethical dilemmas that exist due to the very nature of treating health care as a commodity. As highlighted by policy H-215.981, "Corporate Practice of Medicine," it is not some corporate practices but all corporate practices of medicine that create the potential for ethical dilemmas and

so should be avoided. Any decision to pursue financial incentives over and above patient care is unethical, and physicians' concerns regarding private equity's focus on short-term profits at the expense of patients' and their own well-being are justly warranted. Due to such concerns, physicians should strongly consider whether they can sell their practice to private equity investors while also upholding their ethical and professional obligations to patients and to the profession as a whole. Such reflection is also warranted for any physician considering employment by a corporate entity, such as a private equity firm, MSO, PC, insurance company, or PBM.

It is therefore crucial that policy guidelines be developed to ensure that private equity-acquired hospitals, hospital systems, and physician practices function in an ethical manner that prioritizes patients and patient care over profits. Policies that require greater transparency and disclosure of data on private equity ownership, greater state regulatory control over private equity acquisitions, closing payment and billing loopholes, rules requiring an independent clinical director on the Board of private equity firms engaged in health care, and means for physicians to help set goals and measure outcomes to ensure the alignment of corporate and clinical values should be considered [7]. The growth of private equity investment within the health care marketplace is clearly concerning and is an urgent issue that needs greater regulatory oversight. Beyond established ethical and professional norms, new regulations must be developed to prevent private equity from negatively impacting patient care and the medical profession [6]. A new Senate Budget Committee Bipartisan Staff Report, released in January 2025, calls for greater oversight, transparency, and restrictions of private equity involvement in health care [23]. While the report acknowledges that "not every PE firm operates in an identical fashion, the evidence highlights systemic issues with PE in investment in health care," and goes on to conclude, "the findings of the investigation call into question the compatibility of private equity's profit-driven model with the essential role hospitals play in public health. The consequences of this ownership model—reduced services, compromised patient care, and even complete hospital closures—potentially pose a threat to the nation's health care infrastructure, particularly in underserved and rural areas" [23].

Because the private equity business model creates serious potential risks and conflicts of interest for the practice of medicine, it is essential for physicians considering entering into partnership with private equity firms to first reflect on their ethical and professional obligations. If they do decide to proceed, however, physicians have a duty to evaluate their contracts and require that the agreements are consistent with the norms of medical ethics. Likewise, physicians considering entering into a contractual relation as an employee—whether with a private equity-owned hospital or otherwise—should ensure that their contract does not place them in an untenable conflict of interest or compromise their ability to fulfill their ethical and professional obligations to patients [8]. While we must acknowledge that physicians often have little power in contract negotiations, their ethical obligation remains nonetheless to try to negotiate when contractual agreements are likely to lead to ethical dilemmas. If a contract would prevent a physician from upholding their professional ethical obligations, the contract should not be entered into.

The Preamble to the *Code* stipulates that "[o]pinions of the AMA Council on Ethical and Judicial Affairs lay out the ethical responsibilities of physicians as members of the profession of medicine." Although some areas of concern therefore extend beyond what the *Code* may speak to, CEJA is currently studying the ethical obligations of health care entities that interact with physicians and is considering entering a report in the near future regarding the potential need for a new opinion to address additional stakeholders involved in our evolving health care landscape. CEJA recognizes that private equity investment raises concerns for physicians and for the practice of medicine but also acknowledges the *Code* is unable to speak to the totality of the issues raised by such investment practices. This is why it is crucial that multiple AMA units, such as the Council on

Medical Service's related report on private equity, work in tandem to address the complexity of the many issues raised by private equity firms' investment in health care entities.

It is the conclusion of the Council on Ethical and Judicial Affairs that increasing investment by private equity firms in health care raises ethical concerns regarding dual loyalties of physicians and competing interests between profits and patients. To respond to these issues, CEJA recommends amending Opinion 11.2.3, "Contracts to Deliver Health Care Services," to more clearly address concerns raised by entering into partnerships with private equity firms, physicians employed by corporate entities (including private equity firms, MSOs, insurance companies, and PBMs), and the ethical risks that may arise for both physicians seeking capital to support their private practice as well as physicians entering into employment contracts with private equity-owned health care entities.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that Opinion 11.2.3, "Contracts to Deliver Health Care Services," be amended by addition and deletion as follows and the remainder of this report be filed:

> Prioritizing profits over patients is incompatible with physicians' ethical obligations. No part of the health care system that supports or delivers patient care should place profits over such care. Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires ~~them to~~ that before entering into contracts to deliver health care services, physicians consider carefully the proposed contract to assure themselves that its terms and conditions ~~of contracts to deliver health care services before entering into such contracts to ensure that those contracts~~ do not create untenable conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients. Those physicians who enter into contracts with corporate entities, such as private equity firms, management service organizations, professional services corporations, insurance companies, or pharmaceutical benefit managers, who act within their capacity as a physician, even as administrators or intermediaries, also have a duty to uphold the ethical obligations of the medical profession.
>
> Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians' ability to uphold professional ethical standards ~~of informed consent and fidelity to patients~~ and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.
>
> As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, investment firms, or other entities—they should be mindful that while ~~many~~ some arrangements have the potential to promote desired improvements in care, ~~some~~ other arrangements ~~also~~ have the potential to ~~impede~~ put patients' interests at risk and to interfere with physician autonomy.
>
> When contracting with entities, or having a representative do so on their behalf, to provide health care services, physicians should:

(a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel, ~~or have a representative do so on their behalf~~ to assure themselves that the arrangement:

(i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;

(ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;

(iii) ~~allows~~ ensures the physician can ~~to~~ appropriately exercise professional judgment;

(iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;

(v) is transparent and permits disclosure to patients~~.~~;

(vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing;

(vii) prohibits the corporate practice of medicine.

(b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical or professional standards.

When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians should:

(c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism.

(d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment.

(e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues.

(f) Not enter into any contract that would require the physician to violate their professional ethical obligations.

When contracted by a corporate entity involved in the delivery of health care services, physicians should:

(g) Terminate any contract that requires the physician to violate their professional ethical obligations and report any known or suspected ethical violations through the appropriate oversight mechanisms.

1 (Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 06-A-25

Subject: Amendment to Opinion 1.1.1 "Patient-Physician Relationships"

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

The Council on Ethical and Judicial Affairs (CEJA) believes that the AMA *Code of Medical Ethics* and the profession would be better served by amending guidance to provide a more robust discussion of the nature of patient-physician relationships and physicians' associated ethical obligations. Indeed, the practice of medicine has changed in ways that demand a thorough review and potential reconceptualization of the obligations of both individual physicians and the profession as a whole.

BACKGROUND

Relevant House Policies

Several House policies reference the importance of the patient-physician relationship. Though not an exhaustive list, the following policies capture the spirit of the patient-physician relationship expressed within AMA House policy: H-165.837 "Protecting the Patient-Physician Relationship", H-225.950 "AMA Principles for Physician Employment", and H-275.937 "Patient/Physician Relationship and Medical Licensing Boards" [1-3]. The patient-physician relationship as expressed by these policies is understood to be fundamental and paramount to the practice of medicine. This relationship is understood to carry certain obligations for physicians, including the duty to be patient advocates, to prioritize patient care, and be transparent regarding cost-sharing arrangements. Other considerations, including personal financial concerns, are to be secondary to the relationship. Furthermore, this relationship is not perceived as purely contractual, as termination of employment does not necessarily end the relationship between a physician and persons under their care (H-225.950).

Relevant Code Provisions

Within the AMA *Code of Medical Ethics*, the patient-physician relationship is understood as: "fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering[… that is] based on trust" (Opinion 1.1.1). This relationship is primarily represented as emerging from a physician's fiduciary duty to patients, in which both parties enter into this fiduciary relationship via a consensual agreement. Though not an exhaustive list, the following opinions capture the spirit of the patient-physician relationship expressed within the *Code:* Opinion 1.1.1 "Patient-Physician Relationships", Opinion 1.1.3 "Patient Rights", Opinion 1.1.5

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"Terminating a Patient-Physician Relationship", Opinion 1.1.6 "Quality", Opinion 1.1.7 "Physician Exercise of Conscience", Opinion 8.6 "Promoting Patient Safety" [4-9]. These opinions demonstrate that the patient-physician relationship entails fiduciary responsibility, mutual respect, support for the continuity of care, open communication, quality care, and trust.

ETHICAL ISSUES

Current guidance in Opinion 1.1.1 "Patient-Physician Relationships" focuses heavily on legal considerations about when a relationship is established and has little purchase on the ethical concerns raised by extensive changes to the practice of medicine that have recently occurred. Among these changes are the continuing development of technology (such as augmented intelligence), the use of team-based care, the rising number of employed physicians (as contrasted with those in private practice), interference in the patient-physician relationship by third parties (such as health care administrators, insurers or government), and the recognition that physicians have an obligation to advocate for changes to institutions, policies, and practices in order to improve patient care and promote health care justice.

A major change to the patient-physician relationship over the past few decades has been an increased recognition of the importance of patient autonomy. Ironically, however, this move away from paternalism towards patient autonomy in the setting of the patient-physician relationship has taken place while medicine has come to be dominated by large institutions, financial concerns such as cost-containment, changes in financing designed to influence patient and physician behavior, commercialization, an increasing reliance on markets, and other pressures that have had a de-professionalizing effect on physicians. These changes have led in turn to a loss of autonomy for both physicians and patients. Even as the discretionary space of physicians has shrunk, their responsibilities have expanded. Physicians are now called to engage in cultural competency and humility, trauma-informed approaches to care, and to recognize past harms and historical contexts of patient populations. They are called upon to be the mechanism by which medical inflation will be controlled. They are called upon to advocate not just only for their own individual patients within systems of care but to advocate for changes in the social systems that determine health care needs and distribute illness, injury, and disability unjustly.

Recognizing that each patient brings different experiences to the relationship is now seen as a crucial part of establishing trust within a patient-physician relationship. The question that arises, however, is how is that trust to be earned within systems that often appear untrustworthy and designed to frustrate the commitment of physicians to act for the good of their patients?

ETHICAL ANALYSIS

The patient-physician relationship is foundational for medical ethics. It is characterized by the nature of illness, the need for healing, and a commitment to help, culminating in a decision to take action directed toward healing and the alleviation of suffering caused by disease, injury, or disability. This relationship is inherently unequal. The patient is unavoidably in a position of vulnerability and dependency, while the physician holds the knowledge and the resources that the patient needs [10]. The sick, injured, and disabled therefore have little choice but to trust that their physicians will use the power of medicine for their good as individual patients. That trust is established by the physician's act of profession—the commitment, generally undertaken through an oath, to be worthy of patients' trust—and the patent's agreement to cooperative collaboration.

The heart of professionalism is thus the public commitment of physicians to use their medical knowledge, skills, and judgment for the good of their patients. Moreover, since patients are first and foremost persons, true healing can only take place when the uniqueness and personhood of patients are taken into account, incorporating their biological particularities, beliefs, relationships, emotions, values, and goals into medical decisions. This requires a mutually respectful, trusting collaboration aimed at serving the patient's good. For patients, this entails an obligation to seek care and be as candid as possible with their physicians.

All medical actions are oriented towards the ethical centrality of the patient-physician relationship. While the paradigmatic instance of this dynamic is serious illness, or injury, the care of patients with chronic conditions also requires a sustained, trusting relationship. Palliation, too, aims at the relief of medical suffering and provides healing in a holistic sense even when cure is not possible. Prevention is also oriented towards the good of individual patients and requires trust that interventions are appropriate for that aim. Public health efforts provide the common resources necessary to promote healing and prevent illness, injury, and disability, and thus unite societal commitments to justice and prevention of harm with physicians' duties of beneficence, nonmaleficence, and respect for persons.

This understanding of the patient-physician relationship makes medicine an inherently moral enterprise, qualitatively different from the commercial transactions of providers and consumers. The patient-physician relationship itself is part of the healing process and not a commodity or product. Even economists recognize that the demand for health care is substantially inelastic and nonfungible, placing it outside the assumptions of normative market economics. Medical knowledge is not property that physicians own. It is a social good built up by the work of generations of physicians, scientists, and researchers and made possible by the generosity of generations of patients who have contributed to the advancement of medical progress (and who, it is acknowledged, have not always consented to such participation).

Medicine does not exist in a vacuum. Natural, historical, socioeconomic, and political circumstances always condition the patient-physician relationship. Physicians, for instance, do not always live up to the ideals of the profession. Structural social inequities result in unequal access to health care. While the patient-physician relationship itself is not a market commodity, markets provide many of the goods and services that physicians rely on to care for patients. Unfortunately, this also means that these goods and services are subject to the vicissitudes and inequities inherent to market systems, sexism, racism, and other unjust forms of discrimination.

Political decisions, for good or for ill, can also have a tremendous impact on care, affecting the distribution of physicians, the services they can provide for patients, the conditions under which physicians work, and the tenor of the patient-physician relationship. Therefore, if the good of the patient is the central moral focus of medicine, a commitment to justice will be required to ensure the integrity of the patient-physician relationship and to make the services of physicians available to all who stand in need of their care. In a pluralistic, liberal democracy, this requires, in turn, that professions be granted a relatively independent status outside other social institutions such as the market and the government. Too much encroachment by the market or the government into the legitimate authority of the medical profession ultimately undermines the central moral focus of medicine: the patient-physician relationship. Likewise, without the proper degree of self-regulation and respect for other social institutions, the medical profession itself can lose track of its own moral center. The good of the patient ought never to be made subservient to the political or financial ends of physicians, governments, or markets. Determining what the good of the patient is requires that physicians have the freedom and flexibility to adopt a patient-centered approach to care that allows for patients to feel heard and respected.

As the profession of medicine continues to change, there are concerns about how these changes impact patient-physician relationships and thus the relevance of the patient-physician relationship itself. However, despite the evolving landscape of the medical profession, the patient-physician relationship remains vital to the practice of medicine and to medical ethics. Regardless of changes to their roles that physicians face, clinical encounters will always be subject to the professional and ethical obligations that emerge from patient-physician relationships.

When we examine the patient-physician relationship, what we are really after is the source of the obligations that ground medical ethics. While medicine has always been practiced under non-ideal circumstances that can make it difficult to carry out these obligations to a maximal extent, we recognize that current circumstances are making it more difficult than ever. Moreover, we recognize that a patient-physician relationship may arise in a variety of contexts, and that these may not always be geared towards benefiting the patient, the physician, or both. The goal of this report, however, is to outline the core aspects of ethical and just patient-physician relationships and articulate gaps in the current *Code* Opinion 1.1.1. in order to better support patients and physicians as the medical profession and health care ecosystems continue to evolve.

Trust and the Patient-Physician Relationship

The pressures of increasing de-professionalization and de-personalization in the healthcare environment have sometimes obscured or even seemed to denigrate the value of the patient-physician relationship. New ethical questions have arisen as systems of care have changed in ways that have made it more difficult for physicians to fulfil their duties that arise from a recognition that this relationship is central to the meaning and value of the profession. While the patient-physician relationship has responded and evolved in light of these challenges and in the face of other technological, economic, and sociocultural changes, there can be no doubt that patients' trust in medicine has declined. Nonetheless, there is also a renewed interest in the relational aspect of the patient-physician relationship and new attempts to build the trust that sustains it.

Trust is in many ways the cornerstone of any interpersonal relationship. Social psychologists who study trust have noted that the development of dyadic trust is a process that involves commitment, cooperation, and the building of confidence in benevolent values, motives, goals, and intentions [11]. Trust—and distrust—may be enacted in the immediate but is also built over time. Interpersonal trust is also impacted by (and in turn impacts) social trust, as social trust influences the development of interpersonal trust which then also impacts trust in the institutions in which interpersonal interactions take place [12].

To protect the patient-physician relationship, then, a central goal of the medical profession should be to foster trust in health care, which has been in sharp decline for the past half century [13]. One of the primary means to engender trust is through good communication. Research has shown that aspects of physician communication can impact patient outcomes (such as medication compliance) and patient satisfaction (which is associated with greater continuity of care), and that patient-centered approaches to care, which consider the patient's perspective on equal ground with the physician's clinical diagnosis, enhance communication and the patient-physician relationship [14].

Fostering Trust to Support the Patient-Physician Relationship

Research on physician communication practices have found at least five broad communication categories including: information giving, information seeking (questioning), partnership building, rapport-building behaviors (both verbal and nonverbal behaviors that explicitly convey emotional content), and socioemotional behaviors [15]. How patients and physicians view these aspects of

communication, and the patient-physician relationship in general, are not always the same, however. In one study comparing physician and patient evaluations of the relationship, researchers found that while physicians identified their technical expertise and knowledge as vital for establishing trust in the relationship, emphasizing the importance of competence, devotion, serviceability, and reliability, patients stressed the importance of interpersonal skills as more important, such as caring, appreciation, and empathy [16]. Recognizing this difference in perceptions is crucial for understanding how trust can be gained or lost, especially considering that researchers found trust to make the largest contribution to patient-physician perceived satisfaction [16].

Patient satisfaction is strongly associated with positive physician communication behaviors. Because physicians' communication behaviors vary widely, however, there is significant room here for improving patient-physician relationships. One study found that only 33% of physicians were rated "excellent" on all four communication behaviors analyzed, while 12% were rated either "fair" or "poor" on all four behaviors [17]. Patient-physician communication is one of the strongest factors that impact patient satisfaction and is fundamental to facilitating shared responsibility and trust [18].

Communication is not the only value that engenders and supports trust. Research has found that clinicians whose patients expressed trust in them worked in environments that placed an emphasis on quality, communication, clinical cohesion, and alignment of values between clinicians and organizational leaders [19]. Like communication, physician empathy has also been regarded as central to patient-centered care, and research has found that empathy correlates with patient satisfaction, adherence, outcomes, and enablement [20]. Other models of trust establish foundational factors that include competency, motive, and transparency [21].

The Future of Patient-Physician Relationships

When considering the source of the ideal patient-physician relationship, its emergence is simultaneously contractual, dependent on virtues, and relational. All three of these conceptual models rely on trust, and trust in turn is supported by additional values. Interpersonal trust is reliant upon collaboration, respect, empathy, and reciprocity. Contractual trust is reliant upon competency, transparency, aligned motives, and continuity. These values in many ways become ideal virtues within health care that help create trust in the institution of medicine over time, which is crucial for initial clinical encounters as well as for individuals who lack capacity.

Physicians have an ethical duty to support the patient-physician relationship by upholding the virtues of the profession. This ethical duty is grounded in medical professionalism and the commitment to serve as healers. The relationship that patients and physicians enter into is sustained by trust—in both the profession as whole, as well as in both the patient and the physician who agree to participate in a cooperative and collaborative partnership. This trust gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest. This partnership is unique in that it is inherently unequal in terms of vulnerability, yet equal in importance with respect to both individuals' contributions to the relationship; similarly, the relationship is not a commodity product, yet it involves interacting with market economics. The patient-physician relationship is contextual—biological, historical, socioeconomic, and political elements will always be relevant—but it is also fundamentally a moral activity.

Honavar writes, "[the p]atient–physician relationship is a complex psychosocial interplay of vulnerability, trust, and authority in a professional setting" [22]. Currently, the *Code* primarily speaks to the importance of trust within the patient-physician relationship without acknowledging

that the reason trust is crucial is because of the unequal vulnerabilities and authorities at play. The power dynamics of every patient-physician relationship will be different, of course, but it is crucial that the *Code* address such concepts as patient vulnerability, the importance of respect, communication, and competency in establishing trust. Ultimately, Opinion 1.1.1 must move beyond the current language that focuses on when a patient-physician relationship begins in order to more fully address how to ethically and justly sustain the relationship. Furthermore, knowing that the practice of medicine will continue to change and that as a result, so too will patient-physician relationships, the *Code* needs to clearly acknowledge that patient-physician relationships are inherently dynamic, contextual, and will continue to evolve.

RECOMMENDATION

Your Council on Ethical and Judicial Affairs recommends that Opinion 1.1.1, "Patient Physician Relationships" be amended by addition and deletion and the remainder of this report be filed.

> The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. ~~The relationship between a patient and a physician is based on trust, which gives rise to~~ The relationship that emerges between a patient and a physician must be based on trust. The physician's obligation to be trustworthy entails additional ethical duties such as a commitment to act for the good of patients; to uphold respect for patients as persons; to develop good communication skills; and to be professionally competent. This trust is fostered by physicians' ethical responsibilit~~y~~ies to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.
>
> A patient-physician relationship ~~exists~~ commences when a physician begins to serve a patient's medical needs. ~~Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate). However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:~~ This generally occurs in response to a request by a patient or a patient's surrogate, but can also occur in certain contractual, legally mandated, or emergency settings without the explicit request or consent of the patient.
>
> While the patient-physician relationship may involve one patient and one physician in today's complex health care system, such relationships often involve multiple members of a care team, patient family members and surrogates. The core values of the patient-physician relationship, however, remain unchanged. How these values are implemented will depend on many factors, including the setting, the needs of the patient, the duration of the relationship, and the training, expertise, and experience of the physician, and will necessarily reflect the myriad ways that patients and physicians interact. While every patient-physician relationship will be different and will change over time, the fundamental importance of establishing and sustaining trust through respect for persons, good communication, and professional competency will always be crucial at every layer, node, and time of the relationship. It is the duty of physicians, therefore, to uphold these values and support patients and the primacy of the patient-physician relationship to the best of their ability in all practice settings and at all times.
>
> ~~(a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.~~

~~(b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.~~

(c) ~~When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.~~

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

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REPORT 07 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-25)
Guidelines on Chaperones for Sensitive Exams
(Reference Committee on Ethics and Bylaw)

EXECUTIVE SUMMARY

In this report, CEJA considers the appropriate use of chaperones for sensitive exams, and, in general, how to create safe environments for all patients while maintaining professional boundaries. The report recommends revising Opinion 1.2.4, "Use of Chaperones" to reflect current best practices for sensitive exams. New recommendations include: (1) adoption of an "opt-out" approach for sensitive exams in routine circumstances; (2) the requirement of training/qualifications for chaperones; (3) guidance for when a physician may require a chaperone even if the patient declines; and (4) guidance for sensitive examinations and persons who cannot give informed consent, including children and adolescents.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 07-A-25

Subject: Guidelines on Chaperones for Sensitive Exams

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaw

Policy D-140.950, "Guidelines on Chaperones for Sensitive Exams," was adopted at the 2022 Interim Meeting and reads as follows:

> Our American Medical Association will ask the Council on Ethical and Judicial Affairs to consider amending E-1.2.4, "Use of Chaperones in Code of Medical Ethics," to ensure that it is most in line with the current best practices for adult and pediatric populations and potentially considers the following topics:
>
> a. Opt-out chaperones for breast, genital, and rectal exams.
> b. Documentation surrounding the use or not-use of chaperones.
> c. Use of chaperones for patients without capacity.
> d. Asking patients' consent regarding the gender of the chaperones and attempting to accommodate that preference as able.
> e. Use of chaperone at physician request when physician deems necessary.

This report is being submitted in response to this directive from the House of Delegates.

BACKGROUND

Conducting sensitive examinations in an ethically and clinically sound manner requires physicians to be responsive to both the distinctive characteristics of the individual patient and to the boundaries appropriate to the patient-physician relationship. While a sensitive exam is typically understood as one involving any examination of, or procedure involving, the genitalia, breasts, perianal region or the rectum, physicians should be aware that a patient's personal history, including their cultural background and beliefs or identity may broaden their definition of what constitutes a sensitive examination or procedure [1]. Efforts to provide a comfortable and considerate atmosphere for the patient during sensitive exams are part of respecting patients' dignity. These efforts may include providing appropriate gowns, private facilities for undressing, sensitive use of draping, and clearly explaining various components of the physical examination. They also include the use of chaperones regardless of the gender of the physician or patient [2].

A chaperone "is a trained person who acts as support and witness for a patient exam or procedure" [1]. If the chaperone is trained to do so, they may also assist the provider with equipment and specimen handling. The use of chaperones is appropriate in a variety of specialties and clinical

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Ethics and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council

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settings [3]. Several states have implemented legal mandates ranging in stringency from requiring that physicians offer a chaperone for sensitive examinations, to "defining examination of the genitals or breasts by a physician of the opposite gender without a chaperone as professional misconduct" [4]. Physicians should therefore make themselves aware of local regulations when they consider their chaperone policy.

Having chaperones present can help prevent misunderstandings between the patient and physician and can protect the integrity of the patient-physician relationship. A fair and effective policy on the use of chaperones must balance: (1) concern for physician and patient safety; (2) respect for patient preferences; and (3) the ethical responsibility to maintain clear professional boundaries.

ETHICAL ANALYSIS

Appropriate use of chaperones during sensitive examinations and procedures is meant to protect both the physician and the patient. Having a chaperone present can increase trust between the physician and patient, contribute to the comfort and safety of the patient, and maintain the patient's dignity. The use of chaperones can also help protect the physician against accusations of misconduct that arise from misunderstandings or that are intentionally false.

There is a power imbalance embedded in the patient-physician relationship. Patients make themselves vulnerable to the physician both by permitting procedures and examinations to be conducted on their bodies and by disclosing private information to the physician during the course of the clinical encounter.

The physician guides the care that the patient receives and should adopt practices within the clinical encounter to foster trustworthiness. The presence of a trained chaperone contributes to establishing the formal nature of the contact between physician and patient, and a chaperone may serve as a witness when a patient expresses concern, asks questions, or withdraws consent. Knowing that the encounter has been witnessed allows both the physician and patient reassurance that the encounter was professional and safe, which fosters trustworthiness.

What is considered a sensitive examination or procedure can vary widely among patients. In order to foster trust between the patient and physician and to set appropriate professional boundaries for sensitive examinations and procedures, various factors affecting the particular patient should be considered, including history of trauma, sexual orientation, gender identity, personal beliefs, and cultural norms and expectations.

Since patients may not disclose their history of sexual assault or previous negative healthcare experiences, trauma-informed care (sometimes alternatively described as "healing centered engagement") [5] should be employed for all examinations, including those not usually understood as sensitive. A trauma-informed framework "assumes that all people have experienced trauma, are experiencing it, or may experience it in the future" [6]. This approach is focused on creating "safety, empowerment and trustworthiness" in the clinical encounter [7]. For sexual and gender minority patients, their lived experiences, perspectives and current health needs should guide physicians in jointly identifying which examinations and procedures should be treated as sensitive [7]. Likewise, some patients may have personal or religious beliefs or may adhere to cultural norms that they wish to have respected in the clinical encounter. This may necessitate tailoring the conditions and understanding of what are defined as sensitive exams to the patient's level of comfort and concepts of appropriateness. One way for physicians to provide a consistently safe and respectful environment for *all* patients is to be open to broadening the range of circumstances in which a chaperone is used.

The presence of a chaperone also promotes patient safety by acting as a deterrent to inappropriate behavior [1]. Patients may be more comfortable with someone of a particular gender being present because that person can better understand the kinds of embarrassment or discomfort associated with their sensitive exam and so may be better equipped to provide support [8].

Patients' right to dignity (Opinion 1.1.3 "Patient Rights") is closely tied to their physical privacy (Opinion 3.1.1 "Privacy in Health Care"). Since medical examinations and procedures often require the patient to put aside their norms regarding modesty and give consent to being seen and touched in ways they would not usually allow, maintaining their physical privacy is a critical way to show respect and foster trustworthiness. The presence of a chaperone reinforces the professional nature of the interaction with the goal of providing reassurance that the patient's experience and wishes are taken into account [1].

Having chaperones present can also help prevent misunderstandings between patients and physicians by clarifying expectations and facilitating communication about the examination. Chaperones who are familiar with the elements of sensitive examinations and procedures, know how to properly observe them, and know when to intervene if they have concerns. Chaperones may augment a patient's sense of safety by ensuring for the patient that the interventions are necessary. Further, having a third-party present who can attest to what occurred during the encounter may protect physicians from false allegations of misconduct [1].

Mandatory, Opt-in, and Opt-Out Chaperone Policies

There are three types of chaperone policy: opt-in, opt-out, and mandatory.

- A mandatory policy is one in which a chaperone *must be* present during all sensitive examinations or procedures, or else the examination or procedure will not be performed (except in an emergency).
- An opt-in policy is one in which patients are *automatically offered* a chaperone for sensitive examinations and procedures and in other situations one is made available upon request.
- An opt-out policy is one in which a chaperone *is automatically provided* for all sensitive examinations and procedures (with an option for the patient to decline with physician agreement), and one is made available upon request in other situations.

Currently, the AMA *Code of Medical Ethics* recommends an opt in policy, meaning that physicians should "adopt a policy that patients are free to request a chaperone and communicate that policy to patients" and that a patient's request should always be honored (Opinion 1.2.4 "Use of Chaperones"). Under the opt-in model, the default is to proceed with the examination or procedure unless an explicit request for a chaperone is made by the patient. This opt-in approach provides less protection for both the patient and physician than a mandatory or opt-out approach, since the responsibility to ask for the chaperone belongs to the patient. The difficulty with this type of policy is that it assumes the patient feels empowered to ask for a chaperone without fear of damaging the patient-physician relationship or causing inconvenience or annoyance [3]. Additionally, evidence suggests that patients may not request a chaperone because they think it may insinuate that their physician is untrustworthy [10,11] and only a small percentage of patients feel comfortable asking for a chaperone when none was explicitly offered [12].

By contrast, under an opt-out policy, patients do not need to make a specific request because the policy makes it standard practice to have chaperones present for sensitive examinations. Specifically, chaperones are made available and routinely present during sensitive exams, unless

the patient refuses. Opt-out policies are effective at protecting both the physician and the patient since, by default, they make it the norm to have a third-party present as a witness to sensitive exams or procedures.

Although the opt-out approach offers patients more protection, in some cases, this approach may introduce problems with obtaining informed consent. For instance, once a chaperone is brought into the examination room, a patient may be reluctant to object since this is presented as the usual way things are done. Some patients also may not realize they have a choice. Further, if a patient does not speak up (either way), their silence may be taken to be tacit approval, when in actuality the patient is intimidated or does not understand what is happening [13]. Under ordinary circumstances, remaining silent should not be understood as valid consent. While obtaining explicit consent is important, as noted above, the value of adhering to patient preferences must be balanced against the values of protecting patients and physicians and the maintenance of professional boundaries. These considerations may be weighed differently depending on the specific features of the encounter.

Both opt-in and opt-out policies can create challenges in part because patients' requests and/or consent for use of a chaperone take place directly in the treatment room. For this reason, it has been suggested that patients' preferences regarding chaperones should be solicited by front desk staff or other intake staff as a routine part of the check-in procedure [11,4]. This is an opportunity to provide materials explaining the purpose of the chaperone and to inform patients of the standard policy while allowing patients to express their preferences in a low-pressure environment. However, regardless of where and how consent for the use of a chaperone is solicited and obtained, physicians should keep in mind that what is most important during "the process of obtaining informed consent is equalizing the patient's ability to say *yes* or *no*" [6].

While opt-in policies have historically been regarded as adequate, this is no longer the case in some specialties. There is precedent to believe that a shift to opt-out policies will better protect both patients and physicians in many settings. The American College of Obstetricians and Gynecologists (ACOG) argues that given "the profoundly negative effect of sexual misconduct on patients and the medical profession and the association between misconduct and the absence of a chaperone" regular use of chaperones is necessary to assure patients and the public that significant "efforts are being made to create a safe environment for all patients" [1]. Because physician misconduct undermines the integrity of the profession as a whole, there is strong reason to adopt policies that reduce it. Physicians also deserve to work in an environment where false allegations of misconduct or misunderstandings between physicians and patients do not compromise either their professional reputation or the relationships of trust that they have established with their patients. Likewise, patients deserve to be treated in an environment that supports their agency and improves the quality of their experience, without being expected to make a special request. These goals are best promoted through the implementation of an opt-out policy for the use of chaperones. Therefore, the presence of chaperones should be standard during sensitive exams and procedures. In other situations, it is recommended that chaperones be made available for any examination requiring the patient to disrobe, or when the patient requests one. As such, patients must be informed that they are entitled to request a chaperone whenever they wish. Finally, physicians should honor all patients' preferences for a chaperone even when a trusted companion is present.

Use of Chaperone at Physician Request

There may be times when the physician would prefer to use a chaperone, but the patient declines. In these cases, ACOG suggests:

> "[It] should be explained that the chaperone is an integral part of the clinical team whose role includes assisting with the examination and protecting the patient and the physician. Any concerns the patient has regarding the presence of a chaperone should be elicited and addressed if feasible" [1].

Ideally, these conversations will be a process of joint decision-making between the patient and the physician. If the patient declines a chaperone when the physician determines having a chaperone present is clinically indicated, every effort should be made to accommodate the preferences of the patient, consistent with the requirements of patient safety, physician safety, and the maintenance of professional boundaries. Physicians should inquire about specific concerns the patient may have and suggest ways these might be addressed in a mutually acceptable manner. Physicians should engage the patient in a detailed discussion of how care might be provided in a way that maintains a comfortable and respectful environment before deciding that they cannot perform the exam or procedure. Ultimately, "if an unchaperoned examination is performed, the rationale for proceeding should be documented" [1]. As a last resort, if the patient and physician cannot come to an agreement, then the physician may defer the examination or procedure and refer the patient to another clinician. In this situation, patients should be provided with "reasonable assistance in making alternative arrangements" so they can receive care in a timely fashion (Opinion 1.1.3 "Patient Rights").

Use of Chaperone without Patient Consent in Exceptional Circumstances

In many situations, insisting on a chaperone when the patient declines may be a violation of their autonomy and therefore impermissible. However, in keeping with their best clinical and ethical judgment, physicians may nonetheless proceed with a chaperone in the following circumstances:

- When it is an emergency and failure to proceed rapidly would result in an immediate risk to the patient's life or long-term health, or
- In cases where the integrity of the patient-physician relationship is at risk, such as when a patient's behavior compromises (or has previously threatened) professional boundaries, or the physician has reason to believe such a boundary violation or other unsafe situation is likely to occur. [14]

Documentation of Patient Preference and Chaperone Use

Regardless of the chaperone policy normally implemented in a particular setting, the medical record should reflect the presence or absence of a chaperone for each examination [1,3,11]. The record should include whether the patient requested a chaperone explicitly or one was present as a matter of policy. Additionally, the record should state whether the patient received counseling on the purpose and importance of chaperones, and the name and gender of the chaperone. Note that there are range of acceptable practices for recording chaperone information; the extent of documentation, including what precise data to include, varies among medical specialties. Additionally, with regard to patients' preference for specific characteristics of a chaperone physicians should be mindful not to accede to discriminatory or disruptive patient demands. Disrespectful, derogatory, or prejudiced language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either patients or physicians can undermine trust and compromise the integrity of the patient-physician relationship while also creating an "environment that strains relationships among patients, physicians, and the health care team." (Opinion 1.1.2 " Discrimination & Disruptive Behavior by Patients") Discriminatory requests should not normally be accommodated, and accommodation should only occur after careful weighing of the circumstances.

Pediatric & Adolescent Patients

Appropriate use of chaperones for pediatric and adolescent patient populations is distinct from adult patients because they have different needs and sensitivities. Normally, a parent or guardian may act as the chaperone for young pediatric patients (from newborns to age 11) [15]. In cases where a parent or guardian is unavailable or their presence would interfere with the examination (such as in cases of suspected abuse), another chaperone should be present [15]. Should a parent or guardian decline the physician's request that a chaperone be present in such situations, it may nevertheless be appropriate for the physician to insist for the sake of patient safety.

Addressing the needs of adolescent patients (age 12-17) is more complex. Since many adolescents are "preoccupied with their changing bodies, self-conscious about their appearance, and longing for increased privacy," any examination that requires them to remove their clothes could be distressing [12]. Physicians should not assume that their own definitions of a sensitive examination reflect the understanding of the individual teenage patient [16]. Research shows that 60-70 percent of female adolescents would like the option of a chaperone both for standard and for sensitive examinations. Only 21 percent indicated that they would ask for a chaperone if one was not offered, and substantially more female adolescents wanted a chaperone for sensitive examinations if they had a chaperone in the past [12].

Many adolescents want their parent to act as chaperone instead of a healthcare professional, although in general as their age increases their preference for a non-parent chaperone also increases [16]. Some adolescents did not wish to have chaperones, indicating that it would be more embarrassing, awkward, or uncomfortable to have an additional person in the room [11].

As such, when treating adolescents, the best policy is to explain the role of chaperone in detail and then solicit their preferences. It is also important to ask whether they wish to have their family member or guardian in the room, either in addition to, or instead of, the healthcare professional acting as chaperone. Since adolescents may not have prior experience with chaperones, it is probably not sufficient to have them fill out a form at intake. Instead, their options should be presented during a conversation (and their parent or guardian, if they wish to have them present) so a decision can be made together. Their preferences are also likely to change over time, so this conversation will need to be revisited.

As noted in Opinion 2.2.1 "Pediatric Decision Making," the "more mature a minor patient is […] the stronger the ethical obligation to seek minor patients' assent." This obligation extends to their assent for the presence of a chaperone, as well as their preferences for who the chaperone will be and the gender of the chaperone. In general, physicians and parents/guardians should respect a minor's refusal to assent to a chaperone (except under the conditions mentioned above when a physician may either insist or may decline to proceed with the examination).

Policies around the use of chaperones for adolescents are separate from issues of parental consent for treatment. Physicians should be aware that in some jurisdictions, "the law permits minors to receive confidential services relating to contraception, or to pregnancy testing, prenatal care and delivery services" or to prevent, diagnose, or treat sexually transmitted disease without parental consent and/or notification (Opinion 2.2.2 "Confidential Healthcare for Minors"). Once the legally required consent has been obtained, the minor patient's preferences concerning use of chaperones can be discussed [17].

Patients with Diminished or Lacking Decisional Capacity

It is widely agreed that patients who are unable to give informed consent should always have a chaperone present for sensitive examinations and procedures. These patients might be unconscious, sedated, or have cognitive impairments or severe mental illness [9,2,3]. When treating adult patients who lack capacity to consent, it is desirable to have a trusted companion, social worker, caregiver, or group home escort present alongside the chaperone, "to alleviate potential stress to the patient" [3]. It should be made clear that chaperones are mandatory in these circumstances.

Identifying & Informing Appropriate Chaperones

An authorized member of the health care team should serve as a chaperone and understand the responsibilities of the role. Broadly speaking, chaperones should be provided with information regarding:

- Expected components of the procedures they will be observing;
- Ways to ensure patient comfort during the examination or procedure;
- Appropriate gowning or draping for privacy;
- Suitable positioning in the room such that they can assess the nature of the contact between physician and patient;
- How to intervene or stop an examination or procedure if they are concerned that the patient is distressed or that inappropriate contact has occurred;
- Reporting mechanisms for concerns and non-compliance with established chaperone policy.

Chaperones may feel uncertain or hesitant about intervening during an examination or procedure, or about reporting misconduct. To establish expectations for the role of chaperones, institutions and practices should set policies for both physicians and chaperones in advance. They should also agree on methods of communication to signal patient distress or chaperone concerns while examinations or procedures are in progress [3].

Chaperones are responsible for upholding privacy and confidentiality. Since physicians are obligated to "seek to protect privacy in all settings to the greatest extent possible" opportunities should be provided for private conversation with the patient without the chaperone present. In addition, physicians should minimize inquiries or history taking during a chaperoned examination or procedure. If a patient shares information with the chaperone that is relevant to patient care but requests that this not be disclosed to the physician, the chaperone should make it clear that they cannot maintain confidentiality when this would endanger the health of the patient. The chaperone may also encourage the patient to either raise the issue with the physician themselves or obtain permission from the patient to communicate the information to the physician separately.

Chaperones must be made aware of appropriate mechanisms for reporting unprofessional conduct in keeping with ethics guidance and without fear of retaliation. As far as possible, lines of authority in the reporting process should be removed from the immediate employment and clinical supervisory hierarchy of the reporter [3]. Multiple pathways for patient reporting should be established, including an anonymous option, and this information should be communicated clearly to patients. When a patient reports a concern about misconduct, this must not adversely affect their care.

Expert consensus is that individuals for whom patient care is not a routine part of their ordinary duties (such as front desk or office support staff) should not function as chaperones [1,17]. It may be appropriate for medical students, residents, and fellows to perform the duties of chaperone, provided that special attention is paid to how these duties may be impacted by the power imbalance inherent in the trainee-supervisor relationship. Trainees should be provided with information about their role serving as a chaperone, sufficient knowledge about the procedure or interaction they will be observing, and how to report any concerns without repercussions, fear of retaliation, or other professional disadvantages. The standard approach is to have healthcare staff such as nurses, medical assistants or physician assistants act as chaperones, provided they are fully trained in the responsibilities of the role. Occupying a dual role as chaperone and member of the care team is acceptable when the two sets of responsibilities do not conflict and are well understood by everyone involved. “Parents and other untrained individuals” should not act as chaperones, except in the case of young children, as discussed above [3,17].

Concerns may arise regarding the additional resources needed to implement current best practices for the use of chaperones. In particular, physicians may be concerned that these resources will be diverted away from patient care. However, it has been established that “most patients regard the offer of a chaperone as a sign of respect,” and further, that physician misconduct has significant detrimental effects on patient well-being, the patient-physician relationship, and the integrity of the profession as a whole [1,10]. In light of these considerations, the fact of limited resources or additional costs does not justify the failure to regularly employ chaperones for sensitive examinations and procedures, and/or to make them available in other situations at the patient’s request.

CONCLUSION

Policies surrounding the appropriate use of chaperones for sensitive examinations and procedures have evolved in recent years. New standards specify that use of chaperones should be standard for all sensitive exams and procedures and that chaperones should be made available in all situations when the patient requests one. Use of chaperones should not be influenced by the gender of the physician or patient. Chaperones should receive information regarding the responsibilities of their role, and patient preferences concerning chaperones should be documented. Reporting mechanisms that do not expose chaperones to retaliation must also be established in order for the new standards to serve the purpose of protecting both the physician and the patient.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that alternate Opinion 1.2.4 be adopted in lieu of Opinion 1.2.4 and the remainder of the report be filed:

> Conducting sensitive examinations in an ethically and clinically sound manner requires physicians to be responsive to both the distinctive characteristics of the individual patient and to the professional boundaries of the patient-physician relationship. While a sensitive exam is typically understood as one involving any examination of, or procedure involving, the genitalia, breasts, perianal region or the rectum, physicians should be aware that a patient’s personal history, beliefs or identity may broaden their definition of what constitutes a sensitive examination or procedure. Respecting patient boundaries and promoting patient dignity requires providing a safe and therapeutic clinical encounter during sensitive exams while also empowering patients. Such efforts include measures that promote patient privacy, such as providing appropriate gowns, private facilities for undressing, sensitive use of draping, and clearly explaining various components of the physical examination. They may also include the

use of chaperones regardless of the gender of the physician or patient. Having chaperones present can help protect the integrity of the patient-physician relationship. Physicians should, as always, also be mindful of any applicable legal or regulatory requirements regarding the use of chaperones. A fair and effective policy on the use of chaperones must balance: (1) respect for patient preferences and the integrity and safety of the clinical encounter; (2) protection of physicians; and (3) boundaries of the patient-physician relationship.

Physicians should:

(a) Provide a chaperone for all sensitive exams, with an option for patients to decline if they wish, unless the delay in obtaining a chaperone would result in significant harm to the patient. For all other types of examinations and procedures, patients must be informed that they are entitled to request a chaperone, and one should be made available when they make such a request. Physicians should honor patients' request for a chaperone, even if a patient's trusted companion is present.

(b) Provide an opportunity for private conversation with the patient without the chaperone present and minimize inquiries or history taking during a chaperoned examination or procedure.

(c) Make every effort to accommodate the preferences of the patient, consistent with the interests of patients, physicians and the maintenance of professional boundaries. If the patient and physician cannot arrive at a mutually acceptable arrangement, then the physician may facilitate transfer of care.

(d) Always use a chaperone for sensitive exams if the patient lacks the capacity to consent at the time of care, unless the delay in obtaining a chaperone would result in significant harm to the patient.

(e) Allow a parent or guardian to act as the chaperone for young pediatric patients. If a parent or guardian is unavailable, or their presence may interfere with the examination, another chaperone should be present. For adolescent patients, it is appropriate to use a chaperone either in addition to, or instead of, a family member or guardian as determined during shared decision making between patient and physician.

(f) Have an authorized member of the health care team act as a chaperone. All chaperones should be provided with information and understand the responsibilities of the role. Chaperones should be made aware of mechanisms for reporting unprofessional conduct in keeping with ethics guidance and without fear of retaliation. Physicians should establish clear expectations that chaperones will uphold professional and legal standards of privacy and confidentiality.

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 08-A-25

Subject:	Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blinded Model for Organ Procurement and Transplantation
Presented by:	Jeremy A. Lazarus, MD, Chair
Referred to:	Reference Committee on Ethics and Bylaws

Policy H-370.954 was adopted at A-23 and asks that the Council on Ethical and Judicial Affairs (CEJA) consider amending Opinion 6.2.1, "Organ Transplantation from Deceased Donors," to address concerns regarding immigration status and access to donated organs.

BACKGROUND

Resolution 003-A-23 noted the profound disparities that exist in the United States between undocumented immigrants versus documented immigrants and citizens access to organ transplantation. For example, United Network of Organ Sharing (UNOS) data reveals that only 0.4 percent of liver transplants in the U.S. went to undocumented immigrants, while undocumented immigrants accounted for up to 3 percent of the total deceased liver organ donors in the U.S. [1].

AMA's ethical criteria for organ allocation were set out in a 1993 CEJA report on organ transplantation [2}. Ethical criteria for scarce resource allocation include the likelihood of benefit, change in quality of life, duration of benefit, urgency of need, and the amount of resources required for successful treatment. These criteria must be weighed in a complex analysis that takes into account all these criteria together.

Likelihood of benefit is aimed to "maximize the number of lives saved as well as the length and quality of life" [2]. Change in quality of life is a criterion that one maximizes benefit "if treatment is provided to those who will have the greatest improvement in quality of life", however defining what constitutes "quality of life" is difficult as it will "depend greatly on patients' individual, subjective values" [2]. Duration of benefit can be thought of as the length of time a patient can benefit from a treatment, which often will involve a calculus of life expectancy to be part of analysis; however, life expectancy is not always a determinative factor when making allocation decisions [2]. Urgency of need "prioritizes patients according to how long they can survive without treatment" [2]. The amount of resources gives higher priority to "patients who will need less of a scarce resource" in order to maximize the number of lives saved [2]. Resources in this context does not mean a patient's finances, but rather scarce medical resources like an organ, e.g. a patient who requires two organ transplants may be lower priority than someone who only needs one [2].

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ETHICAL ISSUE

To what extent may non-medical factors such as immigration and/or socioeconomic status be considered in organ transplantation allocation decisions.

REVIEW OF RELEVANT LITERATURE

The ethical problem regarding "fairness" has been well documented, as undocumented immigrants "are able to, and do donate their organs, but they are effectively barred from receiving transplants" [3] or, after receiving transplants, may not have the proper resources down the line to receive continued therapies like immunosuppressive medications [4]. The Organ Procurement and Transplantation Network (OPTN) declares that "residency status cannot factor into decisions on whether to allocate an organ to a specific patient" [5]. The OPTN policy states: "A candidate's citizenship or residency status in the United States must not be considered when allocating deceased donor organs to candidates for transplantation. Allocation of deceased donor organs must not be influenced positively or negatively by political influence, national origin, ethnicity, race, sex, religion, or financial status" [6]. While OPTN's policy strives to achieve equity, the practical reality is that financial and socioeconomic considerations are indirectly weighed, as insurance coverage is usually needed for pre-and post-opt care.

Despite the perception that immigration status may affect health status, "unauthorized immigrants who receive liver transplants in the United States have comparable three-year survival rates to the U.S. citizens", indicating that survival outcomes are not drastically different for undocumented immigrants and that "concern for worse survival should not be used as a reason to deny access to liver transplant" [7]. Additionally, a cardiothoracic transplant study in the U.S. found that citizenship status was not relevant in determining transplant outcomes, noting that "citizenship status does not appear to be an independent determinate of early post-transplant outcomes", reinforcing that immigration status by itself is not a medically relevant characteristic in determining likely success of organ transplantation [8].

Lack of insurance is often the largest obstacle for undocumented immigrants seeking organ donation. Many undocumented immigrants who would otherwise be good candidates for an organ transplant do not have insurance to cover the surgical procedure or the long-term after care, and as a result are removed or not allowed on transplant wait lists [9]. Other practices, such as hospitals asking patients for Social Security numbers while making transplant eligibility assessment—though there is "no legal requirement to do"—also exclude undocumented immigrants from transplant eligibility, further contributing to disparities [10].

ETHICAL ANALYSIS

Numerous factors are involved in the allocation of organs and scarce resources and are all aimed at maximizing the "good", i.e. "number of lives saved, number of years of life saved, and improvement in quality of life" [2]. Opinion 11.1.3, "Allocating Limited Health Care Resources" addresses these criteria. The 1995 CEJA opinion on organ transplantation states that both social worth and ability to pay are not ethically justified criteria to make decisions on how to allocate scarce resources. Additionally, the ethical concerns raised by Res 003 are valid, in that immigrant status itself is being used as an indicator of financial status or socioeconomic status. However, the key aspects associated with the disparities of immigration status, "social worth" and "ability to pay", are both already addressed by H-370.982.

Not all undocumented immigrants have lower economic status. Some immigrants (undocumented or otherwise) may have strong financial means, e.g. wealthy foreign immigrants who travel the U.S. for medical care. Hence, specifically calling out "immigration status" or "undocumented status" is not ideal, as the term is not precise and does not always imply an individual without proper insurance or financial means or a person with lower socioeconomic status.

As previously discussed, it is impossible to truly separate medically relevant and non-medically relevant criteria in the context of organ donation. The *Code's* broader approach to generally avoid lists of specific examples of non-clinical characteristics allows physicians to make their own analysis about what is and is not clinically relevant in specific cases. There is clearly an apparent disparity between those who donate organs and those who receive them and we continue to have disparities in outcomes due to socioeconomic status. While finances and ability to pay are by themselves not medically relevant and in an ideal sense, should not be ethically considered, they often must be considered in the context of organ transplantation eligibility because they can affect the patient's ability to obtain the necessary resources or participate adequately in regiments to ensure the long-term viability of the transplant thus, becoming medically relevant; however, when these non-medical factors are not clinically relevant should not be considered. The result is an ethical tension that is effectively paradoxical. Leaving the paradox outside of the policy allows for more fluidity in interpretation of the *Code* in any context.

RECOMMENDATION

In consideration of the foregoing, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of the report be filed:

When making organ transplantation allocation decisions, physicians have a responsibility to provide equitable and just access to health care, including only utilizing organ allocation protocols that are based on ethically sound and clinically relevant criteria.

When making allocation decisions for organ transplantation, physicians should not consider non-medical factors, such as socioeconomic and/or immigration status, except to the extent that they are clinically relevant.

Given the lifesaving potential of organ transplants, as a profession, physicians should:

(a) Make efforts to increase the supply of organs for transplantation.

(b) Strive to reduce and overcome non-clinical barriers to transplantation access.

(c) Advocate for health care entities to provide greater and more equitable access to organ transplants for all who could benefit.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 09-A-25

Subject: Ethical Impetus for Research in Pregnant and Lactating Individuals

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

Policy D-140.949, "Ethical Impetus for Research in Pregnant and Lactating Individuals," was adopted at the 2024 Annual Meeting and asks "that our Council on Ethical and Judicial Affairs (CEJA) consider updating its ethical guidance on research in pregnant and lactating individuals."

BACKGROUND

More than four million individuals give birth in the United States every year [1] and 70 percent of these individuals will require at least one prescription medication while pregnant [2]. Despite the widespread use of medications during pregnancy, most information about the efficacy and safety of medication used during pregnancy comes from the post-marketing setting and is not derived from clinical research trials [3].

Only a dozen medications have been approved by the United States Food and Drug Administration (FDA) for use during pregnancy, and those medications are for gestation- or birth-related medical issues [4]. Therefore, any medications utilized to treat chronic health conditions in pregnancy are used without FDA approval ("off label"). Only 2.4 percent of those commonly used medications for chronic health conditions have included pregnant individuals in controlled human clinical trials. The lack of clinical trial data is a result of the historical exclusion of pregnant and lactating individuals from clinical trials. Exclusion of pregnant and lactating individuals from clinical trials has often occurred due to the fear of harming the fetus or newborn, as well as concern that physiologic changes in pregnancy or during lactation will impact the results of pharmacologic trials [3,5]. The effect of this exclusion is that physicians and patients are forced to make decisions about whether to utilize medications during pregnancy without adequate fetal and maternal safety data [6].

ETHICAL ISSUES

Pregnant and lactating individuals have been systematically excluded from clinical trials for decades out of concern for negative effects on fetuses and nursing infants. This exclusion has resulted in a paucity of evidence regarding safe and effective medication use in these groups of individuals. Due to the existing knowledge gaps surrounding the use of medications during pregnancy and breastfeeding, physicians and patients are faced with making treatment decisions without appropriately understanding the potential benefits and risks to both the pregnant individual

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and their fetuses or nursing infant. Additionally, these knowledge gaps prevent physicians from being able to appropriately counsel pregnant patients regarding the risks, benefits, and alternatives of treatments. At issue is how to balance respect for pregnant and lactating individuals with the potential benefits and harms of research.

REVIEW OF RELEVANT LITERATURE

Pregnant and lactating individuals have historically been considered "vulnerable" and subjected to additional research protections and exclusion from research [7]. This problem is known as the "protection-inclusion dilemma", whereby groups deemed "vulnerable" are "over-protected" and excluded from research, leading to justice issues including a "lack of relevant health data for under-represented populations" [8]. The consequence of the protection-inclusion dilemma is that most of the medications pregnant individuals are prescribed are not FDA approved for pregnancy. This is problematic because while "there are significant physiologic changes in pregnancy, including near doubling of maternal blood volume and alterations in binding proteins, the pharmacokinetics [PK] and efficacy of drugs in pregnancy are, by and large, unknown" [7]. This uncertainty for prescribers results in dosages labelled for use in nonpregnant individuals being used for pregnant individuals, "with little consideration for the PK changes that occur during pregnancy" [9].

Although the negative effects of excluding pregnant and lactating individuals in clinical trials have been noted for years, little has been done in that time to address the significant knowledge gaps in research that remain. For example, many Institutional Review Boards (IRB) "continue to regard pregnancy as a near-automatic cause for exclusion, regardless of the costs of exclusion or the magnitude or likelihood of the risks of participation," and the lack of research data leads to persistent disparities for chronic disease managements among pregnant individuals [5].

Relevant Laws

The FDA has several relevant regulations. 45 CFR 46, Subpart B "Additional Protections for Pregnant Women, Human Fetuses and Neonates Involved in Research", provides regulations regarding research involving pregnant individuals. 45 CFR §46.204 – "Research involving pregnant women or fetuses" states that:

> Pregnant women or fetuses may be involved in research if all of the following conditions are met:
> (b) The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus; or, if there is no such prospect of benefit, the risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge which cannot be obtained by any other means [10].

Additionally, as of January 21, 2019, the Common Rule no longer labels pregnant individuals as "vulnerable" with regards to IRBs. This is because while pregnant individuals have historically been deemed vulnerable, it has since been recognized that while some individuals who are pregnant may be vulnerable, being pregnant in and of itself does not automatically denote vulnerability [11].

Relevant Code Provision(s)

The *Code of Medical Ethics* encourages the inclusion of pregnant individuals in clinical trials, when appropriate, so long as the research "balance[s] the health and safety of the woman who participates and the well-being of the fetus with the desire to develop new and innovative

therapies" (Opinion 7.3.4). However, the *Code* also places constraints on physicians involved in maternal-fetal research, advising that they should "[e]nroll a pregnant woman in maternal-fetal research only when there is no simpler, safer intervention available to promote the well-being of the woman or fetus" (Opinion 7.3.4).

ETHICAL ANALYSIS

A multitude of historical, legal, scientific, and societal factors have resulted in the exclusion of pregnant and lactating individuals from clinical trials for decades. However, the ethical principle of justice necessitates that the benefits and burdens of research participation be fairly distributed across all groups, including pregnant and lactating individuals, because failure to do so produces disparities that impact both safety and quality of care for pregnant and lactating individuals, fetuses, and nursing infants.

Concerns for fetal safety have served as the primary justification for the exclusion of pregnant individuals from clinical trials for decades, but this exclusion has paradoxically resulted in substantial maternal and fetal harm. Because information about toxicity and dosing for pregnant and lactating individuals has not been determined through smaller scale and well-controlled clinical trials for most medications, far more pregnant and lactating individuals who require medications for chronic medical conditions are being exposed to potentially harmful medications via "off label" uses.

Examples of this harm can be seen in the historical use of thalidomide and diethylstilbestrol in pregnant individuals. While the tragic consequences of their use have been cited as reasons to exclude pregnant individuals from clinical trials, it was actually the lack of controlled data from clinical trials that caused such widespread detrimental effects due to the teratogenic effects of these drugs not being examined until post-marketing surveillance data was available. Had smaller scale and better controlled clinical trials been conducted, mass marketing and exposure to these medications for pregnant individuals may have been avoided because the teratogenic effects would have been discovered during trials [12]. Another example is that of ACE inhibitors, which were used in pregnant individuals for three decades prior to the 1996 discovery that its use in the first trimester can cause congenital anomalies [5]. Had it been studied more rigorously through smaller scale clinical trials with individuals consenting to the risks of participating in research, this discovery may have been made much sooner and far fewer individuals would have been exposed to this drug in the first trimester without knowing the risks of doing so.

Historically, concern for pregnant individuals and fetuses has centered on defining this population as "vulnerable", thus needing broad shielding from risks, such as medical research. Such an approach to research practices has been deemed "overly paternalistic, disempowering, or coercive" [13]. Pregnant and lactating individuals are not automatically vulnerable, and this approach does not respect their autonomy to assess the benefits and risks of participation for themselves and their fetuses or newborns [14]. Pregnant and lactating individuals should always be provided the opportunity to decide whether research participation is in their best interest through informed consent. If pregnant or lactating individuals are unable to be included in research, alternative ways to rectify any gap in knowledge should be developed. For example, pregnant and lactating individuals should be instructed on how to participate in research registries and adverse event reporting programs.

CONCLUSION

The historical exclusion of pregnant and lactating individuals from clinical trials has resulted in a lack of data about the appropriate safety, dosage, and efficacy of most medications in this group. This knowledge gap has created an ethical imperative to include more pregnant and lactating individuals in clinical trials. While consideration of maternal, fetal, and nursing infant well-being should be important criteria included in guidelines for research, wholesale exclusion of pregnant and lactating individuals from clinical trials comes with its own risk to fetal and maternal safety. Theoretical risks for fetal harm should not automatically be assumed to outweigh potential risks of ongoing nonparticipation. Currently, the *Code* does not reference this disparity. Nor does it refer to lactating individuals. It also does not contain gender neutral language, i.e. it references women and not individuals.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

Research involving pregnant and lactating individuals, including but not limited to, research regarding interventions intended to benefit pregnant or lactating individuals and/or their fetuses or nursing infants, must balance the health and safety of individuals who participate and the well-being of their fetuses or nursing infant against the desire to develop new and innovative therapies. Although it is important to carefully consider potential fetal risks involved when pregnant and lactating individuals participate in research, it is critical to realize that large scale exclusion from participation by these individuals has also precluded potential benefits and in some cases resulted in harm for this group. The paucity of data on safe and effective medical treatment during pregnancy and breastfeeding has resulted in physicians and patients choosing between pursuing medical interventions with uncertain risks to themselves and their fetuses or nursing infants, or foregoing the interventions altogether, which might itself cause harm due to undertreatment of medical conditions.

Understanding both the potential risks of participation and of non-participation, physicians conducting research should adhere to general principles for the ethical conduct of research, and should:

(a) Include pregnant and lactating individuals in research, unless there is a significant clinical reason not to, in order to establish a greater knowledge base, produce relevant data, and promote respect for individuals.

(b) Obtain the informed, voluntary consent of the pregnant or lactating individual, as in all human participant's research.

(c) Where scientifically appropriate, base studies on well-designed, ethically sound research with animals and nongravid human participants that has been carried out prior to conducting research on pregnant and lactating individuals to better assess potential risks.

(d) Plan alternative ways to rectify any gap in knowledge, when it is not possible to enroll pregnant or lactating individuals in research.

(e) Ensure risks to the fetus or nursing infants are not greater than minimal, especially when the intervention under study is not intended primarily to benefit the fetus or infant, but

rather for the development of important biomedical knowledge that cannot be obtained by any other means.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 10-A-25

Subject: The Preservation of the Primary Care Relationship

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

Policy D-140.948, "The Preservation of the Primary Care Relationship," was adopted at the 2024 Annual Meeting. Item two of this policy asks:

> Our AMA requests the Council on Ethical and Judicial Affairs review the ethical implications of health systems requiring patients to change to primary care clinicians employed by their system to access specialists.

This report is in fulfillment of this directive.

BACKGROUND

There are concerns that some large health systems are restricting access to specialty care unless patients first change their primary care physician to one employed by their system, resulting in the disruption of well-established patient-physician relationships and continuity of care. This could be particularly challenging for patients whose insurance or socioeconomic status prevents them from changing their primary care physician (PCP). For instance, community health clinics/centers (CHCs), a core health-safety net for many in the US that provides primary care to anyone who walks through their doors, already suffer from limited access to specialty care, and requiring CHC patients to find a new PCP in order to receive specialty care, which can already be challenging to obtain, might not always be possible [1].

Finding a new PCP can also be a challenge in and of itself, as the US is experiencing a shortage of PCPs. An estimated 83 million Americans live in areas with insufficient access to primary care, and it is projected that by 2036, the US will face a shortage of over 68,000 primary care physicians [2,3]. Placing this burden on patients who are actively seeking needed care could easily and needlessly delay their care and lead to a break in the continuity of their care. Proponents argue that having physicians in the same network could improve coordinated care. Conversely, maintaining current PCPs while simply working to improve communication could effectively uphold continuity of care while also supporting coordination. This may be especially important in rural areas.

Relevant AMA Policy

Our American Medical Association (AMA) has several relevant House policies, including D-140.948, "The Preservation of the Primary Care Relationship," which states: "(1) Our American Medical Association opposes health systems requiring patients to switch to primary care physicians within a health system in order to access specialty care. […] (3) Our AMA advocates for policies that promote patient choice, ensure continuity of care, and uphold the sanctity of the patient-physician relationship, irrespective of healthcare system pressures or economic incentives."

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H-160.901, "Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care," states: "Our AMA supports: (1) policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians; (2) the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care when appropriate care is not available within a limited network of providers; and (3) policies that encourage patients to return to their established primary care provider after emergency department visits, hospitalization or specialty consultation."

And H-285.944, "Disease Management and Demand Management," states: "The AMA strongly encourages health insurance plans and managed care organizations that provide disease management to involve the patient's current primary or principal care physician in the disease management process as much as possible, and to minimize arrangements that may impair the continuity of a patient's care across different settings."

Relevant Code *Opinions*

The AMA *Code of Medical Ethics* also has several relevant Opinions that support the preservation of primary care relationships and patient-physician relationships more broadly. These include Opinion 1.1.1, "Patient-Physician Relationships," which states, ""[t]he relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare"; Opinion 1.1.3, "Patient Rights," which states that patients' rights include "courtesy, respect, dignity, and timely, responsive attention to his or her needs" as well as a right "[t]o continuity of care"; and Opinion 1.1.6, "Quality," which states, "physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable." Together, these opinions articulate physicians' obligations to prioritize patients' welfare and highlight the ethical importance of providing care that is timely, equitable, and continuous.

Also of note, Opinion 11.2.3, "Contracts to Deliver Health Care Services," states that physicians "should be mindful that while many arrangements have the potential to promote desired improvements in care, some arrangements also have the potential to impede patients' interests." Relatedly, Opinion 11.2.1 "Professionalism in Health Care Systems," states that physicians in leadership positions within health care organizations should ensure that financial incentives and other tools "do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;" Opinion 11.3.1 "Fees for Medical Services," states that physicians should not charge unnecessary fees "or fees solely to facilitate hospital admission"; and Opinion 11.3.4 "Fee Splitting" states that a fee solely for referral of a patient is unethical.

ETHICS ISSUE

Does requiring patients to switch to primary care physicians within a health system in order to access specialty care violate professional ethical obligations, such as continuity of care, and/or negatively impact the patient-physician relationship by violating the trust that is the foundation of the relationship and source of professional privilege for the practice of medicine?

ETHICAL ANALYSIS

Requiring patients to switch PCPs in order to access specialty care raises several ethical concerns regarding potential wrongs and harms that such requirements may cause. Principal among these

concerns is that such requirements represent an undue barrier to care, that such barriers violate the trust fundamental to the patient-physician relationship, and ultimately undermine public trust in and respect for the practice of medicine.

The AMA *Code of Medical Ethics* is very clear that patients have a right to timely care that is responsive to their needs as well as to continuity of care (Opinion 1.1.3). Respect for these rights by the medical profession is what enables patients to trust that the obligations of the patient-physician relationship will be upheld. Timeliness is also a fundamental aspect of quality care (Opinion 1.1.6). Requiring patients to change PCPs in order to receive needed care could violate these ethical obligations.

Furthermore, such requirements raise concerns regarding issues of equity. If the patient populations of various insurance plans differ, such as those between Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), it is likely that requirements regarding changing PCPs to access specialty care will have stronger impacts on certain patient populations than others. For example, compared to PPOs, HMO patient populations tend to be younger, with higher rates of Black and Hispanic patients [4]. Additionally, because HMOs are generally less costly than PPOs, they are likely to attract more people of lower socioeconomic backgrounds[5]. The *Code* is explicit in its insistence that all financial incentives and tools should be implemented fairly and in ways that do not disadvantage identifiable patient populations (Opinion 11.2.1).

CONCLUSION

As outlined in policy D-140.948, "The Preservation of the Primary Care Relationship," our AMA opposes the practice of "health systems requiring patients to switch to primary care physicians within a health system in order to access specialty care." This policy stems from the 2024 Annual Meeting Resolution 014, "The Preservation of the Primary Care Relationship," the second resolve of which asked your Council on Ethical and Judicial Affairs (CEJA) to "review the ethical implications of health systems requiring patients to change to primary care clinicians employed by their system to access specialists". This report is in fulfillment of the second resolve.

After review, CEJA has found that the AMA *Code of Medical Ethics* has several relevant Opinions that support the preservation of primary care relationships. These include Opinion 1.1.1, "Patient-Physician Relationships," Opinion 1.1.3, "Patient Rights," Opinion 1.1.6, "Quality," Opinion 11.2.3, "Contracts to Deliver Health Care Services," Opinion 11.2.1 "Professionalism in Health Care Systems," and Opinion 11.3.1 "Fees for Medical Services."
Existing Ethics and House policy are clear that the choice of who to see should be between patients and physicians. Such decisions should be based on the best interest of the patient. Policies that influence these decisions should be in accordance with physicians' professional and ethical obligations, and should support patient choice, continuity of care, equity, and the patient-physician relationship. Any practices that may compromise the patient-physician relationship should be closely examined with attention to these considerations. The *Code* opposes any practices that threaten to undermine patient-physician relationships.

RECOMMENDATION

The Council on Ethical and Judicial affairs recommends that Policy D-140.948(2) be rescinded as having been accomplished by this report.

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 11-A-25

Subject: CEJA's Sunset Review of 2015 House Policies

Presented by: Jeremy Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. This policy reads as follows, laying out the parameters for review and specifying the needed procedures:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as

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the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500.

APPENDIX – RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
H-295.877	Medical Treatment of Prisoners of War and Detainees	Our AMA encourages medical schools to include ethics training on the issue of medical treatment of prisoners of war and detainees.	Retain; remains relevant.
H-295.961	Medicolegal, Political, Ethical and Economic Medical School Course	(1) The AMA urge every medical school and residency program to teach the legal, political, ethical and economic issues which will affect physicians. (2) The AMA will work with state and county medical societies to identify and provide speakers, information sources, etc., to assist with the courses. (3) An assessment of professional and ethical behavior, such as exemplified in the AMA Principles of Medical Ethics, should be included in internal evaluations during medical school and residency training, and also in evaluations utilized for licensure and certification. (4) The Speaker of the HOD shall determine the most appropriate way for assembled physicians at the opening sessions of the AMA House of Delegates Annual and Interim Meetings to renew their commitment to the standards of conduct which define the essentials of honorable behavior for the physician, by reaffirming or reciting the seven Principles of Medical Ethics which constitute current AMA policy. (5) There should be attention to subject matter related to ethics and to the doctor-patient relationship at all levels of medical education: undergraduate, graduate, and continuing. Role modeling should be a key element in helping medical students and resident physicians to develop and maintain professionalism and high ethical standards. (6) There should be exploration of the feasibility of improving an assessment of ethical qualities in the admissions process to medical school. (7) Our AMA pledges support to the concept that professional attitudes, values, and behaviors should form an integral part of medical education across the continuum of undergraduate, graduate, and continuing medical education.	Retain; remains relevant.
H-410.987	Practice Parameters - Their Relevance to Physician Credentialing	1. The term practice guidelines should be used to refer to strategies for patient management that are designed to assist physicians in clinical decision-making. The terms should not be used to refer to the criteria for professional training, skills and experience utilized in the granting of general or procedure-specific clinical privileges.	Retain; remains relevant.

		2. The documentation of adherence to, or intent to practice within, relevant practice guidelines should not be used as an additional criterion for the granting of general or procedure-specific clinical privileges unless and until a relationship between adherence to such practice guidelines and desired patient outcomes is adequately documented. 3. Practice guidelines developed by a particular medical specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice guideline by physicians not formally credentialed in that specialty or specialties. Individual character, training, competence, experience, and judgment should continue to be the criteria for granting general or procedure-specific clinical privileges.	
H-450.973	Outcomes Research	1. It is the policy of the AMA to (a) continue to promote outcomes research as an effective mechanism to improve the quality of medical care, (b) urge that the results of outcomes research be used for educational purposes and not as part of punitive processes, (c) promote the use of outcomes research in the development of practice parameters, (d) advocate that findings of outcomes research which identify individual physicians should only be disclosed within formal peer review processes, and (e) monitor outcomes research activities of the federal government, research organizations, and others. 2. The AMA urges state medical societies, national medical specialty societies, hospital medical staffs, and individual physicians to (a) assist organizations in the planning, development, implementation, and evaluation of appropriate outcomes research, (b) identify the significance and limitations of the findings of outcomes research, and (c) ensure that outcomes research is conducted in a manner that protects the confidentiality of patients and physicians. 3. The AMA urges organizations conducting or planning to conduct outcomes research to (a) ensure the accuracy of the data used in outcomes research, (b) include relevant physician organizations and practicing physicians in all phases of outcomes research, including the planning, development, implementation, and evaluation of outcomes research, (c) provide physician organizations and practicing physicians with adequate opportunity to review and comment on interpretations of the results of	Retain; remains relevant.

		outcomes research, and (d) ensure that outcomes research is conducted in a manner that maintains patient and physician confidentiality.	
H-460.898	Principles of Human Subjects Research Shall Apply to Online Medical Research Projects	Our American Medical Association declares social media sites' terms of service as an insufficient proxy for informed consent prior to being enrolled in any medical experiment and recommends that online social networks provide users with specific informed consent outlining the aims, risks and possible benefits of any medical experimental study prior to study enrollment.	Retain; remains relevant.
H-65.993	Abuse of Medicine for Political Purposes	The AMA opposes the use of the practice of medicine to suppress political dissent wherever it may occur.	Retain; remains relevant.
H-85.952	Advance Directives During Pregnancy	1. Our AMA vigorously affirms the patient-physician relationship as the appropriate locus of decision making and the independence and integrity of that relationship. 2. Our AMA will promote awareness and understanding of the ethical responsibilities of physicians with respect to advance care planning, the use of advance directives, and surrogate decision making, regardless of gender or pregnancy status, set out in the Code of Medical Ethics. 3. Our AMA recognizes that there may be extenuating circumstances which may benefit from institutional ethics committee review, or review by another body where appropriate.	Retain; remains relevant.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS[1]

CEJA Report 13-A-25

Subject: Presumed Consent & Mandated Choice for Organs from Deceased Donors

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

Resolution 017-A-24, "Addressing the Historical Injustices of Anatomical Specimen Use," Resolve 7, asks that our AMA amend Opinion 6.1.4 "Presumed Consent & Mandated Choice for Organs from Deceased Donors" as follows:

> Physicians who propose to develop or participate in pilot studies of presumed consent or mandated choice should ensure that the study adheres to the following guidelines:
>
> (a) Is scientifically well designed and defines clear, measurable outcomes in a written protocol.
>
> (b) Has been developed in consultation with the population among whom it is to be carried out.
>
> (c) Has been reviewed and approved by an appropriate oversight body and is carried out in keeping with guidelines for ethical research.
>
> ~~Unless there are data that suggest a positive effect on donation, n~~ Neither presumed consent nor mandated choice for cadaveric organ donation should be widely implemented.

BACKGROUND

Increased organ donation from deceased donors results in lives saved, as one deceased organ donor can save up to eight lives through organ transplantation and improve the lives of up to 75 persons through tissue donation [1]. Although organ donation upholds utilitarian ethical principles, many deceased persons (prior to death) and their families as their surrogates (after death) choose not to donate. The most common reasons cited for choosing not to donate organs include mistrust of doctors, hospitals, and the organ allocation system as well as fears that the deceased persons organs will be sold on a black market or go to someone who does not deserve the organ (i.e. someone who brought on their own illness or is a "bad person") [2]. The widespread mistrust and fear associated with organ donation results in 17 people in the US dying every day while on the waiting list for an organ transplant [1].

Our AMA policy, including the *Code of Medical Ethics*, supports increasing the organ supply (Opinion 6.1.2) and promoting organ donation awareness (D-370.997) while also recognizing the

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need to "continue to monitor ethical issues related to organ transplantation" (H-370.967). Obtaining consent for organ donation, while an ethical imperative, may present a barrier to increasing organ supply (Opinion 6.1.2). There are three common methods of obtaining consent employed to facilitate organ donation including: 1) voluntary consent; 2) mandated choice; and 3) presumed consent. Although the voluntary consent model is traditionally used in the US and supported by *Code* guidance, our AMA has policy which supports "studies that evaluate the effectiveness of mandated choice and presumed consent models for increasing organ donation" (H-370.959). Additionally, the *Code* provides guidance for physicians who propose to develop or participate in pilot studies of presumed consent and mandated choice (Opinion 6.1.4).

ETHICAL ISSUE

Resolution 017-A-24, Resolve 7 proposes striking the phrase "unless there are data that suggest a positive effect on donation . . ." from the guidance regarding the use of presumed consent and mandated choice models for organ donation as outlined in *Code* Opinion 6.1.4. Removal of this phrase would remove a caveat which provides an opportunity for implementing presumed consent or mandated choice when data suggest a positive effect on donation. This ethical analysis weighs the benefits and burdens of adopting a more restrictive informed consent model for organ donation.

ETHICAL ANALYSIS

The *Code of Medical Ethics* requires that informed consent be obtained from the patient or their surrogate prior to organ donation. Among the three methods of informed consent for organ donation (voluntary consent, mandated choice and presumed consent), the *Code* supports voluntary consent (Opinion 6.1.2); however, each of the three methods of consent has advantages and drawbacks. Voluntary consent prioritizes individual autonomy by having potential donors make a voluntary decision to donate organs. While voluntary consent upholds autonomy, its opponents claim it results in a lower donation rate due to passive decision-making. Mandated choice takes consent to a more stringent level by requiring everyone to state their organ donation preference when executing a state supported document, such as receiving a driver's license, potentially resulting in a higher donation rate; however, this system also raises concerns of coercion which may undermine voluntary consent [3]. Conversely, presumed consent operates under an opt-out system which assumes consent to donate unless a person has explicitly registered their refusal to donate. While opt-out systems have the potential to result in the highest yield for organ donation, these systems may exacerbate distrust in the health care system and place additional stress on families who may not be aware of their deceased loved ones wishes regarding organ donation [4]. Additionally, opt-out systems raise ethical concerns surrounding respect for autonomy and voluntary consent.

In a 2005 CEJA report on Presumed Consent and Mandated Choice for Organs from Deceased Donors, the model of voluntary consent was adopted due to the need for data from research studies regarding whether ethically appropriate models of presumed consent or mandated choice would result in a positive effect on organ donation [5]. In the 20 years since this CEJA report was adopted, different models of consent have been utilized worldwide with varying impacts on organ donation models. A 2019 study assessing the effect of opt-out and opt-in approaches to organ donation across 35 similar countries found no significant difference in deceased-donor rates in per million populations [6]. However, a 2019 systematic review of opt-out versus opt-in consent models found that opt-out consent increases both deceased donation rate and deceased transplantation rates [7]. At a macro level, studies comparing aggregate donation rates across countries have reached different conclusions, a trend which is also observed when looking at donation systems at a micro level. For example, in 2015 Wales introduced an opt-out system which

over time significantly increased organ donation consent [8]. Whereas Chile, Singapore, and Sweden provide examples of opt-out systems failing to increase donation [9].

While the data regarding whether opt-in versus opt-out models of consent increase deceased organ donation remain inconsistent, ethics concerns with each model persist which require consideration. From an ethical perspective, voluntary consent upholds patient autonomy and maximizes trust and transparency within the health care system; whereas presumed consent systems may undermine patient autonomy and diminish trust in the health care system [10]. However, voluntary consent models require healthcare professionals to obtain consent from the families of potential donors at the bedside during an emotionally difficult time. This is often without the knowledge of what the patient would have wanted. It is estimated that obtaining family voluntary consent at the bedside for organ donation results in an estimated 15-45 percent loss in potential deceased donors in the US [10].

CONCLUSION

The *Code of Medical Ethics* requires that informed consent be obtained from the patient or their surrogate prior to organ donation and prioritizes the voluntary choice model of consent. Due to the low rate of organ donation and high need in order to save lives, there is an active call to increase organ donation supply through the implementation of mandated choice or presumed consent models. Currently, the *Code* provides guidance that "unless there are data that suggest a positive effect on donation, neither presumed consent nor mandated choice for cadaveric organ donation should be widely implemented." However, the *Code* also recognizes that "these models merit further study to determine whether either or both can be implemented in a way that meets fundamental ethical criteria for informed consent and provides clear evidence that their benefits outweigh ethical concerns" (Opinion 6.1.4).

If the phrase "unless there are data that suggest a positive effect on donation" is removed, *Code* guidance on the utilization of presumed consent and mandated choice models for organ donation will become more stringent and effectively result in guidance to not widely implement either of these two consent models, even when data suggest a positive effect on donation. Given the pressing need for an increase in organ donation and the paucity of conclusory data regarding the effect of consent model type on donation, effectually disallowing a model of informed consent for organ donation when data suggest a positive effect on organ donation would undermine the well-being of potential recipients waiting for a lifesaving organ donation. However, it is important to ensure that regardless of what the data show, the chosen consent model must be ethically implemented to respect both the donor and the recipient and must keep with ethics standards on informed consent and guidance for organ transplantation from deceased donors (Opinion 6.2.1).

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that Resolution 17-A-24 not be adopted and the remainder of this report be filed.

Fiscal Note: Less than $500

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(A-25)

Introduced by: Illinois

Subject: Opposition to Censuring Medical Societies or Organizations Based on Politics or Policies of Governments

Referred to: Reference Committee on Ethics and Bylaws

Whereas, the International Federation of Medical Student Associations (IFMSA) is a global organization that fosters collaboration, education, and advocacy among medical students from diverse countries; and

Whereas, the IFMSA has suspended the Federation of Israeli Students of Medicine, a member society, based on the perceived political or military policies of its host country; and

Whereas, the Illinois State Medical Society and the American Medical Association uphold principles of equity, inclusion, and the importance of engagement in a diverse global community; and

Whereas, It is essential for medical organizations, including international medical organizations, to focus on the advancement of medical education and the promotion of human health rather than engaging in politically motivated actions that may undermine the collaborative nature of their mission; and

Whereas, censure of a member society based solely on the political or military policies of its host government may unfairly penalize medical students who are working toward positive change and who may not have control over their government's policies; therefore be it

RESOLVED, that our American Medical Association adopt a policy opposing the censure of any medical group or society or organization, based on the politics or policies of the local, state or national political leadership, such that the art and science of medicine is kept separate from politics. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/2025

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(A-25)

Introduced by: Indiana

Subject: Physician Disclosures of Relationships in Private Equity Held Organizations

Referred to: Reference Committee on Ethics and Bylaws

Whereas, private equity investment in the United States health care system has expanded to $100 billion in all sectors, including nursing homes, hospitals, primary care, and specialty practices; and

Whereas, complex financial arrangements obscure physician relationships with private equity owned entities at the Medicare enrollment level, i.e. Provider, Enrollment, Chain, and Ownership System (PECOS), including employment, shareholder status, or medical directorship(s); and

Whereas, the American Medical Association has policy (D-140.951) which will study and clarify the ethical challenges raised by the expansion of private equity ownership, including but not limited to the effect on the professional responsibilities and ethical priorities for physician practices; therefore be it

RESOLVED, that our American Medical Association support physician disclosure of private equity relationship(s), including employment, shareholder status, or medical directorship(s) at any accredited education function that bears continuing AMA medical education credit or approval through the Accreditation Council for Continuing Medical Education (New HOD Policy); and be it further

RESOLVED, that our AMA support physician disclosure of private equity relationship(s) for any committee member that reviews state or federal government (i.e. The Relative Value Scale Update Committee) resource allocation as it pertains to provision of medical services. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/16/25

RELEVANT AMA POLICY

D-140.951 Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices
Our American Medical Association will study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership or management of physician practices and report back on the status of any ethical dimensions inherent in these arrangements, including consideration of the need for ethical guidelines as appropriate. Such a study should evaluate the impact of private equity ownership, including but not limited to the effect on the professional responsibilities and ethical priorities for physician practices. Citation: Res. 026, A-22; Reaffirmed: BOT Rep. 14, A-23.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(A-25)

Introduced by: LGBTQ+ Section

Subject: Opposition to Censorship in Public Libraries

Referred to: Reference Committee on Ethics and Bylaws

Whereas, public libraries are widely trusted civic institutions with an extensive population reach, receiving an estimated four million visits each day across over 16,500 public libraries nationwide, that serve as an essential community resource to advance population health and address health disparities[1-4]; and

Whereas, a report by the American Library Association has demonstrated that book challenges have become increasingly prevalent over the past four years with over 4200 unique book titles in public and school libraries being challenged during 2023, representing a 65% increase compared to the previous year, of which nearly 1500 were banned[5,6]; and

Whereas, book challenges are especially impacting access to information in public libraries where the number of titles targeted for censorship increased by 92% in 2023 compared to 2022[5]; and

Whereas, over 95% of book bans were enacted without following the best practice guidelines for book challenges outlined by the American Library Association and the National Coalition Against Censorship[7-9]; and

Whereas, a 2023 analysis by the Washington Post demonstrated that book challenges frequently cited out-of-context concerns about “sexual” (61%), “inappropriate” (29%), and “pornographic” (22%) content as part of their rationale[10]; and

Whereas, LGBTQ+ content is frequently conflated with “harmful” or “obscene” content in book, and this has enabled the recent passage of legislation like Idaho’s House Bill 710 that requires libraries to remove any books deemed harmful based on a definition of obscene materials that includes “any homosexual act”[10-13]; and

Whereas, nearly half (47%) of books targeted for censorship in 2023 represent LGBTQ+ or BIPOC stories, and banning books about the lived experiences and histories of these marginalized communities intensifies feelings of exclusion and stigma, exacerbating their pre-existing risks of developing mental health disorders[5,14-16]; and

Whereas, several of the most frequently banned books include titles that discuss sexual assault, diminishing resources to teach empathy for survivors’ stories and build awareness of sexual violence, which is important for youth given that at least 25% of girls and 5% of boys will experience sexual abuse before the age of 18 and 67% of these incidents go unreported[11,17-20]; and

Whereas, the majority of banned books are young adult books, middle grade books, chapter books, or picture books specifically written and selected for younger audiences, with many of

targeted titles like “It’s Perfectly Normal” providing age-appropriate references to sexuality and real-world context for concepts covered in comprehensive sexual education classes[11,21,22]; and

Whereas, a national 2015 survey found that 84% of teens searched for sexual health information online – including topics like sexually transmitted infections, puberty, pregnancy, sexual assault, and intimate partner violence – but several teens also reported finding “negative” health information with 43% encountering online pornography in these searches[23]; and

Whereas, the American Library Association has launched Unite Against Book Bans, which is a national coalition that the AMA has not yet partnered with, in support of “each person’s constitutionally protected right to choose and read books that raise important issues and lift up the voices of those who are often silenced”[5,24]; and

Whereas, at least 129 library-adverse bills were introduced in 2024, and although most were unsuccessful in current legislatures, it is difficult to predict the future trajectory of these bills especially in the context of the political proposals to diminish libraries’ roles as neutral and inclusive spaces for access to a wide range of information[12,25,26]; and

Whereas, lawsuits challenging book bans implemented in conservative states like Texas and Iowa have been heard in federal courts with mixed success in blocking overreaching legislation that would require removal of books related to gender identity and sexual orientation[27,28]; and

Whereas, the US Supreme Court has previously heard a case on the removal of books from school libraries in Island Trees School District v. Pico, and in April 2025, the US Supreme Court is set to hear a new case of parents who object to their children reading developmentally appropriate books with LGBTQ+ themes in schools[29-31]; and

Whereas, various bills and resolutions have been introduced in the US House of Representatives to address the national issue of discriminatory book bans in public libraries without succes[32,33,34]; and

Whereas, under the new presidential administration and guidance from its recent executive orders, agencies like the Department of Education and the Department of Defense have taken actions in support of restricting access to books and health content curricula dealing with LGBTQ+ themes, even going so far as to revoke all guidance characterizing book bans as civil rights violations[35,36,37]; therefore be it

RESOLVED, that our American Medical Association support efforts to safeguard free access to diverse health information by preventing publicly funded entities from censoring books or educational materials in a manner that discriminates on the basis of race, nationality, gender identity, sexual orientation, religion, disability, political affiliation, or socioeconomic status (New HOD Policy); and be it further

RESOLVED, that our AMA amend Policy H-60.898, “Opposing the Censorship of Sexuality and Gender Identity Discussions in Public Schools” by addition and deletion as follows:

Opposing the Censorship of Sexuality and Gender Identity Discussions in Public Schools and Libraries, H-60.898
1. Our American Medical Association opposes censorship of LGBTQIA+ topics and opposes any policies that limit discussion or restrict mention of sexuality, sexual orientation, and gender identity in schools, or educational curricula, or public libraries.

2. Our AMA will support policies that ensure an inclusive, well-rounded educational environment free from censorship of discussions surrounding sexual orientation, sexuality, and gender identity in public schools. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/2025

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RELEVANT AMA POLICY

Opposing the Censorship of Sexuality and Gender Identity Discussions in Public Schools, H-60.898

1. Our American Medical Association opposes censorship of LGBTQIA+ topics and opposes any policies that limit discussion or restrict mention of sexuality, sexual orientation, and gender identity in schools or educational curricula.

2. Our AMA will support policies that ensure an inclusive, well-rounded educational environment free from censorship of discussions surrounding sexual orientation, sexuality, and gender identity in public schools.

[Res. 442, A-22]

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools, H-170.968

2. Our AMA urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; … (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils.

9. Our AMA supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent.

10. Our AMA encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

[CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Apended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: Res. 405, A-16, Appended: Res. 414, A-18; Appended Res. 428, A-18; Modified: Res. 413, A-22; Reaffirmation: Res. 413, A-24]

Sexual Assault Education and Prevention in Public Schools, H-515.953
Our AMA supports state legislation mandating that public middle and high school health education programs include age appropriate information on sexual assault education and prevention, including but not limited to topics of consent and sexual bullying. [Res. 209, I-18]

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations, H-160.991
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to date education and information to enable the provision of high quality and culturally competent care to LGBTQ people. [CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8, I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation, A-12; Modified: Res. 08, A-16; Modified Res. 903, I-17; Modified Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18; Reaffirmed: CSAPH Rep. 08, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 004
(A-25)

Introduced by: Minority Affairs Section

Subject: Reducing the Harmful Impacts of Immigration Status on Health

Referred to: Reference Committee on Ethics and Bylaws

Whereas, undocumented workers, accounting for 8.3 million of the U.S. workforce in 2022 and contributing over $5 billion in federal taxes, are vital to industries like agriculture, construction, and healthcare but often face wage theft, poor conditions, lack of health insurance, and workplace bullying[1-8]; and

Whereas, the strenuous labor demands and restricted access to basic rights experienced by undocumented workers have been linked to higher rates of alcoholism, depression, anxiety, and social isolation[9-12]; and

Whereas, despite facing systemic human rights violations, undocumented workers are often unable to assert fundamental rights due to fear of deportation, limited legal protections, and policies that violate international standards for workplace equality[13]; and

Whereas, the Department of Labor recognizes that migrant workers, regardless of immigration status, are entitled to rights such as forming unions, receiving minimum wage, and protection from discrimination, harassment, and retaliation, while undocumented workers face barriers that impact their employment, healthcare access, and overall quality of life[14]; and

Whereas, the E-Verify system, which requires employers to check immigration status before hiring, has led to over 300,000 legal workers being denied employment due to database errors, failed to significantly reduce the number of employed undocumented workers, and resulted in reduced wages for undocumented workers, forcing them to work longer hours to make up for lost income[15-16]; and

Whereas, the use of immigration enforcement in the workplace creates an environment of coercion and exploitation for undocumented workers, whose vulnerability extends beyond work to housing, healthcare, and basic needs, with limited legal protections and economic disparities perpetuating a cycle of abuse and leaving them with few options for recourse or recovery[9,17-19]; and

Whereas, undocumented workers have limited options to seek care through community health clinics and federally qualified health centers, which often operate on limited resources and may not be able to serve the comprehensive needs of undocumented workers due to lack of healthcare options outside of working hours, translation services, cultural competency, and lack of funding[20,21]; and

Whereas, despite contributing taxes and supporting the Medicare Trust Fund, nearly half of undocumented immigrants remain uninsured due to ineligibility for Medicaid, CHIP, Medicare, or ACA Marketplace coverage, relying instead on emergency Medicaid under EMTALA, which cost $974 million of the $3.3 trillion in national healthcare expenditures[22,23]; and

Whereas, immigration status significantly impacts health outcomes, with undocumented patients experiencing higher mortality rates compared to citizens due to limited access to preventive and comprehensive healthcare[24,25]; and

Whereas, undocumented individuals ineligible for federal health coverage often have to rely on costly emergency department care for chronic conditions like dialysis, increasing mortality and healthcare expenses[26]; and

Whereas, expanding healthcare access for undocumented people reduces emergency room utilization, lowers overall spending, and improves health outcomes through earlier diagnosis, preventive screenings, and better management of chronic conditions[20,27]; and

Whereas, organizations like the Occupational Safety and Health Administration (OSHA), the National Employment Law Project, and the Virginia Legal Aid Justice Center work to protect undocumented workers through visa support, policy advocacy, and improved labor laws[28-30]; and

Whereas, national and local groups, including National COSH, provide undocumented workers with education, legal services, and safety training, though such resources often fail to reach isolated or rural communities, leaving many unaware of their rights and protections[31-38]; and

Whereas, the threat of deportation prevents undocumented workers from reporting labor violations and exacerbates mental health issues, poverty, and child safety risks among immigrant families[1,40-43]; and

Whereas, while the Department of Homeland Security's deferred action process offers protection from immigration-related retaliation and access to critical resources, its limitations, including a complex application process, language barriers, and temporary protections, leave many non-citizen workers vulnerable to harassment and termination[44-46]; and

Whereas, undocumented individuals, including Deferred Action for Childhood Arrivals (DACA) recipients, face significant barriers to legalization, including limited asylum appointments via the U.S. Customs and Border Protection (CBP) One App, high documentation costs, visa backlogs, and restrictive immigration policies[47-51]; and

Whereas, the UN High Commissioner for Refugees (UNHCR) affirms the right to seek asylum, but high asylum-seeker volumes at the U.S.-Mexico border limit this right, increasing the risk of undocumented workers and abuse, while asylum provides legal protections and benefits not available to undocumented workers[52-54]; and

Whereas, family reunification programs help alleviate the mental health effects of separation by reuniting legalized immigrants with their families, while undocumented children, especially unaccompanied minors, face significant legal and emotional challenges, including difficulties obtaining citizenship and lack of essential services[55-56]; and

Whereas, since 2021, over 400,000 unaccompanied minors have entered the U.S. to escape poverty and violence, many working in unsafe jobs with insufficient safety oversight, which increases the risk of injury and mortality[57]; and

Whereas, unaccompanied minors also face increased stressors due to lack of parental guidance and legal protections, with the Central American Minors (CAM) program offering some children a pathway to refugee or parolee status, helping over 5,000 individuals since 2014[58-63]; and

Whereas, coalitions such as Refugee Council USA, which includes Amnesty International and OXFAM as members, can amplify advocacy efforts and allow the AMA to streamline its advocacy

efforts and broaden its reach by collaborating on initiatives to healthcare access and policy reform for immigrant populations[64]; therefore be it

RESOLVED, that our American Medical Association support protecting the human right to seek asylum (New HOD Policy); and be it further

RESOLVED, that our AMA support pathways to citizenship for undocumented immigrants who entered the US as minors, including Deferred Action for Childhood Arrivals (DACA) recipients and Dreamers (New HOD Policy); and be it further

RESOLVED, that our AMA support family reunification pathways for children and adult immigrants from other countries if their parent/guardian, spouse, or child/dependent has documented status in the U.S. (New HOD Policy); and be it further

RESOLVED, that our AMA support deferral of deportation (and if applicable, employment authorization, driver's licenses, and identification documents) for people with disabilities and significantly limiting chronic illness, people who work in healthcare and social care, and relatives of people with documented or DACA status, and people without violent felonies (New HOD Policy); and be it further

RESOLVED, that our AMA support federal and state efforts to remove immigration enforcement from workplaces and employment consideration, including the removal of E-Verify mandates. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/21/2025

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RELEVANT AMA POLICY

D-515.979 Intimate Partner Violence Policy and Immigration

Our AMA: (1) encourages appropriate stakeholders to study the impact of mandated reporting of domestic violence policies on individuals with undocumented immigrant status and identify potential barriers for survivors seeking care; and (2) will work with community based organizations and related stakeholders to clarify circumstances that would trigger mandated reporting of intimate partner violence and provide education on the implications of mandatory reporting on individuals with undocumented immigrant status. [Res. 002, I-17]

H-65.938 Guiding Principles for the Healthcare of Migrants

1. Our American Medical Association advocates for the development of adequate policies and / or legislation to address the healthcare needs of migrants and asylum seekers in cooperation with relevant legislators and stakeholders based on the following guiding principles, adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the "Colombo Statement."
2. Our AMA recognizes that migration status is a social determinant of health.
3. Our AMA affirms the importance of multi-sectoral coordination and inter-country engagement and partnership in enhancing the means of addressing health aspects of migration.
4. Our AMA recognizes that the enhancement of migrants' health status relies on an equitable and non-discriminatory access to and coverage of health care and cross-border continuity of care at an affordable cost avoiding severe financial consequences for migrants, as well as for their families.
5. Our AMA recognizes that investment in migrant health provides positive dividends compared to public health costs due to exclusion and neglect, and therefore underscore the need for financing mechanisms that mobilize different sectors of society, innovation, identification and sharing of good practices in this regard.
6. Our AMA recognizes that the promotion of the physical and mental health of migrants as defined by the following select objectives from the World Health Organization's 72nd World Health Assembly, Global action plan on promoting the health of refugees and migrants, 2019-2023, is accomplished by
    a. Ensuring that essential components, such as vaccination of children and adults and the provision of health promotion, disease prevention, timely diagnosis and treatment, rehabilitation and palliative services for acute, chronic and infectious diseases, injuries, mental and behavioral disorders, and sexual and reproductive health care for women, are addressed.
    b. Improving the quality, acceptability, availability and accessibility of health care services, for instance by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the migration and displacement process, and by working to prevent occupational and work-related diseases and injuries among migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and social protection systems.
    c. Ensuring that the social determinants of migrants' health are addressed through joint, coherent multisectoral actions in all public health policy responses, especially ensuring promotion of well-being for all at all ages, and facilitating orderly, safe, and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies, as defined in the Sustainable Development Goals of the United Nations.
    d. Ensuring that information and disaggregated data at global, regional and country levels are generated and that adequate, standardized, comparable records on the health of migrants are available to support policy-makers and decision-makers to develop more evidence-based policies, plans and interventions.
    e. Providing accurate information and dispelling fears and misperceptions among migrant and host populations about the health impacts of migration and displacement on migrant populations and on the health of local communities and health systems. [Res. 016, A-24]

H-135.935 OSHA Standards for Lead

Our AMA will advocate with American College of Occupational and Environmental Medicine and other professional organizations to change the Occupational Safety & Health Administration legal standard for temporary medical removal from all lead work environments, regardless of the airborne lead concentrations, which result in workers' blood lead levels exceeding 20 mcg/dL on any two consecutive blood tests, or any single value exceeding 30 mcg/dL, as recommended by a subgroup of an expert panel convened by the Association of Occupational and Environmental Clinics (2007) and by Cal/OSHA (2009). [Res. 423, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

D-350.975 Immigration Status is a Public Health Issue

1. Our AMA declares that immigration status is a public health issue that requires a comprehensive public health response and solution.

2. Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.
3. Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.
4. Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities. [Res. 904, I-22; Reaffirmed: Res. 210, A-23]

H-350.957 Addressing Immigrant Health Disparities
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin. [Res. 804, I-09; Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19]

D-440.927 Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services
Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition. [Res. 254, A-18; Reaffirmed: Res. 259, A-23]

D-365.995 Protecting Workers During Catastrophes
1. Our American Medical Association will advocate for legislation that creates federal standards of safety and protection of workers during natural or man-made catastrophes.
2. Our AMA will advocate that the United States Department of Labor, the Occupational Safety and Health Administration (OSHA), and other appropriate parties develop and enforce evidence-based policies, guidelines, and protections for workers at their place of employment during catastrophes. [Res. 411, A-23]

H-60.906 Opposing the Detention of Migrant Children
Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children "without unnecessary delay" when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the "least restrictive setting" possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities. [Res. 004, I-18; Reaffirmed: Res. 234, A-22]

H-315.966 Patient and Physician Rights Regarding Immigration Status
Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. [Res. 018, A-17]

H-440.876 Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients
1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and

other healthcare providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents. [Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14]

D-135.967 Advocating for Heat Exposure Protections for All Workers
Our AMA: (1) will advocate for all workers to have access to preventive cool-down rest periods in shaded, ventilated, and/or cooled areas for prevention of injury from sun exposure and heat injury as well as appropriate access to emergency services when signs and symptoms of heat exposure injury; (2) will advocate for legislation that creates federal standards for protections against heat stress and sun exposure specific to the hazards of the workplace; (3) supports policy change at the federal level via legislation or administrative rule changes by the Occupational Safety and Health Administration (OSHA) that would require that workers receive health educational materials about prevention and recognition of heat exhaustion and heat exposure injury that is in the worker's primary language: (4) will work with the United States Department of Labor, OSHA, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for workers independent of legal status; and (5) recognizes there are particular medical conditions and medications, including but not limited to psychotropics, which increase an individual’s vulnerability to the negative impacts of heat and sun exposure and advocate for recognition of this, as well as additional protections as part of any guidelines, legislation or other policies. [Res. 502, I-21]

H-130.967 Action Regarding Illegal Aliens
Our AMA supports the legislative and regulatory changes that would require the federal government to provide reasonable payment for federally mandated medical screening examinations and further examination and treatment needed to stabilize a condition in patients presenting to hospital emergency departments, when payment from other public or private sources is not available. [BOT Rep. MM, A-89; Reaffirmed by BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17]

D-440.985 Health Care Payment for Undocumented Persons
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level. [Res. 148, A-02; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmation: A-19; Reaffirmation: I-19]

H-165.823 Options to Maximize Coverage under the AMA Proposal for Reform
1. That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
e. The public option is financially self-sustaining and has uniform solvency requirements.
f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.
3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:

a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the"coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. [CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22; Reaffirmed: CMS Rep. 5, I-23]

H-430.976 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies

1. Our AMA acknowledges that systemic racism is a root of incarcerated labor policies and practices.
2. Our AMA supports:

(a) Efforts to ensure that all work done by individuals who are incarcerated in correctional facilities is fully voluntary.

(b) Eliminating policies that require forced labor or impose adverse consequences on incarcerated workers who are unable to carry out their assigned jobs due to illness, injury, disability, or other physical or mental limitations.

(c) Eliminating policies that negatively impact good time, other reductions of sentence, parole eligibility, or otherwise extend a person's incarceration for refusal to work when they are unable to carry out their assigned jobs due to illness, injury, disability, or other physical or mental limitations.

(d) The authority of correctional health care professionals to determine when an individual who is incarcerated is unable to carry out assigned work duties.

3. Our AMA encourages:

(a) Congress and state legislatures to clarify the meaning of "employee" to explicitly include incarcerated workers within that definition to ensure they are afforded the same workplace health and safety protections as other workers.

(b) Congress to enact protections for incarcerated workers considering their vulnerabilities as a captive labor force, including anti-retaliation protections for workers who are incarcerated who report unsafe working conditions to relevant authorities.

(c) Congress to amend the Occupational Safety and Health Act to include correctional institutions operated by state and local governments as employers under the law.

(d) The U.S. Department of Labor to issue a regulation granting the Occupational Safety and Health Administration jurisdiction over the labor conditions of all workers incarcerated in federal, state, and local correctional facilities.

4. Our AMA encourages:

(a) Comprehensive safety training that includes mandatory safety standards, injury and illness prevention, job-specific training on identified hazards, and proper use of personal protective equipment and safety equipment for incarcerated workers.

(b) That safety training is delivered by competent professionals who treat incarcerated workers with respect for their dignity and rights.

(c) That all incarcerated workers receive adequate personal protective equipment and safety equipment to minimize risks and exposure to hazards that cause workplace injuries and illnesses.

(d) Correctional facilities to ensure that complaints regarding unsafe conditions and abusive staff treatment are processed and addressed by correctional administrators in a timely fashion.

5. Our AMA acknowledges that investing in valuable work and education programs designed to enhance incarcerated individuals' prospects of securing employment and becoming self-sufficient upon release is essential for successful integration into society.

6. Our AMA strongly supports programs for individuals who are incarcerated that provides opportunities for advancement, certifications of completed training, certifications of work performance achievements, and employment-based recommendation letters from supervisors. [BOT Rep. 02, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
A-25

Introduced by: Minority Affairs Section

Subject: Dedicated Interfaith Prayer and Reflection Spaces in Medical Schools and Healthcare Facilities

Referred to: Reference Committee on Ethics and Bylaws

Whereas, spirituality is important to many patients with serious illness;[1] and

Whereas, frequent religious service attendance was associated with lower risk of all-cause mortality, suicide, and depression;[2] and

Whereas, early research indicates broad agreement that religion is a social determinant of health and involvement in religion is linked to mostly beneficial health outcomes;[3] and

Whereas, many faiths, including but not limited to Islam, Christianity, Judaism, Buddhism, and Baha'i preach daily prayer, reflection, or meditation as spiritual practices;[4] and

Whereas, the most likely religious group to experience discrimination in institutional settings were Muslims, according to The Institute for Social Policy and Understanding's (ISPU) American Muslim Poll 2022: A Politics and Pandemic Status Report;[5] and

Whereas, numerous studies have highlighted how the lack of cultural competence and healthcare accommodations, such as prayer spaces, are reasons Muslim patients delay healthcare, and Muslim patients have expressed that it is difficult for them to complete their obligatory daily prayers when admitted to in-patient medical institutions and while accessing medical care;[6–8] and

Whereas, many physicians note that their religion and faith has contributed positively to providing exceptional patient care;[9] and

Whereas, a 2021 study found an association between better spiritual well-being of residents with greater sense of work accomplishment, overall self-rated health, decreased burnout and depressive symptoms;[10] and

Whereas, a 2021 study found that identification as an active participant within a religious affiliation had statistically significant lower burnout scores among medical students ;[11] and

Whereas, Muslims must perform ablution, or *wudhu*, before prayer and pray 5 times a day in a quiet, clean space;[6,7] and

Whereas, Oriental Orthodox Christians must pray the canonical hours seven times a day, and Jewish law requires Jews to pray three times a day;[12,13] and

Whereas, the provision of spiritual care in the medical care of patients with serious illness is associated with better end-of-life outcomes;[1] and

Whereas, results from a survey following implementation of reflection spaces in the hospital showed that 90% of responders displayed a preference for using the reflection room versus a hospital unit;[14] and

Whereas, interfaith prayer and reflection rooms are a viable solution to providing diverse student populations a space for spirituality, while also creating an opportunity for awareness of religious pluralism on university campuses;[15] and

Whereas, medical students would feel more supported if their religious and cultural beliefs are valued;[16] and

Whereas, recently, some medical institutions and schools are recognizing the importance and need for interfaith prayer spaces and have started to create those spaces for their students and personnel;[16-19] and

Whereas, Liaison Committee on Medical Education (LCME) standard IS-16 and element 3.3 state that medical education programs must engage in ongoing, systematic, and focused efforts to attract and retain students, faculty, staff, and others from demographically diverse backgrounds;[20] and

Whereas, in 2011, the Association of American Medical Colleges (AAMC) "encouraged medical institutions to embrace a framework for diversity that included removing social…barriers to diversity," but stated almost a decade later that this has not happened;[21] and

Whereas, the AAMC's Chief Diversity and Inclusion Officer, David A. Acosta, MD, has stated that true equity is reached when "*every* person in the academic medical community" can obtain their full potential regardless of their social identity;[22] and

Whereas, AMA's 2024-2025 Organizational Strategic Plan to Advance Health Equity will "amplify and integrate often 'invisible-ized' narratives of historically marginalized physicians and patients" in all that the AMA does;[23] and

Whereas, the AMA states it is committed to maintaining diversity, equity, and inclusion among medical students and physicians;[24] and

Whereas, Policy H-160.900 states that the AMA recognizes the impact spirituality has on health and encourages patient access to spirituality;[25] and

Whereas, Policy D-200.985 states that the AMA will encourage the LCME to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty;[26] and

Whereas, Policy H-295.927 encourages the AMA, LCME, medical schools, and teaching hospitals to address issues related to the health and well-being of medical students;[27] and

Whereas, Policy D-350.996 states that as part of their advocacy and public health efforts, the AMA will incorporate strategies that eliminate minority health care disparities;[28] therefore be it

RESOLVED, that our American Medical Association support the establishment and maintenance of dedicated interfaith prayer and reflection spaces in medical schools, teaching hospitals, and healthcare facilities, including spaces for ritual purification, as a component of

fostering inclusive, supportive environments for patients, students, and healthcare workers from all religious and spiritual backgrounds (New HOD Policy); and be it further

RESOLVED, that our AMA encourage the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and other relevant accrediting bodies to consider access to interfaith prayer, reflection, and purification spaces as part of their standards related to diversity, equity, inclusion, and learner well-being (New HOD Policy); and be it further

RESOLVED, that our AMA encourage medical schools and healthcare institutions to engage affected communities, including students, trainees, and patients from diverse religious and spiritual traditions, in the planning, implementation, and upkeep of interfaith prayer and reflection spaces to ensure these spaces are welcoming, accessible, and responsive to user needs (New HOD Policy); and be it further

RESOLVED, that our AMA support the development, evaluation, and dissemination of best practices for implementing inclusive interfaith prayer, reflection, and purification spaces in clinical and educational settings, including research on their impact on learner well-being, patient experience, and institutional culture. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/21/25

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RELEVANT AMA POLICY

H-160.900 Addressing Patient Spirituality in Medicine
Our AMA recognizes the importance of individual patient spirituality and its impact on health and encourages patient access to spiritual care services. [Res. 004, I-16; Modified: Res. 304, A-24]

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 and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.

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; Modified: CME Rep. 02, I-22; Modified: Res. 320, A-23]

D-350.996 Strategies for Eliminating Minority Health Care Disparities
Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate. [Res. 731, I-02; Modified: CCB/CLRPD Rep. 4, A-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22; Reaffirmed: CMS Rep. 03, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(A-25)

Introduced by: American Association of Public Health Physicians, Medical Student Section,

Subject: Military Deception as a Threat to Physician Ethics

Referred to: Reference Committee on Ethics and Bylaws

Whereas, the United States Central Intelligence Agency (CIA)'s use of a fake, physician-led hepatitis immunization program to gather military intelligence in Pakistan in 2011 made legitimate polio vaccination clinics a target for militant violence, with public health workers becoming the target of attacks[1-3]; and

Whereas, disclosure of these operations contributed to a subsequent decline in polio and hepatitis vaccination rates in Pakistan despite an unchanged provision of health services, suggesting the vaccine ruse damaged the reputation of vaccines and of formal medicine in the region[1,4]; and

Whereas, growing global distrust in healthcare institutions and providers is a threat to global vaccine uptake and improved health outcomes[5-7]; and

Whereas, the World Health Organization's declaration of polio's re-emergence as a public health emergency of international concern (PHEIC), political rhetoric surrounding the COVID-19 pandemic, and other emerging threats underscores the importance of political neutrality in public health campaigns and global medical interventions in order to maintain trust in health institutions[1]; and

Whereas, our AMA Code of Medical Ethics serves as the foundational ethical guidance for all AMA policy and a codification of expectations regarding physician conduct and the "responsibility towards patients first and foremost, as well as to society, to other health professionals, and to self", including in settings of armed conflict and military intervention; and

Whereas, our AMA Code of Medical Ethics Opinions 1.1.1, 1.1.3, 8.11, and 11.1.1 provide strong, clear guidance on physicians' ethical responsibilities to prioritize patient welfare, advocate for informed, transparent decision making, protecting vulnerable populations, and protecting patient rights; and

Whereas, current AMA Policy "support[s] medical neutrality, under the principles of the Geneva Convention" (H-520.998) and "support[s] the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime" (D-65.993); and

Whereas, AMA Code of Medical Ethics Opinion 9.7 affirms that while physicians have civic duties, they are not required to perform duties that conflict with fundamental medical ethics, offering guidance limited to medical testimony, court-initiated treatment, capital punishment, interrogation, and torture; and

Whereas, the Geneva Conventions, AMA Code of Medical Ethics, and AMA policies lack clear ethical guidance on physician conduct when government entities use medical, public health, or humanitarian aid deceptively for military gain or non-patient welfare purposes, highlighting a significant gap; and

Whereas, the World Medical Association (WMA), in collaboration with international organizations, has endorsed the Ethical Principles of Care in Times of Armed Conflict and Other Emergencies, which emphasize that healthcare privileges and facilities must only serve healthcare needs, and that physicians' primary ethical obligation is to their patients[8]; and

Whereas, the WMA's Statement in Times of Armed Conflict and Other Situations of Violence reaffirms that physicians must never exploit the vulnerability of the wounded and sick or misuse healthcare privileges for unintended purposes[9]; and

Whereas, the misuse of medical aid as a cover for military intelligence gathering undermines the physician duty to patients and threatens public trust of healthcare providers and institutions; therefore be it

RESOLVED, that our American Medical Association oppose the deceptive use of medical, public health, and humanitarian aid for secret or ulterior motives by government and military entities, including to gather national security intelligence or gain leverage in an armed conflict. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 04/10/2025

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RELEVANT AMA POLICY

AMA Code of Medical Ethics Opinion 8.11: Health Promotion & Preventive Care
Health promotion should be a collaborative, patient-centered process that promotes trust and recognizes patients' self-directed roles and responsibilities in maintaining health.

AMA Code of Medical Ethics Opinion 1.1.1: Patient-Physician Relationships
The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

AMA Code of Medical Ethics Opinion 11.1.1: Defining Basic Health Care
Physicians regularly confront the effects of lack of access to adequate care and have a corresponding responsibility to contribute their expertise to societal decisions about what health care services should be included in a minimum package of care for all.

Individually and collectively as a profession, physicians should advocate for fair, informed decision making about basic health care that:

(a) Is transparent.
(c) Protects the most vulnerable patients and populations, with special attention to historically disadvantaged groups.

AMA Code of Medical Ethics Opinion 1.1.3: Patient Rights
The health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have, to seek care and to be candid with their physicians.

Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients' advocates and by respecting patients' rights. These include the right:

(h) To be advised of any conflicts of interest their physician may have in respect to their care.

D-65.993 War Crimes as a Threat to Physicians' Humanitarian Responsibilities
1. Our American Medical Association will implore all parties at all times to understand and minimize the health costs of war on civilian populations generally and the adverse effects of physician persecution in particular.
2. Our AMA will support the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime, episodes of civil strife, or sanctions and condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, by any party, wherever and whenever it occurs.
3. Our AMA will advocate for the protection of physicians' rights to provide ethical care without fear of persecution. [BOT Action in response to referred for decision Res. 620, A-09; Modified: BOT Rep. 09, A-19; Modified: Res. 002, I-22; Reaffirmed: Res. 603, A-24]

H-520.998 Medical Neutrality
Our American Medical Association supports medical neutrality, under the principles of the Geneva Convention, for all health care workers and the sick and wounded in all countries. [Sub. Res. 72, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11; Reaffirmed in lieu of Res. 601, I-13; Reaffirmed: CEJA Rep. 05, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(A-25)

Introduced by: Medical Student Section, LGBTQ+ Section

Subject: Use of Inclusive Language in AMA Policy

Referred to: Reference Committee on Ethics and Bylaws

Whereas, in 2019, our American Medical Association established the Center for Health Equity to embed and advance equity across all aspects of health care, including within the American Medical Association itself; and

Whereas, our AMA, in partnership with the Association of American Medical Colleges (AAMC) Center for Health Justice, developed "Advancing Health Equity: A Guide to Language, Narrative and Concepts," a comprehensive health equity communication guide[1]; and

Whereas, AMA policy H-65.942, "Supporting the Use of Gender-Neutral Language," provides a model for broad-based updates to the AMA policy compendium via ongoing use of the reaffirmation and sunset mechanisms; and

Whereas, existing AMA policies continue to utilize other language or terminology that is outdated, obsolete, exclusive, inaccurate, or offensive, which hinders our mission to promote the art and science of medicine and the betterment of public health; and

Whereas, despite this, existing policy is not comprehensively updated to use inclusive language via the sunset and reaffirmation mechanisms unless initiated by resolutions submitted to the House of Delegates (HOD), AMA staff, or an AMA Council[6]; and

Whereas, ad hoc resolutions submitted to the HOD largely result in reactionary, targeted changes to existing policy, creating cyclical administrative burden on AMA staff; and

Whereas, AMA Councils annually have the opportunity to review policies for sunset and have existing, though variable, mechanisms by which to edit policy language in their sunset report, providing a process to proactively update AMA policy to utilize inclusive language; and

Whereas, prior Sunset reports did not fully incorporate gender-neutral language updates, leaving the discrepancies to be identified and rectified by the House of Delegates [2-5]; and

Whereas, there is no explicit and comprehensive policy directive to ensure that future AMA policy or amendments to existing policy are standardized to use inclusive language; therefore be it

RESOLVED, that our American Medical Association, in consultation with relevant parties, including the AMA Center for Health Equity, amend existing policies to ensure the use of the most updated, inclusive, equitable, respectful, non-stigmatizing, and person-first language and use such language in all future AMA policies and amendments (Directive to Take Action); and be it further

RESOLVED, that our AMA, in consultation with relevant parties, including the AMA Center for Health Equity, identify other types of outdated language in AMA policies and devise a timely mechanism for editorial changes, including both one-time updates and a protocol for editorial changes to language at the HOD Reference Committee recommendation stage and whenever a policy is amended, modified, appended, reaffirmed, or reviewed for sunset; and report back to the House of Delegates. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 4/17/25

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RELEVANT AMA POLICY

H-70.912 Eliminating Use of the Term "Mental Retardation" by Physicians in Clinical Settings
Our American Medical Association recommends that physicians adopt the term “intellectual disability” instead of “mental retardation” in clinical settings. [Res. 024, A-19]

H-440.821 Person-First Language for Obesity
Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of person-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully. [Res. 402, A-17; Modified: Speakers Rep., I-17]

H-65.942 Supporting the Use of Gender-Neutral Language
Our American Medical Association will (1) Recognize the importance of using gender-neutral language such as gender neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity, (2) prospectively amend all current AMA policy, where appropriate, to include gender-neutral language by way of the reaffirmation and sunset processes, (3) utilize gender-neutral language in future policies1 internal communications, and external communications where gendered language does not specifically need to be used, (4) encourage the use of gender-neutral language in public health and medical messaging, (5) encourage other professional societies to utilize gender-neutral language in their work, and (6) support the use of gender-neutral language in clinical spaces that may serve both cisgender and gender-diverse individuals. [Res. 602, A-23]

D-65.990 Utilization of "LGBTQ" in Relevant Past and Future AMA Policies
1. Our American Medical Association will utilize the terminology “lesbian, gay, bisexual, transgender, and queer plus” and the abbreviation “LGBTQ+” in all future policies and publications when broadly addressing this population.

2. Our AMA will revise all relevant and active policies to utilize the abbreviation “LGBTQ+” in place of the abbreviations “LGBT” and “GLBT” where such text appears.

3. Our AMA will revise all relevant and active policies to utilize the terms “lesbian, gay, bisexual, transgender, and queer plus” to replace “lesbian, gay, bisexual, and transgender” where such text appears. [Res. 016, A-18; Modified: CCB Rep. 05, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(A-25)

Introduced by: Medical Student Section

Subject: Humanism in Anatomical Medical Education

Referred to: Reference Committee on Ethics and Bylaws

Whereas, when beginning cadaveric donor dissection, medical students commonly experience negative emotional or physical reactions which they are expected to quickly overcome, even though many continue to feel discomfort and prolonged guilt[1-2]; and

Whereas, the term "donor" can be more humanistic than the objectifying commonly used term "cadaver"[3,4]; and

Whereas, a diverse medical student community should nurture religious, cultural, and spiritual views towards deceased bodies[5-6]; and

Whereas, most schools conduct donor ceremonies before, during, and/or after dissection courses to convey respect and gratitude to donors and their families, but less than half of these schools include donor names in ceremonies[7-9]; and

Whereas, a survey of students who attended a donor ceremony shared more positive responses regarding their studies, reflection on death, and development of empathy compared to those not attend[10]; and

Whereas, memorial ceremonies and/or daily rituals demonstrate positive educational effects and help prevent decline of students' responsibility and respect during dissection courses[1]; and

Whereas, multiple studies show that students appreciate knowing their donors' identities, which increases positive response to working with donors[1,9]; and

Whereas, a study showed that donors supported anonymous disclosure of information after learning that students wanted to know more about their background to establish the idea of their donor as their first patient[11]; and

Whereas, another study found that "person-minded" medical students developed complex rules regarding respectful behavior towards donors, including habits that reinforced donors' humanity, in contrast to "specimen-minded" students[12]; and

Whereas, Indigenous students engaging in a cultural ceremony showed their respect and appreciation to donors, while also supporting their own spiritual and mental health[13]; therefore be it

RESOLVED, that our American Medical Association supports the incorporation of humanism in human anatomy education programs, including, but not limited to, time for HIPAA-compliant

recognition of donor backgrounds, reflection, discussion, and feedback (New HOD Policy); and be it further

RESOLVED, that our AMA supports accommodations for learners' and donors' cultural observances surrounding the deceased when appropriate (New HOD Policy); and be it further

RESOLVED, that our AMA supports donor memorial ceremonies at centers that utilize cadaveric-based human anatomy education programs. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/17/25

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RELEVANT AMA POLICY

H-295.896 Conscience Clause: Final Report
Principles to guide exemption of medical students from activities based on conscience include the following:
(1) Medical schools should address the various types of conflicts that could arise between a physician's individual conscience and patient wishes or health care institution policies as part of regular curricular discussions of ethical and professional issues.
(2) Medical schools should have mechanisms in place that permit students to be excused from activities that violate the students' religious or ethical beliefs. Schools should define and regularly review what general types of activities a student may exempt as a matter of conscience, and what curricular alternatives are required for students who exempt each type of activity.

(3) Prospective students should be informed prior to matriculation of the school's policies related to exemption from activities based on conscience.
(4) There should be formal written policies that govern the granting of an exemption, including the procedures to obtain an exemption and the mechanism to deal with matters of conscience that are not covered in formal policies.
(5) Policies related to exemption based on conscience should be applied consistently.
(6) Students should be required to learn the basic content or principles underlying procedures or activities that they exempt. Any exceptions to this principle should be explicitly described by the school.
(7) Patient care should not be compromised in permitting students to be excused from participating in a given activity. [CME Rep .9, I-98; Reaffirmed: CEJA Rep. 11, A-08; Reaffirmed: CME Rep. 01, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(A-25)

Introduced by: New England

Subject: Patient centered health care as a Determinant of Health

Referred to: Reference Committee on Ethics and Bylaws

Whereas, this resolution enforces, and emphasizes the importance of patient centered health care and the role of physicians in supporting informed involuntary patient decision-making; and

Whereas, it is a call for the American Medical Association to advocate for the recognition and reinforcement of patient centered health care as a fundamental personal right. This right empowers individuals to actively engage in their healthcare decisions, ensuring these choices are informed, voluntary and reflective of their personal values and goals; and

Whereas, it is the professional and ethical duty of physicians to facilitate patient centered health care by providing comprehensive information, guidance, and support. Empowering patients to make rigorous ethical decisions, free from coercion, and undue influence; and

Whereas, this commitment underscores respect for patient dignity, and the central role of patients in determining their healthcare journey; and

Whereas, patient centered health care is the foundational, ethical principle, that each person should have the right to make their own decisions about their goals and direction in life, such that they control their own destiny, and claim personal responsibility for their choices, actions, words, and responses to others and to events. It is a defining aspect of the declaration by the World Health Organization in 1988[1] that personal behavior is a major determinant of a person's health; and

Whereas, health is defined as a holistic state of security and well-being; physical, mental, social, and environmental. Health is determined by many factors that are broadly classified as three interrelated, and inter-dependent dimensions; that are attributed to the patient/person individually and collectively, (community/culture); to the environment, in which each person lives, (SDOH), social determinants of health); and that provided by your health profession and healthcare system, with its ability to mentor and sustain wellness; restore and remediate human suffering, illness, and injury; and

Whereas, as trusted members of the profession of medicine, we are obligated to bring safe, rigorous, comprehensive, critical thinking, and actions to those we serve. The road to health and all its dimensions is about the orchestration of personal, environmental and health system (professional) development. It's about assessing and taking meaningful action in the relevant aspects of all three areas, not being unduly preoccupied with one area over another, depending on the health fad of the day; and

Whereas, the Massachusetts Medical Society has made great progress in the development of policy and advocacy that advances the social (environmental) determinants, caregiver development (resilience and burnout) and health system reform there is renewed interest in the

historical traditional area of individual patient development namely personal critical, thinking, behavior, and responsibility which may lead to better outcomes for patients individually and collectively; and

Whereas, the Massachusetts Medical Society has declared and its policy compendium[2] now states that " healthcare is a basic human right – enjoyment of the highest attainable, standard of health in all its dimensions, including healthcare, is a basic human right. The provision of healthcare services, as well as optimizing the social determinants of health is an ethical obligation of a civil society." The challenge thus becomes, how do we fulfill this promise? Despite enormous efforts in reforming our health system, addressing the social determinants of health, and ever-increasing funding by private and government means the gap between the production of illness and injury grows relative to the level of resources available to sustain and restore health. Could it be that asking our patients for help might be a promising idea? John F Kennedy alluded to this issue when he proclaimed in his inaugural address on January 20, 1961. The following quote "ask not what your country can do for you, ask what you can do for your country"; and

Whereas, our patients increasingly ask: "What can I as a patient, family member, or friend do to help sustain, or restore my health, and/or mitigate my suffering and disability? Indeed act to better my life and that of others?"; and

Whereas, patients look to the profession of medicine for answers they are seeking to be active participants in health. The theme of personal responsibility and action is about trusting and effective partnerships, and collaborative relationships that facilitate health. Daniel Johnson, MD as president of our AMA from 1996 to 1997 spoke to the role and obligation of our profession to patients in his presidential address. He spoke of the patient caregiver relationship and its enduring value. He likened it to a stagecoach, full of passengers on a wild ride through a terrifying landscape. The driver, the passengers and the shotgun, are on a journey to health. The medical profession is the shotgun and serves as a guide for the stagecoach, and its powerful horses moving through the hostile countryside. The horses and the stagecoach are the health system. The intent of his story is to illustrate the value, endurance and power of our relationship to one another, the patient physician relationship. It highlights that human relationships are necessary tools to guide a successful, safe and productive life's journey; and

Whereas, with this background in mind, the Ethics Committee of the Massachusetts Medical Society anonymously voted to recommend the following resolution[3] to our House of Delegates. It has been adopted and placed in our policy compendium. We in turn, as we have done many times before, offer it to our AMA for consideration; therefore be it

RESOLVED, that our American Medical Association adopt that patient centered health care is a fundamental right of individuals to actively participate in decisions concerning their health care, allowing them to make informed choices, aligned with their values and goals (New HOD Policy); and be it further

RESOLVED, that our AMA physicians have a professional and moral obligation to empower patients to make informed decisions about their care, free from coercion, or undue influence. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/15/25

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RELEVANT AMA POLICY

AMA Code of Medical Ethics
1.1.3 Patient Rights

The health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have, to seek care and to be candid with their physicians.
Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients' advocates and by respecting patients' rights. These include the right:

(a) To courtesy, respect, dignity, and timely, responsive attention to his or her needs.

(b) To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.

(c) To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.

(d) To make decisions about the care the physician recommends and to have those decisions respected. A patient who has decision-making capacity may accept or refuse any recommended medical intervention.

(e) To have the physician and other staff respect the patient's privacy and confidentiality.

(f) To obtain copies or summaries of their medical records.

(g) To obtain a second opinion.

(h) To be advised of any conflicts of interest their physician may have in respect to their care.

(i) To continuity of care. Patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care.

AMA Principles of Medical Ethics: I, IV, V, VIII, IX

AMA Code of Medical Ethics
1.1.4 Patient Responsibilities

Successful medical care requires ongoing collaboration between patients and physicians. Their partnership requires both individuals to take an active role in the healing process.

Autonomous, competent patients control the decisions that direct their health care. With that exercise of self-governance and choice comes a number of responsibilities. Patients contribute to the collaborative effort when they:

(a) Are truthful and forthcoming with their physicians and strive to express their concerns clearly. Physicians likewise should encourage patients to raise questions or concerns.

(b) Provide as complete a medical history as they can, including providing information about past illnesses, medications, hospitalizations, family history of illness, and other matters relating to present health.

(c) Cooperate with agreed-on treatment plans. Since adhering to treatment is often essential to public and individual safety, patients should disclose whether they have or have not followed the agreed-on plan and indicate when they would like to reconsider the plan.

(d) Accept care from medical students, residents, and other trainees under appropriate supervision. Participation in medical education is to the mutual benefit of patients and the health care system; nonetheless, patients' (or surrogates') refusal of care by a trainee should be respected in keeping with ethics guidance.

(e) Meet their financial responsibilities with regard to medical care or discuss financial hardships with their physicians. Patients should be aware of costs associated with using a limited resource like health care and try to use medical resources judiciously.

(f) Recognize that a healthy lifestyle can often prevent or mitigate illness and take responsibility to follow preventive measures and adopt health-enhancing behaviors.

(g) Be aware of and refrain from behavior that unreasonably places the health of others at risk. They should ask about what they can do to prevent transmission of infectious disease.

(h) Refrain from being disruptive in the clinical setting.

(i) Not knowingly initiate or participate in medical fraud.

(j) Report illegal or unethical behavior by physicians or other health care professionals to the appropriate medical societies, licensing boards, or law enforcement authorities.

AMA Principles of Medical Ethics: I, IV, VI

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(A-25)

Introduced by: Organized Medical Staff Section

Subject: Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure

Referred to: Reference Committee on Ethics and Bylaws

Whereas, exacting and specific disclosures are a key component of the social compact between physicians and society at large, such that patients can have some assurances the care they receive is not unduly influenced by physicians' financial or contractual obligations; and

Whereas, value-based care payment systems task physicians with not only being care providers, but also with being cost managers; and

Whereas, physicians have reported anecdotally being pushed out of value-based contracts when their practices account for greater spending while lower-spending physicians did not seem to report the same risks; and

Whereas, physicians have reported experiencing pressure to cut medication costs even to the extent of changing patient prescriptions or treatment options specifically due to the threat to outcome scores having a negative impact on physicians' ratings; and

Whereas, regulatory and legislative attempts to address these concerns in the form of sunshine and disclosure laws may not be a comprehensive fix as such laws and regulations are not universal and lead to a patchwork of rules across states; and

Whereas, the effect of transparency on cost and physician and patient behavior is limited with studies showing that exposing patients to greater transparency about their healthcare costs had only a modest association with decreased healthcare spending; and

Whereas, it is not enough to abandon efforts to ensure equity is achieved even if patients themselves are not particularly inclined to pay attention to incentive structures and physicians' ethical code of conduct should still require that physicians make certain disclosures; therefore be it

RESOLVED, that our American Medical Association advocate for legislation at the state and federal level requiring complete disclosure of financial arrangements with physicians that are potentially against patients' best interests, including financial incentives and disincentives, by insurers, facilities that employ physicians, and pharmacy benefit managers (Directive to Take Action); and be it further

RESOLVED, that our AMA produce a report with the aim of updating our Code of Medical Ethics to include guidance on disclosure of financial arrangements between physicians and healthcare facilities, employers, or payors that are potentially against patients' best interests (Directive to Take Action).

Fiscal Note: Modest – between $1,000 - $5,000

Received: 2/28/2025

RELEVANT AMA POLICY

Physician Pay-for-Performance Programs H-140.872

Physician pay-for-performance (PFP) compensation arrangements should be designed to improve health care quality and patient safety by linking remuneration to measures of individual, group, or organizational performance. To uphold their ethical obligations, physicians who are involved with PFP programs must take appropriate measures to promote patients' well-being.

(1) Physicians who are involved in the design or implementation of PFP programs should advocate for:
(a) incentives that are intended to promote health care quality and patient safety, and are not primarily intended to contain costs;
(b) program flexibility that allows physicians to accommodate the varying needs of individual patients;
(c) adjustment of performance measures by risk and case-mix in order to avoid discouraging the treatment of high-risk individuals and populations;
(d) processes to make practice guidelines and explanations of their intended purposes and the clinical findings upon which they are based available to participating physicians.

(2) Practicing physicians who participate in PFP programs while providing medical services to patients should:
(a) maintain primary responsibility to their patients and provide competent medical care, regardless of financial incentives;
(b) support access to care for all people and avoid selectively treating healthier patients for the purpose of bolstering their individual or group performance outcomes;
(c) be aware of evidence-based practice guidelines and the findings upon which they are based;
(d) always provide care that considers patients' individual needs and preferences, even if that care conflicts with applicable practice guidelines;
(e) not participate in PFP programs that incorporate incentives that conflict with physicians' professional values or otherwise compromise physicians' abilities to advocate for the interests of individual patients.
Citation: CEJA Rep. 3, I05; Reaffirmed: A-06; Reaffirmed: I-06; Reaffirmed: CEJA Rep. 3, A-16; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17

Informed Consent and Decision-Making in Health Care H-140.989
(1) Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient.

(2) Individuals should, at their own option, provide instructions regarding their wishes in the event of their incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interests of the patient.

(3) A patient's health record should include sufficient information for another health care professional to assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy.

(4) Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or

others.
(5) Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.

(6) A patient should have access to the information in his or her health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.

(7) Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those cases in which the third party has a legal or predetermined right to gain access to such information.
Citation: BOT Rep. NN, A-87; Reaffirmed: Sunset Report: I-97; Reaffirmed: Res. 408, A-02; Reaffirmed: BOT Rep. 19, I06; Reaffirmed: A-07; Reaffirmed: A-09; Reaffirmed: BOT Rep. 5, I-16

The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987
1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
- Utilization information;
- Rebate and discount information;
- Financial incentive information;
- Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee’s formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
- Percentage of sole source contracts awarded annually.
6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.
Citation: CMS Rep. 5, A-19; Reaffirmed: CMS Rep. 6, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(A-25)

Introduced by: Resident and Fellow Section, International Medical Graduates Section

Subject: Opposition of Health Care Entities from Reporting Individual Patient Immigration Status

Referred to: Reference Committee on Ethics and Bylaws

Whereas, the Emergency Medical Treatment and Labor Act (EMTALA) prevents any hospital emergency department that receives Medicare funds from refusing to treat patients for any reason[1]; and

Whereas, Governor Greg Abbott issued an executive order directing the Texas Health and Human Services Commission (HHSC) to collect information on undocumented immigrants immigrant status who utilize Texas public hospitals for inpatient and emergency care[2]; and

Whereas, the executive order directs public hospitals and acute care facilities that receive funding from Medicaid and/or Children's Health Insurance Program (CHIP) to collect information regarding the cost of medical care provided to undocumented immigrants beginning November 1, 2024[2]; and

Whereas, the executive order directs those hospitals and providers to inform the patient that federal law mandates that any response to immigration status questions will not affect patient care[2]; and

Whereas, undocumented immigrants are one of the most marginalized and vulnerable ethnic minority communities in the US and face extreme difficulties accessing healthcare[3]; and

Whereas, the aim of the executive order is to seek compensation from the federal government for care provided to undocumented immigrants since rates of uncompensated care in Texas is high; however, much of this is due to current Texas legislation excluding people from accessing health coverage due to non-expansion of Medicaid and eliminating options for non-US citizens from accessing insurance[4]; and

Whereas, one study demonstrated that undocumented immigrants encounter significant barriers to emergency healthcare currently due to lack of insurance and severity at presentation, increasing the risk of long-term hospitalizations[5]; and

Whereas, similar tracking efforts have been released in Florida where the state found that undocumented immigrants made up 0.8% of hospital visits from June to December of 2023[6]; and

Whereas, at least 50% of those without Deferred Action for Childhood Arrivals (DACA) reported experiencing barriers to healthcare related to documentation status and DACA recipients had 80% decreased odds of facing discrimination when seeking healthcare and 70% decreased odds of documentation status[7]; and

Whereas, experts are predicting in today's climate of anti-immigrant rhetoric and fears of mass deportations, requiring hospital staff to inquire the immigration status of patients before providing care is likely to intimate undocumented immigrants and deter them from seeking medical care for themselves or their children, potentially endangering the health and lives of these families[8]; and

Whereas, as physicians and as the AMA we recognize that enjoyment of the highest attainable standard of health, in all its dimensions, is a basic right (H-65.960); and

Whereas, the use of de-identified healthcare data is an essential method for protecting patient privacy and a sense of security for many patients[9]; and

Whereas, implicit and explicit bias in healthcare directly impact marginalized groups of patients and may lead to discriminatory behavior and potentially suboptimal delivery of healthcare[10]; therefore be it

RESOLVED, that our American Medical Association amend Policy H-440.876, "Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients" by addition and deletion to read:

1. Our American Medical Association opposes
    a. any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants;
    b. any policies, regulations, or legislation requiring physicians, ~~and~~ other health care providers, and healthcare entities to collect and report data regarding an individual patient's legal resident status; and
    c. proof of citizenship as a condition of providing health care~~.~~;and
    d. withholding federal funds if institutions fail to comply with policies which mandate collection of a patient's immigration status.

2. Our AMA opposes any legislative proposals that would criminalize the provision of health care to undocumented residents (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA supports collection of de-identified patient information regarding immigration status for funding and research purposes only. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

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RELEVANT AMA POLICY

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876

1. Our American Medical Association opposes:
    a. any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants;
    b. any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and
    c. proof of citizenship as a condition of providing health care.
2. Our AMA opposes any legislative proposals that would criminalize the provision of health care to undocumented residents.

[Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14; Modified: BOT Rep. 09, A-24]

Health, In All Its Dimensions, Is a Basic Right H-65.960

1. Our American Medical Association acknowledges that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right.
2. Our AMA acknowledges that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.

[Res. 021, A-19; Reaffirmed: Res. 234, A-22]

Immigration Status is a Public Health Issue D-350.975

1. Our American Medical Association declares that immigration status is a public health issue that requires a comprehensive public health response and solution.
2. Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.
3. Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.
4. Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities.

[Res. 904, I-22; Reaffirmed: Res. 210, A-23]

Health Care Payment for Undocumented Persons D-440.985

Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.

[Res. 148, A-02; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmation: A-19; Reaffirmation: I-19]

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

1. That our American Medical Association advocates for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
    a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
    b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
    c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
    d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
    e. The public option is financially self-sustaining and has uniform solvency requirements.
    f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
    g. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.
3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
    a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
    b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
    c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
    d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
    e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
    f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
    g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
    h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
4. Our AMA:
    a. will advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections.

b. will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions.
c. supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status.
d. recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.

5. Our American Medical Association supports federal and state efforts to provide subsidies for undocumented immigrants to purchase health insurance, including by extending eligibility for premium tax credits and cost-sharing reductions to purchase Affordable Care Act (ACA) plans.

[CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22; Reaffirmed: CMS Rep. 5, I-23; Appended: Res. 817, I-24]

Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992

1. Our American Medical Association will take immediate action by releasing an official statement that acknowledges that the health of unaccompanied immigrant children without proper documentation is a humanitarian issue.

2. Our AMA urges special consideration of the physical, mental, and psychological health in determination of the legal status of unaccompanied minor children without proper documentation.

3. Our AMA will immediately meet and work with other physician specialty societies to identify the main obstacles to the physical health, mental health, and psychological well-being of unaccompanied children without proper documentation.

4. Our AMA will participate in activities and consider legislation and regulations to address the unmet medical needs of unaccompanied minor children without proper documentation status, with issues to be discussed to include the identification of:

    a. The health needs of this unique population, including standard pediatric care as well as mental health needs.

    b. Health care professionals to address these needs, to potentially include but not be limited to non-governmental organizations, federal, state, and local governments, the US military and National Guard, and local and community health professionals.

    c. The resources required to address these needs, including but not limited to monetary resources, medical care facilities and equipment, and pharmaceuticals.

    d. Avenues for continuity of care for these children during the potentially extended multi-year legal process to determine their final disposition.

[Res. 5, I-15; Reaffirmed: BOT Action in response to referred for decision: Res. 003, I-18; Reaffirmed: Res. 210, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(A-25)

Introduced by: Resident and Fellow Section, American College of Physicians

Subject: Carceral Systems and Practices in Behavioral Health Emergency Care

Referred to: Reference Committee on Ethics and Bylaws

Whereas, law enforcement officers (LEOs) often serve as first responders during behavioral health emergencies (BHEs), including as transport to hospitals[1–4]; and

Whereas, although some LEOs may possess de-escalation skills, effective trainings are not universally implemented, and the mere presence of armed, uniformed officers with police vehicles can exacerbate feelings of distress and escalate BHEs, particularly in communities where relationships with police are characterized by tension and distrust[5]; and

Whereas, individuals with untreated mental illness are 16 times more likely to be killed during a police encounter than other civilians[6]; and

Whereas, Black children have a 1.8-times greater odds of being handcuffed during a BHE than white children, with 2.6-times greater odds among Black girls compared to white girls and 1.5-times greater odds in the most disadvantaged neighborhoods compared to the least[7]; and

Whereas, from 2003-2018, compared to white adolescents, Black and Hispanic adolescents had six and three times greater risk of firearm-related mortality due to legal intervention, respectively[8,9]; and

Whereas, the high-profile deaths of individuals like a 15-year-old Black teen with autism who was killed by a deputy responding to a BHE call, have reinvigorated long standing clarion calls to reform BHE response systems[10–12]; and

Whereas, the American Civil Liberties Union has argued that reliance on police creates a disparity between responses to physical and mental health emergencies, thereby discriminating against people with mental health conditions and developmental disabilities[13]; and

Whereas, the U.S. Department of Justice indicated in February 2024 that existing civil rights statutes like the Americans with Disabilities Act “may require dispatching a different type of response to mental health emergencies when appropriate, such as mobile crisis teams staffed with behavioral health professionals, to avoid discrimination on the basis of disability”[14]; and

Whereas, alternatives to carceral BHE responses which prioritize leadership by trained mental health professionals, coordination with community-based services, and compassionate person-centered responses have existed for decades in cities across the U.S. with remarkable efficacy and cost savings[6,12,15–17]; and

Whereas, the 9-8-8 Implementation Act, which our AMA has not yet actively supported despite endorsement from numerous other organized medical societies, would provide federal funding

and guidance for more states to implement crisis response infrastructure which relies on trained mental health specialists instead of armed law enforcement[18]; and

Whereas, our AMA Code of Ethics 1.2.7 is clear that patients should "never be restrained punitively, for convenience, or as an alternative to reasonable staffing",[19] and international human rights standards note that – especially for children and youth – physical restraints "can only be used in exceptional cases, where all other control methods have been exhausted and failed"[20]; and

Whereas, incarcerated youth are often routinely and indiscriminately shackled when seeking emergency mental health care regardless of their safety or elopement risk, which is inconsistent with the rehabilitative goals of the juvenile justice system, our AMA's own Code of Ethics, international human rights standards, and the policy positions of leading public health organizations[21–24]; therefore be it

RESOLVED, that our American Medical Association amend policy H-345.972 (Mental Health Crisis Interventions) by addition and deletion to read as follows:

1. Our American Medical Association continues to support jail diversion and community based treatment options for mental illness.
2. Our AMA advocates for funding and implementation of evidence-based interventions to decouple behavioral health response systems from carceral systems, including but not limited to diverting acute mental illness and social-service related calls to mobile crisis teams staffed by mental health trained professionals rather than solely or primarily relying on armed law enforcement.
   ~~Our AMA supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs.~~
3. Our AMA supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs.
4. Our AMA supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections and law enforcement officers in effectively interacting with people with mental health crises or ~~and~~ other behavioral dysregulation ~~issues~~ in all ~~detention and~~ correctional facilities and communities.
5. Our AMA supports:
   a. increased research on disparate use of force and non-violent de-escalation tactics during ~~for~~ law enforcement encounters with people who have mental illness and/or developmental disabilities.
   b. research on fatal encounters with law enforcement and the prevention thereof (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA support ending routine reliance on law enforcement to triage, evaluate, or transport individuals experiencing behavioral health emergencies and instead support improved funding for Emergency Medical Services to meet communities' needs (New HOD Policy); and be it further

RESOLVED, that our AMA advocate against the routine application of physical restraints, including handcuffs, during behavioral health emergency responses or as part of police protocols when transporting non-incarcerated individuals to receive health care services (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate against the indiscriminate shackling of children and adults during prehospital and hospital care, as the use of restraints should be limited to the least restrictive option and only applied when medically necessary (Directive to Take Action); and be it further

RESOLVED, that our AMA ask the Council on Judicial and Ethical Affairs to study this topic to provide clearer guidance for healthcare professionals regarding interacting with law enforcement while caring for patients and the indiscriminate shackling of youth and adults in carceral custody, with particular attention to the removal of shackles in lieu of the least restrictive restraint option. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 04/21/25

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RELEVANT AMA POLICY

1.2.7 Use of Restraints
All individuals have a fundamental right to be free from unreasonable bodily restraint. At times, however, health conditions may result in behavior that puts patients at risk of harming themselves. In such situations, it may be ethically justifiable for physicians to order the use of chemical or physical restraint to protect the patient.

Except in emergencies, patients should be restrained only on a physician's explicit order. Patients should never be restrained punitively, for convenience, or as an alternate to reasonable staffing.

Physicians who order chemical or physical restraints should:
(a) Use best professional judgment to determine whether restraint is clinically indicated for the individual patient.
(b) Obtain the patient's informed consent to the use of restraint, or the consent of the patient's surrogate when the patient lacks decision-making capacity. Physicians should explain to the patient or surrogate:
(i) why restraint is recommended;
(ii) what type of restraint will be used;
(iii) length of time for which restraint is intended to be used.
(c) Regularly review the need for restraint and document the review and resulting decision in the patient's medical record.

In certain limited situations, when a patient poses a significant danger to self or others, it may be appropriate to restrain the patient involuntarily. In such situations, the least restrictive restraint reasonable should be implemented and the restraint should be removed promptly when no longer needed.

Mental Health Crisis Interventions H-345.972
1. Our American Medical Association continues to support jail diversion and community based treatment options for mental illness.
2. Our AMA supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs.
3. Our AMA supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs.
4. Our AMA supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities.
5. Our AMA supports:
    1. increased research on non-violent de-escalation tactics for law enforcement encounters with people who have mental illness and/or developmental disabilities.
    2. research of fatal encounters with law enforcement and the prevention thereof.

[Res. 923, I-15; Appended: Res. 220, I-18; Reaffirmed: CSAPH Rep. 2, A-21; Reaffirmed: BOT Rep. 2, I-21; Appended: Res. 408, A-22]

Shackling of Pregnant Women in Labor H-420.957
1. Our American Medical Association supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:
    - An immediate and serious threat of harm to herself, staff or others.
    - A substantial flight risk and cannot be reasonably contained by other means."

If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used.

2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist.

[Res. 203, A-10; Reaffirmed: BOT Rep. 04, A-20; Reaffirmed: CSAPH Rep. 06, A-23]

CMS Interim Final Rule on the Use of Seclusion and Restraints H-280.952

Our AMA uses the following principles in establishing policy regarding restraints and seclusion:
(1) the patient has the right to be free of restraints and seclusion unless medically necessary.
(2) the least restrictive means be considered first.
(3) the use of restraints and seclusion is a medical decision and should not be dictated by government agencies.
(4) when a physician is not physically present a properly trained and authorized health care professional may institute seclusion and restraints when this is clinically appropriate. In such cases the physician shall be contacted immediately. The patient must be examined by a physician within a period of time that meets an acceptable clinical standard.

[Sub. Res. 101, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19]

Policing Reform D-65.987

1. Our American Medical Association will advocate for efforts to implement evidence-based policing and the creation of evidence-based standards for law enforcement.
2. Our AMA will advocate for sentinel event reviews in the criminal justice system following an adverse event, such as an in-custody death.
3. Our AMA encourages further research by subject matter experts on the issues related to the transfer of military equipment to law enforcement agencies, including the impact on communities, particularly those in minoritized and marginalized communities.
4. Our AMA supports greater police accountability, procedurally just policing models, and greater community involvement in policing policies and practices.
5. Our American Medical Association advocates for research to be conducted that examines the public health consequences of negative interactions with police, including the impact on civilians and law enforcement professionals.
6. Our AMA advocates for a change to the U.S. Standard Certificate of Death to include a “check box” that would capture deaths in custody and further categorize the custodial death using cause and manner of death and information from the “How Injury occurred” section of the death certificate.

[BOT Rep. 2, I-21; Appended: Res. 425, A-23]

Policing Reform H-65.954

1. Our American Medical Association recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color.
2. Our AMA will work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers.
3. Our AMA will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures.
4. Our AMA will advocate for legislation and regulations which promote trauma-informed, community-based safety practices.
5. Our American Medical Association recognizes the way we police our communities is a social determinant of health.
6. Our AMA advocates for the reform of qualified immunity and other measures that shield law enforcement officers from consequences of misconduct to further address systemic racism in policing and mitigate use of excessive force.
7. Our AMA supports research on the impact upon employed physicians in law enforcement and the potential risk for exacerbating the physician workforce shortage within correctional medicine if qualified immunity was eliminated.

[Res. 410, I-20; Reaffirmed: CSAPH Rep. 2, A-21; Reaffirmed: BOT Rep. 2, I-21; Appended: Res. 431, A-23]

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955

1. Our American Medical Association encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Our AMA affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Our AMA encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Our AMA encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Our AMA encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.

[Res. 406, A-16; Modified: BOT Rep. 28, A-18; Reaffirmed: BOT Rep. 2, I-21; Reaffirmed: CSAPH Rep. 4, I-23]

Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections D-430.993

1. Our American Medical Association supports the development of:
    1. Best practices for acute care of patients in the custody of law enforcement or corrections.
    2. Clearly defined and consistently implemented processes between health care professionals and law enforcement that:
        a. can best protect patient confidentiality, privacy, and dignity while meeting the needs of patients, health professionals, and law enforcement and
        b. ensures security measures do not interfere with the capacity to provide medical, mental health, pregnancy, end of life care, palliative care, and substance use care, especially in emergency situations, and
    3. If conflict arises during an incarcerated individual’s hospitalization that the hospital’s bioethics committee should convene to address the issue and not a law enforcement liaison.
2. Our AMA affirms that:
    1. the adoption of best practices in the acute care of patients in the custody of law enforcement or corrections is an important effort in achieving overall health equity for the U.S. as a whole.
    2. it is the responsibility of the medical staff to ensure quality and safe delivery of care for incarcerated patients.
2. Our AMA supports universal coverage of essential health benefits for all individuals in the custody of law enforcement or corrections and who are incarcerated.
3. Our AMA will work with interested parties, including but not limited to, the American College of Emergency Physicians and the American College of Correctional Physicians, to develop model federal legislation requiring health care facilities to inform patients in custody about their rights as a patient under applicable federal and state law.

[Res. 407, A-22; Modified: CSAPH Rep. 06, A-23; Reaffirmed: CSAPH Rep. 4, I-23]

Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting H-130.932

1. Our American Medical Associatio believes that current evidence does not support “excited delirium” or “excited delirium syndrome” as a medical diagnosis and opposes the use of the terms until a clear set of diagnostic criteria are validated.
2. Our AMA recognizes that the treatment of medical emergency conditions outside of a hospital is usually done by a subset of healthcare practitioners who are trained and have expertise as emergency medical service (EMS) practitioners. It is vital that EMS practitioners and systems are overseen by physicians who have specific experience and expertise in providing EMS medical direction.
3. Our AMA is concerned about law enforcement officer use of force accompanying “excited delirium” that leads to disproportionately high mortality among communities of color, particularly among Black

men, and denounces “excited delirium” solely as a justification for the use of force by law enforcement officers.

4. Our AMA opposes the use of sedative/hypnotic and dissociative agents, including ketamine, as a pharmacological intervention for agitated individuals in the out-of-hospital setting, when done solely for a law enforcement purpose and not for a legitimate medical reason.
5. Our AMA recognizes that sedative/hypnotic and dissociative pharmacological interventions for agitated individuals used outside of a hospital setting by non-physicians have significant risks intrinsically, in the context of age, underlying medical conditions, and also related to potential drug-drug interactions with agents the individual may have taken.
6. Our AMA encourages the continued use of the necessary and effective dual-response method of communication between law enforcement and EMS to appropriately care for all patients encountered by first responders, including those patients demonstrating agitated or combative behavior.
7. Our AMA calls for comprehensive, independent analysis of law enforcement agencies to:
    a. Review cases labeled as “excited delirium” to determine frequency of use of the term, including prevalence of its use by race, ethnicity, gender, age, and other demographic factors.
    b. Assess the available training and guidelines used to prepare law enforcement first responders to respond to individuals with agitated or combative behavior, including de-escalation training.
    c. Assess efforts to ensure adherence to approved training on an ongoing basis.
8. Our AMA calls for comprehensive, independent analysis, performed by appropriate medical and behavioral health professionals, of EMS agencies to:
    a. Review the usage of ketamine and other sedative-hypnotic medications used to sedate patients with agitated or combative behavior and correlation of the tern “excited delirium” with race, ethnicity, gender, age or other demographic factors.
    b. Assess whether existing training and guidelines, including continuous quality improvement processes, have been properly established by supervising EMS medical directors and behavioral health specialists, to:
        i. Require appropriate monitoring of any patient who receives sedative/hypnotic and dissociative pharmacological interventions for treatment in the out-of-hospital setting.
        ii. Ensure proper use of ketamine and other sedative/hypnotic and dissociative pharmacological interventions under defined protocols/guidelines after appropriate education on indications, usage and complications.
        iii. Include an appropriate stepwise approach to the treatment of patients in the out-of-hospital setting, including de-escalation training, that provides safety to the patient and providers.
    c. Assess, on an ongoing basis, that personnel are conducting themselves according to guidelines and training.
9. Our AMA urges law enforcement and frontline emergency medical service personnel, who are a part of the “dual response” in emergency situations, to participate in appropriate training, overseen by EMS medical directors. The training should minimally include de-escalation techniques and the appropriate use of pharmacological intervention for agitated individuals in the out-of-hospital setting.
10. Our AMA urges medical and behavioral health specialists, not law enforcement, to serve as first responders and decision makers in medical and mental health emergencies in local communities and that administration of any pharmacological treatments in the out-of-hospital setting be done equitably, in an evidence-based, anti-racist, and stigma-free way.

[CSAPH Rep. 2, A-21; Appended: BOT Action in response to referred for decision: CSAPH Rep. 2, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013
(A-25)

Introduced by: Senior Physicians Section

Subject: Continued Support of World Health Organization (WHO) & United States Agency for International Development (USAID)

Referred to: Reference Committee on Ethics and Bylaws

Whereas, the American Medical Association Senior Physicians Section is concerned that a withdrawal from the World Health Organization (WHO) poses a threat to the health of United States of America citizens by limiting access to information on emerging infections in WHO member countries[1,2,3,4,5]; and

Whereas, the United States Agency for International Aid (USAID), a Congressional authorized agency, has had its funds and staff suspended, making it difficult to continue providing life-saving health programs in developing countries for disease outbreaks and epidemics for seniors[6,7]; and

Whereas, it is critical for the U.S. to remain a global leader in public health in order to protect the interests of Americans and provide continued guidance on reforms that enhance accountability and cost-effectiveness within international organizations, which in turn strengthens America's leadership role; and

Whereas, the United States Agency for International Development (USAID) works in many areas, including agriculture, economic growth, education, democracy, human rights, governance, and the environment to promote prosperity, democracy, and security worldwide[8]; therefore be it

RESOLVED, that our American Medical Association opposes withdrawal from the World Health Organization (WHO) as a continued public health threat to the U.S population by limiting early access to evolving worldwide epidemics (Directive to Take Action); and be it further

RESOLVED, that our AMA opposes any cuts to USAID (United States Agency for International Development) programs that increase the risk of infection among vulnerable populations, including senior citizens, or that withhold funding from critical initiatives supporting agriculture, economic development, environmental protection, education, democracy, human rights, and governance in developing countries. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/20/25

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3. Park, A. (2025, February 19). *What leaving the WHO means for the U.S. and the world.* Time Magazine. What Leaving the WHO Means for the U.S and the World | TIME
4. Edwards, C. (2025, January 21). *What is the World Health Organization and why does Trump want to leave it?* . What is the World Health Organization and why does Trump want to leave it? | CNN
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RELEVANT AMA POLICY

G-630.070 International Strategy

1. Our American Medical Association recognizes the importance of the involvement of the medical profession in this country in influencing the standards utilized by other nations with regard to ethics, medical education and medical practice, and the commitment to the patient-physician relationship.
2. Our AMA supports the activities of the World Medical Association (WMA) to improve health care in developing countries and supports WMA commendation of those countries that demonstrate exemplary efforts to improve health care delivery to their populations.
3. Our AMA:
    a. continues to support the World Health Organization as an institution.
    b. advocates full funding as understood by the United States Government for the World Health Organization.
    c. will participate in coalitions with other interested organizations to lend its support and expertise to assist the World Health Organization.
    d. encourages the World Medical Association to develop a cooperative work plan with the World Health Organization as expeditiously as possible.
4. Our AMA supports the position of the U.S. government to preserve the integrity of the World Health Organization (WHO) and opposes any attempts to politicize the WHO.
5. Our AMA will include the International Medical Graduates Section as a resource for international medical initiatives.
6. Our AMA will:
    a. continue to focus its international activities on and through organizations that are multinational in scope.
    b. encourage ethnic and other medical associations to assist medical education and improve medical care in various areas of the world.
    c. encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world.
    d. work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in global health programs, including but not limited to international electives and summer clinical experiences are held accountable to the same ethical standards as students participating in domestic service-learning opportunities.
    e. work with the AAMC to ensure that international electives provide measurable and safe educational experiences for medical students, including appropriate learning objectives and assessment methods.
    f. communicate support for a coordinated approach to global health education, including information sharing between and among medical schools, and for activities, such as the AAMC Global Health Learning Opportunities (GHLOTM), to increase student participation in international electives.
7. Our AMA will adhere to a focused strategy that channels and leverages our reach into the global health community, primarily through participation in the World Medical Association and the World Health Organization.

[BOT Rep. 21 and Res. 618, A-97; Consolidated: CLRPD Rep. 3, I-01; Modified: CC&B Rep. 2, A-11; Modified: CCB/CLRPD Rep. 1, A-21]

Reference Committee A

Report(s) of the Council on Medical Service

02 Reconsidering the Affordable Care Act (ACA) Eligibility Firewall
05 Medicaid Estate Recovery Reform
06 Prescription Medication Price Negotiation
09 Minimum Requirements for Medication Formularies

Resolutions

101 Uniform Adoption of Service Intensity Tools to Support Medical Decision-making and Service Gap Analysis
102 Access to Single Maintenance and Reliever Therapy for Asthma
103 Inadequate Reimbursement for Biosimilars
104 Study of Whether the HSA Model Could Become an Option for Medicaid Beneficiaries
105 Development of an Educational Resource on Opting Out of Medicare for Physicians
106 Advocating for All Payer Coverage for Custom Breast Prostheses for Patients with History of Mastectomy Secondary to Breast Cancer Treatment
107 Advocating for All Payer Coverage of Reconstructive and Cosmetic Surgical Care Related to Cleft Lip and Palate
108 Firearm Storage Diagnosis and Counseling Reimbursement
109 Medicare Advantage Plans Double Standard
110 Study of the Federal Employee Health Benefit Plan (FEHBP)
111 New Reimbursement System Needed for Rural Hospital Survival
112 Continuation of Affordable Connectivity Program
113 Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts
114 An Assessment of Physician Support for Value-Based Payment Models and its Impact on Healthcare to Inform AMA Advocacy Efforts—A Survey
115 Supporting Legislative Efforts to Remove Certain High-Cost Supplies and Equipment from the Medicare Physician Fee Schedule
116 Medicare Coverage of Registered Dietitian (RD) and Certified Nutrition Support Specialist (CNSS) Visits Beyond Type 2 Diabetes and Renal Disease
117 Liberalized Remorse Period for Medicare Advantage Plan Insureds
118 Improving Access to Peripartum Pelvic Floor Physical Therapy
119 Cancer Survivorship Program Coverage
120 Medigap, Pre-Existing Conditions, and Medicare Coverage Education

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (A-25)
Reconsidering the Affordable Care Act (ACA) Eligibility Firewall
(Resolution 103-A-23)
(Reference Committee A)

EXECUTIVE SUMMARY

As highlighted in this report, employer-sponsored health insurance (ESI) remains the dominant source of health coverage in this country and most people seem satisfied with it. However, because of shortcomings inherent to the ESI system—namely equity and affordability concerns, and rising costs—it does not work well for everyone. Some workers, especially those with lower incomes, may be contributing more for an employer plan than they would pay for subsidized marketplace coverage. A provision in the Affordable Care Act (ACA), colloquially referred to as "the firewall," prohibits workers with "affordable" and "adequate" ESI offers from receiving premium tax credits to purchase marketplace plans.

The main concerns from Council on Medical Service about eliminating the firewall abruptly and fully include the potential impacts on physician payment and practice sustainability, employer behavior and ESI stability, and federal expenditures, since allowing millions of people to opt out of ESI coverage and into the ACA marketplace could prove to be prohibitively expensive, while also disrupting both ESI and ACA markets. Instead, the Council recommends an incremental approach to reducing the affordability threshold that prioritizes workers most in need. As such, we believe it makes the most sense to support a firewall policy change that targets individuals and families with the lowest incomes who could benefit the most from ACA premium tax credits and cost-sharing subsidies that are not available under ESI. Accordingly, the Council recommends that it be the policy of our AMA that the ACA eligibility firewall not apply to individuals offered employer-sponsored coverage whose household incomes are at or below 200 percent of the federal poverty level. We believe this recommendation is an appropriate first step in addressing ESI affordability challenges while at the same time preserving physician practice sustainability, stability in the ESI market, and limits on federal spending increases.

Because ESI enrollees with lower incomes are more likely to report difficulties covering the costs of medical care and may not know if they are subject to the firewall, the Council recommends amending Policy H-165.843 to encourage employers to 1) implement programs that improve affordability of ESI premiums and/or cost-sharing; 2) provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of ESI; and 3) provide employees with information regarding available health plan options, including the plans' cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs.

To address physician payment concerns, the Council also recommends advocating that physician payments by insurers participating in the ACA marketplace be sustainable, reflect the full cost of practice and the value of the care provided, include inflation-based updates, and pay no less than prevailing Medicare rates.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-25

Subject: Reconsidering the Affordable Care Act (ACA) Eligibility Firewall (Resolution 103-A-23)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee A

At the June 2023 Annual Meeting, the House of Delegates referred Resolution 103, which was sponsored by the Medical Student Section and asked the American Medical Association (AMA) to: (1) recognize the inefficiencies and complexity of the employer-sponsored health insurance system and the existence of alternative models that better align incentives to facilitate access to high quality health care; (2) support movement toward a health care system that does not rely on employer-sponsored health insurance and enables universal access to high quality health care; (3) amend Policy H-165.828[1], "Health Insurance Affordability," by addition and deletion to read as follows:

Health Insurance Affordability H-165.828[1]
~~1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA).~~Our AMA advocates for the elimination of the employer-sponsored insurance firewall such that no individual would be ineligible for premium tax credits and cost-sharing assistance for marketplace coverage solely on the basis of having access to employer-sponsored health insurance.

and (4) amend Policy H-165.823[2] by deletion to read as follows:

Options to Maximize Coverage Under the AMA Proposal for Reform H-165.823[2]
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
~~b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.~~
b~~e~~. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
c~~d~~. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
d~~e~~. The public option is financially self-sustaining and has uniform solvency requirements.

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ef. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
fg. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid—having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits—at no or nominal cost.

Council on Medical Service Report 2-A-24 was referred back to the Council to ensure that the recommendations maximize patient access to care while protecting physician practice revenue and sustainability. This report discusses employer-sponsored insurance (ESI) affordability, explains the ACA affordability threshold (known as the "firewall"), summarizes relevant AMA policy, and makes policy recommendations.

BACKGROUND

Almost a decade and a half after enactment of the ACA, employer-sponsored insurance ESI continues to be the dominant source of health coverage for Americans under 65 years of age. In 2023, 164.7 million people under age 65, or 60 percent of the non-elderly population, had health insurance coverage through an employer.[1] Although ESI is the most common type of health insurance, coverage varies significantly by income as well as race and ethnicity. While 84 percent of individuals with incomes at or above 400 percent of the federal poverty level (FPL) had ESI, it covered fewer than one-quarter of individuals with incomes below 200 percent FPL. Additionally, larger percentages of white and Asian people have ESI while individuals who are African American and Latino are less likely to have employer-based coverage.[2,3]

Overall, most Americans appear satisfied with employment-based coverage. According to KFF's survey of consumer experiences with health insurance, in 2023, 80 percent of adults with ESI and 73 percent of those with ACA marketplace coverage rated their health coverage as "excellent" or "good" although people in poorer health gave more negative ratings across all plan types. Regardless of health status, enrollees in marketplace plans were most likely to rate their experiences with health insurance as fair or poor.[4] Ninety-three percent of workers responding to a 2022 poll sponsored by the U.S. Chamber of Commerce expressed high rates of satisfaction with ESI, with a large majority (89 percent) expressing a preference for ESI over other types of coverage.[5] Eighty percent of respondents to this survey ranked health insurance as the most important workplace benefit provided to them, and a majority cited "affordability" and "high quality" as ESI's most critical features.[6]

Although ESI is popular, it has become increasingly costly for employers and employees, especially small firms and lower-income workers. According to 2024 data from the KFF Employer Health Benefits Survey:

- Fifty-four percent of all firms offered health benefits, including almost all (98 percent) large employers (those with 200 or more workers) and just over half (53 percent) of smaller firms (those with three to 199 workers). Eight percent of firms with at least 50 employees that offer health benefits offer a plan that has a narrow provider network.[7]
- Seventy-five percent of eligible employees took up coverage when it was offered to them, a slight decrease from 2013 (80 percent) and a more sizeable decrease from 2003 (84 percent). Across both firms that offer health benefits and those that do not, more than half (54 percent) of workers have employer coverage.[8]
- Annual health insurance premiums averaged $8,951 for individual coverage and $25,572 for family coverage, six and seven percent more than last year, respectively. In comparison, the

Bureau of Labor Statistics found that wages increased 4.5 percent while inflation grew by 3.2 percent. Notably, premiums for family coverage have increased 24 percent over the last five years while, during the same time period, inflation has risen 23 percent and wages have increased 28 percent. Workers pay, on average, $1,368 annually for individual coverage and $6,296 toward the cost of family premiums.

- Seventy-six percent of firms offering coverage offered only one type of plan. Large firms were significantly more likely to offer more than one plan type than small firms.
- Almost half (48 percent) of covered employees are enrolled in preferred provider organizations (PPOs), the most common plan type offered. Twenty-seven percent of covered workers are enrolled in a high-deductible health plan (HDHP) with savings option.[9]

ESI Affordability

To manage costs, many employer-based plans include substantial deductibles and other out-of-pocket cost-sharing that, together with premium contributions, increase employee health costs and impact affordability.[10] The comparability of ESI and ACA marketplace plan affordability is complicated by differences among enrollees across plans; differences in plan design and regulatory requirements; and enrollee tax savings. In a 2024 report, the U.S. Government Accountability Office (GAO) found that average premiums for employer plans in 2022 were lower than average premiums for marketplace plans. However, after accounting for employer contributions to workers' premiums and federal premium tax credits for marketplace plans, average worker premium contributions to ESI plans were higher than average enrollee premium contributions to marketplace plans.[11] A report from The Commonwealth Fund and Urban Institute found that, prior to the American Rescue Plan Act of 2021 (ARPA) enhancements to marketplace premium tax credits, adults with nongroup coverage reported higher average premiums and health care costs than ESI enrollees and were more likely to report foregoing health care and having problems affording care.[12]

According to KFF's 2024 Employer Health Benefits Survey, the average annual deductible for employees with single coverage was $1,787, a figure that has held relatively steady over the last five years but is 47 percent higher than the average deductible amount 10 years ago.[13] Overall, nearly a third of employees (32 percent) had plan deductibles of $2,000 or more, including half of workers at small firms, whose average annual deductible was $2,575 compared to $1,538 for employees of larger firms.[14]

High-Deductible Health Plans: Not only are deductible amounts rising, but more workers are now covered by high-deductible health plans (HDHPs), which typically have higher deductibles and lower premiums when compared to traditional plans. Such plans generally require patients to pay the full cost of health services and medications until deductibles are met. Although an HDHP's lower premium may be attractive to some people, the responsibility for out-of-pocket expenses becomes problematic when deductibles are too high for enrollees to afford and patients are unable to cover their costs. Not surprisingly, studies have found that reductions in health spending achieved through HDHPs are primarily due to patients simply receiving less medical care as they become more cost-conscious when seeking services.[15] As previously highlighted by the Council on Medical Service (Council on Medical Service Report 2-Nov-20, Mitigating the Negative Effects of High-Deductible Health Plans), the imposition of greater consumer cost-sharing is frequently used to ensure that those receiving health care services "have skin in the game," and as a lever to minimize premium growth.

Over the years, HDHPs have become a more common ESI offering. Among workers with HDHPs, 52 percent had plans with Health Savings Accounts (HSAs) while eight percent participated in

plans with Health Reimbursement Arrangements (HRAs), figures that varied considerably between high and low wage employees. Among workers in the lowest 25 percent wage category, 32 percent had plans with HSAs and 12 percent had HRAs. Among workers in the highest 25 percent wage category, 66 percent had plans with HSAs and seven percent had HRAs.[16] Theoretically, lower premiums may result in higher wages that may help offset the risk associated with HDHPs.

Small Employer Coverage: Health coverage is especially challenging for small business, whose employees frequently pay more for health coverage. According to the Commonwealth Fund, these workers generally contribute a greater share of premium costs and have larger deductible amounts than large-firm employees.[17] KFF has also highlighted the lack of affordable family coverage options for workers at smaller firms employing fewer than 200 people. These employees pay on average $8,334 towards family coverage premiums each year with a quarter paying at least $12,000 annually, not including deductibles and other cost-sharing expenses.[18]

Lower-Income Employees and Affordability: Several analyses have pointed out that workers with lower incomes are disproportionately burdened by ESI costs and usually pay a greater share of income toward employer plan premiums and other out-of-pocket expenses.[19, 20, 21] A KFF analysis of data from its 2023 survey of consumer experiences with health insurance found that adults with incomes below 200 percent FPL who have ESI were significantly more likely than higher-income peers to report difficulties paying for medical care; treatment delays and declines in health due to insurance problems, such as prior authorization; dissatisfaction with the availability and quality of health providers in their plan's network; and more difficulty comparing plans and signing up for coverage.[22] Additional KFF research from 2022 found that, on average, families with incomes below 200 percent FPL pay approximately 10.4 percent of income toward health care premiums and out-of-pocket expenses (7.7 percent for premiums) while those with incomes at or above 400 percent FPL pay about 3.5 percent toward premiums and medical expenses (2.3 percent for premiums).[23] Though employers could utilize health benefit design strategies to address affordability issues facing lower-income workers, few seem to do so; in 2022, 10 percent of large firms reportedly had programs that lowered premium costs for lower-income employees while only five percent reported programs to lower their cost-sharing expenses.[24] COBRA coverage is often too costly an option for workers who are leaving a job.

Though many workers mistakenly think otherwise, they—not the firms they work for—pay the majority of ESI costs, both directly through contributions and indirectly through wage adjustments made to cover employers' health care costs.[25] Building on the literature linking growth in health insurance costs to stagnant wages, a 2023 *JAMA* analysis suggests a likely association between increased premium costs for workers with ESI family coverage and decreased earnings and increased income inequality.[26] Because workers earning lower wages contribute a greater share of income toward ESI premiums, the analysis posits that making employer plans more affordable for lower-wage workers could help address earnings inequality. This study also identified large disparities in premium costs as a percentage of income by race (African American and Latino families paid higher percentages of earnings toward premium costs than white families), and found that over 30 years, families with ESI may have cumulatively lost, on average, more than $125,000 in earnings due to increases in premium costs.[27]

ACA Provisions on Affordability and Employer Shared Responsibility

Though not nearly as dominant as ESI, ACA marketplace plans have become a growing source of health coverage; in January 2025, more than 23 million people had enrolled in marketplace plans, up from 11 million in 2020.[28] Under the ACA, individuals are not eligible for marketplace premium tax credits if they are eligible for "minimum essential coverage," which is broadly

defined to include Medicare, Medicaid, and other public programs as well as ESI. Accordingly, individuals with offers of coverage from an employer do not qualify for ACA marketplace subsidies unless their ESI offer is deemed either unaffordable or inadequate. In 2025, an employer plan was considered unaffordable if an employee's premium contribution exceeded 9.02 percent of that person's household income.[29] To be considered adequate, a plan must cover at least 60 percent of average costs (actuarial value); anything less is deemed inadequate.[30] The ACA provision making workers with affordable and adequate ESI offers ineligible to receive premium tax credits to purchase marketplace coverage is colloquially referred to as "the firewall." This affordability threshold was established to address multiple concerns with the landmark legislation; namely, to prevent disruption to the ESI market and prevent prohibitive increases in federal spending (for marketplace subsidies) while preserving ESI as the principal source of health coverage in this country. Notably, the affordability threshold changes from year to year based on a methodology that considers rates of premium growth and income growth.

As explained in a 2014 Council on Medical Service Report on the future of ESI, the ACA aimed to build upon the ESI framework and provide low-income, non-elderly individuals without access to ESI with either Medicaid coverage or subsidized private coverage offered through the nongroup marketplace. As such, provisions in the ACA statute included incentives and penalties intended to prevent disruption to the ESI market. For example, to incentivize employers to continue offering coverage, the ACA contained an "employer shared responsibility" provision, also called the "employer mandate," which requires employers with 50 or more full-time employees to either offer affordable minimum essential coverage to full-time employees and their dependents or pay a penalty to the Internal Revenue Service (IRS).[31] Under this provision, employers face two potential penalties:

- If an employer does not offer minimum essential coverage to at least 95 percent of its full-time employees and dependents, and at least one employee receives a premium tax credit for coverage offered through an ACA exchange, the employer faces a penalty that is based on all full-time employees (except 30), including those who have ESI or coverage from another source. In 2024, the penalty was $2,970 per employee.[32]
- If an employer offers coverage to at least 95 percent of its employees but at least one employee obtains a premium tax credit for ACA coverage due to the employer's coverage not being "affordable" or "adequate," the employer must pay a penalty for each employee who receives the premium tax credit. In 2024, the penalty is $4,460 per employee.[33]

AMA Policy on the ACA Affordability Threshold

In the early years of ACA implementation, a 2015 Council on Medical Service report on health insurance affordability recommended making changes to how affordable coverage is defined under the law in order to provide more workers and their families with access to marketplace plans when those plans are more affordable than employer plans. This report established Policy H-165.828, which included several provisions calling for the ACA's "family glitch" to be fixed and capping the tax exclusion for ESI as a funding stream to improve insurance affordability. Policy H-165.828[1] as originally written (prior to being amended in 2021) established AMA support for:

> … modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered ESI by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the ACA.

In 2015 when this policy was adopted, individuals were deemed exempt from the ACA's individual mandate—which was repealed in 2017—if the lowest-priced coverage available to them cost more than 8.05 percent of their household income. The same year, individuals with employer coverage offers were eligible for ACA marketplace plan premium tax credits if their ESI premium contributions exceeded 9.56 percent of income. The aforementioned Policy H-165.828[1] was crafted to align the definitions of affordability with respect to being exempt from the individual mandate (>8.05 percent) and premium tax credit eligibility for individuals with ESI offers (>9.56 percent).

Policy H-165.828[1] was amended via adoption of the recommendations in a 2021 Council on Medical Service report to address new inconsistencies between the definition of affordability pertaining to premium tax credit eligibility and provisions in ARPA, which extended eligibility for premium subsidies to people with incomes greater than 400 percent FPL and capped premiums for those with the highest incomes at 8.5 percent of their income. ARPA increased the generosity of premium tax credits and lowered the cap on the percentage of income individuals are required to pay for premiums of the benchmark (second-lowest-cost silver) plan for everyone. At the time the report was written, in 2021, employer coverage with an employee share of the premium less than 9.83 percent of income was considered "affordable." To open the door to premium tax credit eligibility to individuals with ESI premiums that were above the maximum affordability threshold applied to subsidized marketplace plans, Policy H-165.828[1] was amended to establish AMA support for:

> … modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered ESI by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized ACA coverage.

Federal Subsidies for ACA Premium Tax Credits and Cost-Sharing

In 2023, the federal government subsidized coverage obtained through the ACA marketplaces and the Basic Health Program (BHP) at a cost of $92 billion.[34] This figure includes ARPA federal subsidy enhancements for premium tax credits and cost-sharing reductions that were extended through 2025 by the Inflation Reduction Act (IRA), which decreased the maximum required contribution for previously eligible enrollees and extended eligibility to people with incomes exceeding 400 percent FPL, effectively reducing premium costs by 44 percent, on average. [35] Prior to ARPA, required premium contribution percentages ranged from about two percent of household income for people with poverty level income to nearly 10 percent of income for people with incomes between 300 to 400 percent FPL; people earning more than 400 percent FPL were not eligible for premium tax credits.[36] This year, as shown in Table 1, required premium contribution percentages range from zero for people with less than 150 percent FPL to 8.5 percent for those making around 400 percent FPL or more.

Table 1: Required Individual Contribution Percentage for 2025[37]

Household income percentage of Federal poverty line:	% at start of range	% at top of range
Less than 150%	0.00%	0.00%
At least 150% but less than 200%	0.00%	2.00%
At least 200% but less than 250%	2.00%	4.00%
At least 250% but less than 300%	4.00%	6.00%
At least 300% but less than 400%	6.00%	8.50%
At least 400% and higher	8.50%	8.50%

The more generous federal subsidies have made marketplace plan premiums much more affordable while targeting the largest premium tax credits to people most in need. Notably, more than 90 percent of the 21 million people enrolled in marketplace coverage in 2024 received subsidies that lowered their premium amounts. If the subsidies are not extended beyond 2025, many people will face substantial premium increases, making marketplace coverage less affordable and less attractive as an insurance option. According to the Congressional Budget Office (CBO), without a permanent extension of the premium tax credits, healthier people will leave the ACA marketplace and premiums will rise for remaining enrollees by an estimated 4.3 percent in 2026, 7.7 percent in 2027, and 7.9 percent, on average, over the 2026-2034 period. The CBO also estimates that the number of uninsured people will increase by 2.2 million in 2026, 3.7 million in 2027, and 3.8 million on average between 2026 and 2034.[38] The Urban Institute projects that expiration of the enhanced subsidies will cause four million people to lose health insurance, especially in states that have not adopted Medicaid expansion.[39] According to the Commonwealth Fund, the loss of enhanced subsidies after 2025 would also cause significant economic harm to states, including job losses to health providers and other economic sectors.[40]

Premium tax credits for ACA marketplace coverage are calculated by subtracting the required contribution from the actual cost of the "benchmark" (second-lowest-cost silver) plan, though the credit can be applied toward any marketplace plan except catastrophic coverage.[41] People with incomes below 250 percent FPL also receive subsidies for cost-sharing expenses that are based on income, so that people with incomes between 100 and 150 percent FPL receive the most generous subsidies.[42] These cost-sharing reductions are only available to those enrolled in silver plans. According to the CBO, in 2023 the average federal subsidy per ACA marketplace/BHP enrollee was $5,990,[43] although the range of subsidy amounts is considerable.

Federal Subsidies for ESI

For many decades, the U.S. tax code has provided a sizeable tax benefit to both employers and employees by excluding premium contributions towards ESI from federal income and payroll taxes. As ESI premiums have risen over the years, so has the tax benefit. The amount of an individual's subsidy depends on that person's marginal tax rate that would be owed if employer-paid premiums were taxed as wages. Accordingly, people with greater incomes and higher marginal tax rates receive larger federal ESI subsidies than people with lower-incomes and lower tax rates.[44] According to the CBO, the average federal subsidy per ESI enrollee in 2023 was $2,170.[45]

In part due to the enhanced subsidies for marketplace enrollees established by ARPA and extended by the IRA, several analysts have observed a growing disparity between federal subsidies that help defray ACA marketplace plan costs, and subsidies for ESI coverage. To illustrate this expanding gap, a 2024 American Enterprise Institute (AEI) paper calculated the value of subsidies that would be received by a family of four with $75,000 in income, depending on whether they purchased ESI or marketplace coverage. According to AEI, if the family enrolled in an employer-based plan, their tax subsidy would be around $4,100, compared to the more than $15,000 in federal premium subsidies the family would be eligible for if enrolled in a marketplace plan.[46] Other analyses have noted that workers with lower incomes may be contributing more for an employer-based plan than they would pay for coverage under a subsidized marketplace plan, and that it could be financially advantageous for these workers to move to the marketplace.[47] However, lower-income workers, including those with incomes at or below 200 percent of FPL ($30,120 for an individual; $62,400 for a family of four), cannot enroll in marketplace coverage if they have an offer of ESI. Without the firewall, and if current subsidy enhancements are extended, workers earning less than 150

percent of FPL would be eligible for zero premium silver plans in the ACA marketplace as well as generous cost-sharing reductions. Employees making 200 percent of FPL would also be eligible for cost-sharing reductions and their premium contributions would be capped at two percent of household income.[48] Thus, lower-income workers at or below 200 percent of FPL may find more affordable coverage on the marketplace, depending on how much they must pay for premiums, deductibles and copayments under their ESI plan.

Importantly, some lower-income employees who would be financially incentivized to enroll in a marketplace plan if the firewall is repealed might opt to retain ESI coverage if they are satisfied with their plan and able to see the physicians they want in a timely manner. The Centers for Medicare & Medicaid Services has previously acknowledged the proliferation of narrow networks among ACA exchange plans, and several studies have demonstrated varying degrees of challenges facing marketplace enrollees attempting to access in-network providers, most commonly mental health specialists. A 2020 *JAMA* study found that provider networks were broader in ESI plans and narrower in marketplace plans but that networks may also be limited in lower-quality employer plans.[49] The Council has previously observed that, while marketplace plans may be attractive to some people because their premium prices are lower, purchasers may not be aware that a plan's provider network could be narrower and that they may have trouble getting needed care from in-network physicians, hospitals, and other providers. Therefore, some workers with ESI coverage who would become newly eligible for marketplace subsidies if the firewall is repealed may decide to keep their employer plan to avoid possible care disruptions and to preserve relationships with their treating physicians. Depending on income and a range of other factors, this could be true for some employees who utilize more services and medications or who have a family member on their plan who has a health condition that requires timely access to specialty care.

POLICY OPTIONS ADDRESSING ESI AFFORDABILITY

During the development of this report, the Council reviewed papers from a broad spectrum of organizations and also met with subject matter experts who suggested a range of approaches to improving affordability in ESI and nongroup markets. Review of the literature uncovered a handful of data analyses and a range of conflicting opinions on the best way forward. The studies generally agreed that lifting the firewall would increase access to less expensive insurance for people with low incomes. However, they differed in their assessment of the percent of the population that would move from ESI to the ACA marketplace, the impact of employer behavior, and their willingness to support increased federal health spending. These studies are summarized below in alphabetical order.

American Enterprise Institute (AEI): A 2020 paper published by AEI recognizes both the value of ESI to many Americans as well as its flaws, including rising costs for both employers and employees. AEI asserts that ESI is worth preserving and suggests tax reforms as the centerpiece of a framework for a more stable ESI system, including the provision of a tax benefit for employers that would be applied to employee premiums. According to AEI, such firm-level tax credits could be structured to provide greater support to lower-income employees but less support to those with higher incomes.[50]

Bipartisan Policy Center (BPC): A 2022 BPC report recognized that ESI is less affordable for lower-wage workers but suggests that fully eliminating the firewall would be quite costly for the federal government. Instead, BPC recommended that Congress adjust the affordability threshold to align with the percentage cap on premium contributions for marketplace plans.[51] As discussion of broad tax cut extensions (and the need to pay for them) intensified late last year, BPC suggested

that the ESI tax exclusion be capped at the 80th percentile of premiums, or around $10,000 for single plans and $30,000 for family plans.[52]

Center on Budget and Policy Priorities (CBPP): A 2019 CBPP analysis acknowledged that eliminating the firewall would improve equity but concluded that a full repeal would be too costly to recommend. Instead, the CBPP suggested strengthening the standards for employer coverage offers, such as by raising the minimum value standard (from 60 to 70 percent) or establishing more robust benefit standards for ESI plans.[53]

Commonwealth Fund: A 2020 analysis found that, depending on marketplace subsidy amounts in place, between six and 13 percent of people with ESI would pay lower premium amounts if they were able to switch to marketplace plans. Importantly, the paper pointed out that people with the lowest incomes would benefit the most from lower marketplace premiums, as would African American, Latino, American Indian and Alaska Native individuals. According to the brief, much is unknown about potential employer responses to elimination of the firewall, including whether firms will incentivize sicker workers to move to exchange plans or stop offering coverage altogether.[54] A 2024 Commonwealth Fund paper on automatic enrollment in health insurance posits that 1.2 million people with incomes below 150 percent of FPL and 6.5 million people with income between 150 percent and 200 percent of FPL would become eligible for marketplace subsidies if the firewall were eliminated. The analysis states that "most" of these newly eligible individuals currently have ESI although some are paying full premiums for nongroup plans.[55]

Congressional Budget Office (CBO): In 2020, the CBO estimated that approximately 25 percent of workers with ESI would become eligible for marketplace subsidies if the firewall was repealed. For 20 percent of those newly eligible, post-subsidy premiums for marketplace plans would be lower than ESI premiums, thus making the nongroup market an attractive option. The CBO maintained that, although firms would respond differently to a lifting of the firewall, most of the savings incurred would likely be passed on to employees and adverse selection would be minimized.[56]

Urban Institute: Urban Institute data presented to the Council and published by The Commonwealth Fund estimated that eliminating the firewall would decrease ESI coverage by two percent or less, meaning approximately 1.8 million people would transition out of ESI, with most of these workers shifting to marketplace coverage. Urban Institute's modeling assumes that most workers would stay enrolled in ESI coverage because ESI tax benefits are substantial. In this scenario, federal spending on marketplace premium tax credits would increase by $17.8 billion, or 18 percent; state spending would increase by $460 million; employer spending on premium contributions would decrease $8.1 billion; and households would save $4.4 billion per year in health spending. This study also projected that 1.4 million fewer people would be uninsured if the firewall was eliminated, including 0.4 million people between 138 percent and 200 percent of the poverty line, 0.8 million people between 200 percent and 400 percent of the poverty line, and 0.1 million people above 400 percent of the poverty line. It is estimated that this would save an estimated $1.5 billion in uncompensated care costs. The study also noted additional benefits may occur from elimination of the ESI firewall due to elimination of red tape that will make it easier for individuals who already qualify for PTCs to actually receive those benefits.[57]

RELEVANT AMA POLICY

Policy H-165.829 encourages the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage offered through health

insurance exchanges, and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges. Among its many provisions, Policy H-165.920 supports:

- A system where individually owned health insurance is the preferred option but employer-provided coverage is still available to the extent the market demands it;
- An individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer-provided coverage; and
- A replacement of the present federal income tax exclusion from employee's taxable income of employer-provided insurance coverage with tax credits for individuals and families.

Under Policy H-165.851, the AMA supports incremental steps toward financing individual tax credits for the purchase of health insurance, including but not limited to capping the tax exclusion for employment-based health insurance. Policy H-165.843 encourages employers to promote greater individual choice and ownership of plans; enhance employee education regarding how to choose health plans that meet their needs; and support increased fairness and uniformity in the health insurance market. Policy H-185.918 further encourages employers to: (a) provide robust education to help patients make good use of their benefits to obtain the care they need, (b) collaborate with employees to understand their health insurance preferences and needs, (c) tailor benefit designs to the health insurance preferences and needs of their employees, and (d) pursue strategies to help enrollees spread the costs associated with high out-of-pocket costs across the plan year. Policy H-165.881 advocates for equal-dollar contributions by employers irrespective of an employee's health plan choice. Policy H-165.854 supports Health Reimbursement Arrangements (HRAs)—account-based health plans that employers can offer to reimburse employees for their medical expenses—as one mechanism for empowering patients to have greater control over health care decision-making. Under Policy D-165.971, the AMA will work to ensure that any Association Health Plan Programs safeguard state and federal patient protection laws.

Policy H-165.824 supports improving affordability in health insurance exchanges by expanding eligibility for premium tax credits beyond 400 percent FPL; increasing the generosity of premium tax credits; expanding eligibility for cost-sharing reductions; and increasing the size of cost-sharing reductions. Policy H-165.828, which as previously noted addresses the affordability threshold (firewall), also supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability. This policy further supports education regarding deductibles, cost-sharing, and Health Savings Accounts (HSAs).

Policy H-165.823 supports a pluralistic health care system and advocates that eligibility for premium tax credit and cost-sharing assistance to purchase a public option be restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits. This policy sets additional standards for supporting a public option and states that it shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid at no or nominal cost.

DISCUSSION

The AMA has long supported health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. To expand coverage to all Americans, the AMA has advocated for the promotion of individually selected and owned health insurance; the maintenance of the safety net that Medicaid and CHIP provide; and the preservation of employer-sponsored coverage to the extent the market

demands it. ESI continues to be the dominant source of health coverage for people under 65 years of age, and most people enrolled in employer coverage seem satisfied with it. Still, the Council acknowledges that because of shortcomings inherent to the ESI system—including equity and affordability concerns, and rising costs—it does not work well for everyone, especially workers with lower incomes and those employed by smaller firms.

As explained in this report, people with higher earnings receive larger federal ESI subsidies than their lower-income peers, and lower-income people pay a greater share of earnings towards ESI. The Council recognizes that federal tax benefits available to ESI subscribers facing the greatest affordability challenges are not nearly as generous as the enhanced subsidies currently available to lower-income individuals enrolled in ACA marketplace plans. However, the affordability "firewall" makes employees with "affordable" ESI offers ineligible for federal subsidies to purchase ACA plans. To illustrate, an employee of a big box retailer earning 200 percent of FPL or less could pay up to 9.02 percent of his income towards "affordable" ESI. However, if he was eligible to move to the ACA marketplace, his premium contributions would be capped at two percent of income and he would also be eligible for cost-sharing subsidies. Under Policy H-165.828[1]), the AMA supports lowering the affordability threshold (firewall) to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage (currently 8.5 percent).

During the development of this report, the Council reviewed the literature and heard from experts presenting an array of views regarding the potential impacts of fully eliminating the firewall, which is the policy change requested by referred Resolution 103-A-23. The Council found that estimates varied regarding how many workers would transition from ESI to exchange plans if the firewall was repealed. Therefore, we cannot predict with certainty how coverage patterns and payments to physicians would be affected. The Council's revised recommendations reflect, in part, our concerns regarding the harms that significant coverage transitions out of ESI and into ACA plans could have on physician payment and the sustainability of physician practices. Although payment rates in the nongroup market tend to vary, they are generally lower than rates paid by ESI plans. In fact, a study published in 2024 found that, in 2021, marketplace nongroup insurers paid health providers substantially less than employer small-group plans. Even though the study found that marketplace rates were generally higher than Medicare payments,[58] the Council is aware that in some states marketplace plan payments barely exceed, or are even lower than, Medicare rates. In the current environment of Medicare and Medicaid physician payment inadequacies, the Council recognizes that significant shifts from ESI to the ACA marketplace could have deleterious effects on physician practices, adding to their considerable burdens and threatening their viability.

The Council is also concerned about potential employer responses to a repeal of the firewall, which cannot be predicted and will likely vary, with some firms possibly shifting certain employees to the marketplace or ceasing to offer health coverage altogether, and without assurances that employer savings would be passed along to workers. Still, we understand that the firewall is problematic for lower-income workers who may be contributing more for an employer plan than they would pay for marketplace coverage and for people working for small employers whose ESI costs have become increasingly expensive. Given the enhanced subsidies for premium tax credits and cost-sharing reductions available under current law, it is likely that at least some employees with incomes at or below 200 percent of FPL—whose premium contributions for exchange plans would be capped at two percent of income—would find marketplace coverage significantly more affordable than their ESI plan. However, if the more generous premium tax credits are allowed to expire at the end of this year, the cost of marketplace coverage will rise, potentially making ACA plans less attractive. Even among employees who would benefit financially from transitioning to the marketplace, some may opt to retain ESI coverage if they are satisfied with that plan, concerned

about the network breadth of exchange plans, or interested in preserving relationships with their treating physicians.

If the firewall was eliminated, the Council is also concerned about the potential costs that would be incurred by the federal government, which already spends upwards of $1.8 trillion on health insurance subsidies—across all coverage programs—each year.[59] Allowing potentially millions of ESI enrollees to access ACA marketplace subsidies could prove to be prohibitively expensive. We cannot estimate the exact costs of eliminating the firewall, which would depend on how many workers ultimately move to exchange plans, but expect it could total tens of billions of dollars or more per year. We believe that budgetary considerations may make the full repeal option unrealistic, financially, and also politically since it would be unpopular with ESI proponents, including employers (and employees) who value and want to preserve the ESI tax exclusion.

For all of these reasons, the Council decided to recommend an incremental approach to reducing the affordability threshold so that it first benefits workers most in need, after which the effects of this change on coverage patterns, federal and consumer health spending, and employer behavior could be monitored. At this time, we support a firewall policy change that targets employees with the lowest incomes who could benefit the most from ACA premium tax credit and cost-sharing subsidies not available under ESI. Accordingly, the Council recommends that the ACA eligibility firewall not apply to individuals offered employer-sponsored coverage whose household incomes are at or below 200 percent of the FPL, so they can receive federal premium tax credits and cost-sharing assistance if they opt to enroll in a marketplace health plan. We believe this recommendation is an appropriate first step to addressing ESI affordability challenges among the lowest-wage workers while at the same time preserving physician practice sustainability, stability in the ESI market, and limits on federal spending increases. We recommend 200 percent of the FPL since it represents workers most in need and, as the studies cited in this report note, more data are available for individuals with incomes at this threshold. Furthermore, we believe that defining the affordability threshold by a percentage of FPL should make it easier for employees to determine whether they are eligible for ACA subsidies. To protect employees and their ability to choose a health plan that best meets their needs, the Council maintains that some level of employer shared responsibility requirements will need to continue so that employers do not push workers to the marketplace involuntarily or stop offering ESI to certain income groups.

Because ESI enrollees with lower incomes are more likely to report difficulties covering the costs of medical care and who may not know if they are firewalled, the Council recommends amending Policy H-165.843 to encourage employers to: 1) implement programs that improve affordability of ESI premiums and/or cost-sharing; 2) provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of ESI; and 3) provide employees with information regarding available health plan options, including the plans' cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs. The Council recognizes that employers are already required to provide employees with notice about the ACA marketplace and that, depending on income and ESI offer, they may be eligible for lower-cost coverage in the marketplace. However, it may be challenging for some employees to determine whether they are eligible for marketplace subsidies without tools to help them do so.

To address physician payment concerns, the Council also recommends advocating that physician payments by insurers participating in the ACA marketplace be sustainable, reflect the full cost of practice and the value of the care provided, include inflation-based updates, and pay no less than prevailing Medicare rates. This policy mirrors other AMA physician payment policies and is critical to ensuring physician practice sustainability.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 103-A-23, and that the remainder of the report be filed.

1. That it be the policy of our American Medical Association (AMA) that the Affordable Care Act (ACA) eligibility firewall not apply to individuals offered employer-sponsored coverage whose household incomes are at or below 200 percent of the federal poverty level, so they can receive federal premium tax credits and cost-sharing assistance if they opt to enroll in a marketplace health plan as an affordable alternative to their employer-based plan. (New HOD Policy)

2. That our AMA amend Policy H-165.843 by addition and deletion to read:

   Our AMA encourages employers to:
   a) promote greater individual choice and ownership of plans;
   b) implement plans to improve affordability of premiums and/or cost-sharing, especially expenses for employees with lower incomes and those who may qualify for Affordable Care Act marketplace plans based on affordability criteria;
   c) ~~help employees determine if their employer coverage offer makes them ineligible or eligible for federal marketplace subsidies~~ provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of employer-sponsored insurance;
   ~~b~~d) ~~enhance employee education regarding available health plan options and how to choose health plans that meet their needs~~ provide employees with information regarding available health plan options, including the plan's cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs;
   ~~c~~e) offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
   ~~d~~f) support increased fairness and uniformity in the health insurance market; and
   ~~e~~g) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care. (Modify HOD Policy)

3. That our AMA advocate that physician payments by health insurers participating in the ACA marketplace be sustainable, reflect the full cost of practice and the value of the care provided, include inflation-based updates, and pay no less than prevailing Medicare rates. (New HOD Policy)

Fiscal Note: Less than $500.

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REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (A-25)
Medicaid Estate Recovery Reform
(Resolution 104-A-24)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2024 Annual Meeting, the House of Delegates referred Resolution 104, which was sponsored by the Medical Student Section and asked the American Medical Association (AMA) to oppose federal or state efforts to impose liens on or seek adjustment or recovery from the estate of individuals who received long-term services or supports coverage under Medicaid. During the development of this report, the Council reviewed the literature on Medicaid estate recovery, met with an expert, and discussed potential reforms. Of note, the Council's deliberations took place at a time of heightened concern regarding potential reductions in Medicaid funding, which would have deleterious effects on state budgets and Medicaid programs.

Because Medicaid estate recovery is not directly addressed in AMA policy, the Council found that new policy is needed and that, given widespread concerns regarding potential federal Medicaid funding cuts, new policy must allow for state flexibility. The Council's recommendations are thus intended to support and encourage meaningful estate recovery reforms without requiring states to abandon the practice. In some states, the return on investment may not be worth the costs of administering Medicaid estate recovery programs; however, states that recoup the most funds may not want to forego that revenue, especially if federal Medicaid funds are reduced. For these reasons, the Council decided not to oppose estate recovery efforts outright. Instead, this report recommends support for specific reforms intended to help maintain Medicaid as a safety net and ensure that long-term services and supports (LTSS) are provided to people most in need.

To acknowledge the variance in estate recovery efforts and allow states more flexibility than they currently have, the Council recommends that the AMA support making Medicaid estate recovery optional, instead of mandatory. This recommendation allows states to decide whether (or not) to continue their estate recovery programs, which is consistent with longstanding AMA policy allowing states some flexibility in implementing their Medicaid programs. When Medicaid estate recovery is pursued, the Council recommends: 1) limiting recoupment to the costs of LTSS and not for other Medicaid services that were provided; 2) standards for hardship waivers that prohibit claims against a sole income-producing asset of heirs, homes of modest value, and any estate less than a specified threshold value; 3) exempting estates from recovery efforts when the value of the recovery is projected to be less than the cost of recoupment efforts; 4) basing estate recovery on the costs of LTSS care when managed care organizations are utilized, instead of the capitation amount, when the cost of LTSS is lower than the capitation amount; 5) providing education regarding state Medicaid estate recovery requirements; 6) screening patients for hardship waivers and assisting them with filing, if eligible; and 7) collecting and making publicly available important data regarding estates that have been pursued and amounts that have been recovered.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-25

Subject: Medicaid Estate Recovery Reform (Resolution 104-A-24)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee A

At the 2024 Annual Meeting, the House of Delegates (HOD) referred Resolution 104, which was sponsored by the Medical Student Section and asked the American Medical Association (AMA) to oppose federal or state efforts to impose liens on or seek adjustment or recovery from the estate of individuals who received long-term services or supports coverage under Medicaid. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. This report describes federal Medicaid estate recovery requirements, discusses the pros and cons of estate recovery, and makes policy recommendations for future reforms.

BACKGROUND

Since the Medicaid program's inception in 1965, states have been permitted to try to collect repayments for certain Medicaid services after older enrollees had died. In 1982, the Tax Equity and Fiscal Responsibility Act gave states the option to utilize property liens to prevent Medicaid enrollees from evading estate recovery efforts by transferring their homes to someone else shortly before their death. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) mandated estate recovery efforts targeting certain deceased enrollees who had used Medicaid long-term services and supports (LTSS), including nursing facility services and home and community-based services (HCBS), while allowing states some discretion in how estate recovery programs are implemented. Under OBRA 93, states must attempt to recover payments from the estates of individuals who received Medicaid LTSS when they were aged 55 or older; enrollees of any age expected to reside permanently in long-term care facilities; and, under certain circumstances, individuals with long-term care insurance.[1]

For the age 55 and older group, federal law stipulates that states must pursue estate payments for amounts that are at least equal to the costs of a patient's nursing facility care, HCBS, and hospital services and prescriptions provided while an enrollee was receiving LTSS. States have the option to also pursue estate recovery for the costs of other Medicaid-covered services, except for Medicare cost-sharing assistance that is provided to individuals who are dually eligible for Medicaid and Medicare. According to KFF, 37 states go beyond minimum federal estate recovery requirements and apply recoupment efforts to optional Medicaid services, including 32 states that try to recover the costs of all Medicaid services (as long as LTSS services were provided); 28 states that target some people under age 55; and five states that focus on certain optional benefits.[2]

Generally speaking, and depending on a specific state's policies, elements of an individual's estate that can be subject to recovery efforts include cash, checking and savings accounts, stocks and bonds, remaining funds in certain types of trusts (e.g., Qualified Income Trust and/or Irrevocable

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Funeral Trust) and any other items of value, including an individual's home. Life insurance policies are generally protected unless the beneficiary is the Medicaid enrollee's estate.[3]

Federal law also places some parameters around estate recovery efforts. For example, states are not permitted to seek recovery from the estate of a deceased Medicaid enrollee who is survived by a spouse until the spouse has died, and once the spouse has died, states can waive recovery if they determine efforts will not be cost effective. Similarly, states must exempt or defer recovery from the estates of enrollees who are survived by a child under 21 or a child of any age who is blind or has a disability.[4] As such, states may not try to take the homes of deceased enrollees that are occupied by a surviving spouse, child under 21, child of any age who is blind or has a disability, or a sibling who has an equity stake in that home. However, states are allowed to impose liens on the property of enrollees who are receiving institutionalized care and are not expected to return home, unless the home is occupied by the individual's spouse, child under age 21, child of any age who is blind or has a disability, or sibling who has an equity interest in the home.[5] Once survivors have died or a surviving child has turned 21, states can—and often do—proceed with attempting to recoup payments from estates. Pursuant to court judgments, states are also permitted to impose liens to pay for Medicaid benefits that were incorrectly provided.

OBRA 93 required states to establish procedures for waiving estate recovery due to undue hardships, which the Centers for Medicare & Medicaid Services (CMS) has stated could include: 1) an estate that is the sole income-producing asset for survivors (e.g., family farm); 2) a home of modest value, defined as roughly half the average home value in the county; and 3) other compelling circumstances. Although states are not required to implement these particular hardship examples, most (49) have reported adopting at least one of the three, including 35 states that said they use the "sole income-producing asset" criteria.[6] Notably, only 15 states report waiving estate recovery for homes of modest value.[7]

For Medicaid managed care organization (MCO) enrollees who would be subject to estate recovery under fee for service (FFS), states can seek recoupment of MCO capitation payments rather than the costs of Medicaid services that were provided. In states that pursue estate recovery for all Medicaid services, the total capitation payment for the period the individual was enrolled in the MCO must be sought. If the state applies estate recovery to some, but not all services, the state must pursue recoupment of the part of the capitation payment attributed to those services.[8] According to KFF, 30 states report trying to recoup payments for MCO capitation payments which, notably, can exceed the amount that Medicaid had actually spent on the enrollee.

Medicaid Long-Term Services and Supports (LTSS)

LTSS refers to the broad range of clinical health and related services provided to help people who have functional or cognitive limitations with activities of daily living (ADL) when these individuals need extra care either at home or in a facility. ADLs include eating, bathing, dressing, and instrumental tasks like medication management, house cleaning, and meal preparation. LTSS are intended to help individuals with self-care needs over an extended time period, which differentiates them from post-acute services, such as home health or skilled nursing facility (SNF) care, that are designed to help individuals recover after a hospitalization.[9]

Older adults and people living with chronic illnesses and disabilities are among the estimated nine million users of Medicaid LTSS, a figure that includes the 7.8 million enrollees who received HCBS in 2022 and 1.5 million individuals who received LTSS that year in an institutional setting.[10] The significantly larger share of people receiving HCBS reflects a shift over the years in the provision of LTSS from nursing homes and other facilities to home and community settings. Over half (57

percent) of enrollees receiving Medicaid LTSS are under 65, although—not surprisingly—more than two-thirds of individuals receiving institutional care are 65 and older.[11] Importantly, these statistics exclude individuals receiving unpaid LTSS that is generally provided by family members and friends outside of Medicaid, as well as individuals paying for LTSS (including assisted living or nursing home care) out of pocket. Although more people have private long-term care insurance than was the case years ago, in 2021 only about 80,000 people filed claims for such benefits.[12] Of note, insurance coverage for LTSS is profoundly different than coverage for other health care services in that it is quite limited outside of Medicaid and, within Medicaid, LTSS is only available to people meeting strict eligibility requirements who must spend down their income and assets to qualify.

Although nursing facility services are a mandatory benefit under Medicaid, coverage for most HCBS—other than home health—is optional and, therefore, varies by state. Complex eligibility rules regarding income, assets, and functional limitations also vary significantly by state, as do LTSS eligibility pathways. In general, applicants for Medicaid LTSS must "spend down" their income and assets in order to qualify for LTSS, and "look-back" rules are in place to try to keep people from transferring assets to others to become Medicaid-eligible. Although data are somewhat lacking on this topic, analyses have found that advantaged groups are more likely to engage in estate planning to circumvent "look-back" and estate recovery requirements.[13]

As the largest payer, Medicaid covers the costs of roughly 60 percent of total LTSS expenditures in the United States. Additional payments are made out of pocket by individuals and by private long-term care insurers, the Department of Defense, the Department of Veterans Affairs, and state and local governments.[14] In 2022, Medicaid LTSS spending totaled just over $200 billion, which included $129.4 billion for HCBS and $71 billion for institutional care. The average expenditure per user on institutional care was over $48,000, significantly higher than average per-person spending on HCBS ($16,491).[15] Demonstrating the need for LTSS, approximately 700,000 people are on waiting lists for HCBS.[16] In 2020, CBO estimated that, in 2030, $160 billion will be spent on HCBS and $80 billion on institutional care.[17] Recognizing that people are aging and living longer, which will impact the use of and spending for LTSS, the Council on Medical Service has addressed long-term care in this country and presented reports on LTSS financing reforms (Council Report 5-A-18) and financing structures for HCBS (Council Report 4-N-21).

PROS AND CONS OF MEDICAID ESTATE RECOVERY

The Federal Estate Recovery Mandate was established as a program integrity tool intended to help ensure that Medicaid LTSS recipients use their own resources to cover the costs of their care. Proponents of estate recovery underscore that such efforts are needed to ensure that families are not transferring or otherwise protecting their financial resources in order to qualify for Medicaid LTSS and that Medicaid funds are used to care for the neediest enrollees. Additionally, the recovery of assets may help supplement Medicaid funding in some states and even federally, since a portion of the money recovered must be paid to the federal government for the share of the services that were federally funded. Within federal parameters, states have discretion in how aggressively they choose to pursue estate recovery and, therefore, there is wide variability in how states administer their recovery programs.

Criticisms over the years have highlighted that Medicaid estate recovery primarily targets individuals and families who are poor, that families of color are disproportionately affected, and that the process contributes to wealth inequality and intergenerational poverty. To qualify for Medicaid LTSS in the first place, individuals must have limited incomes and have spent down most of their financial resources, though the value of a person's home and certain other assets are not counted in eligibility assessments. Due to the high cost of long-term care in this country, many middle-income

people also qualify for Medicaid once their savings have been spent down. However, critics also note that middle- and higher-income people frequently use estate planning vehicles (e.g., trusts) to protect their assets and evade recovery efforts, while people who cannot afford estate planning services tend to give up more to the state, thus widening estate recovery disparities. The lack of available data prevents a thorough understanding of how many people shelter assets from state Medicaid programs, but it is not an unusual practice. Notably, the Medicaid and CHIP Payment Access Commission (MACPAC) has concluded from its surveys and interviews that estate recovery is not very effective in recouping money from people who may have the means to cover LTSS themselves.[18]

Advocates concerned about estate recovery efforts have noted that estate recovery programs can dissuade people in need of LTSS from applying for Medicaid services. Critics also argue that very little payment is collected by most states and that recovered dollars represent a small slice of what Medicaid spends on LTSS. In 2019, when an estimated $733 million was recovered overall from estates, only eight states recouped more than one percent of the cost of FFS LTSS and 28 states recovered less than 0.5 percent.[19] Based in part on each state's priorities and program administration, amounts recovered vary significantly by state. For example, in 2019, Iowa recovered over 14 percent of FFS LTSS spending in the state while Hawaii, Louisiana, and West Virginia recovered only 0.02 percent. Moreover, five states with the largest recoveries (Massachusetts, New York, Pennsylvania, Ohio, and Wisconsin) recouped nearly half of all collections in the U.S.[20] As noted by the authors of Resolution 104-A-24, the administrative costs of implementing estate recovery programs can be substantial, thus diminishing the utility of such efforts. Although little data are available on state administrative costs, there seems to be a wide range of spending on estate recovery across states. According to MACPAC's data from five states, the administrative costs of recovery ranged from 3.7 percent to 32.1 percent of the amount collected. MACPAC's research also suggests that states could collect more from estates if their program efforts mirrored those in states that recoup the most money.[21]

REFORM PROPOSALS

At the national level, MACPAC published a thorough analysis of the state-of-play in a 2021 report to Congress on estate recovery reforms. This report recommended that Congress amend the Social Security Act to:

1. Make Medicaid estate recovery optional for the populations and services for which it is required under current law;
2. Allow states providing LTSS under managed care arrangements to pursue estate recovery based on the cost of care when the cost of services used by an enrollee was less than the capitation payment made to an MCO; and
3. Direct the Department of Health and Human Services Secretary to set minimum standards for hardship waivers so that states are not allowed to pursue recovery for: a) any asset that is the sole income-producing asset of survivors; b) homes of modest value; and c) any estate valued under a certain threshold.[22]

Federal legislation from the last Congress includes H.R. 7573, which was sponsored solely by Democrats and prohibits all estate recovery efforts, and H.R. 8094, which was introduced by a Republican House member and would prohibit states from pursuing estate recovery when the individual's home is transferred to someone who is eligible for medical assistance or has an income below 138 percent of the Federal Poverty Level (FPL).[23]

Although states must meet minimum federal requirements for estate recovery, within those parameters, they can implement their own reforms. Examples of recent state activity include legislation in Maine and Massachusetts that scaled back recovery efforts to federal minimum requirements. Additionally, Georgia, Illinois, Massachusetts, and South Carolina have established cost effectiveness thresholds that essentially waive recovery of estates worth less than $25,000. [24] Illinois has also begun requiring the state Medicaid agency to publicly report data on estate recovery. Some states, like Massachusetts, also provide enrollees with more thorough explanations of estate recovery requirements when they are applying for Medicaid LTSS.

RELEVANT AMA POLICY

AMA policy does not specifically address Medicaid estate recovery efforts, although numerous policies focus on long-term care and LTSS. Under Policy H-280.991, the AMA maintains that programs to finance long-term care should:

- Assure access to needed services when personal resources are inadequate to finance care;
- Prevent impoverishment of the individual or family in the face of extended or catastrophic service costs.
- Cover needed services in a timely, coordinated manner in the least restrictive setting;
- Provide coverage for the medical components of long-term care through Medicaid for all individuals with income below 100 percent of the FPL; and
- Provide sliding scale subsidies for the purchase of LTC insurance coverage for individuals with income between 100-200 percent of the FPL.

Although not specific to Medicaid estate recovery, Policy H-290.982 supports increasing investments in HCBS; allowing states to use long-term care eligibility criteria which distinguish between people who can be served in a home or community-based setting and those who can only be serviced in a nursing facility; buy-ins for home and community-based care for people with incomes and assets above Medicaid eligibility limits; and grants to states to develop new long-term care infrastructures and encourage expansion of long-term care financing to middle-income families who need assistance. Policy H-280.945 also supports incentivizing states to expand access to HCBS. Policy D-280.982 directs the AMA to:

- Advocate for business models in long-term care for the elderly which incentivize and promote the ethical and equitable use of resources to maximize care quality, staff and resident safety, and resident quality of life, and which hold patients' interests as paramount over maximizing profit; and
- Advocate for further research into alternatives to current options for long-term care to promote the highest quality and value LTSS models as well as functions and structures which best support these models for care.

DISCUSSION

The Council reviewed the literature on Medicaid estate recovery, met with an expert, and deliberated at length about potential reforms. At the request of the Medical Student Section, which sponsored referred Resolution 104-A-24, the Council limited its study to estate recovery and, therefore, does not make recommendations regarding Medicaid LTSS eligibility requirements (e.g., spend-down rules), which are equally complex and should be addressed separately.

Of note, the Council's deliberations took place at a time of heightened unease among state medical associations, national medical specialty societies, the AMA, and many states and advocacy groups

regarding potential reductions in Medicaid funding, which would have deleterious effects on state budgets and Medicaid programs. At the time this report was written, Congress had not enacted any Medicaid cuts; however, many states were considering how to prepare for federal Medicaid changes. For context, it is also important to point out that the AMA has not received any inquiries or requests for assistance with estate recovery reforms. Still, because estate recovery is not directly addressed in AMA policy, the Council agrees that new policy is needed and that, given the uncertainties around federal Medicaid funding, this policy should retain state flexibility. Accordingly, the Council crafted recommendations that support and encourage meaningful estate recovery reforms without requiring states to abandon the practice or take other immediate actions.

Medicaid LTSS provides a critical safety net for lower-income people who have few resources and need assistance with ADLs, including older adults with chronic illnesses or dementia and younger people living with disabilities. The Council recognizes that demand for critical LTSS services is likely to grow as the U.S. population ages and people live longer, and that Medicaid services should be available to those most in need of LTSS. We do not believe that Medicaid should pay for the long-term care costs of people who have financial means to do so themselves; however, because LTSS is exorbitantly expensive and not covered by most insurers, we understand the challenges of preventing people from sheltering their assets and misusing the system.

As discussed in this report, federal law requires states to perform estate recovery as a condition of their participation in Medicaid. Based on surveys and interviews with key stakeholders, MACPAC reported that states primarily recoup funds from modest-sized estates and that individuals with more financial means often evade recovery efforts, raising equity concerns. We acknowledge these concerns and believe that additional guardrails may be needed. We also recognize that states and other stakeholders, including physicians, hold differing views on the benefits and harms of estate recovery programs. For example, in some states, the return on investment may not be worth the costs of administering estate recovery programs; however, states that recoup the most funds may not want to forego that revenue, especially in a challenging fiscal environment. For these reasons, the Council decided not to oppose estate recovery efforts outright. Instead, we recommend support for specific reforms intended to help maintain Medicaid as a safety net and ensure that, as intended, LTSS are provided to people most in need. To acknowledge the variance in estate recovery across states and allow states more flexibility than they currently have, the Council recommends that the AMA support making Medicaid estate recovery optional, instead of mandatory. This recommendation allows states to decide whether (or not) to continue their estate recovery programs, which is consistent with longstanding AMA policy allowing states some flexibility in implementing their Medicaid programs.

When Medicaid estate recovery is pursued, the Council recommends supporting the following additional reforms:

- First, the Council learned that more than half of states apply recoupment efforts beyond LTSS and attempt to recover the costs of some or all other Medicaid-covered services provided to an enrollee. We do not believe it is appropriate to pursue recovery beyond the costs of LTSS care, and, therefore, recommend that estate recovery be limited to the costs of LTSS and not other Medicaid services that may have been utilized.
- The Council also recommends support for developing standards for hardship waivers that prohibit claims against a sole income-producing asset of heirs; homes of modest value; and any estate less than a specified threshold value. This language mirrors one of MACPAC's recommendations and was also used by CMS to describe sample hardship waiver criteria. The Council discussed recommending a specified threshold value but believe that other stakeholders are better equipped to determine an appropriate threshold amount.

- Relatedly, the Council recommends support for exempting estates when the value of the recovery is projected to be less than the cost of recoupment efforts. We do not believe it makes sense to pursue estate recovery when the return would be so low.
- When MCOs are utilized, the Council recommends basing estate recovery on the costs of LTSS care, instead of the capitation amount, when the cost of LTSS is lower. Similar to the first reform (see above), we do not believe that estates should be pursued for amounts exceeding the cost of care that was provided. Our recommended approach would also be easier for families to understand since they may not know the amount of capitation that was paid for them.
- Similarly, the Council feels strongly that LTSS enrollees and their families must be better educated about estate recovery requirements so they are not surprised by a state's recoupment efforts after the enrollee has died. Although states are required to provide basic information to enrollees, it is not always adequate or easy to find. Accordingly, the Council recommends supporting education at the time of enrollment in LTSS, and during any renewal process, that is appropriate to enrollees' language and health literacy abilities.
- To ensure that available hardship waivers are offered to eligible enrollees, the Council recommends screening patients for hardship waivers and assisting them with filing such waivers, if eligible.
- Finally, the Council also recommends supporting data collection and public reporting on estate recovery programs. We found data to be lacking and believe more information is needed to accurately evaluate the impacts and effectiveness (or not) of estate pursuits.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 104-A-24, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support making Medicaid estate recovery optional, instead of mandatory, for states. (New HOD Policy)

2. That our AMA support the following when Medicaid estate recovery is pursued:

    a. Limiting recoupment to the costs of long-term services and supports (LTSS) and not for other Medicaid services that were provided;
    b. Establishing standards for hardship waivers that prohibit claims against a sole income-producing asset of heirs; homes of modest value; and any estate less than a specified threshold value;
    c. Exempting estates from recovery efforts when the value of the recovery is projected to be less than the cost of recoupment efforts;
    d. Basing estate recovery on the costs of LTSS care when managed care organizations are utilized, instead of the capitation amount, when the cost of LTSS is lower than the capitation amount;
    e. Providing education regarding state Medicaid estate recovery requirements at the time of enrollment in LTSS, and during any renewal process, that is appropriate to enrollees' language and health literacy abilities;
    f. Screening patients for hardship waivers and assisting them with filing, if eligible; and
    g. Collecting and making publicly available important data regarding estates that have been pursued and amounts that have been recovered. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-A-25

Subject: Prescription Medication Price Negotiation (Resolution 113-A-24)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee A

At the 2024 Annual Meeting, the House of Delegates referred Resolution 113, which was sponsored by the New England Delegation, and asked our American Medical Association (AMA) to support drug price negotiation for all payers, advocate that any medication in which the price rises faster than inflation be automatically added to the negotiation schedule, and support extending the annual Medicare cap on out-of-pocket prescription drug spending to all payers. The following report discusses the history and current state of medication price negotiation, out-of-pocket caps, AMA efforts on the topic, and offers recommendations in line with the spirit of the resolution.

BACKGROUND

Enactment of the Inflation Reduction Act of 2022 (IRA) has had far-reaching impacts in the health care sector, particularly regarding Medicare drug pricing.[1] Most notably, the IRA allows the Centers for Medicare & Medicaid Services (CMS) to directly negotiate the prices of certain high-cost drugs.[2,3] CMS initially selected 10 medications that are considered "high expenditure," are single source, and do not have a biosimilar/generic alternative. Additionally, manufacturers are required to pay rebates to the federal government if the price of medications for Medicare Part B or Part D beneficiaries are raised faster than the rate of overall inflation as measured by the Consumer Price Index for All Urban Consumers (CPI-U).[1,2]

At the time this report was written, there had not been significant movement in either direction regarding implementation of the drug pricing regulations by the Trump administration. However, it seems likely that they will choose to maintain current drug pricing practices put in place by the Biden administration, implement modifications to these practices, or repeal them altogether.[4] A focus on reducing drug prices through Medicare negotiations remains a cause with bipartisan support. Over half of all Americans report believing that Medicare drug pricing should be a "top priority" of the current administration.[5] CMS released a statement declaring that the current administration intends to focus on the issue by negotiating drug prices,[6] although recent actions may indicate a change in focus from the Biden administration. For example, shortly after taking office, President Trump signed executive orders rescinding regulations designed to lower Medicare beneficiaries' drug spending. Specifically, the two-dollar generic out-of-pocket (OOP) cap was removed and the reduction of Medicare payment for accelerated Food and Drug Administration (FDA) medications was reduced.[7] Additionally, three ongoing projects through the CMS Innovation Center designed to explore strategies to lower drug prices were halted .[7] It is also possible that the administration will not directly support nor reject the Medicare negotiations, thereby indirectly supporting drug industry opposition. For example, the administration may choose not to defend the existing laws and regulations against legal challenge or may propose rules designed to exempt more drugs from negotiations.[4]

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Pharmaceutical prices are typically categorized in three ways: public list price, net price, and OOP expense for the patient.[8] The public list price of a drug is set by the manufacturer and is typically the starting point for negotiations. The net price of a drug is the amount that is actually paid by the plan sponsor or, in the case of public plans, the government. This price is determined through either negotiation, mostly done by pharmacy benefit managers (PBMs), or in some rare cases by the payer itself. This is also the price that is typically dictated by legislation or regulations when applicable. Finally, patient OOP cost is the amount that the patient pays to receive the medication.[8,9] There are many elements that are incorporated in price determination, such as the number of medications available to treat the same condition, the route of administration of the medication, and the payer. These elements are used to set the prices that are paid by patients and plans.[8,9] Without PBMs, this process is relatively straightforward. Manufacturers sell prescription drugs to pharmacies who, in turn, sell the drug to the patient at a price determined by their insurance coverage and plan. However, the addition of PBMs to this process increases complexity and reduces transparency. These benefit managers become the "middlemen" between manufacturers, pharmacies, insurance companies, and consumers, which allows them to determine the actual OOP cost to the patient.[8,10]

PRICE NEGOTIATION

Private payers engage in drug price negotiation, primarily relying on PBMs to handle the negotiations. PBMs work directly with drug manufacturers to negotiate drug prices and associated rebates to find the lowest cost for the payer. While, in theory, this should lead to beneficiaries having access to lower cost medications, in reality PBMs often favor the higher priced drugs. This is due to the rebates, calculated as a percentage of the list price, that are kept by the PBM and payer, and rarely directly benefit beneficiaries.[11] These rebates are not typically passed on to the patient and, as a result, patients may end up paying a higher price and/or not benefiting from the PBM negotiations.[11,12] Additionally, a significant portion of PBMs are vertically integrated with payers, stifling competition. This lack of competition, which is not just a result of vertical integration but also the process of rebate negotiation, often results in higher insurance premiums for beneficiaries and lower pharmaceutical reimbursement rates.[12] While the negotiation practices of private payers, often via PBMs, may not be as advantageous for patients as it should be, the bottom line is that these payers do currently negotiate drug prices to lower overall insurer costs.

Historically, public payers have not negotiated drug prices in the manner that was implemented by the aforementioned IRA. Since its inception in 2022, the IRA has allowed CMS to negotiate the price of Medicare Part B and D prescription drugs. This negotiation process began in 2024 for Part D and included 10 drugs in the initial negotiation cycle.[1] The Maximum Fair Prices (MFPs) for these 10 drugs will go into effect in January 2026. These drugs include blood thinners and medications to treat diabetes, heart failure, psoriasis, rheumatoid arthritis, blood cancers, and Crohn's disease. Medicare negotiated prices ranged from a price drop as small as $6 and as large as $22,027. Not surprisingly, the drug with the highest list price, Stelara,® showed the most significant price decrease while the drug with the lowest list price, NovoLog®/Fiasp,® yielded the smallest price reduction. A full and regularly updated table of the Medicare negotiated drug prices can be accessed via the Peterson-KFF Health System Tracker. In early 2025, CMS announced 15 additional drugs that will be included in the Medicare drug pricing negotiation schedule. Assuming the cycle of negotiation continues as intended, the MFPs for these drugs will go into effect January 2027.[2,3] CMS projects that the negotiated MFPs will save approximately $1.5 billion in its first year.[2] In order for prescription drugs to be eligible for negotiation, they must meet certain criteria. Specifically, they must be covered by Medicare and be a single brand-name drug or biologic that does not have a therapeutically equivalent generic or biosimilar that is being marketed. Additionally, eligible biologics must be 11 years past the earliest FDA approval or licensure and

name-brand small-molecule drugs must be at least seven years past approval/licensure. Until 2028, negotiation is limited to Part D plans adding 15 drugs each year through 2028. In 2029 Part B plans will be included and the number of negotiated drugs will increase to 20.[1,3,13]

Importantly, there is no "trigger" that automatically includes a medication in future negotiations. However, under the IRA if the cost of a drug rises faster than inflation, manufacturers are required to provide Medicare with rebates.[3] This provision is designed to discourage manufacturers from unnecessarily raising drug prices without valid reasoning, as in 2015 when the manufacturer for Daraprim® increased the price by over 5,000 percent overnight.[3,13] Though a medication's price increasing faster than inflation *might* be a reason for inclusion, it is not *necessarily* a reason. There are valid reasons that a drug price may increase, such as when a medication's treatment value increases or an increase in the cost of raw materials.[14,15] While it is important to discourage unnecessary hikes in drug prices, it is also important to ensure that medications are accessible to patients when needed. Therefore, drugs should not be automatically included in negotiations without complete assessment from appropriate regulators, legislators, and/or experts. A discussion surrounding the criteria states have utilized to select regulated or negotiated medications can be found in CMS Report 8-A-25.

Pharmaceutical manufacturers have pursued litigation to stop these government negotiation practices, citing that the negotiated prices may harm competition and, as a result, innovation. At the time this report was written, there were nine open legal cases against the federal government and/or CMS.[16] These lawsuits generally center around the claim that the program will violate the Fifth Amendment by forcing manufacturers to provide selected medications to the government without fair compensation, that the program limits corporate free speech, and that associated penalties are "excessive fines" which is in violation of the Eighth Amendment. Some cases also claim that the negotiation program violates portions of the Due Process Clause by not allowing for adequate separation of powers.[14,15] To date, none of these legal challenges have been successful in blocking or minimizing the drug negotiation. However, most of these cases are still ongoing and one has recently found minor traction via an appeals court.[17] Most experts following these cases agree that it is likely one will end up being heard by the United States Supreme Court. Although the voracity with which the current administration will defend the program is uncertain, potentially mitigating the need for a Supreme Court ruling.[15,16]

IMPACT OF PRICE NEGOTIATION

While experts do agree that reducing the amount patients pay for drugs will improve medication adherence, and as a result health outcomes, there is some debate regarding whether price negotiation, and particularly the establishment of MFPs, are the best method to reduce drug prices. Some experts suggest that increasing drug price negotiation is a tactic that could be used in tandem with other tactics to lower drug prices in the U.S.[18] Specifically, the Congressional Budget Office (CBO) analyzed a bill asserting more aggressive negotiation and found that it could yield over $450 billion in savings for Medicare over a 10-year period. It is estimated that if the negotiated prices were expanded to commercial insurance plans, anticipated savings to the system could reach the trillion-dollar mark over 10 years.[17] These experts stress that drug price negotiation alone is not likely to solve the problem of U.S. drug prices. However, in tandem with other efforts such as rebate reform, administrative simplification, and increased transparency, costs could be reduced.[17]

Other experts have voiced concerns surrounding the increased use of price negotiation. Many drug manufacturers claim that the implementation of negotiation and MFPs will stifle innovation and potentially prevent, or slow, the development of new pharmaceuticals.[18] Importantly, much of the

resistance to price negotiation has come from entities that benefit from the current system, such as manufacturers, potentially calling the motives of these challenges into question.[14,15,18]

In addition to the lowered costs that may result from negotiation, the price transparency required in the IRA may improve pricing.[17,19] The public access to a drug's Medicare Negotiated Price, the MFP, is a relatively novel level of transparency that may encourage private payers to follow the lead on CMS negotiated prices. While the current legislation does not require private payers to follow the set MFPs, it is common for private insurance companies to eventually follow the lead of CMS.[18] Research has demonstrated that increases in transparency throughout the drug pricing system could be a significant help in lower drug prices overall.[17]

Federal efforts, like the Prescription Pricing for the People Act of 2025, have been introduced to regulated PBM business practices and drug pricing. Additionally, the Transparency in Coverage rule, released in 2020, outlines the requirements for payers/plans to disclose negotiated rates and historical net price for prescription drugs. In addition to federal efforts, a number of states have enacted laws related to portions of the drug pricing process. These laws center around affordability reviews, consumer cost sharing, PBMs, increased transparency, and purchasing processes. However, since none of these state laws have been enacted at a federal level, no impact has been seen nationally.[20] Due to the lack of transparency in the drug pricing process, the result of each specific element, be it negotiation, PBMs, or another aspect, is difficult to assess.

OUT-OF-POCKET CAPS

In addition to introducing CMS drug price negotiations, the IRA also lowered the prescription drug OOP cap for Medicare Part D beneficiaries. Historically, this cap has been between $3,300 and $3,800. Starting in 2025, this has been lowered to $2,000 due to elimination of the coinsurance cost in the catastrophic coverage phase. Experts estimate that if this cap had been implemented in 2021, 1.5 million beneficiaries would have saved in OOP costs.[21]

While the IRA did not expand the prescription drug OOP cap to non-Medicare payers, most, if not all, plans have caps on annual OOP spending. Research has demonstrated that median annual OOP spending on medical expenses ranged between $360 and $1,500 with the top 10 percent spending at least $7,000.[22] Importantly, this is for all medical spending, not just prescription drugs. Because many private payers do not separate prescription drug OOP costs from overall OOP medical costs, it is challenging to make a direct comparison to Medicare levels.[21] Researchers and other experts agree that high OOP costs can be detrimental to patients, some suggesting spending caps as a potential solution to this issue.[23,24] The financial burden of high OOP costs can often lead to patients accruing significant medical debt and potentially forgoing future, necessary treatment. If a patient cannot afford their OOP cost, they may delay or skip treatment altogether, leading to lower medication adherence and poorer health outcomes. OOP caps could have potential to increase prescription drug affordability for patients in turn potentially leading to better health outcomes.[23,24]

While experts agree that high OOP costs can be detrimental to patients, some voice concerns around the unintended consequences of OOP caps such as disproportionate financial burdens to lower income patients.[24,25] If all beneficiaries are given a uniform cap, this may be affordable for some but not for others. Even more importantly, these caps are often not paid for by insurers but rather shifted to patients through premium increases. These premium raises could, and often do, make insurance unaffordable for many beneficiaries. Some experts argue that this could be mitigated by adding income-based eligibility requirements for OOP costs or income-proportional caps.[23,24,25] Nonetheless, it is essential to ensure that the potential economic impacts of universal

OOP caps be weighed against the potential benefits to ensure that patients still have access to reasonably priced insurance coverage.

AMA POLICY AND ADVOCACY

The AMA has undertaken robust advocacy efforts to lower drug costs for patients, especially around regulation and increasing the transparency of PBMs. Specifically, over the past two years the AMA has written a number of letters to payers, regulators, and legislators and testified before both the House and Senate regarding regulation of PBMs. The AMA also has an ongoing grassroots campaign, TruthinRx, designed to support patients and physicians in understanding and fighting the lack of transparency through education and advocacy. Additionally, the AMA has expressed support to federal legislators to implement drug price negotiation, regulators in reducing patient OOP costs, and for reasonable OOP caps on drug spending. The AMA is continuing to work with legislators, regulators, drug manufacturers, and payers to ensure that patients not only have access to affordable medications but also affordable health coverage.

In addition to the advocacy on drug pricing transparency and affordability, the AMA has extensive policies that address the issue. Policies H-110.980 and H-110.987 outline the AMA's efforts to ensure that patients have access to affordable medications. These policies discuss AMA standards for drug affordability, process transparency, and patient access. Policy H-110.980 highlights different strategies and approaches, such as supporting increased transparency and promoting value-based pricing, that the AMA utilizes to ensure that medications are accessible and affordable. Policies H-110.986 and H-110.979 expand on this support for value-based strategies to manage drug coverage. Specifically, H-110.986 discusses AMA support for adding value metrics into drug prices and H-110.979 outlines AMA advocacy for formulary development to incorporate value-based processes. In conjunction with the aforementioned policies that address all payer types, Policy D-330.954 focuses on managing prescription drug prices in Medicare and outlines support for price negotiation. Finally, Policies D-110.987, D-120.988, and D-120.934 target PBMs and the need for increased regulation and transparency. Policy D-120.934 outlines AMA steps to ensure that PBMs do not prevent physicians from appropriately treating patients, Policy D-120.988 details prevention of appropriate treatment by PBMs, and Policy D-110.987 discusses the impacts of these, and other, negative PBM practices.

The AMA also has policy and ongoing advocacy to address concerns from experts surrounding unintended consequences of introducing OOP caps or extending drug price negotiations. Policies H-320.939 and D-320.982, along with the AMA's Fix Prior Auth grassroots campaign, work to mitigate concerns regarding increases in utilization management/prior authorization. Policy H-320.939 outlines the efforts that the AMA has made to reduce the amount of utilization management and fix the system as a whole. Policy D-320.982 outlines strategies, including emerging technology, that could be used to assist in minimizing the impact of utilization management on patients and physicians. Finally, Policies H-165.828, H-290.954, and H-165.824 outline AMA efforts to support the affordability of health insurance for all. Policy H-165.828 centers around the AMA efforts to ensure that health coverage is affordable for all patients, while Policies H-165.824 and H-290.954 center on ACA and public plan affordability.

DISCUSSION

Despite the current uncertainty of Medicare drug price negotiations, the practice of negotiation has been a part of drug pricing in the private sector for decades. The current drug pricing system, hallmarked by close relationships between private insurers and their PBM negotiators, is complicated and opaque. As a result, the system often still yields drug prices that remain

unaffordable for many patients. While this system is not simple to fix, it is possible that the current CMS negotiation efforts may be a step in the right direction. While some experts voice concern that negotiation may stifle innovation, many anticipate that it has the potential to save both consumers and public payers significant amounts of money, helping prescriptions become more affordable. Regardless of the impact of price negotiation, it is clear that payers of all types participate in the negotiation process. For private payers this is often done by PBMs and for public payers via CMS. The Council believes that when used responsibly, prescription drug price negotiation has real potential to make significant changes, and that the AMA should support utilization of all ongoing efforts, to make drug prices affordable. The AMA has a strong body of policy and ongoing advocacy to address drug affordability. Therefore, the Council recommends the reaffirmation of Policy H-110.987, which details the AMA's efforts to encourage regulators, legislators, physicians, and patients to work together towards transparency and affordability in drug pricing. To ensure that this support is explicit for all medications, including those used to manage health and prevent future complications, the Council recommends the adoption of new HOD policy as outlined in Recommendation 1. Additionally, as outlined in the report, PBMs are exceptionally influential in setting drug prices, as they are currently faced with little regulation. Therefore, the Council recommends that Policy D-110.987 be reaffirmed, as it outlines how the AMA continues to hold legislators and regulators accountable to ensure that PBMs are monitored and transparency is increased. The Council believes that this new HOD policy, along with the suggested reaffirmations, will ensure that efforts to increase medication affordability continue.

As previously discussed, OOP costs are another aspect of drug pricing that elicit affordability concerns for patients. Researchers agree that high OOP medical costs can cause significant financial burden to patients and adverse health outcomes. Specifically, when OOP costs are higher, patients are less likely to adhere to treatment and often experience worse health outcomes. However, blanket OOP caps may not be a simple solution to the problem. Experts have called the actual impact of these caps into question and expressed concern that payers might shift costs to patients via premium increases. It is clear that OOP caps need to be handled in a manner that balances the potential positives and negatives. Therefore, the Council recommends the adoption of new HOD policy that supports the establishment of a reasonable OOP prescription drug cap while maintaining patient premiums. The Council believes that this new policy captures the intent of the third resolve of Resolution 113-A-24 while balancing potential unintended consequences.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 113-A-24, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support efforts to ensure that patients have affordable access to medications. (New HOD Policy)

2. That our AMA encourage all payers, both public and private, in efforts to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums. (New HOD policy)

3. That our AMA reaffirm Policy H-110.987, which supports efforts to ensure drug prices are affordable to patients. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-110.987, which supports efforts to increase PBM transparency and regulation. (Reaffirm HOD Policy)

Fiscal Note: Less than $500

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Council on Medical Service Report 6-A-25
Prescription Medication Price Negotiation
Policy Appendix

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices, H-110.980
1. Our American Medical Association (AMA) will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
a. The arbitration process should be overseen by objective, independent entities.
b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel.
c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process.
d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question.
e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision.
f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer.
g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases.
h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision.
i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation.
b. The use of any international drug price index or average should preserve patient access to necessary medications.
c. The use of any international drug price index or average should limit burdens on physician practices.
d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.
3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction. (CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Modified: CMS Rep. 4, A-22)

Pharmaceutical Costs, H-110.987
1. Our American Medical Association (AMA) encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.

4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports:
a. drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10 percent or more each year or per course of treatment and provide justification for the price increase;
b. legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and
c. the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10 percent or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation. (CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22; Reaffirmed: Res. 801, I-23; Reaffirmed: Res. 801, I-23)

Value-Based Management of Drug Formularies, H-110.979
Our American Medical Association: (1) will advocate that pharmacy benefit managers (PBMs) and health plans use a transparent process in formulary development and administration, and include practicing network physicians from the appropriate medical specialty when making determinations regarding formulary inclusion or placement for a particular drug class; (2) will advocate that any refunds or rebates received by a health plan or PBM from a pharmaceutical manufacturer under an outcomes-based contract be shared with impacted patients; and (3) opposes indication-based formularies in order to protect the ability of patients to access and afford the prescription drugs they need, and physicians to make the best prescribing decisions for their patients. (CMS Rep. 6, I-20)

Incorporating Value into Pharmaceutical Pricing, H-110.986
1. Our American Medical Association (AMA) supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles:
a. value-based prices of pharmaceuticals should be determined by objective, independent entities;
b. value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes;
c. processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role;
d. processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients;
e. processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and
f. value-based pricing of pharmaceuticals should allow for patient variation and physician discretion.
2. Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research.
3. Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size. (CMS Rep. 05, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS-CSAPH Rep. 01, A-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: CSAPH Rep. 2, I-19; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: Res. 113, A-23)

Prescription Drug Prices and Medicare, D-330.954
1. Our American Medical Association (AMA) will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS. (Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 113, I-21; Reaffirmed: CMS Rep. 4, A-22; Reaffirmed in lieu of: Res. 810, I-22)

The Impact of Pharmacy Benefit Managers on Patients and Physicians, D-110.987
1. Our American Medical Association (AMA) supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:

- Utilization information;
- Rebate and discount information;
- Financial incentive information;
- Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
- Percentage of sole source contracts awarded annually.

6. Our AMA encourages increased transparency in how DIR fees are determined and calculated. (CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-20)

Inappropriate Actions by Pharmacies and Pharmacy Benefit Mangers, D-120.988
Our American Medical Association, in cooperation with pharmacy benefit managers, pharmacy companies, and other drug retailing organizations, shall develop model procedures that physicians may use when prescribing off-formulary pharmaceuticals that are medically indicated and that these procedures be in compliance with the Health Insurance and Portability and Accountability Act of 1996. (Res. 528, A-02; Reaffirmation I-04; Reaffirmation A-06; Reaffirmed: CSAPH Rep. 01, A-16)

Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care, D-120.934
1. Our American Medical Association (AMA) will take steps to implement AMA Policies H-120.947 and D-35.981 that prescriptions must be filled as ordered by physicians or other duly authorized/licensed persons, including the quantity ordered.
2. Our AMA will work with pharmacy benefit managers, payers, relevant pharmacy associations, and stakeholders to: (a) identify the impact on patients of policies that restrict prescriptions to ensure access to care and urge that these policies receive the same notice and public comment as any other significant policy affecting the practice of pharmacy and medicine; and (b) prohibit pharmacy actions that are unilateral medical decisions.
3. Our AMA will report back at the 2018 Annual Meeting on actions taken to preserve the purview of physicians in prescription origination. (Res. 233, I-17; Reaffirmed: CMS Rep. 05, A-23)

Prior Authorization and Utilization Management Reform, H-320.939
1. Our American Medical Association (AMA) will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.

4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests. (CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22)

Prior Authorization Reform, D-320.982
Our American Medical Association will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens. (Res. 704, A-19; Reaffirmation: A-22)

Health Insurance Affordability, H-165.828
1. Our American Medical Association (AMA) supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage and household income.
3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.
6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace. (CMS Rep. 8, I-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmation: A-17)

Improving Medicaid and CHIP Access and Affordability, H-290.954
1. Our American Medical Association (AMA) opposes premiums, copayments, and other cost-sharing methods for Medicaid and the Children's Health Insurance Program, including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries.
2. Our AMA encourages the Centers for Medicare & Medicaid Services to amend existing Section 1115 waivers to disallow states the ability to charge premiums or copayments to Medicaid beneficiaries. (Res. 803, I-23)

Improving Affordability in the Health Insurance Exchanges, H-165.824

1. Our American Medical Association (AMA) will:

a. support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits.

b. support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level.

c. support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income.

d. encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections.

2. Our AMA supports:

a. eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL).

b. increasing the generosity of premium tax credits.

c. expanding eligibility for cost-sharing reductions.

increasing the size of cost-sharing reductions. (CMS Rep. 02, A-18; Appended: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 9-A-25

Subject: Minimum Requirements for Medication Formularies (Resolution 809-I-24)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee A

At the 2024 Interim Meeting, the House of Delegates referred Resolution 809, which was introduced by the Mississippi Delegation, and asked that our American Medical Association (AMA) advocate for all payers to create, maintain, and enforce a minimum formulary for all beneficiaries that includes all "commonly prescribed, inexpensive, and generic" medications unless there are reasonable safety or economic concerns. The following report discusses the background and current state of formularies, impacts of their expansion, and AMA efforts on the topic. Additionally, the report recommends the adoption and reaffirmation of policies designed to balance formulary inclusion and economic concerns.

BACKGROUND

Formularies were initially simple lists of medications implemented by the military in the late 1700s during the American War of Independence.[1] In the mid-1900s, the concept of formularies became more widespread and took root in hospital pharmacies needing authorization to dispense interchangeable medications.[2] In 1965, with the inception of Medicare, formularies became well established as part of reimbursement eligibility requirements.[3] By the 1980s, formularies began to take a more contemporary shape, primarily due to the development of multi-brand categories of drugs with similar, but not identical, uses and prices. To encourage the use of their drugs, manufacturers began to offer rebates to purchasers. As a result, payers placed the more advantageous drugs, often due to higher rebates, in more favorable formulary positions.[4] Today's formularies continue to tout the goal of managing costs, ensuring patient access to therapies, and improving health outcomes.[4,5] While the actual outcomes delivered by formularies are diverse and occasionally questionable, they are highly influential in dictating what medications are accessible to patients.[4]

Contemporary formularies tend to follow similar rebate incentive structures as were developed in the 1980s, but with time have become increasingly complicated and, in many cases, opaque.[4,6] Formularies today are usually one of four types; open, closed, value-based, and tiered. Open structured formularies are those in which coverage for all prescription medications is granted.[6] While this may seem to be the most advantageous to patients, these types of formularies often see significantly higher cost to the patient and can actually block access due to high out-of-pocket (OOP) costs and/or high premiums.[4,6] Closed formularies are those that offer a narrower range of covered medications, but often at a lower cost to patients.[6] Within these formularies payers often select the medications that have higher rebates and, therefore, are financially advantageous to the payer.[4,6] Tiered formularies are more common and more complex in their execution. Within the tiers, payers incentivize the use of medications by placing them on lower tiers which, in turn, come

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with a lower OOP expense for the patient. While there is no limit on the number of tiers, it is most common for plans to have a three-tiered structure. Typically, tier one includes the most preferred medications, tier two includes preferred name brand drugs, and tier three includes non-preferred name brand drugs. Drugs are typically considered to be "preferred" by the payer when more attractive rebates are offered by the manufacturer or if the list price of the medication is lower.[4,6] Finally, value-based formularies are based on an assessment of the impact of a treatment on overall health care spending and long-term health compared to other structures which are based solely on the upfront cost of the drug. While value-based formularies vary in the specific criteria used to determine high versus low value drugs, most take clinical parameters, quality of life, and utilization of health care resources into account. Similar to tiered formularies, the use of preferred drugs, in this case defined as the higher value drugs, is encouraged by lower OOP costs.[4,6]

While it may seem that generic medications would often be placed on lower formulary tiers, that is not always the case. In practice, many payers place name-brand drugs on lower tiers due to greater price concessions offered by manufacturers. Therefore, drugs with higher list prices can often yield payers higher rebates, although these cost savings are often not passed on to the patient.[6] In some cases, patient OOP costs are determined by the list price, and as a result patients end up paying more than a generic option.[7] While the data for private plans are limited, anecdotal evidence and research based on Medicare Part D plans seem to confirm the underuse of generic drugs to reduce cost. For example, one study found that 72 percent of Medicare Part D formularies had at least one branded product place on a lower tier than the comparable generic medication and 30 percent of branded multisource drugs had fewer utilization management requirements than the generic product.[8] Additionally, trends of generic drug usage in Medicare Part D seem to be declining as there was a 22 percent drop in generic medications placed on tiers between 2016 and 2025.[7,8]

Regardless of the formulary structure or drug type, the placement of medications is determined by a pharmacy and therapeutics (P&T) committee.[5] These committees are typically made up of physicians, other practitioners, legal experts, and administrators. P&T Committees will generally assess the safety, clinical efficacy, patient adherence, patient satisfaction, and economic factors of a drug in order to determine if it is placed on a formulary and/or the appropriate tier.[4,6] While payers are able to develop their own formularies, most choose to rely on pharmacy benefit managers (PBMs) to create and maintain formularies due to the high associated costs.[6] Typically, PBMs will create a number of formulary choices for payers to select from and, if desired, customize. While there are no federal legislative or regulatory guidelines for non-Medicare plans, Part D plans must follow guidelines and participate in annual reviews coordinated by the Centers for Medicare & Medicaid Services (CMS). These requirements were put in place by CMS in 2006 and are designed to regulate how private Part D plans create and manage formularies.[4,5,6,9]

FORMULARY REQUIREMENTS

Since its founding, Medicare has required payers to provide formularies in order to be approved for reimbursement. In 2003, the Medicare Prescription Drug Improvement and Modernization Act (MMA) was signed into law and included specific details as to minimum formulary requirements. MMA's goal was to not only update Medicare's prescription benefits, but to ensure that all associated carriers and their plans provide beneficiaries with high-quality and cost-effective drug benefits.[9,10] Since 2006, Medicare has required that at least two medications from each class are included in the plan formulary. However, there is some flexibility in this requirement should a medication class not include two or more medications. Additionally, in cases when there are therapeutic advantages of a specific medication for patients with certain diseases, more than two medications may be required to be included in the formulary.[9,11]

The Patient Protection and Affordable Care Act (ACA), signed into law in 2010, also includes minimum formulary requirements for associated plans.[12] Due to the structure of the ACA, specific formulary requirements vary significantly across states. However, prescription medication is considered one of the Essential Health Benefits (EHBs) that plans are required to cover. Specifically, states must ensure that plans either cover one drug in each of the United States Pharmacopeia (USP) class or at least the same number of drugs in each category and class of the EHB Benchmark plan for the respective state.[13] The 2025 USP list includes 50 medication categories, 175 medication classes, 207 Pharmacotherapeutic informational groups, and over 2,055 example drugs and how each example fits into each category, class, and group.[14] States have the ability to, within reason, establish their own EHB Benchmark plan, or the floor plan, for their state. As a result, some states, like Washington, require that plans cover at least one drug in every USP class, while other states, like Illinois and South Dakota, have more nuanced basic requirements. Each state is required to submit a plan to the Center for Consumer Information and Insurance Oversight (CCIIO) for approval.[13] Part of the role of CCIIO is to ensure that EHB Benchmark plans allow consumers access to high quality insurance plans while minimizing payer ability to discriminate between types of beneficiaries and to encourage marketplace competition.[13]

Although private health insurance plans operating outside of Medicare do not have blanket minimum drug formulary requirements, some states require plans to meet the ACA minimum. Additionally, many organizations, including the AMA, have offered guidance around formulary best practices. Specifically, the AMA, along with other relevant organizations, endorsed the Principles of a Sound Drug Formulary System.[15] While these principles do not specifically outline a minimum formulary requirement, they do delineate the need to ensure that formularies provide patients with medications necessary to address their diagnosis in a manner that is clinically appropriate and economically responsible.[15] Other organizations, including the American Academy of Family Physicians and American Society of Health-System Pharmacists, have outlined the need for formularies to be balanced based on efficacy, safety, cost, and patient outcomes.[16,17]

FORMULARY EXCEPTION PROCESS

An important aspect of formularies is the exception process. Since the vast majority of plans do not cover every medication on the market, patients and physicians may need to engage with exceptions to seek coverage of a medication. These exceptions occur when the covered medication is not an option for a patient. Commonly, this is due to allergies, a history of unsuccessful use of covered medications, covered medications not meeting therapeutic need, and/or concern that a covered medication would exacerbate an existing condition(s).[18] There may also be the need to submit an exception if a patient needs a quantity, dosage, or delivery method that is not typically covered. Importantly, exceptions are not limited to medications that are not covered at all by a payer. In some cases, if a medication is placed on a formulary tier that makes it unaffordable to the patient, an exception can be requested. This type of exception is called a tiering exception while the traditional exception process is called a formulary exception.[18,19]

While there is not one standardized process for exceptions, typically the process includes a request from the patient/patient representative paired with a physician statement. In some cases, the physician may directly request the exception and provide the statement for the patient.[19] When requesting a formulary exception, the physician statement typically includes information regarding the medical necessity of the alternative medication and potential consequences should the covered drug be used. When requesting a tiering exception, the physician statement will discuss the medical necessity of the medication and why it is unaffordable. In some cases, payers may require a statement of patient financial hardship.[18] Payers will typically respond to exception requests within

72 hours from the submission of the physician statement, although in urgent or emergency situations the payer should respond within 24 hours.[18,19]

As previously mentioned, there is not a requirement for payers to utilize a standard exception process, and as a result there is variance in the criteria utilized to review exception requests. Most plans will compare applicable scientific evidence on the efficacy and safety of the covered and requested drugs. Should an exception request be denied by the payer, the patient and/or physician may file an appeal to reverse the decision.[19] Similar to the original exception request, there is not a standardized process for appeals, however plans should have a defined method in place. For example, Medicare Part D plans provide a multistep appeals process starting with redetermination by the drug plan and escalating to an appeal in a federal court.[10,19]

IMPACTS OF FORMULARY EXPANSION

While it may seem beneficial for all medications to be included in drug formularies, research has shown that this may have unintended consequences. Specifically, economists have shown that, at least among ACA plans, those that cover more EHB drugs have significantly more utilization management requirements in place.[20] This seems to hold true when new drugs are added to formularies, as plans are increasingly likely to add utilization management requirements, often in the form of prior authorization. As discussed in a number of previous Council reports (CMS 6-A-24; CMS 8-A-17; CMS 7-A-16) prior authorization and other forms of utilization management are extremely burdensome for physicians/physician offices and potentially dangerous to patients. However, utilization management is not the only way that physicians are impacted by formulary placement and expansion. Many physicians report challenges with securing payment for high cost, but necessary physician-administered medications placed on higher tiers. Others have reported difficulties in receiving the full payment rate for administering vaccines, especially in private practice settings, from public payers.[21] A fuller discussion of the challenges faced by physicians in adequate vaccine payment can be found in CMS Report 3-I-20.

In addition to the potential challenges faced by physicians if formularies are expanded, patients may face adverse consequences. A main concern is that if payers incur additional costs, in this case due to formulary expansion, those costs may be passed on to the beneficiary through premium increases or higher OOP costs. Specifically, payers could simply require higher levels of patient cost sharing if they are required to include more medications on a formulary. Additionally, payers may react to forced formulary expansion by placing more medications on less desirable formulary tiers, leading to higher patient OOP costs and/or more utilization management requirements.[22] In conjunction with the potential negative impacts on patients with expanded formularies, research has demonstrated that overall, stricter formularies may not negatively impact patients. In some cases, research has shown that stricter formularies are actually associated with reported positive impacts, such as better medication adherence and clinical outcomes.[22] At the same time, other research seems to show that these policies also reduce costs in the majority of cases.[23] Together these concerns and conclusions may suggest that more stringent formularies are not harmful to patients and may actually lower drug-related costs.

However, research has also demonstrated that when formularies are too restrictive, there can be negative outcomes like lower medication adherence and, in some cases, higher OOP costs for patients.[22,24] These two metrics go hand in hand as patients who face higher OOP costs are less likely to adhere to treatment plans, potentially incurring additional costs to treat the consequences from non-adherence down the line.[22,24] Additionally, the aforementioned utilization management does not just impact physicians but patients, as well. Patients who experience prior authorization have significantly increased wait times to access their medications and those who experience other

forms of utilization management, like step therapy, can face long, uphill battles to obtain the necessary medication(s).[22,25] Therefore, it is important that formularies are balanced enough to allow patients to access necessary medications while also ensuring that utilization management and patient cost-sharing are not egregious.

AMA POLICY AND ADVOCACY

The AMA has established a number of policies that address the development and maintenance of drug formularies. Policy H-125.979 outlines the need for formulary information to be available to physicians and prescribers in real-time at the point of prescribing. This policy outlines efforts to ensure that formulary lists are also accessible to patients and that medications are not removed during the policy term. Policy H-110.979 outlines the AMA's advocacy efforts to ensure that both PBMs and payers are not just transparent in the creation of formularies, but also that rebates and refunds received will be shared with patients. Policy H-125.991 details the AMA standards for the makeup of P&T committees, the approval of their decisions by medical staff within hospital or institutional settings, and suggested guidelines for the creation and maintenance of a formulary system. Finally, Policy H-125.985 encourages all entities who design formularies or benefit packages, including managed care organizations and PBMs, to follow the principles outlined in the aforementioned Principles of a Sound Drug Formulary System.

The AMA also has several policies outlining the ideal formulary exception process for payers. Policy H-285.965 outlines the steps that physicians should take to ensure that patients have awareness of the most advantageous course of treatment, even when engaging with a formulary exception process is necessary. Policy H-320.949 outlines efforts to ensure that payers are required to provide exception processes that have clear response times and appeal processes. This policy also dictates support for legislative and regulatory efforts to ensure that these standards are implemented. Policy H-185.942 details the basic criteria that should be followed by payers and physicians in relation to utilization management criteria and when it can be appropriately utilized. In addition to these policies, the second principle of the AMA Prior Authorization and Utilization Management Reform Principles outlines the flexibility that should be provided by payers to ensure that patients have the ability receive effective and individualized care. In addition to policies related to the formulary exception process, Policies H-320.939 and D-320.982 detail the AMA's fight to make sure physicians are not experiencing undue burdens related to prior authorization and to mitigate the number of prior authorizations required. Additionally, the AMA has a longstanding grassroots campaign (Fix Prior Auth) working to educate about how prior authorization impacts patients and physicians as well as working to fix the system.

Finally, the AMA has many policies outlining the need for prescription medications to be affordable and accessible to patients. Specifically, Policy H-110.997 outlines support for programs that work to lower the cost of prescription drugs while also maintain quality of care and physician autonomy. Policy H-100.964 builds on the previously mentioned policy and expands the support for efforts to ensure that medications are covered in a manner that allows patients to access medications affordably. Policy H-125.984 reiterates support for generic medications when deemed appropriate and cost effective for the patient. This policy also supports programs that are designed to bolster generic development and federal approvals. Among other strategies to improve the affordability of prescription medications, Policy H-110.987 outlines AMA support for legislation and regulation that works to reduce drug prices, anticompetitive behaviors, and price gouging in an effort to increase drug affordability. In addition to the AMA body of policy on drug pricing, there have been extensive advocacy efforts over the last few years to bring awareness and offer solutions to high drug prices through letters to regulators (CMS 2023, CMS 2024), legislators (Senate 2024), and payers (NAIC 2023), along with testimony provided to the House of

Representatives (House 2023, House 2023(a)). Additionally, the AMA grassroots campaign, TruthinRx, works to gather and disseminate physician and patient stories as well as to advocate for lower drug prices and increased process transparency.

DISCUSSION

While formularies have been around, in some form, for centuries, the current iteration is exceptionally complicated and, in many cases, opaque. As a result, the effectiveness of formularies increasingly has been called into question. Formularies are developed by P&T committees and, at least among private payers, are typically maintained by PBMs. Medication placement on these coverage lists is often heavily dictated by the rebates given to payers by drug manufacturers. Rebates, and other financial incentives are not required to be passed to the patient and, as a result, patients rarely see a share of the financial incentives that payers receive. Current formulary minimums vary greatly by payer type and state. While there is not a national minimum formulary requirement for private payers, public payers do have minimum standards that generally require a certain number of medications in each class to be included in each plan's formulary.

Patients must have access to medications deemed as most appropriate by their physicians and such access must be affordable in order to be effective. Formularies are one method designed to decrease medication costs. In some situations, more limited formularies have resulted in their intended outcomes: lower costs and greater patient access. Yet, when formularies are too restrictive, they may have the opposite effect: higher costs and lower access. In order to ensure that patients have access to affordable coverage and medications, the Council believes that formularies must find a middle ground between being too limited or too expansive, balancing the need for coverage with the potential for OOP or premium cost increases. It is essential to acknowledge that PBMs have significant negotiation power in formulary creation and drug placement and thus yield substantial power in the process. The complications of the negotiation process and the potential economic tradeoffs indicate the need for a nuanced approach to formulary minimum requirements. As such, support for a mandate to cover all medications could have serious adverse consequences on patients and physicians.

Therefore, the Council recommends the adoption of new AMA policy that supports a more nuanced approach, supporting all payers in setting a minimum formulary that covers all drugs in each of the protected classes and at least two medications in each of the non-protected classes. The Council believes that this minimum formulary requirement balances the intent of Resolution 809-I-24 while ensuring that patients and physicians will not face significant increases in OOP cost or utilization management requirements. Additionally, to ensure that patients have access to medications that are prescribed by their physician in an affordable manner, formularies exhibit transparency, and cost-savings are passed to the patient, the Council recommends that Policy H-110.979 be reaffirmed. While affordability and formulary composition are exceptionally important, it is also vital that patients and physicians have an avenue to request coverage when a medication is not included in a formulary. In order to protect and simplify this process the Council also recommends reaffirmation of Policy H-320.949, which details the AMA principles to ensure that utilization management, including formulary exception processes, are clear, not overly burdensome, and have a defined appeals process.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 809-I-24, and the remainder of the report be filed:

1. Our American Medical Association (AMA) support all public and private payers in maintaining a formulary that includes at least:
    a. Coverage for substantially all drugs in the six protected classes; immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics; and
    b. Coverage for at least two medications in each non-protected therapeutic category. (New HOD Policy)

2. That our AMA reaffirm Policy H-110.979, which outlines AMA efforts to advocate for transparency in formularies and that patients can access medications (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-320.949, which details AMA principles regarding requirements for the formulary exception process (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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Council on Medical Service Report 9-A-25
Minimum Requirements for Medication Formularies
Policy Appendix

Private Health Insurance Formulary Transparency, H-125.979

1. Our American Medical Association (AMA) will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing.
2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.
3. Our AMA will develop model legislation:
    a. requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic.
    b. requiring insurance carriers to make this information available to consumers by October 1 of each year.
    c. forbidding insurance carriers from making formulary deletions within the policy term.
4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.
5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.
6. Our AMA
    a. promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide.
    b. supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans.
7. Our AMA will continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits.
8. Our AMA will develop model state legislation on the development and management of pharmacy benefits. (Sub. Res. 724, A-14; Appended: Res. 701, A-16; Appended: Alt. Res. 806, I-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: BOT Rep. 20, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 2, A-21; Reaffirmed: CMS Rep. 06, A-24)

Value-Based Management of Drug Formularies, H-110.979

Our American Medical Association: (1) will advocate that pharmacy benefit managers (PBMs) and health plans use a transparent process in formulary development and administration, and include practicing network physicians from the appropriate medical specialty when making determinations regarding formulary inclusion or placement for a particular drug class; (2) will advocate that any refunds or rebates received by a health plan or PBM from a pharmaceutical manufacturer under an outcomes-based contract be shared with impacted patients; and (3) opposes indication-based formularies in order to protect the ability of patients to access and afford the prescription drugs they need, and physicians to make the best prescribing decisions for their patients. (CMS Rep. 6, I-20)

Drug Formularies and Therapeutic Interchanges, H-125.991

It is the policy of the American Medical Association (AMA):

(1) That the following terms be defined as indicated:

(a) Formulary: a compilation of drugs or drug products in a drug inventory list; open (unrestricted) formularies place no limits on which drugs are included whereas closed (restrictive) formularies allow only certain drugs on the list;

(b) Formulary system: a method whereby the medical staff of an institution, working through the pharmacy and therapeutics committee, evaluates, appraises, and selects from among the numerous available drug entities and drug products those that are considered most useful in patient care;

(c) Pharmacy & Therapeutics (P&T) Committee: an advisory committee of the medical staff that represents the official, organizational line of communication and liaison between the medical staff and the pharmacy department; its recommendations are subject to medical staff approval;

(d) Therapeutic alternates: drug products with different chemical structures but which are of the same pharmacological and/or therapeutic class, and usually can be expected to have similar therapeutic effects and adverse reaction profiles when administered to patients in therapeutically equivalent doses;

(e) Therapeutic interchange: authorized exchange of therapeutic alternates in accordance with previously established and approved written guidelines or protocols within a formulary system; and

(f) Therapeutic substitution: the act of dispensing a therapeutic alternate for the drug product prescribed without prior authorization of the prescriber.

(2) That our AMA reaffirms its opposition to therapeutic substitution (dispensing a therapeutic alternate without prior authorization) in any patient care setting.

(3) That drug formulary systems, including the practice of therapeutic interchange, are acceptable in inpatient hospital and other institutional settings that have an organized medical staff and a functioning Pharmacy and Therapeutics (P&T) Committee, provided they satisfy the following standards:

(a) The formulary system must:

(i) have the concurrence of the organized medical staff;

(ii) openly provide detailed methods and criteria for the selection and objective evaluation of all available pharmaceuticals;

(iii) have policies for the development, maintenance, approval and dissemination of the drug formulary and for continuous and comprehensive review of formulary drugs;

(iv) provide protocols for the procurement, storage, distribution, and safe use of formulary and non-formulary drug products;

(v) provide active surveillance mechanisms to regularly monitor both compliance with these standards and clinical outcomes where substitution has occurred, and to intercede where indicated;

(vi) have enough qualified medical staff, pharmacists, and other professionals to carry out these activities;

(vii)provide a mechanism to inform the prescriber in a timely manner of any substitutions, and that allows the prescriber to override the system when necessary for an individual patient without inappropriate administrative burden;

(viii) provide a mechanism to assure that patients/guardians are informed of any change from an existing outpatient prescription to a formulary substitute while hospitalized, and whether the prior medication or the substitute should be continued upon discharge from the hospital;

(ix) include policies that state that practitioners will not be penalized for prescribing non-formulary drug products that are medically necessary; and

(x) be in compliance with applicable state and federal statutes and/or state medical board requirements.

(b) The P&T Committee must:

(i) objectively evaluate the medical usefulness and cost of all available pharmaceuticals (reliance on practice guidelines developed by physician organizations is encouraged);

(ii) recommend for the formulary those drug products which are the most useful and cost-effective in patient care;
(iii) conduct drug utilization review (DUR) activities;
(iv) provide pharmaceutical information and education to the organization's (e.g., hospital) staff;
(v) analyze adverse results of drug therapy;
(vi) make recommendations to ensure safe drug use and storage; and
(vii) provide protocols for the timely procurement of non-formulary drug products when prescribed by a physician for the individualized care of a specific patient, when that decision is based on sound scientific evidence or expert medical judgment.
(c) The P&T Committee's recommendations must be approved by the medical staff;
(d) Within the drug formulary system, the P & T Committee shall recommend, and the medical staff must approve, all drugs that are subject to therapeutic interchange, as well as all processes or protocols for informing individual prescribing physicians; and
(e) The act of providing a therapeutic alternate that has not been recommended by the P&T Committee and approved by the medical staff is considered unauthorized therapeutic substitution and requires immediate prior consent by the prescriber; i.e., authorization for a new prescription.
(4) That drug formulary systems in any outpatient setting shall operate under a P&T Committee whose recommendations must have the approval of the medical staff or equivalent body, and must meet standards comparable to those listed above. In addition:
(a) That our AMA continues to insist that managed care and other health plans identify participating physicians as their "medical staff" and that they use such staff to oversee and approve plan formularies, as well as to oversee and participate on properly elected P&T Committees that develop and maintain plan formularies;
(b) That our AMA continues to insist that managed care and other health plans have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated, that this process impose minimal administrative burdens, and that it include access to a formal appeals process for physicians and their patients; and
(c) That our AMA strongly recommends that the switching of therapeutic alternates in patients with chronic diseases who are stabilized on a drug therapy regimen be discouraged.
(5) That our AMA encourages mechanisms, such as incentive-based formularies with tiered co-pays, to allow greater choice and economic responsibility in drug selection, but urges managed care plans and other third party payers to not excessively shift costs to patients so they cannot afford necessary drug therapies. (BOT Rep. 45, I-93; Reaffirmed by Sub. Res. 501, A-95; Appended: BOT Rep. 7, I-99; Modified: Sub. Res. 524 and Reaffirmed: Res. 123, A-00; Reaffirmed: Res. 515, I-00; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: Res. 533, A-03; Modified: CMS Rep. 6, A-03; Modified: CSA Rep. 2, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 535, A-05; Reaffirmed: BOT Action in response to referred for decision Res. 503, A-05; Reaffirmed: CMS Rep. 2, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, A-10; Reaffirmed: CMS Rep. 01, A-20)

Expanded Use of the AMA's Principles of a Sound Drug Formulary, H-125.985
Our American Medical Association (AMA) urges managed care organizations, pharmacy benefit managers, and others who design benefit packages and/or make pharmacy benefit decisions, to utilize the Principles of a Sound Drug Formulary System (as described in BOT Rep. 28, I-00) as they develop their pharmaceutical benefit plan(s) and that the Principles of a Sound Drug Formulary System be readily available on the AMA web site.(Res. 520, A-01; Amended: Res. 514, A-02; Reaffirmed: CSA Rep. 2, A-04; Reaffirmation I-04; Reaffirmed: Sub. Res. 529, A-05; Reaffirmed in lieu of Res. 535, A-05; Reaffirmed: BOT Action in response to referred for decision Res. 503, A-05; Reaffirmation A-06; Reaffirmed: CSAPH Rep. 01, A-16)

Prior Authorization and Utilization Management Reform, H-320.939

1. Our American Medical Association (AMA) will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests. (CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22)

Prior Authorization Reform, D-320.982

Our American Medical Association will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens. (Res. 704, A-19; Reaffirmation: A-22)

Cost of Prescription Drugs, H-110.997

Our American Medical Association (AMA):

(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;

(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;

(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;

(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;

(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;

(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and
(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients. (BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep.3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18)

Pharmaceutical Costs, H-110.987

1. Our American Medical Association (AMA) encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports:
    a. drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10 percent or more each year or per course of treatment and provide justification for the price increase;
    b. legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and
    c. the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10 percent or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.

13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation. (CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22; Reaffirmed: Res. 801, I-23; Reaffirmed: Res. 801, I-23)

Generic Drugs, H-125.984
Our American Medical Association (AMA) believes that: (1) Physicians should be free to use either the generic or brand name in prescribing drugs for their patients, and physicians should supplement medical judgments with cost considerations in making this choice.
(2) It should be recognized that generic drugs frequently can be less costly alternatives to brand-name products.
(3) Substitution with Food and Drug Administration (FDA) "B"-rated generic drug products (i.e., products with potential or known bioequivalence problems) should be prohibited by law, except when there is prior authorization from the prescribing physician.
(4) Physicians should report serious adverse events that may be related to generic substitution, including the name, dosage form, and the manufacturer, to the FDA's MedWatch program.
(5) The FDA, in conjunction with our AMA and the United States Pharmacopoeia, should explore ways to more effectively inform physicians about the bioequivalence of generic drugs, including decisional criteria used to determine the bioequivalence of individual products.
(6) The FDA should fund or conduct additional research in order to identify the optimum methodology to determine bioequivalence, including the concept of individual bioequivalence, between pharmaceutically equivalent drug products (i.e., products that contain the same active ingredient(s), are of the same dosage form, route of administration, and are identical in strength).
(7) The Congress should provide adequate resources to the FDA to continue to support an effective generic drug approval process. (CSA Rep. 6, A-02; Reaffirmed: CSAPH Rep. 2, A-07; Reaffirmation A-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 525, A-10; Reaffirmed in lieu of Res. 224, I-14; Reaffirmed in lieu of: Res. 922, I-18)

Managed Care Cost Containment Involving Prescription Drugs H-285.965
(1) Physicians who participate in managed care plans should maintain awareness of plan decisions about drug selection by staying informed about pharmacy and therapeutics (P&T) committee actions and by ongoing personal review of formulary composition. P&T committee members should include independent physician representatives. Mechanisms should be established for ongoing peer review of formulary policy. Physicians who perceive inappropriate influence on formulary development from pharmaceutical industry consolidation should notify the proper regulatory authorities.
(2) Physicians should be particularly vigilant to ensure that formulary decisions adequately reflect the needs of individual patients and that individual needs are not unfairly sacrificed by decisions based on the needs of the average patient. Physicians are ethically required to advocate for additions to the formulary when they think patients would benefit materially and for exceptions to the formulary on a case-by-case basis when justified by the health care needs of particular patients. Mechanisms to appeal formulary exclusions should be established. Other cost-containment mechanisms, including prescription caps and prior authorization, should not unduly burden physicians or patients in accessing optimal drug therapy.

(3) Limits should be placed on the extent to which managed care plans use incentives or pressures to lower prescription drug costs. Financial incentives are permissible when they promote cost-effectiveness, not when they require withholding medically necessary care. Physicians must not be made to feel that they jeopardize their compensation or participation in a managed care plan if they prescribe drugs that are necessary for their patients but that may also be costly. There should be limits on the magnitude of financial incentives, incentives should be calculated according to the practices of a sizable group of physicians rather than on an individual basis, and incentives based on quality of care rather than cost of care should be used. Physician penalties for non-compliance with a managed care formulary in the form of deductions from withholds or direct charges are inappropriate and unduly coercive. Prescriptions should not be changed without physicians having a change to discuss the change with the patient.
(4) Managed care plans should develop and implement educational programs on cost-effective prescribing practices. Such initiatives are preferable to financial incentives or pressures by HMOs or hospitals, which can be ethically problematic.
(5) Patients must fully understand the methods used by their managed care plans to limit prescription drug costs. During enrollment, the plan must disclose the existence of formularies, the provisions for cases in which the physician prescribes a drug that is not included in the formulary and the incentives or other mechanisms used to encourage physicians to consider costs when prescribing drugs. In addition, plans should disclose any relationships with pharmaceutical benefit management companies or pharmaceutical companies that could influence the composition of the formulary. If physicians exhaust all avenues to secure a formulary exception for a significantly advantageous drug, they are still obligated to disclose the option of the more beneficial, more costly drug to the patient, so that the patient can decide whether to pay out-of-pocket.
(6) Research should be conducted to assess the impact of formulary constraints and other approaches to containing prescription drug costs on patient welfare.
(7) Our AMA urges pharmacists to contact the prescribing physician if a prescription written by the physician violates the managed care drug formulary under which the patient is covered, so that the physician has an opportunity to prescribe an alternative drug, which may be on the formulary.
(8) When pharmacists, insurance companies, or pharmaceutical benefit management companies communicate directly with physicians or patients regarding prescriptions, the reason for the intervention should be clearly identified as being either educational or economic in nature.
(9) Our AMA will develop model legislation which prohibits managed care entities, and other insurers, from retaliating against a physician by disciplining, or withholding otherwise allowable payment because they have prescribed drugs to patients which are not on the insurer's formulary, or have appealed a plan's denial of coverage for the prescribed drug.
(10) Our AMA urges health plans including managed care organizations to provide physicians and patients with their medication formularies through multiple media, including Internet posting
(11) In the case where Internet posting of the formulary is not available and the formulary is changed, coverage should be maintained until a new formulary is distributed
(12) For physicians who do not have electronic access, hard copies must be available. (CEJA Rep. 2, A-95; Res. 734, A-97; Appended by Res. 524 and Sub. Res.714, A-98; Reaffirmed: Res. 511, A-99; Modified: Res. 501, Reaffirmed: Res. 123 and 524, A-00; Modified: Res. 509, I-00; Reaffirmed: CMS Rep. 6, A-03; Reaffirmation I-04; Reaffirmed: Sub. Res. 529, A-05; Reaffirmation A-08; Reaffirmation A-10; Reaffirmed in lieu of Res. 822, I-11; Reaffirmation A-14; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-2)

Clinical Practice Guidelines and Clinical Quality Improvement Activities H-320.949
Our American Medical Association (AMA) adopts the following principles for the development and application of utilization management guidelines:

1. The criteria or guidelines used for utilization management shall be based upon sound clinical evidence and consider, among other factors, the safety and effectiveness of diagnosis or treatment, and must be age appropriate.
2. These utilization management guidelines and the criteria for their application shall be developed with the participation of practicing physicians.
3. Appropriate data, clinical evidence, and review criteria shall be available on request.
4. When used by health plans or health care organizations, such criteria must allow variation and take into account individual patient differences and the resources available in the particular health care system or setting to provide recommended care. The guidelines should also include a statement of their limitations and restrictions.
5. Patients and physicians shall be able to appeal decisions based on the application of utilization management guidelines.
6. The competence of non-physician reviewers and the availability of same-specialty peer review must be delineated and assured.
7. Maintaining the best interests of the patient uppermost, the final decision to discharge a patient, or any other patient management decision, remains the prerogative of the physician. (BOT Rep. 6, A-99; Reaffirmed: Res. 820, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: Res. 708, A-16; Reaffirmed: CMS Rep. 08, A-17; Reaffirmed: CMS Rep. 4, A-21)

Third Party Payer Quantity Limits H-185.942

1. Our American Medical Association (AMA) supports the protection of the patient-physician relationship from interference by payers and Pharmacy Benefit Managers (PBMs) via various utilization control mechanisms, including medication and testing and treatment supply quantity limits.
2. Our AMA will work with third party payers and PBMs to ensure that if they use quantity limits for prescription drugs or testing and treatment supplies, an exceptions process must be in place to ensure that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, and that any such process should place a minimum burden upon patients, physicians and their staff.
3. Our AMA supports interested states legislative efforts and federal action and will develop model state legislation to ensure that third party payers or PBMs that institute quantity limits for prescription drugs or testing and treatment supplies include an exceptions process so that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, including provisions such as the following:
    - physicians can specify limited supplies of medications during initial trials of a medication, or if a larger quantity of medication would expose an at-risk patient to potential harm (e.g., opioids, benzodiazepines, or psychostimulants)
    - physicians can appeal adverse determinations regarding quantity limitations;
    - payers must provide an easily accessible list of all medications and testing and treatment supplies with quantity limits and the requirements for the exception process on the payer's Web site;
    - payers must indicate, what, if any, clinical criteria (e.g., evidence-based guidelines, FDA label, scientific literature) support the plan's quantity limitations;
    - physicians with specialized qualifications may not be subject to quantity limits;
    - payers cannot charge patients for an additional co-pay if an exception request for a higher medication or testing and treatment supply quantity has been approved based on medical necessity;
    - payer decisions on exception, and subsequent appeal requests, of quantity limits must be made within two working days in non urgent situations and one working day in urgent cases; and

- physicians or patients can submit any denied appeals to an independent review body for a final, binding decision. (BOT Rep. 12, A-12; Reaffirmation: I-17; Modified: CMS Rep. 05, A-23)

Drug Issues in Health System Reform H-100.964

1. Our American Medical Association (AMA) consistent with AMA Policy H-165.925, supports coverage of prescription drugs, including insulin, in the AMA standard benefits package.
2. Our AMA supports consumer choice of at least two options for their pharmaceutical benefits program. This must include a fee-for-service option where restrictions on patient access and physician autonomy to prescribe any FDA-approved medication are prohibited.
3. Our AMA reaffirms AMA Policy H-110.997, supporting the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourage physicians to supplement medical judgments with cost considerations in making these choices.
4. Our AMA supports a managed pharmaceutical benefits option with market-driven mechanisms to control costs, provided cost control strategies satisfy AMA criteria defined in AMA Policy H-110.997 and that drug formulary systems employed are consistent with standards defined in AMA Policy H-125.991.
5. Our AMA supports prospective and retrospective drug utilization review (DUR) as a quality assurance component of pharmaceutical benefits programs, provided the DUR program is consistent with Principles of Drug Use Review defined in AMA Policy H-120.978.
6. Our AMA encourages physicians to counsel their patients about their prescription medicines and when appropriate, to supplement with written information; and supports the physician's role as the "learned intermediary" about prescription drugs.
    a. Our AMA encourages physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office-based practice, which may include the use of medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral counseling and, as appropriate, other written information.
7. Our AMA reaffirms AMA Policy H-120.991, supporting the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge, and to oppose legislation or regulation whose intent is to ban drug sampling.
8. Our AMA supports CEJA's opinion that physicians have an ethical obligation to report adverse drug or device events; supports the FDA's MedWatch voluntary adverse event reporting program; and supports FDA efforts to prevent public disclosure of patient and reporter identities.
9. Our AMA opposes legislation that would mandate reporting of adverse drug and device events by physicians that would result in public disclosure of patient or reporter identities.
10. Our AMA reaffirms AMA Policy H-120.988, supporting physician prescribing of FDA-approved drugs for unlabeled indications when such use is based upon sound scientific evidence and sound medical opinion, and supporting third party payer reimbursement for drugs prescribed for medically accepted unlabeled uses.
11. Our AMA reaffirms AMA Policy H-100.989, supporting the present classification of drugs as either prescription or over-the-counter items and opposing the establishment of a pharmacist-only third (transitional) class of drugs. (BOT Rep. 53, A-94; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CSA Rep. 3, A-97; Amended: CSA Rep. 2, I-98; Renumbered: CMS Rep. 7, I-05; Reaffirmation A-10; Reaffirmed in lieu of Res. 201, I-11; Modified: CMS Rep. 1, A-21)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(A-25)

Introduced by: American Academy of Child and Adolescent Psychiatry, American Society of Addiction Medicine

Subject: Uniform Adoption of Service Intensity Tools to Support Medical Decision-making and Service Gap Analysis

Referred to: Reference Committee A

Whereas, our nation is in the midst of a mental health and an opioid crisis; and

Whereas, most insurers are not in compliance with state and federal parity law[1]; and

Whereas, health plans utilize proprietary service intensity decision-making criteria for medical necessity and utilization management[2]; and

Whereas, there exist evidence-based, nationally-recognized service intensity assessment instruments and level of care placement criteria consistent with generally accepted mental health and substance use disorder that determine the level of treatment services needed for a patient based on a clinically derived and empirically tested service intensity algorithm standards of care[3]; and

Whereas, since 2020, four states have passed legislation requiring health plans to adopt and utilize evidence-based, nationally recognized service intensity assessment instruments and level of care placement criteria consistent with generally accepted mental health and substance use disorder standards of care developed by professional medical associations[4]; and

Whereas, gaps in the mental health and addiction service array exist in communities across America issues; and

Whereas, utilization of nationally recognized service intensity assessment instruments and level of care placement criteria consistent with generally accepted mental health and substance use disorder standards of care can help identify gaps in the continuum of mental health and addiction treatment services in communities and certain patient populations; therefore be it

RESOLVED, that our American Medical Association advocate that federal and state policymakers utilize evidence-based nationally recognized service intensity assessment instruments and level of care placement criteria developed by professional medical associations to require coverage of treatment and recovery services in mental health and substance use disorder treatment. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/2025

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RELEVANT AMA POLICY

H-285.920 Criteria for Level of Care Status

1. Our American Medical Association support the development and use of level of care guidelines that meet the following criteria:
   a. Level of care guidelines should function as guidelines only, and should not be used as requirements for all instances and cases. That is, level of care guidelines must allow for appropriate physician autonomy in making responsible medical decisions.
   b. Level of care guidelines should acknowledge the complexity of care for each patient under the particular set of clinical circumstances.
   c. Level of care guidelines should apply to all facility support systems so that patients are not assigned a level of care that slows or stalls their treatment.
   d. Level of care guidelines should be developed under the direction of actively practicing physicians.
   e. Level of care guidelines should be developed based on individual patient severity of illness and intensity of service.
   f. Level of care guidelines should be validated through standard data quality control checks and professional advisory consensus.
   g. Level of care guidelines should be reviewed and updated.
   h. Level of care guidelines should allow for a timely appeal process.
2. It is the policy of the AMA that private sector accrediting organizations, where applicable, should adopt standards that are consistent with AMA criteria for the development and use of level of care status guidelines.
   [CMS Rep. 5, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: CMS Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:102
(A-25)

Introduced by: American College of Chest Physicians

Subject: Access to Single Maintenance and Reliever Therapy for Asthma

Referred to: Reference Committee A

Whereas, asthma inhaler adherence is as low as 22 to 63% in patients prescribed an inhaled corticosteroid maintenance inhaler with a short-acting beta-agonist reliever inhaler: and

Whereas, 60% of asthma-related hospitalizations can be attributed to poor inhaler adherence: and

Whereas, Single Maintenance and Reliever Therapy (SMART) utilizes a combined inhaled corticosteroid/long-acting beta-agonist inhaler for both maintenance and reliever therapy: and

Whereas, SMART has been shown to improve inhaler adherence, reduce asthma exacerbations, reduce emergency room visits, and reduce hospitalizations: and

Whereas, the Global Initiative for Asthma (GINA) and the National Asthma Education and Prevention Program (NAEPP) recommend SMART for patients with moderate to severe asthma; and

Whereas, SMART may require patient to use more medication than a typical 30-day supply and may require up to three inhalers per month; and

Whereas, at least 33 states have quantity limits in their Medicaid programs more restrictive than three inhalers per month for inhaled corticosteroid/long-acting beta-agonist combination inhalers; and

Whereas, commercial insurers have quantity limits as low as 1 inhaled corticosteroid/long-acting beta-agonist combination inhalers per 30-day period; and

Whereas, SMART medications are currently covered in 45 state Medicaid plans, with 35 states requiring a copay to access SMART medications in some or all plans; and

Whereas, copays as low as $1 to $5 are associated with reduced adherence and increased use of costlier services, such as the emergency room; therefore be it

RESOLVED, that our American Medical Association work with the Centers for Medicare and Medicaid Services and major national insurance carriers to remove or increase quantity limits for inhaled corticosteroid/long-acting beta-agonist combination inhalers when prescribed in accordance with evidence-based guidelines (Directive to Take Action); and be it further

RESOLVED, that our AMA work with state medical associations to advocate for the removal of copays for asthma inhalers in all state Medicaid plans. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/2025

RELEVANT AMA POLICY

Patient Access to Asthma Medications H-185.906
Our American Medical Association supports efforts to ensure access to and insurance coverage, including Medicaid coverage, and reduce cost-sharing for metered-dose **inhaler** formulations for children and others who require it for optimal medication administration.

Asthma Control H-160.932
1. Our American Medical Association encourages physicians to make appropriate use of evidence-based guidelines, including those contained in the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group 2020 Focused Updates to the Asthma Management Guidelines.
2. Our AMA encourages physicians to provide self-management education tailored to the literacy level of the patient by teaching and reinforcing appropriate self-monitoring, the use of a written asthma action plan, taking medication correctly, and avoiding environmental factors that worsen asthma.
3. Our AMA encourages physicians to incorporate the four components of care (assessment and monitoring; education; control of environmental factors and comorbid conditions; and appropriate medication selection and use).
4. Our AMA will, in collaboration with interested parties and organizations, develop content to help physicians talk through the different asthma control options and their known economic costs and environmental impacts.

Third Party Payer Quantity Limits H-185.942
1. Our American Medical Association supports the protection of the patient-physician relationship from interference by payers and Pharmacy Benefit Managers (PBMs) via various utilization control mechanisms, including medication and testing and treatment supply quantity limits.

2. Our AMA will work with third party payers and PBMs to ensure that if they use quantity limits for prescription drugs or testing and treatment supplies, an exceptions process must be in place to ensure that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, and that any such process should place a minimum burden upon patients, physicians and their staff.

3. Our AMA supports interested states legislative efforts and federal action and will develop model state legislation to ensure that third party payers or PBMs that institute quantity limits for prescription drugs or testing and treatment supplies include an exceptions process so that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, including provisions such as the following:

    - physicians can specify limited supplies of medications during initial trials of a medication, or if a larger quantity of medication would expose an at-risk patient to potential harm (e.g., opioids, benzodiazepines, or psychostimulants)
    - physicians can appeal adverse determinations regarding quantity limitations;
    - payers must provide an easily accessible list of all medications and testing and treatment supplies with quantity limits and the requirements for the exception process on the payer's Web site;
    - payers must indicate, what, if any, clinical criteria (e.g., evidence-based guidelines, FDA label, scientific literature) support the plan's quantity limitations;
    - physicians with specialized qualifications may not be subject to quantity limits;

- payers cannot charge patients for an additional co-pay if an exception request for a higher medication or testing and treatment supply quantity has been approved based on medical necessity;
- payer decisions on exception, and subsequent appeal requests, of quantity limits must be made within two working days in non urgent situations and one working day in urgent cases; and
- physicians or patients can submit any denied appeals to an independent review body for a final, binding decision.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 103
(A-25)

Introduced by: American Society for Gastrointestinal Endoscopy, American College of Rheumatology, American Gastroenterological Association

Subject: Inadequate Reimbursement for Biosimilars

Referred to: Reference Committee A

Whereas, biologics are vitally important therapeutic options for patients with certain chronic diseases; and

Whereas, biosimilars have the potential to promote a sustainable, robust market that encourages competition, cost savings, and better patient care; and

Whereas, insurers and their pharmacy benefit managers (PBMs) have exerted disproportionate sway on drug formularies by pressuring pharmaceutical companies to offer significant rebates in exchange for preferred formulary placement, including “fail first” status; and

Whereas, these rebates are reflected in manufacturers ’quarterly Average Sales Price (ASP) reporting to the Centers for Medicare and Medicaid Services (CMS), and thus artificially lower the ASP to the point that many providers ’acquisition costs substantially exceed Medicare and other private health plan payments; and

Whereas, the ASP for most biosimilars continues to fall short of many providers ’acquisition costs – even for the earliest biosimilars – forcing providers to either administer the drug at a financial loss, transfer care to another site of service (e.g. a hospital), or switch the patient’s therapy when they are stable on current therapy, which may be further complicated by “step therapy” requirements imposed by payers; and

Whereas, the Inflation Reduction Act’s temporary increase of the ASP “add-on” from 6% to 8% does not go nearly far enough to ensure that physicians are not infusing biosimilars at a loss; and

Whereas, biosimilars will never be fully integrated into the healthcare system and many patients will be left without access to life-saving therapies until Congress removes manufacturer rebates from the ASP; therefore be it

RESOLVED, that our American Medical Association work with stakeholders to advocate for legislation that will Amend Section 1847A(c)(3) of the Social Security Act to permanently remove manufacturer rebates from the ASP methodology for biologics. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/22/2025

RELEVANT AMA POLICY

Biosimilar Coverage Structures H-100.940

1) Our American Medical Association supports the development and implementation of strategies to incentivize the use of lower cost biosimilars when safe, fiscally prudent for the patient and not financially disadvantageous to the clinical practice, clinically appropriate, and agreed upon as the best course of treatment by the patient and physician.
2) Our AMA advocates to eliminate acquisition cost and reimbursement disparities for in-office biosimilar treatment across diverse treatment locations.
3) Our AMA supports patient education regarding biosimilars and their safety and efficacy.

CMS Rep. 04, I-24

Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability H-330.864

1. Our American Medical Association supports the creation of a new reimbursement model for Part B drugs that;

    a. disentangles reimbursement from the drug price, or any weighted market average of the drug price, by reimbursing physicians for the actual cost of the drug; and

    b. ensures adequate compensation for the cost of acquisition, inventory, storage, and administration of clinically-administered drugs that is based on physician costs, not a percent of the drug price.

2. Our AMA maintains the principles that any revised Part B reimbursement models should promote practice viability, especially for small physician practices, practices in rural and/or underserved areas, and practices with a significant proportion of Medicare patients, to promote continued treatment access for patients. Res. 221, A-24

Cuts in Medicare Outpatient Infusion Services D-330.960

1. Our AMA will actively support efforts to seek legislation to ensure that Medicare payments for drugs fully cover the physician's acquisition, inventory and carrying cost and that Medicare payments for drug administration and related services are adequate to ensure continued patient access to outpatient infusion services.

2. Our AMA will continue strong advocacy efforts working with relevant national medical specialty societies to ensure adequate physician payment for Part B drugs and patient access to biologic and pharmacologic agents.

Res. 926, I-03Reaffirmed and Modified: CMS Rep. 3, I-08Reaffirmation A-15Reaffirmed: CMS Rep. 10, A-16Reaffirmation: I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(A-25)

Introduced by: Daniel H. Johnson, Jr, MD

Subject: Study of Whether the HSA Model Could Become an Option for Medicaid Beneficiaries

Referred to: Reference Committee A

Whereas, one in five Americans are enrolled in Medicaid; and

Whereas, states have some limited flexibility in administering the benefits of Medicaid; therefore be it

RESOLVED, that our American Medical Association conduct a thorough study to determine whether subsidies of low-income beneficiaries enrolled in Medicaid could be applied using the HSA model as one option in a more pluralistic system of Medicaid insurance plan design, with a report back at the I-25 Meeting of our House of Delegates. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/15/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(A-25)

Introduced by: Florida, New York, Maryland, Mississippi, Tennessee, New Jersey, West Virginia

Subject: Development of an Educational Resource on Opting Out of Medicare for Physicians

Referred to: Reference Committee A

Whereas, recent Medicare reimbursement cuts have created significant financial challenges for physicians, particularly in maintaining viable practices and delivering quality care; and

Whereas, physicians participating in Medicare face increasing administrative burdens and financial strain due to payment rates that fail to keep pace with inflation and rising practice costs; and

Whereas, many physicians are unaware of the process and implications of opting out of Medicare as a means to explore alternative practice models; and

Whereas, the American Medical Association is committed to supporting physicians' ability to make informed decisions about their participation in federal programs; therefore be it

RESOLVED, that our American Medical Association create and maintain a prominently featured page on its website dedicated to providing clear, comprehensive information on the process of opting out of Medicare, including:

1. A step-by-step guide on how to opt out of Medicare, including sample documents and timelines;
2. An overview of the legal, financial, and ethical considerations for physicians considering this option;
3. Information on alternative payment models and strategies to ensure continuity of patient care; and
4. Frequently Asked Questions (FAQs) to address common concerns and scenarios physicians may face when opting out of Medicare (Directive to Take Action); and be it further

RESOLVED, that our AMA ensure this educational resource is easily accessible via the AMA website's search function and is regularly updated to reflect changes in Medicare policies and regulations (Directive to Take Action); and be it further

RESOLVED, that our AMA conduct outreach efforts to promote awareness of this resource among its members and provide additional support for physicians exploring alternative practice models. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/21/2025

RELEVANT AMA POLICY

D-390.961 Medicare Physician Payment Reform
1. Our American Medical Association will continue to advocate for adequate investment in comparative effectiveness research that is consistent with AMA Policy H-460.909, and in effective methods of translating research findings relating to quality of care into clinical practice.
2. Our AMA will advocate for better methods of data collection, development, reporting and dissemination of practical clinical decision-making tools for patients and physicians, and rapid, confidential feedback about comparative practice patterns to physicians to enable them to make the best use of the information at the local and specialty level.
3. Our AMA urges physician organizations, including state medical associations and national medical specialty societies, to develop and recruit groups of physicians to experiment with diverse ideas for achieving Medicare savings, including the development of organizational structures that maximize participation opportunities for physician practices.
4. Our AMA will continue to advocate for changes in antitrust and other laws that would facilitate shared-savings arrangements, and enable solo and small group practices to make innovations that could enhance care coordination and increase the value of health care delivery.
5. Our AMA supports local innovation and funding of demonstration projects that allow physicians to benefit from increased efficiencies based on practice changes that best fit local needs.
6. Our AMA will work with appropriate public and private officials and advisory bodies to ensure that bundled payments, if implemented, do not lead to hospital-controlled payments to physicians. [CMS 6, A-09 Reaffirmation A-10 Reaffirmation I-13 CMS Rep. 5, I-16 Reaffirmation: A-22]

H-390.849 Physician Payment Reform
1. Our American Medical Association will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
a. Promote improved patient access to high-quality, cost-effective care.
b. Be designed with input from the physician community.
c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.
d. Not require budget neutrality within Medicare Part B.
e. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.
f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
h. Use adequate risk adjustment methodologies.
i. Incorporate incentives large enough to merit additional investments by physicians.
j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.
k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.
m. Include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society- developed clinical guidelines/standards.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment. [CMS Rep. 6, A-09 Reaffirmation A-10 Appended: Res. 829, I-10 Appended: CMS Rep. 1, A-11 Appended: CMS Rep. 4, A-11 Reaffirmed in lieu of Res. 119, A-12 Reaffirmed in lieu of Res. 122, A-12 Modified: CMS Rep. 6, A-13 Reaffirmation I-15 Reaffirmation: A-16 Reaffirmed in lieu of: Res. 712, A-17 Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17 Reaffirmation: A-19 Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19 Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19 Reaffirmed: Res. 212, I-21 Reaffirmed: Res. 240, A-22 Reaffirmation: A-22 Modified: CMS Rep. 04, A-23 Reaffirmed: Res. 214, A-23 Reaffirmation: A-23]

D-385.945 Advocacy and Action for a Sustainable Medical Care System
1. Our American Medical Association will declare Medicare physician payment reform as an urgent advocacy and legislative priority for our AMA.
2. Our AMA will prioritize significant increases in funding for federal and state advocacy budgets specifically allocated to achieve Medicare physician payment reform to ensure that physician payments are updated annually at least equal to the annual percentage increase in the Medicare Economic Index.
3. Our AMA Board of Trustees will report back to the House of Delegates at each annual and interim meeting on the progress of our AMA in achieving Medicare payment reform until predictable, sustainable, fair physician payment is achieved. [Res. 214, A-23]

D-390.922 Physician Payment Reform and Equity
Our American Medical Association will implement a comprehensive advocacy campaign, including a sustained national media strategy engaging patients and physicians in promoting Medicare physician payment reform, to achieve enactment of reforms to the Medicare physician payment system consistent with AMA policy and in accord with the principles (Characteristics of a Rational Medicare Payment System) endorsed by over 120 state and medical specialty Federation of Medicine members. [Res. 240, A-22 Modified: Res. 214, A-23]

D-390.946 Sequestration
a. Our American Medical Association will continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022.
b. Our AMA will seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs;
c. Our AMA will ensure Medicare physician payments are sufficient to safeguard beneficiary access to care.
d. Our AMA will work towards the elimination of budget neutrality requirements within Medicare Part B.
e. Our AMA will eliminate, replace, or supplement budget neutrality in MIPS with positive incentive payments.
f. Our AMA will advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option.
g. Our AMA will advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services. [Res. 212, I-21 Reaffirmed: Res. 240, A-22 Reaffirmed: CMS Rep. 02, A-23 Reaffirmed: Res. 214, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(A-25)

Introduced by: Illinois

Subject: Advocating for All Payer Coverage for Custom Breast Prostheses for Patients with History of Mastectomy Secondary to Breast Cancer Treatment

Referred to: Reference Committee A

Whereas, treatment of breast cancer commonly includes a combination of surgery, chemotherapy, radiation therapy, and/or hormone therapy; and

Whereas, more than 100,000 women in the United States undergo some form of mastectomy to surgically treat breast cancer per year[1]; and

Whereas, patients who undergo mastectomy are often provided the option of breast reconstruction; and

Whereas, an estimated 25-50% of patients opt for breast reconstruction[2,3,4]; and

Whereas, patients who do not undergo breast reconstruction typically opt for a breast prosthesis; and

Whereas, women who use breast prostheses report that prostheses can increase confidence, enhance body image and self-esteem, and provide a sense of normalcy[5]; and

Whereas, the three main types of breast prostheses are leisure prostheses, silicone prostheses, and custom prostheses; and

Whereas, a leisure breast prosthesis is typically made of foam, fiberfill, polyester fiberfill, or beaded materials encased in a cloth shell; designed to slip into a pocketed mastectomy bra; and are lighter in weight which can be helpful for patients when exercising; and

Whereas, a silicone breast prosthesis is heavier, designed to wear inside a pocketed mastectomy bra, but are typically uncomfortable to wear in hot weather; and

Whereas, pocketed mastectomy bras are an added expense that patients must account for when purchasing leisure and silicone breast prostheses; and

Whereas, a custom breast prosthesis is worn directly on the chest wall and allows for a precise fit[6]; and

Whereas, benefits of custom breast prostheses include appropriate weight distribution; alleviation of stress and friction against sensitive areas of the chest wall; and a precise match of skin tone, breast shape, and areola size and color[7]; and

Whereas, alleviation of stress and friction along with a precise fit against the chest wall can be especially helpful, as patients may have scarring secondary to mastectomy or radiation therapy; and

Whereas, patients who wear custom breast prostheses also have less sweating and perceived dislodgement[8]; and

Whereas, patients report that, compared to conventional prostheses, custom prostheses were more satisfying, comfortable, easy to wear, and coupled with a sense of feeling less like a victim[9]; and

Whereas, medicare and some insurance companies do not cover custom breast prostheses[10,11,12]; and

Whereas, the wholesale cost of a breast prosthesis is $1,500[13], and the retail cost of a custom breast prosthesis can be as high $5,000[14] and

Whereas, custom breast prostheses evidently provide a better fit, comfort, and appearance; therefore be it

RESOLVED, that our American Medical Association work with all relevant medical specialty societies, third party payers, including CMS, and other national stakeholders as deemed appropriate to require third party payers to include reimbursement for custom breast prosthesis for patients who have had mastectomy secondary to breast cancer treatment. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/16/2025

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RELEVANT AMA POLICY

Symptomatic and Supportive Care for Patients with Cancer H-55.999
Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate hemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.
CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 514, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Breast Reconstruction H-55.973
Our AMA: (1) believes that reconstruction of the breast for post-treatment rehabilitation of patients with in situ or invasive breast neoplasm should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or salpingo-oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided.
CCB/CLRPD Rep. 3, A-14; Modified: Res. 912, I-18

Quality Cancer Care Preservation Act H-330.897
Our AMA continues to support existing policy principles in evaluating legislative language on matters relating to Medicare reimbursement for physician acquisition and administration of prescription drugs.
BOT Action in response to referred for decision Res. 129, A-03; Reaffirmed: BOT Rep. 28, A-13; Reaffirmation A-15

Adequacy of Health Insurance Coverage Options H-165.846
1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:
A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.
B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.
C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.
D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.
2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.
3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses.
CMS Rep. 7, A-07; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: Res. 103, A-09; Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11;

Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res. 101, A-19

Insurance Coverage for Compression Stockings H-330.876
Our AMA supports Medicare payment for gradient compression stockings as prescribed by a physician under Medicare benefits coverage.
Res. 126, A-17

Third Party Responsibility for Payment H-185.981
Our AMA (1) will develop, with the assistance of the Blue Cross and Blue Shield Association, the Group Health Association of America, the Health Insurance Association of America, and other relevant health care organizations, guidelines for a standardized system of verifying eligibility for health benefits; (2) will assume a leadership role with these organizations in the development of guidelines for a standardized system of verifying eligibility for health benefits; and (3) following the development of such guidelines, will work with major insurers and managed care plans to promote the development of a standardized, national health benefits verification system based on the guidelines, which would include an obligation on the part of the insurer or managed care plan to pay physicians for any services rendered to patients whose eligibility for benefits have been verified erroneously.
Sub. Res. 721, A-92; Reaffirmed: Sub. Res. 828, A-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Sub. Res. 813, I-13

Reference Pricing H-185.935
Our AMA supports the appropriate use of reference pricing as a possible method of providing health insurance coverage of specific procedures, products or services, consistent with the following principles:
1. Practicing physicians must be actively involved in the identification of services that are appropriate for a reference pricing system.
2. Appropriate reference pricing strategies may be considered for elective services or procedures for which there is evidence of a significant variation in cost that does not correspond
to a variation in quality of care. Additional considerations include the relative complexity of the service, the potential for variation either across patients or during the course of a treatment, and the sufficient availability of providers in a geographic region.
3. Reference prices should be set at a level that reflects current market conditions and ensures that patients have access to a choice of providers. Prices should be reviewed annually and adjusted as necessary based on changes in market conditions.
4. Hospitals or facilities delivering services subject to reference pricing should avoid cost-shifting from one set of services to another.
5. Information about the services subject to reference pricing and the potential patient cost-sharing obligations must be fully transparent and easily accessible to patients and providers, both prior to and at the point of care. Educational materials should be made available to help patients and physicians understand the incentives and disincentives inherent in the reference pricing arrangement.
6. Insurance companies must notify patients of all services subject to reference pricing at the time of health plan enrollment. Patients must be indemnified against any additional charges associated with changes to reference pricing policies for the balance of the contract period.
7. Insurers that use reference pricing must develop and maintain systems that allow patients to effectively and appropriately compare prices among providers, including systems that help patients calculate their estimated costs for each provider prior to seeking care.
8. Plan sponsors should continually monitor and evaluate the effect of reference pricing policies on access to high quality patient care, and ensure that procedures are in place to make plan modifications as necessary.
CMS Rep. 3, I-14

Value-Based Insurance Design H-185.939
Our AMA supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:
a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.
b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.
c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.
d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.
e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.
f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices.
g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.
h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence.
i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972).
CMS Rep. 2, A-13; Reaffirmed in lieu of Res. 122, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed: CMS Rep. 05, I-16; Reaffirmation I-16; Reaffirmed: Joint CMS/CSAPH Rep. 01, I-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: Joint CMS CSAPH Rep. 01, I-18; Reaffirmed: CMS Rep. 06, A-19

Oppose Local Coverage Determination for Lower Limb Prostheses H-330.882
Our AMA (1) opposes local coverage determinations on lower limb prostheses that undermine physician judgment and compromise patient access; and (2) will request that the Centers for Medicare and Medicaid Services expeditiously host a national meeting open to all interested parties to focus on appropriate standards for lower limb prostheses that optimize care for patients. Sub. Res. 818, I-15

Survivorship Care Plans H-55.969
Our American Medical Association supports the voluntary use of survivorship care plans for cancer survivors when deemed appropriate by a patient's treating physician and supports reimbursement for physician preparation of survivorship care plans for patients. Res. 108, A-15; Reaffirmation: A-18

Breast Implants H-525.984
Our AMA: (1) supports that individuals be fully informed about the risks and benefits associated with breast implants and that once fully informed the patient should have the right to choose; and (2) based on current scientific knowledge, supports the continued practice of breast augmentation or reconstruction with implants when indicated.
CSA Rep. M, I-91; Modified: Sunset Report, I-01; Reaffirmed: Res. 727, I-02; Modified: CSAPH Rep. 1, A-12; Modified: CSAPH Rep. 1, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(A-25)

Introduced by: Illinois

Subject: Advocating for All Payer Coverage of Reconstructive and Cosmetic Surgical Care Related to Cleft Lip and Palate

Referred to: Reference Committee A

Whereas, Children with cleft lip and palate (CLP) typically require extensive, multidisciplinary care, often utilizing more medical services for longer periods compared to unaffected children[1]; and

Whereas, There is no national standard governing the scope of these benefits, so each state determines the extent of coverage [1]; and

Whereas, In Illinois, individual or group policies of accident and health insurance covers for medically necessary care and treatment of CLP for individuals under the age of 19 [2]; and

Whereas, Many patients with CLP have osseous and dental abnormalities; and

Whereas, Facial abnormalities from CLP can significantly affect social development and psychosocial well-being during adolescence; and

Whereas Patients experience increased anxiety and depression; appearance-related distress; social and functional challenges such as public speaking, being photographed, or participating in school activities; and adverse effects on their peer relationships [3-11]; and

Whereas, Approximately 66% of adults with CLP are concerned about their oral and nasal appearance even after having initial reconstructive surgeries completed which impacts overall psychosocial well-being, leading to decreased self-esteem and impaired social interactions [3-11]; and

Whereas, Certain reparative procedures, such as orthognathic surgery, can only be performed after skeletal maturity and require associated orthodontic treatments, including the use of fixed appliances to align and level the teeth, establish proper occlusion, and prepare the dental arches for surgery[12-16]; and

Whereas, Patients are often only eligible for these procedures in late adolescence or early adulthood; and

Whereas, For example, to address maxillary hypoplasia, patients require orthognathic surgery to advance the maxilla and remedy malocclusion, providing patients with vast medical benefits including improved occlusion and function, enhanced airway function, and speech improvement [17-25]; and

Whereas, After the completion of orthognathic surgeries, revision rhinoplasty is typically the final stage of cleft care, especially for patients with unilateral cleft, to improve nasal structure, function, and aesthetics[26-28]; and

Whereas, These concerns may persist well beyond the age of 18 and warrant continued surgical care and coverage into adulthood [29-31]; and

Whereas, CLP reconstruction procedures (i.e., orthodontic work, orthognathic surgery, revision rhinoplasty, scar revision) address functional and aesthetic concerns which persist into adulthood, as facial growth and development continues to affect the outcomes of previous surgeries [26-28, 31, 32]; and

Whereas, Prior studies demonstrate that comprehensive, long-term treatment for CLP reduces overall healthcare costs by preventing further complications and improves long-term quality of life [33,34]; therefore, be it

RESOLVED, that our American Medical Association work with all relevant medical specialty societies, third party payers, including the Centers for Medicare and Medicaid Services and other national entities as deemed appropriate to require third party payers to include reimbursement for reconstructive medical services for the treatment of cleft lip and palate. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/2025

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RELEVANT AMA POLICY

Definitions of "Cosmetic" and "Reconstructive" Surgery H-475.992
(1) Our AMA supports the following definitions of "cosmetic" and "reconstructive" surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. (2) Our AMA encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer. CMS Rep. F, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed, A-03; Reaffirmed: CMS Rep. 4, A-13

Coverage of Children's Deformities, Disfigurement and Congenital Defects H-185.967
(1)Our American Medical Association declares: (a) that treatment of a minor child's congenital or developmental deformity or disorder due to trauma or malignant disease should be covered by all insurers; (b) that such coverage shall include treatment which, in the opinion of the treating physician, is medically necessary to return the patient to a more normal appearance (even if the procedure does not materially affect the function of the body part being treated); and (c) that such insurability should be portable, i.e., not denied as a pre-existing condition if the patient's insurance coverage changes before treatment has been either initiated or completed. (2) Our AMA will advocate for appropriate funding for comprehensive dental coverage (including dental implants) for children with orofacial clefting. Sub. Res. 119, I-97Reaffirmed, A-03Reaffirmation A-05Reaffirmation A-08Appended: Res. 109, A-13Reaffirmed: CMS Rep. 01, A-23

Insurance Coverage for Adults with Childhood Diseases H-185.963
Our AMA: (1) urges public and private third party payers to increase access to health insurance products for adults with congenital and/or childhood diseases that are designed for the unique needs of this population; and (2) emphasizes that any health insurance product designed for adults with congenital and/or childhood diseases include the availability of specialized treatment options, medical services, medical equipment and pharmaceuticals, as well as the accessibility of an adequate number of physicians specializing in the care of this unique population CMS Rep. 2, I-99Modified and Reaffirmed: CMS Rep. 5, A-09Reaffirmed: CMS Rep. 01, A-19

Evaluating Health System Reform Proposals H-165.888
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles: (A) Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.(B) Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.(C) All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be. (D) All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan. (E) Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care. (F) Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency

programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system. (G) All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President. (H) True health reform is impossible without true tort reform. 2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation. 3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation. 4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients. Res. 118, I-91 Res. 102, I-92 BOT Rep. NN, I-92 BOT Rep. S, A-93 Reaffirmed: Res. 135, A-93 Reaffirmed: BOT Reps. 25 and 40, I-93 Reaffirmed in lieu of Res. 714, I-93 Res. 130, I-93 Res. 316, I-93 Sub. Res. 718, I-93 Reaffirmed: CMS Rep. 5, I-93 Res. 124, A-94 Reaffirmed by BOT Rep. 1- I-94 CEJA Rep. 3, A-95 Reaffirmed: BOT Rep. 34, I-95 Reaffirmation A-00 Reaffirmation A-01 Reaffirmed: CMS Rep. 10, A-03 Reaffirmed: CME Rep. 2, A-03 Reaffirmed and Modified: CMS Rep. 5, A-04 Reaffirmed with change in title: CEJA Rep. 2, A-05 Consolidated: CMS Rep. 7, I-05 Reaffirmation I-07 Reaffirmed in lieu of Res. 113, A-08 Reaffirmation A-09 Res. 101, A-09 Sub. Res. 110, A-09 Res. 123, A-09 Reaffirmed in lieu of Res. 120, A-12 Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(A-25)

Introduced by: Indiana

Subject: Firearm Storage Diagnosis and Counseling Reimbursement

Referred to: Reference Committee A

Whereas, firearm-related injuries remain a leading cause of accidental death in children aged 0-17, are the leading cause of death in children aged 1-19, and are the most common cause of completed suicide. These death rates disproportionately affect people of color and are also true for Indiana where firearms were responsible for 1,211 deaths and 61% of completed suicides in 2022; and

Whereas, firearm storage counseling is widely agreed to be a critical intervention for firearm harm reduction and is recommended by multiple specialty organizations, including our American Medical Association; and

Whereas, several disorders and behaviors are recognized as warranting specific screening, diagnosis, and intervention, such as substance use disorders and tobacco use. These have specific diagnostic codes (such as F10.1 for Alcohol Abuse Disorder and Z72.0 for Tobacco Use) which help clarify illness severity for documentation, communicate risk factors between providers, allow for billing of pertinent services provided, and facilitate statistical health care data collection; and

Whereas, no ICD-10 diagnostic code currently exists for unsafe firearm storage. Counseling on unsafe firearm storage can only be documented using code Z71.89 for “Other Specific Counseling,” which includes “guns in the home counseling” but also encompasses over 100 other forms of counseling from Accutane and circumcisions to asthma and routine vaccination; and

Whereas, Current Procedural Terminology (CPT) codes exist for the reimbursement of specific interventions addressing diseases and social determinants of health such as alcohol abuse screening and counseling (CPT codes 99408-99409) and tobacco cessation counseling (CPT codes 99406-99407) including requirements on the type and duration of intervention specific to their diagnoses; and

Whereas, no CPT code currently exists specific to firearm storage counseling. CPT codes 99401-99404 cover “preventive medicine counseling” and can be used but have no requirements specific to firearm storage counseling and mandate a minimum of 8 minutes of counseling which is inappropriate for most firearm counseling; and

Whereas, improving the management of unsafe firearm storage requires enabling its appropriate diagnosis by providers and incentivizing counselling interventions; therefore be it

RESOLVED, that our American Medical Association advocate for the creation of an ICD-10 code specifically designating counseling for firearm storage and a new Current Procedural Terminology coding, which specifically encompasses the provision of Firearm Storage

Counseling, its minimum requirements for qualification, and its reimbursement. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/16/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(A-25)

Introduced by: Indiana

Subject: Medicare Advantage Plans Double Standard

Referred to: Reference Committee A

Whereas, according to Medicare Advantage and Part D Final Rule (CMS-4201-F), Medicare states that only “coverage criteria based on current evidence in widely used treatment guidelines or clinical literature” may be used to determine insurance company payment to hospitals for the care they provide; and

Whereas, Medicare Advantage plans treat hospitals with a Medicare Advantage plan contract differently than hospitals without a contract; and

Whereas, Medicare Advantage plan denials on hospitals without a Medicare Advantage contract go through five different levels of appeal which include neutral Medicare auditors; and

Whereas, Medicare Advantage plan denials for hospitals contracted with a Medicare Advantage plan are processed by Medicare Advantage plan employees or their subcontractors with limited external oversight; and

Whereas, some of these denials by Medicare Advantage plan employees no longer follow sound scientific principles or the standard of care; and

Whereas, Medicare Advantage plans profit by these unsupervised denials at the expense of hospitals and physicians; and

Whereas, hospitals serving in medically underserved areas including rural hospitals are often forced to choose between terminating contracts with Medicare Advantage plans that are abusing the denials process or leaving their patients with costly out-of-network coverage; therefore be it

RESOLVED, that our American Medical Association seek legislation to require all payors, including Medicare Advantage plans, to use uniform payment denial appeals processes, which includes external review, for all appeals regardless of whether the physician or provider is contracted with the payor. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/16/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(A-25)

Introduced by: Louisiana

Subject: Study of the Federal Employee Health Benefit Plan (FEHBP)

Referred to: Reference Committee A

Whereas, the Federal Employee Health Benefit Plan (FEHBP) offers an expanded array of health insurance options for its beneficiaries; and

Whereas, FEHBP beneficiaries have the annual opportunity to switch plans if dissatisfied with the previous choice; and

Whereas, the FEHBP provides employees with the same premium support no matter which plan they choose; therefore be it

RESOLVED, that our American Medical Association conduct a thorough study of the FEHBP to understand the successes and failures, strengths and weaknesses of the program (Directive to Take Action); and be it further

RESOLVED, that our AMA determines how the FEHBP compares with AMA policy H-165.881 to see whether it might be an appropriate model to achieve private and public health system reform, with a report back to the I-25 Meeting of our House of Delegates. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/17/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(A-25)

Introduced by: Mississippi

Subject: New Reimbursement System Needed for Rural Hospital Survival

Referred to: Reference Committee A

Whereas, rural patients require hospitalization by their physicians and deserve to be treated close to their communities; and

Whereas, the current hospital reimbursement system is adversarial to rural hospitals and communities and negatively impacting their access to healthcare, specifically acute hospitalization; and

Whereas, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), which are located in underserved and rural areas, qualify for specific reimbursement systems under Medicare and Medicaid; and

Whereas, current efforts to support rural hospitals, such as Critical Care status and Rural Emergency Hospital designation require the closing of acute hospital beds, which results in rural residents having to receive basic acute care long distances from their homes; and

Whereas, rural hospitals, which often operate very efficiently and provide high quality care, need to be reimbursed differently than the current system does to survive; and

Whereas, a reimbursement system for rural hospitals which provides global reimbursement in the manner established for RHCs and FQHCs could be a successful model for the provision of acute hospitalization in rural areas; therefore be it

RESOLVED, that our American Medical Association study the issue and report back the best options for achieving a new reimbursement system for rural hospital survival in our country. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/2025

RELEVANT AMA POLICY

Rural Hospital Payment Models D-190.969
1. Our American Medical Association supports and encourages efforts to develop and implement proposals for improving payment models to rural hospitals.
2. Our AMA will report back no later than the 2026 Annual Meeting on data analysis and appropriate recommendations for improved rural hospital payments based on innovative payment models such as the Pennsylvania Rural Health Model (PARHM).
CMS Rep. 6, I-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(A-25)

Introduced by: New York

Subject: Continuation of Affordable Connectivity Program

Referred to: Reference Committee A

Whereas, funding for the Affordable Connectivity Program (ACP), which offered a monthly discount on broadband internet services, ended on June 1, 2024 for; and

Whereas, there are healthcare disparities and an inability of some patients to afford internet access; and

Whereas, the COVID-19 health pandemic heightened awareness and dramatically increased the need for use of telehealth; and

Whereas, “Telehealth offers patients and providers significant benefits as a lower cost, easier way to access quality care”; and

Whereas, Telehealth has been shown in surveys to benefit both physicians and patients and physicians would be able to maintain continuity of care to those patients who are unable to make in-person visits; and

Whereas, Telehealth would benefit patients as it would increase patient access to a greater number of physicians particularly for the homebound, increase choice of patients for their physicians and has been shown to increase patient satisfaction; and

Whereas, “The rise of telehealth during pandemic boosted mental health treatment rates” in a society where “90% of US adults say the U.S. is experiencing a mental health crisis”; and

Whereas, “An American Medical Association (AMA) survey released shows physicians have enthusiastically embraced telehealth and expect to use it even more in the future and “Nearly 85% of physician respondents indicated they are currently using telehealth to care for patients, and nearly 70% report their organization is motivated to continue using telehealth in their practice”; therefore be it.

RESOLVED, that our American Medical Association advocate for continuing the Affordable Connectivity Program to enable all patients to have access to telehealth and to decrease healthcare disparities. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/22/2025

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(A-25)

Introduced by: Ohio

Subject: Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts

Referred to: Reference Committee A

Whereas, multiple pharmacies closed in Ohio in 2024, leaving many small towns without pharmacy services and creating pharmacy deserts; and

Whereas, over 15.8 million people in the U.S. live in areas without adequate access to pharmacies; and

Whereas, pharmacy closures have been associated with reduced patient adherence to cardiovascular medications among older U.S. adults; and

Whereas, multiple factors contribute to pharmacy closures; and

Whereas, pharmacy reimbursement rates for Medicare and Medicaid prescriptions have lagged behind private insurance payments, disproportionately affecting pharmacies in rural and low -income urban areas, especially independent pharmacies; and

Whereas, independent pharmacies are more likely to close than chain pharmacies; and

Whereas, pharmacy closures are more prevalent in rural and low -income urban areas, exacerbating pharmacy deserts; and

Whereas, some insurance companies designate preferred pharmacies that often exclude independent pharmacies; and

Whereas, over 20 states have adopted rules permitting telepharmacy, helping to alleviate pharmacy deserts; therefore be it

RESOLVED, that our American Medical Association support efforts to expand telepharmacy as a potential solution to pharmacy deserts (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for equitable reimbursement rates for pharmaceuticals between Medicare, Medicaid, and private insurers to ensure sustainable pharmacy operations in rural and underserved areas (Directive to Take Action); and be it further

RESOLVED, that our AMA study and address the impact of preferred pharmacy networks on patient access to pharmacy services, particularly in pharmacy deserts, with attention to supporting independent pharmacies. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/22/225

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 114
(A-25)

Introduced by: Private Practice Physicians Section

Subject: An Assessment of Physician Support for Value-Based Payment Models and its Impact on Healthcare to Inform AMA Advocacy Efforts—A Survey

Referred to: Reference Committee A

Whereas, value-based payment (VBP)'s impact on care: The Center for Medicare and Medicaid Innovation's VBP models have not only failed to improve quality but have likely led to a decline in the quality of care patients receive[1-6]; and

Whereas, VBP's impact on access: VBP programs such as the Hospital Readmission Reduction Program and the Merit-based Incentive Payment System risk increasing health disparities because they have been shown to disproportionately penalize safety-net hospitals and physicians caring for greater numbers of vulnerable patients[7-9]; and

Whereas, VBP's impact on physicians: Although there may have been response bias, a survey piloted through the New York County Medical Society in 2023 found most physicians thought VBP models would harm patients (78 percent). Few physicians were supporters of VBP (28 percent). It was particularly concerning that 94 percent of physicians believed VBP models would add to physician burnout. Responses to survey questions were remarkably similar for both employed and private practitioners; and

Whereas, VBP's impact on cost: A Congressional Budget Office review of The Center for Medicare and Medicaid Innovation's programs, created to reign in cost, not only resulted in a more than five billion dollar increase in cost but are projected to increase costs over the next ten years[10]; and

Whereas, the Center for Medicare and Medicaid Innovation plans to have all Medicare beneficiaries care for by physicians who are accountable for cost and quality of care by 2030; and

Whereas, county and state medical societies and the American Medical Association have been steadily losing members, likely due in part to physicians' lack of faith that these organizations endeavor to understand their needs, value their opinions, and advocate effectively for their interests and the quality of patient care; therefore be it

RESOLVED, that our American Medical Association conducts a physician survey of adequate size and scope to ascertain the impact of value-based payment models on a wide spectrum of both employed and independent physician practices, exploring its specific effects on the quality of care physicians provide (i.e., help or harm quality), patient access to care (i.e., limit Medicare patients), physician professionalism (i.e., honoring patient preferences, managing conflict of interest), and adequacy of the physician workforce (i.e., availability of primary care, burnout, early retirement) to provide legislators a better understanding and inform future AMA advocacy efforts. (Directive to Take Action)

Fiscal Note: $594,118 – Contract to survey physicians and staffing.

Received: 2/28/2025

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RELEVANT AMA POLICY

Advocacy of Private Practice Options for Healthcare Operations in Large Corporations D-160.909

1. Our American Medical Association will inform corporate efforts about the value of private practices to successfully participate in new “value-based” models.
2. Our AMA will identify and work with a corporate entity that is advancing these models to explore a two year pilot among independent private practices in which our AMA will:
    a. convene physician practices in a community.
    b. provide educational resources and technical assistance to practices to support their participation with the corporate entity.
    c. formally evaluate the pilot for outcomes.
3. Our AMA will advocate with commercial payers and health plans and federal and state payers and policymakers to support private practice through policies and models that provide adequate payment, infrastructure and data to succeed in “value-based” models.
   Citation: BOT Rep. 14, A-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 115
(A-25)

Introduced by:	Society for Cardiovascular Angiography and Interventions, American Association of Clinical Urologists, American College of Cardiology, American Vein & Lymphatic Society, American Venous Forum, Outpatient Endovascular and Interventional Society
Subject:	Supporting Legislative Efforts to Remove Certain High-Cost Supplies and Equipment from the Medicare Physician Fee Schedule
Referred to:	Reference Committee A

Whereas, Medicare Physician Fee Schedule (MPFS) reimbursement cuts have become so severe for certain non-facility services that, in 2025, 300 non-facility services are paid at rates less than the direct costs associated with those procedures, according to data from the Centers for Medicare and Medicaid Services (CMS)[1]; and

Whereas, the number of non-facility services reimbursed at less than direct costs grew 50% since 2024[2]; and

Whereas, because these data do not account for other costs, including indirect costs and physician work, the number of services under the MPFS for which reimbursement does not even cover cost likely is much higher than 300 services; and

Whereas, non-facility services are increasingly unsustainable under the MPFS, which is a catalyst for (1) private practice closure[3], (2) site-of-service reimbursement disparities[4], (3) higher Medicare spending and beneficiary coinsurance as services migrate to high-cost sites of service[5], (4) reduced rural access to important specialty care services[6]; and

Whereas, non-facility services are critical to the MPFS (1) as a lowest cost option to Medicare beneficiaries[7], (2) for rural access where ambulatory surgical centers are not typically present[8], and (3) as an option during pandemics so hospitals can focus on the most vulnerable patients; and

Whereas, the migration of non-facility care to higher cost settings results in higher Medicare spending, higher Medicare beneficiary coinsurance, and reduced access to care[9]; and

Whereas, in many states, certificate of need laws and cost considerations are a barrier to ambulatory surgical centers, thus making hospitals the only site-of-service option outside of a non-facility setting[10]; and

Whereas, office-based services under the MPFS for which reimbursement does not cover cost predominantly utilize high-cost supplies and equipment; and

Whereas, the decades-long migration of high-cost supplies and equipment from the Hospital Outpatient Prospective Payment System to the PFS has not been accompanied by corresponding funding allocations and has contributed to the dilution of the MPFS; and

Whereas, in 2010, CMS removed high-cost Part B drugs from the PFS in 2010 due to similar concerns relating to the impact on the MPFS[11]; and

Whereas, the AMA RUC has recommended for many years that CMS separately identify and pay for high-cost disposable supplies priced more than $500, but, since 2011, CMS has consistently stated its inability to adopt such recommendations[12]; and

Whereas, CMS also has noted its concern with very expensive equipment items[13]; and

Whereas, removing certain high-cost supplies priced more than $500 as well as certain high-cost equipment from the PFS would (1) help to address the ongoing closures of non-facility centers, (2) bolster resources available for the PFS, and (3) meaningfully address site-of-service reimbursement differences; therefore be it

RESOLVED, that our American Medical Association support legislative proposals to reform the Medicare Physician Fee Schedule by removing and separately paying for certain services containing high-cost supplies priced more than $500 as well as certain services containing high-cost equipment from the Medicare Physician Fee Schedule. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/22/2025

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10. National Conference of State Legislatures, Certificate of Need State Laws, 26 February 2024
11. CY 2010 PFS Proposed and Final Rules. 74 FR 33650 and 74 FR 61965
12. CY 2025 PFS Final Rule. 89 FR 97734
13. CY 2025 PFS Final Rule. 89 FR 97735

RELEVANT AMA POLICY

H-400.957 Medicare Reimbursement of Office-Based Procedures
Our AMA will: (1) encourage CMS to expand the extent and amount of reimbursement for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective; (2) seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures; and (3) work with CMS to develop consistent regulations to be followed by carriers that include reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based procedures and surgery. (Sub. Res. 103, I-93 Reaffirmed by Rules & Credentials Cmt., A-96 Reaffirmation A-04 Reaffirmation I-04 Reaffirmed: CMS Rep. 1, A-14 Reaffirmed: CMS Rep. 3, A-14)

H-330.925 Appropriate Payment Level Differences by Place and Type of Service
Our AMA (1) encourages CMS to adopt policy and establish mechanisms to fairly reimburse physicians for office-based procedures; (2) encourages CMS to adopt a site neutral payment policy for hospital outpatient departments and ambulatory surgical centers; (3) advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; (4) advocates that in place of the Consumer Price Index for all Urban Consumers (CPI-U), CMS use the hospital market basket index to annually update ambulatory surgical center payment rates; (5) encourages the use of CPT codes across all sites-of-service as the only acceptable approach to payment methodology; and (6) will join other interested organizations and lobby for any needed changes in existing and proposed regulations affecting payment for ambulatory surgical centers to assure a fair rate of reimbursement for ambulatory surgery. [Sub. Res. 104, A-98Reaffirmation I-98Appended: CMS Rep. 7, A-99Reaffirmation A-00Reaffirmation I-03Reaffirmation A-11Reaffirmed: CMS Rep. 3, A-13Reaffirmed: Sub. Res. 104, A-14Reaffirmed: Res. 116, A-14Modified: CMS Rep. 3, A-14Reaffirmation A-14 Reaffirmation A-15Reaffirmation: I-17]

D-330.902 The Site-of-Service Differential
1. Our American Medical Association supports Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments.

2. Our AMA supports Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting.

3. Our AMA will urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured.

4. Our AMA encourages CMS to both:
a. Base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data.
b. Study the costs to independent physician practices of providing uncompensated care.

5. Our AMA will collect data and conduct research both:
a. to document the role that physicians have played in reducing Medicare spending.
b. to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.

6. Our AMA will produce a graphic report illustrating the fiscal losses and inequities that practices without facility fees have endured for decades as a result of the site of service differential factoring in inflation.

7. Our AMA will consider disseminating the resulting educational materials and graphics.
[CMS Rep. 04, I-18Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19Appended: Res. 826, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 116
(A-25)

Introduced by: Senior Physicians Section

Subject: Medicare Coverage of Registered Dietitian (RD) and Certified Nutrition Support Specialist (CNSS) Visits Beyond Type 2 Diabetes and Renal Disease

Referred to: Reference Committee A

Whereas, Medicare coverage for dietary counseling is currently restricted to individuals with type 2 diabetes and renal disease under existing regulations[1]; and

Whereas, Medicare lack of coverage for dietary consult visits, including those for obesity, pancreatic insufficiency, hyperlipidemia, irritable bowel syndrome (IBS), small intestinal bacterial overgrowth (SIBO), gout, and allergies places a financial strain on both patients and their physicians; and

Whereas, the American Medical Association should advocate for patients to access personalized, evidence-based advice that complement medical treatments improving health outcomes and potentially reducing the need for more costly interventions in the future[2,3]; and

Whereas, it is essential that a licensed registered dietitian (RD) or certified nutrition support specialist (CNSS) provides dietary counseling, as many individuals with minimal or no training wrongly identify themselves as nutritionists; therefore be it

RESOLVED, that our American Medical Association support legislation for Medicare coverage for registered dietitian (RD) or certified nutrition support specialist (CNSS) visits referred by physicians for conditions such as obesity, pancreatic insufficiency, hyperlipidemia, irritable bowel syndrome (IBS), small intestinal bacterial overgrowth (SIBO), gout, and allergies, recognizing that other significant chronic conditions can also benefit from tailored dietary interventions (Directive to Take Action); and be it further

RESOLVED, that our AMA specify that payment for registered dietician or certified nutrition support specialist services should be made separately from Medicare physician services (i.e. outside the Medicare physician fee schedule) to avoid having a negative impact on the conversion factor that would impact payment for all physician services. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/20/2025

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RELEVANT AMA POLICY

H-440.859 American's Health

1. Our American Medical Association will make improving health through increased activity and proper diet a priority.
2. Our AMA will propose legislation calling on the federal government and state governments to develop new and innovative programs in partnership with the private sector that encourage personal responsibility for proper dietary habits and physical activity of individual Americans.
3. Our AMA will continue to work in conjunction with the American College of Sports Medicine, American Heart Association, US Department of Health and Human Services and any other concerned organizations to provide educational materials that encourage a healthier America through increased physical activity and improved dietary habits.

[Res. 201, A-09; Reaffirmation A-12; Reaffirmed: BOT Rep. 9, A-22]

H-440.866 The Clinical Utility of Measuring Body Mass Index, Body Composition, Adiposity, and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity

1. Our American Medical Association supports greater emphasis in physician educational programs on the risk differences within and between demographic groups at varying levels of adiposity, BMI, body composition, and waist circumference and the importance of monitoring these in all individuals.
2. Our AMA supports additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain.
3. Our AMA supports more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks.

[CSAPH Rep. 1, A-08; Reaffirmed: CSAPH Rep. 3, A-13; Modified: CSAPH Rep. 07, A-23; Reaffirmed: CSAPH Rep. 08, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 117
(A-25)

Introduced by: Mississippi

Subject: Liberalized Remorse Period for Medicare Advantage Plan Insureds

Referred to: Reference Committee A

Whereas, healthcare is a vital component of wellbeing; and

Whereas, the healthcare system is increasingly complicated, expensive, and difficult for the average adult to navigate in their favor; and

Whereas, health insurance is, for most Americans currently, necessary to access standard of care treatment and prevention for acute and chronic diseases; and

Whereas, health insurance costs and coverage options vary greatly, even within the same company; and

Whereas, currently, patients are allowed to leave their Medicare Advantage plan from January through March of each year; and

Whereas, patients covered by Medicare Advantage plans often experience “buyer’s remorse” after March of each year due to unanticipated health crises that increase or change the healthcare resources they need and, thusly, cause Traditional Medicare to be a better option for their needs; and

Whereas, the harm caused by these changes and lack of access to unanticipated needs are not simply remedied; therefore be it

RESOLVED, that our American Medical Association advocate for the Centers for Medicare Services to expand the period that Medicare Advantage (MA) plan insureds can leave their MA plan and obtain coverage by traditional Medicare part B and D plans from the current policy of January through March to any month for any reason with plan changes becoming effective on the first day of the next month (Directive to Take Action); and be it further

RESOLVED, that our AMA prepare a “tool-kit” for both patients and physicians to help patients make an informed choice regarding their Medicare coverage options. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/21/2025

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 118
(A-25)

Introduced by: Women Physicians Section

Subject: Improving Access to Peripartum Pelvic Floor Physical Therapy

Referred to: Reference Committee A

Whereas, pelvic floor disorders during and after childbirth have significant lifelong consequences for women, including pelvic organ prolapse, urinary incontinence, bowel dysfunction, and pelvic-perineal pain syndrome, and is common among adult women[1–5]; and

Whereas, pelvic floor injuries occur in roughly 1 in 5 primiparous women, and prevalence is projected to increase 46% by 2050 due to an aging pregnant population and increasing rates of comorbidities during delivery[3,4,6,7]; and

Whereas, pelvic floor physical therapy is recommended in the peripartum period as a first-line treatment for pelvic floor dysfunction, yet more than 300,000 women – 10% of all women who give birth vaginally each year – have surgery to correct pelvic floor disorders annually[3,8]; and

Whereas, many pelvic floor injuries after childbirth go underdiagnosed and under-repaired, with lack of insurance coverage, and time constraints reported as the most significant barriers to care[3,5,9]; and

Whereas, while Federally Qualified Health Centers (FQHCs) provide care to one-third of all low-income women of reproductive age (who are at higher risk for pelvic floor disorders), only 5% of FQHCs have access to pelvic floor physical therapy and have identified cost to patient, insurance status, and wait times as barriers to care[10,11]; and

Whereas, pelvic floor physical therapist providers are increasingly operating out-of-network or through cash- based services due to low reimbursement rates, non-coverage by insurance, and discrepancies in what insurance companies deem “medically necessary”[12]; and

Whereas, multiple bills have previously been introduced to the United States Congress supporting Medicaid and the Children’s Health Insurance Program (CHIP) coverage for postpartum pelvic health services, including pelvic floor physical therapy[13,14]; therefore be it

RESOLVED, that our American Medical Association advocates for all relevant payers to cover timely access to comprehensive pelvic floor physical therapy during the antepartum and postpartum period in all health care facilities (Directive to Take Action); and be it further

RESOLVED, that our AMA supports efforts to improve education for clinicians and patients on the risk factors of pelvic floor dysfunction during childbirth and the benefits and indications of pelvic floor physical therapy. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Date Received: 04/21/2025

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RELEVANT AMA POLICY

Extending Medicaid Coverage for One Year Postpartum D-290.974
Our AMA will work with relevant stakeholders to: (1) support and advocate, at the state and federal levels, for extension of Medicaid and Children's Health Insurance Program (CHIP) coverage to at least 12 months after the end of pregnancy; and (2) expand Medicaid and CHIP eligibility for pregnant and postpartum non-citizen immigrants.
[Res. 221, A-19; Modified: Joint CMS/CSAPH Rep. 1, I-21; Modified: Res. 701, I-21]

Reducing Inequities and Improving Access to Insurance for Maternal Health Care H-185.917
1. Our American Medical Association acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color.
2. Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust.

3. Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.
4. Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers.
5. Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be:

Informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories),
Carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections.
Lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.

6. Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.
7. Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.
8. Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.
9. Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.
10. Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives.
11. Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care.
[Joint CMS/CSAPH Rep. 1, I-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 119
(A-25)

Introduced by: Women Physicians Section

Subject: Cancer Survivorship Program Coverage

Referred to: Reference Committee A

Whereas, per the National Cancer Institute and American Cancer Society, an individual is considered a cancer survivor from the time of diagnosis through life regardless of their stage of treatment or remission status[1,14]; and

Whereas, cancer survivors have the ethical right to continued follow-up with basic standards of care that address their specific needs[10]; and

Whereas, cancer survivors are at an elevated risk for both recurrence of their previous cancer as well as development of new primary cancers[12]; and

Whereas, cancer survivors experience a combination of physical and psychosocial symptoms, related to their cancer survivorship status that necessitate specialized care[5]; and

Whereas, survivorship care is a complex, multidisciplinary process requiring coordination among multiple providers[13]; and

Whereas, per the National Cancer Institute, the status of current survivorship care is suboptimal, leaving survivors with persistent symptoms and unmet needs while perpetuating healthcare disparities[14]; and

Whereas, among surveys and interviews conducted by the American Society of Clinical Oncology Cancer Survivorship Committee concerning insurance coverage, more than half of respondents reported denials for symptom management and supportive care services, with fertility services, indicated dental services, and mental health services being denied “always” or “most of the time” in 23.1%, 22.5%, and 12.8% of cases, respectively[4]; and

Whereas, facilities reported coverage denials for numerous survivorship related screenings and treatments for breast cancer survivors (63.46%), for Hodgkin lymphoma survivors (49.04%), and for maintenance therapies (41.74%)[4]; and

Whereas, recent studies suggest that established breast cancer survivorship care interventions that improve patient-provider communication are especially promising[6]; and

Whereas, care of the gynecologic cancer survivor extends beyond cancer treatment to encompass multisystem health; management of fertility, contraception, and vasomotor symptoms; and genetic counseling[8]; and

Whereas, as of 2022, over 50% of cancer survivors between 18-65 years old experience financial hardship, have higher annual out-of-pocket medical expenses (more than double than

those without cancer), and over 50% carry some medical debt from cancer related treatment[2]; and

Whereas, reductions in disparities after implementation of the Affordable Care Act were present, in terms of sociodemographic factors in noninsurance and care unaffordability among cancer survivors under age 65 with largest decreases in women, those with low or medium income, multiple comorbid conditions, the unemployed, and those residing in Medicaid expansion states, disparities still remain in coverage, including the uptick of 82,750 uninsured survivors in 2017 in mainly non-expansion states[9,11]; and

Whereas, cancer survivors were more likely than those without cancer history to report delays in care, forgone medical care, and experience inability to afford medications and medical care[15]; and

Whereas, cancer survivorship care standards recommend that health systems serve survivors by providing resources related to financial hardship and insurance coverage as well as cancer treatment sequelae[13]; and

Whereas, although, 74% of identified NIH grants are focused on cancer survivors from underrepresented populations, there is a clear lack of grants focused on cancer survivors from Pacific Islander populations as well as sexual and gender minorities[13]; and

Whereas, there are currently no established billing codes categorized specifically for survivorship care[3]; and

Whereas, the Comprehensive Cancer Survivorship Act, introduced in 2023, would establish programs and requirements to support services for cancer survivors, including Medicare coverage for cancer care planning and coordination services, employment assistance, and Medicaid and CHIP coverage of fertility services[7]; therefore be it

RESOLVED, that our American Medical Association recognizes cancer survivorship as a critical component of comprehensive cancer care and supports insurance coverage for prevention and early detection of new primary cancers and recurrences, as well as for supportive care services aimed at managing the long-term consequences and sequelae of cancer and its treatment (New HOD Policy); and be it further

RESOLVED, that our AMA advocates for work with key stakeholders to achieve adequate coverage for cancer survivorship care. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 04/21/2025

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RELEVANT AMA POLICY

Survivorship Care Plans H-55.969

Our American Medical Association supports the voluntary use of survivorship care plans for cancer survivors when deemed appropriate by a patient's treating physician and supports reimbursement for physician preparation of survivorship care plans for patients.
[Res. 108, A-15 Reaffirmation: A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 120
(A-25)

Introduced by: Association for Clinical Oncology, American College of Rheumatology

Subject: Medigap, Pre-Existing Conditions, and Medicare Coverage Education

Referred to: Reference Committee A

Whereas, patients may be attracted to Medicare Advantage (MA) plans because of the low premiums and other benefits; and

Whereas, many of these patients may be unaware that many MA plans may deny coverage for specialty drugs or cover specialty drugs with a coinsurance (a percentage of the drug cost) instead of copays (a fixed amount); and

Whereas, the median coinsurance for specialty drugs is 25% for Medicare Part D (linked to Medicare Fee-for-Service (FFS)) enrollees and is 30% for MA enrollees, which can lead to higher out-of-pocket costs for the same drug for MA enrollees; and

Whereas, patients who wish to switch back to Medicare FFS find that they frequently cannot purchase a Medicare Supplement Insurance (Medigap) plan that covers their pre-existing condition(s) because these plans are allowed to deny coverage or adjust premiums based on pre-existing conditions if not purchased within a limited timeframe from first eligibility for Medicare or do not afterwards fall within limited exceptions that allow for guaranteed issue; and

Whereas, the Patient Protection and Affordable Care Act (ACA) prohibited other plans from denying patients coverage because of pre-existing conditions; therefore be it

RESOLVED, that our American Medical Association compile information to supply to practices and patients about Medicare Supplement Insurance (Medigap) plans' policies regarding noncoverage for pre-existing health conditions if these plans are not purchased at specific times (Directive to Take Action); and be it further

RESOLVED, that our AMA create an educational campaign on both Medicare Advantage (MA) and Medicare Fee-for-Service (FFS) coverage (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the elimination of Medigap insurers' ability to deny coverage due to a patient's pre-existing health conditions and work with Congress and the Centers for Medicare & Medicaid Services (CMS) to ensure coverage in MA is, at a minimum, no less than coverage provided under Medicare FFS. (Directive to Take Action).

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/22/25

REFERENCES

1. Medicare Part D in 2025: A First Look at Prescription Drug Plan Availability, Premiums, and Cost Sharing | KFF
2. A Snapshot of Sources of Coverage Among Medicare Beneficiaries | KFF
3. Medigap May Be Elusive for Medicare Beneficiaries with Pre-Existing Conditions | KFF
4. CMS NAIC Q and A And Follow-Ups
5. What Are the Medicare Out-of-Pocket Costs for 2025? – NCOA

RELEVANT AMA POLICY

Medigap Patient Protections H-330.866

1. Our American Medical Association supports annual open enrollment periods and guaranteed lifetime enrollment eligibility for Medigap plans.
2. Our AMA will extend advocacy efforts to ensure federal “guaranteed issue” protections are enacted, allowing beneficiaries the freedom to switch from Medicare Advantage to Traditional Medicare plans without facing prohibitive barriers.
3. Our AMA will advocate for extending modified community rating regulations to Medigap supplemental insurance plans, similar to those enacted under the Affordable Care Act for commercial insurance plans.
4. Our AMA supports efforts to expand access to Medigap plans to all individuals who qualify for Medicare benefits.
5. Our AMA supports efforts to improve the affordability of Medigap supplemental insurance for lower income Medicare beneficiaries.

Ensuring Marketplace Competition and Health Plan Choice H-165.825

Our AMA will: (1) support health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits; (2) oppose the sale of health insurance plans in the individual and small group markets that do not guarantee: (a) pre-existing condition protections and (b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited duration insurance offered for no more than three months; and (3) support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation.

Health Insurance Market Regulation H-165.856

Our American Medical Association supports the following principles for health insurance market regulation:

1. There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan.
2. State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection.
3. Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges.
4. Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium.
5. Insured individuals should be protected by guaranteed renewability.
6. Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices.
7. Guaranteed issue regulations should be rescinded.
8. Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.

9. Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage.
10. The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically:
    a. legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed;
    b. benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and
    c. any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.

Reference Committee B

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201 Inclusion of DICOM Imaging in Federal Interoperability Standards

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203 Supporting SUPPORT Act modifications to enhance care of patients with chronic pain

204 Protecting the Prescriptive Authority of Plenary Licensed Physicians

205 AMA Support for Continuance of the Section 1115 - Social Security Act, Medicaid Waiver Program

206 AMA Support for Renewal of Section 1115 - Social Security Act, Medicaid Waiver Demonstration Projects Supporting Food and Nutrition Services

207 Abolishing Venue Shopping

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209 Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Addiction Medications for Legitimate Medical Purposes

210 Impact of Tariffs on Healthcare Access and Costs

211 Support for State Provider and Managed Care Organization Taxes to Sustain Federal Medicaid Matching Funding

212 Setting Standards for Forensic Toxicology Laboratories Used in Litigation

213 Emergency Department Designation Requires Physician on Site

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215 Support for Changing Standards for Minors Working in Agriculture

216 Support for Aging-Out Foster Youth with Mental Health and Psychotropic Needs

217 Regulation and Oversight of the Troubled Teen Industry

218 Distribution of Resident Slots Commensurate with Shortages

219 Opposing Unwarranted National Institutes of Health Research Institute Restructuring

220 Strengthening AMA Policy on Noncompete Clauses in Ownership Transitions

221 Preservation of Medicaid

222 Need for Separate H1B Pathway for IMG Doctors in the USA

223 Preservation of Medicaid

224 Support SAVE Plan and Public Service Loan Forgiveness (PLSF) Applications
225 The Private Practice Physicians in the Community
226 Regulations for Algorithmic-Based Health Insurance Utilization Review
227 Payment Recoupment—Let Sanity Prevail
228 CHIP Coverage of OTC Medications
229 Guaranteeing Timely Delivery and Accessibility of Federal Health Data
230 Advocating to expand private insurance coverage of anti-obesity medications (AOM)
231 Preventing Venue Shopping in Medical Liability to Protect Physician Practices and Access to Care
232 Preservation of Medicaid
233 Increasing Transparency of AMA Medicare Payment Reform Strategy
234 Protection for International Medical Graduates
235 CMS Payment Monitoring Following Government Staff Reductions

REPORT OF THE BOARD OF TRUSTEES

B of T Report 09-A-25

Subject:	Council on Legislation Sunset Review of 2015 House Policies
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee B

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates (HOD) adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after 10 years unless action is taken by the HOD to retain it. Any action of our AMA HOD that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the HOD identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification; or (f) The Speakers shall determine the best way for the HOD to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the HOD should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA HOD Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

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RECOMMENDATION

The Board of Trustees recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-105.995	Protecting Social Media Users by Updating FDA Guidelines	Our AMA will lobby the Food and Drug Administration to: (1) update regulations to ensure closer regulation of paid endorsements of drugs or medical devices by individuals on social media; and (2) develop guidelines to ensure that compensated parties on social media websites provide information that includes the risks and benefits of specific drugs or medical devices and off-use prescribing in every related social media communication in a manner consistent with advertisement guidelines on traditional media forms.	Retain – this policy remains relevant.
D-130.976	Implications of the November 2003 Emergency Medical Treatment and Labor Act (EMTALA) Final Rule	Our AMA will: (1) ask the EMTALA Technical Advisory Group (TAG) and the Centers for Medicare and Medicaid Services (CMS) for assistance in ameliorating the differential economic and staffing burdens on certain categories of facilities, including but not limited to academic health centers, trauma centers, critical access hospitals, and safety net hospitals, which are likely to receive high volumes of patients as a result of the EMTALA regulations; (2) work with the EMTALA TAG and CMS to ensure that physicians staffing emergency departments and on-call emergency services be appropriately compensated for providing EMTALA mandated services; (3) with input from all interested Federation members, coordinate an effort to educate the membership about emergency department coverage issues and the efforts to resolve them; (4) seek to require all insurers, both public and private, to pay promptly and fairly all claims for services mandated by	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		EMTALA for all plans they offer, or face fines and penalties comparable to those imposed on providers; and (5) seek to have CMS require all states participating in Medicaid, as a condition of continued participation, establish and adequately fund state Emergency Medical Services funds which physicians providing EMTALA-mandated services may bill, and from which those physicians shall receive prompt and fair compensation.	
D-165.961	Physician Taxes	Our AMA will (1) proactively and vigorously oppose taxes on physician services, physician-owned facility taxes or "pass-through" taxes on medical services; and (2) work closely with national specialty societies and state medical societies to assist with advocacy efforts to combat existing and proposed taxes on physician services and physician-owned facilities.	Retain – this policy remains relevant.
D-165.989	Managed Care Organization Reimbursement Formulas	Our AMA will continue to assist states medical associations in their efforts to enact meaningful legislation that protects patients and patient access through network adequacy provisions.	Retain – this policy remains relevant.
D-180.998	Insurance Parity for Mental Health and Psychiatry	Our AMA in conjunction with the American Psychiatric Association and other interested organizations will develop model state legislation for the use of state medical associations and specialty societies to promote legislative changes assuring parity for the coverage of mental illness, alcoholism, and substance abuse.	Sunset this policy. The AMA worked with the American Psychiatric Association and other organizations to develop and promote model state legislation that has been successfully enacted in multiple states and provisions have been introduced in at least four states in the 2025 state legislative sessions.
D-185.999	Information Included On Health Insurance Identification Cards	Our AMA will continue to work with payers, the federal and state governments, and standards organizations to adopt and implement appropriate policies, technologies (e.g., smart cards, telephone hot lines, electronic data interchange, and website access), and national technology standards to provide physicians with	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		accurate and real time verification of patient eligibility, co-payment due, deductible payable information, and claims processing.	
D-260.993	Opposition to Laboratory Reporting Provisions of H.R. 4302	Our American Medical Association will work with federation members and other major stakeholders, including the clinical laboratory and hospital associations, to identify and pursue viable congressional and regulatory strategies to eliminate or substantially reduce the reporting burden associated with Medicare rate setting for laboratory fee schedule services and procedures while supporting access to clinical laboratory services among the spectrum of providers of these services.	Retain – this policy remains relevant.
D-265.990	Strategic Lawsuits Against Public Participation (SLAPP)	Our AMA will make available, but not as a matter of advocacy priority, model anti-SLAPP legislation protecting physicians? First Amendment rights in the context of proceedings relating to quality of health care.	Retain – this policy remains relevant.
D-270.995	Physician Ownership and Referral for Imaging Services	Our AMA will work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary exception to physician self-referral laws, including as they apply to imaging services.	Retain – this policy remains relevant.
D-275.955	MOC Provisions of Interstate Medical Licensure Compact	Our American Medical Association will, in collaboration with the Federation of State Medical Boards and interested state medical boards, request a clarifying statement from the Interstate Medical Licensure Compact Commission that the intent of the language in the model legislation requiring that a physician "holds" specialty certification refers only to initial specialty certification recognized by the American Board of Medical Specialties or the American Osteopathic Association's (AOA's) Bureau of Osteopathic Specialists and that there is no requirement for participation in ABMS's Maintenance of Certification or AOA's Osteopathic Continuous Certification (OCC) program in order to receive initial or continued	Sunset this policy. This directive has been accomplished. In 2015, the AMA requested a clarifying statement from the Interstate Medical Licensure Compact Commission (IMLCC) as specified in this directive. In a response letter, the IMLCC clarified that a physician must hold specialty certification at the time of their application to the Compact but is not required to participate in MOC or OCC. The letter stated that

Policy Number	Title	Text	Recommendation
		licensure under the Interstate Medical Licensure Compact.	the Compact does not have any language requiring that physicians participate in MOC or OCC and has no requirement for continued certification beyond the initial authorization of licensure.
D-285.963	Out of Network Coverage Denials for Physician Prescriptions and Ordered Services	Our American Medical Association will pursue regulation or legislation to prohibit any insurer from writing individual or group policies which deny or unreasonably delay coverage of medically necessary prescription drugs or services based on network distinctions of the licensed health care provider ordering the drug or service.	Retain – this policy remains relevant.
D-305.955	Funding for Teaching Health Center Graduate Medical Education Program	Our American Medical Association will encourage Congress to reauthorize the Teaching Health Center Graduate Medical Educational Program to its full and ongoing funding needs to continue the training of primary providers in community based health centers in underserved areas to assure a continuing supply of primary providers and dentists for the underserved populations.	Retain – this policy remains relevant.
D-315.977	Indemnity for Breaches in Electronic Health Record Cybersecurity	Our AMA will advocate for indemnity or other liability protections for physicians whose electronic health record data and other electronic medical systems become the victim of security compromises.	Retain – this policy remains relevant.
D-315.978	Protecting Consumers' Personal Data	Our AMA supports legislation that prohibits the inappropriate sharing of health and other personal information obtained from health insurance marketplaces.	Retain – this policy remains relevant.
D-330.907	Protect Medicare Beneficiary Access to Complex Rehabilitation Wheelchairs	Our AMA strongly encourages the Centers for Medicare and Medicaid Services (CMS) to refrain from implementing policies on January 1, 2016 that would curtail access to complex rehabilitation technology (CRT) wheelchairs and accessories by applying competitively bid prices to these specialized devices. In the event that CMS does not refrain from implementing policies limiting access to	Sunset this policy. This policy has been accomplished. The 2022 Inpatient Rehabilitation Facility final rule permanently exempted (across all settings) complex rehabilitation technology wheelchairs and accessories from

Policy Number	Title	Text	Recommendation
		CRT wheelchairs, our AMA will encourage Congress to support legislation (e.g. H.R. 3229) that would provide a technical correction to federal law to clarify that CMS cannot apply Medicare competitive bidding pricing to CRT wheelchairs.	Medicare's competitive bidding program.
D-330.908	Improving the Local Coverage Determination Process	1. Our AMA will advocate through legislative and/or regulatory efforts as follows: A. When Medicare Administrative Contractors (MACs) propose new or revised Local Coverage Determinations (LCDs) said Contractors must: (1) Ensure that Carrier Advisory Committee meeting minutes are recorded and posted to the Contractor's website; and (2) Disclose the rationale for the LCD, including the evidence upon which it is based when releasing an approved LCD; B. That the Centers for Medicare and Medicaid Services adopt a new LCD reconsideration process that allows for an independent review of a MAC's payment policies by a third-party, with appropriate medical and specialty expertise, empowered to make recommendations to the Secretary of Health and Human Services that said policies should be withdrawn or revised; and C. That MACs shall be prohibited from adopting another MAC's LCD without first undertaking a full and independent review of the underlying science and necessity of such LCD in their jurisdiction. 2. Our AMA will work with interested state medical and national specialty societies to develop model legislation or regulations requiring commercial insurance companies, state Medicaid agencies, or third party payers to: A. Publish all edits that are to be used in their claims processing in a manner that is freely accessible and downloadable to physicians; and B. Participate in a transparent process that allows for review, challenge, and deletion of unfair edits.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
D-330.944	Admission Criteria for Inpatient Rehabilitation Services	Our AMA will seek a legislative change to the admission criteria for Inpatient Rehabilitation Facilities to diagnosis-specific, functional-level and limitations of the individual patient as opposed to diagnosis-specific criteria alone.	Sunset this policy. The intent of this policy has been realized through regulatory updates to the 2017 Inpatient Rehabilitation Facilities (IRF) Reference Booklet, which outlines both diagnosis-specific and functional-level assessments in determining IRF admissions.
D-330.948	Medicare Demonstration Projects	Our AMA will: (1) encourage CMS to continue to seek input at the earliest possible occurrence from medical associations in the development of Medicare demonstration projects that are intended to contain costs and/or improve the appropriateness or quality of patient care; (2) encourage CMS to continue to vary the types of physician practices (e.g., by size, geographic location) that it utilizes in its Medicare demonstration projects; (3) encourage CMS to limit requirements that may make participation in Medicare demonstration projects financially and/or administratively impracticable for a wide range of physician practices; and (4) join state and specialty societies early on to assist with developing Medicare demonstration projects to protect the interests of patients and physicians.	Retain – this policy remains relevant.
D-35.982	AMA Support for States in Their Development of Legislation to Support Physician-Led, Team Based Care	1. Our AMA will continue to assist states in opposing legislation that would allow for the independent practice of certified registered nurse practitioners. 2. Our AMA will assist state medical societies and specialty organizations that seek to enact legislation that would define the valued role of mid-level and other health care professionals within a physician-led team based model structured to efficiently deliver optimal quality patient care and to assure patient safety.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		3. Our AMA will actively oppose health care teams that are not physician-led.	
D-383.980	Health Care Entity Consolidation	Our AMA will (1) study the potential effects of monopolistic activity by health care entities that may have a majority of market share in a region on the patient-doctor relationship; and (2) develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities.	Retain – this policy remains relevant.
D-385.974	Freedom of Practice in Medical Imaging	Our AMA will: (1) encourage and support collaborative specialty development and review of any appropriateness criteria, practice guidelines, technical standards, and accreditation programs, particularly as Congress, federal agencies and third party payers consider their use as a condition of payment, and to use the AMA Code of Ethics as the guiding code of ethics in the development of such policy; (2) actively oppose efforts by private payers, hospitals, Congress, state legislatures, and the Administration to impose policies designed to control utilization and costs of medical services unless those policies can be proven to achieve cost savings and improve quality while not curtailing appropriate growth and without compromising patient access or quality of care; (3) actively oppose efforts to require patients to receive imaging services at imaging centers that are mandated to require specific medical specialty supervision and support patients receiving imaging services at facilities where appropriately trained medical specialists can perform and interpret imaging services regardless of medical specialty; and	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(4) actively oppose any attempts by federal and state legislators, regulatory bodies, hospitals, private and government payers, and others to restrict reimbursement for imaging procedures based on physician specialty, and continue to support the reimbursement of imaging procedures being performed and interpreted by physicians based on the proper indications for the procedure and the qualifications and training of the imaging specialists in that specific imaging technique regardless of their medical specialty.	
D-390.952	96-Hour Rule for Critical Access Hospitals	1. Our American Medical Association will support and lobby for passage of legislation that would provide relief to Critical Access Hospitals from the "96-hour rule." 2. Our AMA will join with other affected stakeholders to enhance efforts for passage of legislation that would provide relief to Critical Access Hospitals from the "96-hour rule."	Retain – this policy remains relevant.
D-390.979	Economic Impact of Shifts in Site of Service	Our AMA will strongly advocate that, should the Sustainable Growth Rate formula continue to be used, the Centers for Medicare and Medicaid Services increase the SGR target to take into account procedures that are newly priced in the office setting, and continue to analyze the shift in site of service of these procedures to determine if the SGR target adjustments are accurate.	Sunset this policy. This policy is outdated. The SGR formula was permanently repealed in 2015 with the passage of the Medicare Access and CHIP Reauthorization Act.
D-40.990	Support for the Veterans to Paramedics Transition Act of 2015	Our AMA supports legislation to enable veterans who desire to serve as paramedics to obtain training to satisfy emergency medical services personnel certification requirements, taking into account previous medical coursework and training received when such veterans were members of the armed forces.	Sunset this policy. The Veterans to Paramedics Transition Act of 2015 has not been reintroduced since 2015.
D-410.995	Fairness in Medical Imaging Interpretation	1. Our AMA will continue to work with specialty societies and CMS to ensure that fair Medicare accreditation standards for advanced imaging services are adopted by the selected accrediting organizations.	Retain this policy in part. Delete clauses 2 and 3. The MIPPA accreditation program has been fully implemented and the two-

Policy Number	Title	Text	Recommendation
		~~2. Our AMA will encourage Congress and the Administration to allow the MIPPA-mandated Medicare accreditation program to be fully implemented and evaluated before further changes to Medicare's imaging standards and payments are made.~~ ~~3. Our AMA will monitor the two-year Medicare appropriateness program, scheduled to begin in 2010, and work with specialty societies and the CMS to develop appropriateness (and exceptions) criteria if it decides to move forward with a permanent program.~~ ~~4~~2. Our AMA will continue to work with specialty societies to correct payer and RBM policies that unfairly exclude qualified physicians from providing imaging services.	year Medicare appropriateness program ended over a decade ago.
D-435.969	Liability Related to Referrals from Free Clinics	That our American Medical Association will work with interested medical associations to enact state legislation that provides medical liability immunity, similar to the protections granted under the Federal Tort Claims Act (FTCA), to physicians who provide charity care in hospitals, offices, clinics or other health care settings to patients referred from free clinics.	Retain – this policy remains relevant.
D-435.980	Inclusion of Residents in Medical Liability Reform	Our AMA: (1) officially supports the inclusion of all physicians, including unlicensed residents, in state and federal medical liability caps; (2) will advocate for the inclusion of unlicensed residents in all pending and future federal medical liability reform legislation; and (3) will work with state medical societies to advocate for the inclusion of unlicensed residents in all current, pending, and future state medical liability reform legislation.	Retain – this policy remains relevant.
D-450.964	Medicare Quality and Resource Use Reports	Our AMA will continue to work with the Centers for Medicare & Medicaid Services to improve the design, content, and performance indicators included in the Quality and Resource Use Reports	Sunset this policy. The QRURs and VBM program were discontinued after

Policy Number	Title	Text	Recommendation
		(QRURs) for physicians, so that the reports reflect the quality and cost data associated with these physicians in calculating Value-Based Payment Modifiers (VBM).	December 31, 2018, after the transition to the Merit-based Incentive Payment System.
D-450.967	The PQRI Reporting Standard Should be Amended	Our AMA will petition the Centers for Medicaid and Medicare Services to streamline and make less arduous the reporting standard of the Physicians' Quality Reporting Initiative and ask Congress to delay implementation of the mandatory nature of the program until the system has been refined to be more efficient and physician friendly.	Sunset this policy. The Physicians' Quality Reporting Initiative was discontinued and replaced by the Merit-based Incentive Payment System.
D-95.975	Physician Self-Monitoring of Controlled Substance Prescriptions	Our American Medical Association will work with the National Alliance for Model State Drug Laws (NAMSDL), as well as other appropriate national organizations and stakeholders, to update the NAMSDL's Model Prescription Monitoring Program Act to provide health care professionals the opportunity to review their schedule 2-5 controlled substance prescribing patterns as a means to help monitor appropriate prescribing and detect and identify fraudulent prescriptions dispensed under their respective Drug Enforcement Administration numbers.	Sunset this policy. Every state now has a functional Prescription Drug Monitoring Program, and there are procedures to permit an authorized user the opportunity to review their prescribing history.
H-120.939	Physicians Should be Able to Cancel or Rescind Renewals of Prescriptions After the Prescription has Been Delivered to the Pharmacy	Our AMA will support legislation or regulations that: (i) authorize physicians to cancel or rescind renewals of prescriptions previously written; (ii) mandate pharmacies, including pharmacy benefit plans, to implement easy-to- use procedures to permit physicians to issue orders to cancel or rescind renewals of prescriptions previously written; (iii) prevent such renewals from being filled or mailed to the patient; and (iv) enable the pharmacy or pharmacy benefit plan to readily implement such renewal orders, when directed by the physician, regardless of the state of residence of the patient, the state of practice or licensure of the physicians, and the state of business operation of the pharmacy or the pharmacy benefit plan.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
H-120.955	Non-Physician Prescribing	1. Our AMA advocates that prescriptive authority include the responsibility to monitor the effects of the medication and to attend to problems associated with-the use of the medication. This responsibility includes the liability for such actions. 2. Our AMA supports the development of methodologically valid research on the relative impact of non-physician prescribing on the quality of health care.	Retain – this policy remains relevant.
H-130.941	Legal Issues Surrounding the Deployment and Utilization of Licensed Physicians in Response to Declared Disasters	Our AMA: (1) encourages physicians who are interested in volunteering during a disaster to register with their state's Emergency System for Advance Registration of Volunteer Health Professionals program, local Medical Reserve Corps unit, or similar registration systems capable of verifying that practitioners are licensed and in good standing at the time of deployment; and (2) (a) supports the National Conference of Commissioners on Uniform State Laws (NCCUSL) Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) with the liability language of Alternative A; and (b) continues to advocate for civil liability protections for qualified physicians that provide care in a disaster who are not covered under the UEVHPA, but are covered in AMA model legislation titled "To Protect Physicians from Civil Liability Arising from Health Care Provided During a Disaster."	Retain – this policy remains relevant.
H-140.861	Physicians' Self-Referral	Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		trust in the profession. In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships--including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices--are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:(1) Ensure that referrals are based on objective, medically relevant criteria. (2) Ensure that the arrangement: (a) is structured to enhance access to appropriate, high quality health care services or products; (b) within the constraints of applicable law: (i) does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation; (ii) does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and (iii) adheres to fair business practices vis-a-vis the medical professional community--for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians. (3) Take steps to mitigate conflicts of interest, including:	

Policy Number	Title	Text	Recommendation
		(a) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products; (b) establishing mechanisms for utilization review to monitor referral practices; and (c) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated. (4) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.	
H-140.874	Opposition to Legislation that Presumes to Prescribe Patients' Preferences for Artificial Hydration and Nutrition	Our AMA opposes legislation that would presume to prescribe the patient's preferences for artificial hydration and nutrition in situations where the patient lacks decision-making capacity and an advance directive or living will.	Retain – this policy remains relevant.
H-180.947	Maintaining Freedom of Choice with Insurance Products	Our AMA opposes consolidation in the health insurance industry that may result in anticompetitive markets.	Retain – this policy remains relevant.
H-185.932	Support for Inclusion of Vasectomy in the ACA Preventive Services and Contraceptive Mandate	Our American Medical Association will work in concert with national specialty and state medical societies to advocate for patient access to the full continuum of evidence-based contraceptive methods and sterilization procedures, including vasectomy and male contraceptive counseling, to promote gender equity in contraceptive services under the ACA.	Retain – this policy remains relevant.
H-190.955	Virtual Credit Card Payments	1. Our American Medical Association will educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		of electronic funds transfer via the Automated Clearing House. 2. Our AMA will advocate for advance disclosure by third-party payers of transaction fees associated with virtual credit cards and any rebates or other incentives awarded to payers for utilizing virtual credit cards. 3. Our AMA supports transparency, fairness, and provider choice in payers' use of virtual credit card payments, including: advanced physician consent to acceptance of this form of payment; disclosure of transaction fees; clear information about how the provider can opt out of this payment method at any time; and prohibition of payer contracts requiring acceptance of virtual credit card payments for network inclusion.	
H-230.969	Strengthening Medical Staff Bylaws	The AMA: (1) will study the feasibility of assisting states in developing legislation to mandate that hospital medical staff bylaws be viewed as contracts; and (2) will study the feasibility of introducing federal legislation to mandate that medical staff bylaws be viewed as a contract.	Retain – this policy remains relevant.
H-275.955	Physician Licensure Legislation	Our AMA reaffirms earlier policy urging licensing jurisdictions to adopt laws and rules facilitating the movement of physicians between states, to move toward uniformity in requirements for the endorsement of licenses to practice medicine, and to base endorsement of medical licenses on an assessment of competence rather than on passing a written examination of cognitive knowledge.	Sunset this policy. This policy has been superseded by Policy H-275.978, as modified.
H-275.965	Health Care Quality Improvement Act of 1986 Amendments	The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
H-280.950	Medicare's Three-Day Hospital Stay Requirement	Our AMA will ask the leadership of the American Association of Retired Persons, the Federation, the American Hospital Association, the Federation of American Hospitals, and the American Osteopathic Association to join with the AMA as signatories on a letter requesting that the Centers for Medicare & Medicaid rescind Medicare's three-day hospital stay requirement for access to skilled nursing care.	Sunset this policy. The HOD adopted more recent policy on this topic (i.e., H-280.947 "Three-Day Stay Rule"), and continues to advocate (e.g., sign-on letter) to the Centers for Medicare & Medicaid Services with other organizations.
H-280.977	Direct Admission of Medicare Patients to Skilled Nursing Facilities	Our AMA supports regulatory change and any necessary legislation which would delete the 3-day prior hospitalization requirement for provision of skilled nursing facility benefits under Medicare, so as to allow coverage for direct admission of Medicare patients to a skilled nursing facility whether or not they have been discharged from an acute care hospital within the last 30 days.	Retain – this policy remains relevant.
H-320.946	Radiology Benefits Manager	Our American Medical Association: (1) strongly encourages radiology benefits managers (RBMs) to adhere to uniform physician-developed best practice guidelines; (2) supports the use of appropriate use criteria developed by physicians with relevant expertise working in a collaborative process involving all national medical specialty societies that provide and/or order the imaging service in question; (3) supports an independent study assessing the magnitude of the cost and administrative burden of imaging utilization strategies on ordering physician offices, imaging providers, and patients and the impact these strategies have on patient safety and outcomes; (4) strongly encourages each radiology benefit manager (RBM) to publish and distribute the specific diagnostic codes used by their firm to approve or disapprove specific imaging procedures. This information should be distributed by the RBM via electronic or paper means to each physician who is credentialed to participate on health plans that utilize that particular RBM; and (5) opposes the practice of forced	Retain this policy in part. Clauses 1-5 of this policy remains relevant. The Physician Consortium for Performance Improvement referenced in clause 6 no longer exists, so this clause can be deleted.

Policy Number	Title	Text	Recommendation
		test substitution and arbitrary denial of requested imaging services by RBMs contracted by third-party payers that meet appropriate use criteria, and that RBMs be held accountable for harm caused by substitution or delay of requested studies~~; and (6) encourages the Physician Consortium for Performance Improvement? to continue to develop patient-centered measures, including those that address the appropriate use of imaging~~.	
H-330.897	Quality Cancer Care Preservation Act	Our AMA continues to support existing policy principles in evaluating legislative language on matters relating to Medicare reimbursement for physician acquisition and administration of prescription drugs.	Retain – this policy remains relevant.
H-330.928	Managed Medicare Reimbursement	The AMA advocates that Medicare managed care plans (e.g., Medicare Advantage, etc.) that use the RBRVS do so in a manner that maintains the relativity of the RBRVS utilized in the traditional Medicare program.	Retain – this policy remains relevant.
H-330.939	Reimbursement by Medicare for Psychotherapy Provided by Residents	The AMA will work with CMS to accomplish regulations for Medicare Part B payment for attending physicians' services that would not require the "physical presence" of the attending physician in the room at the same time that a resident provided psychotherapy.	Retain – this policy remains relevant.
H-340.903	Quality Improvement Organization Status	The AMA urges CMS to carefully review the potential for conflict of interest when the same organization that contracts as a Medicare Quality Improvement Organization fulfills similar quality improvement contracts in the private sector.	Retain – this policy remains relevant.
H-340.990	QIO Involvement in Quality Review and Physician Sanctions	The AMA urges modification of CMS's QIO contracts and regulations to provide that: (1) any perceived quality review assessment involving a member of a hospital's organized medical staff be concurrently presented for comment and review by the appropriate committee(s) of the organized medical staff; (2) the organized medical staff have the opportunity to make appropriate	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		recommendations for corrections, when it deems that it is applicable, before the QIO shall act on a quality review matter; (3) the organized medical staff should act and inform the QIO organization in a reasonable period of time concerning what action, if any, was taken in relation to a perceived quality review problem; and (4) the QIO should be prohibited from taking any further action, such as sanctions of a member of the medical staff, before such medical staff involvement, review and reporting has been completed.	
H-370.958	Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool	1. Our AMA supports the efforts of the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation. 2. Our AMA supports well-designed studies investigating the use of incentives, including valuable considerations, to increase living and deceased organ donation rates. 3. Our AMA will seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living and deceased organ donation.	Retain – this policy remains relevant.
H-375.973	Protecting Physicians at the Peer Review Process in the Current Managed Care Environment	Our AMA: (1) will work with the Federation of State Medical Boards to adopt a policy to support state legislative efforts to protect the integrity and effectiveness of the peer review process by prohibiting managed care companies from automatically terminating providers who have been sanctioned by state medical boards or by information being provided by the National Practitioners Data Bank without providing due process to the provider; and (2) espouses as policy the guarantee of due process and civil rights safeguards to physicians in peer review and in credentialing.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
H-375.990	Peer Review of the Performance of Hospital Medical Staff Physicians	Our American Medical Association encourages peer review of the performance of hospital medical staff physicians, which is objective and supervised by physicians. Membership on peer review committees and hearing panels should be open to all physicians on the medical staff and should not be restricted to those physicians who have an exclusive contract with the hospital, salaried physicians, or those on the faculty.	Retain – this policy remains relevant.
H-385.914	Stark Law and Physician Compensation	Our AMA opposes and continues to advocate against the misuse of the Stark Law and regulations to cap or control physician compensation.	Retain – this policy remains relevant.
H-385.941	Opposition to CMS User Fees	Our AMA strongly: (1) opposes any attempt on the part of the federal or state governments or other entities to impose user fees, provider taxes, access fees, or bed taxes on physicians and other health care providers to subsidize or fund any health care program; (2) opposes any directive from the CMS to slow down the rate of payment of Medicare claims or reduce administrative services to patients, physicians, and other health care providers; and (3) urges Congress to appropriate sufficient funds to enable the CMS and its carriers to carry out their statutorily required functions.	Retain – this policy remains relevant.
H-40.992	Prohibition of Pay Allowances to Military Physicians Serving in Managerial and Administrative Positions	The AMA opposes legislative or regulatory prohibition of the application of various special pay allowances to military physicians serving in executive and managerial positions.	Retain – this policy remains relevant.
H-405.989	Physicians and Surgeons	1. It is AMA policy to refer only to Doctors of Medicine (MDs) and Doctors of Osteopathy (DOs) as “physicians and surgeons.” 2. The AMA supports working to ensure that federal and state regulations and hospital medical staff bylaws comply with this designation.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
H-435.953	Minor Statute of Repose/Limitations	Our AMA supports federal legislation that would establish a Minor Statute of Repose/Limitations that includes the following language: An action by a minor upon a medical claim shall be commenced within 3 years from the date of the alleged manifestation of injury, except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, whichever provides the longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.	Retain – this policy remains relevant.
H-435.956	Professional Liability Alternative Financing	Our AMA supports legislation that would amend the Internal Revenue Code to allow medical professionals and entities to establish tax-exempt professional liability trusts to pay medical liability claims.	Retain – this policy remains relevant.
H-435.969	Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability	Our AMA: (1) reaffirms its support for investigating promising Alternative Dispute Resolution (ADR) mechanisms, in the context of demonstration projects designed to evaluate whether they resolve medical liability claims fairly and in a more timely and cost-effective manner. (2) The AMA strongly recommends that if cost containment goals are to be achieved, ADR proposals designed to provide greater access to legal process must incorporate effective mechanisms to: (a) identify non-meritorious claims and dispose of them; (b) decrease the proportion of cases being litigated; (c) increase the portion of any settlement payment received by the patient; and (d) identify appropriate guidelines for the payment of damages; and (3) continues to monitor and disseminate information to state and component medical societies about state and federal initiatives that address the issue of protections from liability risks	Retain this policy in part. The reference to MICRA should be deleted. MICRA has been amended since this policy was first adopted and some states have stronger liability protections for physicians.

Policy Number	Title	Text	Recommendation
		for physicians who provide volunteer activities and care of the indigent, as well as the effectiveness of those initiatives. Effective medical liability reform~~, based on the California Medical Injury Compensation Reform Act (MICRA) model,~~ is integral to health system reform.	
H-435.975	~~Bush Administration Professional Liability Proposal~~ Federal Medical Liability Reform Policy	(1) Our AMA ~~commends the Bush Administration for its legislative efforts designated to achieve medical liability reform and~~ supports the elements of medical liability reform legislative proposals ~~introduced in the 102nd Congress~~ which are consistent with Association policy, including (1) limitations of $250,000 or lower on recovery of non-economic damages; (2) the mandatory offset of collateral sources of plaintiff compensation; (3) a decreasing, sliding scale regulation of attorney contingency fees; (4) periodic payment of future awards of damages; and (5) a limitation on the period for suspending the application of state statutes of limitations for minors to no more than six years after birth. Effective medical liability reform~~, based on the California Medical Injury Compensation Reform Act (MICRA) model,~~ is integral to health system reform.	Retain this policy in part. The substance of this policy remains relevant; however, a new title and edits will more accurately describe this policy without tying it to a prior Congress or Administration. Also, the reference to MICRA should be deleted. MICRA has been amended since this policy was first adopted and some states have stronger liability protections for physicians.
H-435.983	Impact of Product Liability on the Development of New Medical Technologies	The AMA (1) urges the continuation of efforts at the state and federal level to reform product liability laws, (2) supports creative solutions to prevent product liability suits from slowing the development and utilization of medical technologies in this country. Effective medical liability reform~~, based on the California Medical Injury Compensation Reform Act (MICRA) model,~~ is integral to health system reform; and (3) continues to support efforts to alleviate the growing health crisis caused by decreasing availability or provision of biomaterials to manufacturers of medical devices and implants and to support legislative efforts to provide legal	Retain this policy in part. The reference to MICRA should be deleted. MICRA has been amended since this policy was first adopted and some states have stronger liability protections for physicians.

Policy Number	Title	Text	Recommendation
		protection to biomaterial suppliers to ensure that all Americans have access to medical devices.	
H-5.998	Public Funding of Abortion Services	Our American Medical Association reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.	Retain – this policy remains relevant.
H-95.937	Abuse-Deterrent Prescription Drugs	Our AMA supports the Food and Drug Administration's ongoing efforts to evaluate the efficacy, safety, and labeling of abuse-deterrent technology, and opposes barriers to appropriate access to and coverage of prescription drugs with abuse-deterrent properties.	Retain – this policy remains relevant.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-A-25

Subject: The Uniform Health-Care Decisions Act (Resolution 250-A-24)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee B

INTRODUCTION

This American Medical Association (AMA) Board of Trustees report arises from Resolution 250-A-24, "Endorsement of the Uniform Health-Care Decisions Act." As introduced by the Michigan Delegation. Resolution 250-A-24 called upon the AMA to amend policy D-140.968, "Standardized Advance Directives," as follows:

> Our AMA will endorse the "Uniform Health-Care Decisions Act," which was drafted and adopted by the National Conference of Commissioners on Uniform State Laws (NCCUSL) in ~~1993~~ 2023, and work with our state medical societies to advocate for its adoption in the states.

Testimony in support of Resolution 250-A-24 emphasized that AMA had endorsed the 1993 version of the Uniform Health-Care Decisions Act (UHCDA), that a new and updated version of the UHCDA had been approved in 2023, and that endorsement of the 2023 version was a needed update to AMA policy. Supportive testimony also praised the UHCDA's new provisions related to end-of-life care. On the other hand, other testimony voiced concern about the UHCDA provisions related to mental health and expressed that the UHCDA inadequately addressed complex issues that would negatively impact medical practice.

Resolution 250-A-24 was referred. This report examines the binary question of whether the AMA should endorse the 2023 UHCDA as adopted by the Uniform Laws Commission (ULC). This report does not seek or recommend changes to the UHCDA.

BACKGROUND

The ULC is a nonpartisan, non-profit association comprised of state commissions on uniform laws from each state. Members of the ULC are licensed attorneys. The ULC's purpose is "to study and review the law of the states to determine which areas of law should be uniform [and] promote the principle of uniformity by drafting and proposing specific statutes in areas of the law where uniformity between the states is desirable."[1] Importantly, the ULC drafts model legislation, but the legislation must be enacted by a state legislature to be effective.

In 1993, the ULC, then known as the National Conference of Commissioners on Uniform State Laws, promulgated the UHCDA, a third-generation model bill that addressed advance health care directives and health care decision-making on behalf of patients lacking capacity. Subsequently, the AMA adopted policy to endorse the 1993 UHCDA. Six states (Alaska, Hawaii, Maine,

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Mississippi, New Mexico, and Wyoming) enacted the 1993 UHCDA. In 2020, the ULC appointed a drafting committee to modernize and expand the UHCDA, and in 2023 the ULC approved and recommended the 2023 UHCDA for enactment in all states.

The 2023 UHCDA governs powers of attorney for health care, advance directives, and other forms of health care instructions intended to inform health care professionals and agents about a patient's wishes, priorities, and values regarding health care decisions made for them when they are unable to make such decisions themselves. The UHCDA also governs determination of capacity, judicial review, and appointment of surrogate decisionmakers when there is no advance directive. In addition, the UHCDA establishes certain duties and powers of agents and health care professionals and shields them from liability when they act reasonably and in good faith.

Among the changes in the 2023 UHCDA is the authorization of advance directives specifically for mental health care. These directives enable individuals to provide specific instructions reflecting their preferences for mental health care and/or to authorize an agent to make mental health care decisions on their behalf. The provisions also allow an individual to limit their own ability to revoke an advance mental health care directive when experiencing an acute mental health event.

To date, one state (Delaware) has enacted the 2023 UHCDA.

AMA POLICY

As noted earlier in this report, AMA Policy D-140.968, "Standardized Advance Directives," endorses the 1993 UHCDA and urges state medical societies to advocate for its adoption.

Policy H-85.957, "Encouraging Standardized Advance Directives Forms Within States," encourages each state medical society to develop a standardized form of advance directives for use by physicians and other health care providers as a template to discuss end-of-life care with their patients.

Policy H-140.845, "Encouraging the Use of Advance Directives and Health Care Powers of Attorney," states that AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work

with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives.

Policy H-85.956, "Educating Physicians About Advance Care Planning," supports efforts to increase the prevalence and quality of meaningful advance care planning, including the use of advance directives, to improve recognition of and adherence to a patient's advance care decisions, the development of materials to educate physicians, patients and others about advance care planning and the requirements and implications of the Patient Self-Determination Act, and patient education resources. The Policy also encourages medical schools and residency programs to increase awareness of advance care planning and educate trainees about the use of such tools.

Policy H-140.970, "Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients," states that: (1) Advance directives (living wills and durable powers of attorney for health care) are the best insurance for individuals that their interests will be promoted if they become incompetent. Generally, it is most effective if the individual designates a proxy decisionmaker and discusses with the proxy his or their values regarding decisions about life support. (2) Without an advance directive that designates a proxy, the patient's family should become the surrogate decisionmaker. Family includes people with whom the patient is closely associated. In the case when there is no person closely associated with the patient, but there are people who both care about the patient and have some relevant knowledge of the patient, such relations should be involved in the decision-making process and may be appropriate surrogates. (3) It is the responsibility of physicians to provide all relevant medical information and to explain to surrogate decisionmakers that decisions should be based on substituted judgment (what the patient would have decided) when there is evidence of patients' preferences and values. If there is not adequate evidence of preferences and values, the decision should be based on the best interests of the patient (what outcome would most likely promote the patient's well-being). (4) Institutional ethics committees should be established for the purpose of facilitating sound decision-making. These ethics committees should be structured so that a diversity of perspectives, including those from outside medicine, are represented. (5) The surrogate's decision should almost always be accepted by the physician. However, there are four situations that may require either institutional or judicial review and/or intervention in the decision-making process. These situations are when: (a) there is no available family willing to be the patient's surrogate decisionmaker; (b) there is a dispute among family members and there is no decisionmaker designated in an advance directive; (c) a health care provider believes that the family's decision is clearly not what the patient would have decided if competent; and (d) a health care provider believes that the decision is not a decision that could reasonably be judged to be in the patient's best interests. Decisions based on a conflict of interest generally would not be in the patient's best interest. In these four cases, the guidelines outlined in the report should be followed. When there are disputes among family members or between family and health care providers, the use of ethics committees specifically designed to facilitate sound decision-making is recommended before resorting to the courts. (6) Judicial reviews for decisions about life-sustaining treatment should be a last resort. It is strongly encouraged that when judicial review is necessary, in nonemergency situations, the courts should determine who is to make treatment decisions, including appointing a guardian, rather than making treatment decisions. (7) When a permanently unconscious patient was never competent or had not left any evidence of previous preferences or values, since there is no objective way to ascertain what would be in the

best interests of the patient, the surrogate's decision should not be challenged as long as the decision is based on the decisionmaker's true concern for what would be best for the patient. (8) In the case of seriously ill or handicapped newborns, present and future interests of the infant must be considered. Due to the complexities involved in deciding about life support for seriously ill newborns, physicians should specifically discuss with parents the risks and uncertainties involved. When possible, parents should be given time to adjust to the shock of the situation and absorb the medical information presented to them before making decisions about life-sustaining treatment. In addition, counseling services and an opportunity to talk with couples who have had to make similar decisions should be available to the parents. (9) Due to the complexity of decisions for permanently unconscious patients and newborns, an ethics committee should be available, whenever possible, to facilitate the surrogate's decision-making. (10) Hospitals and other health care facilities should establish protocols regarding assessment of decision-making capacity, informing patients about advance directives, identifying surrogate decisionmakers, the use of advance directives, substituted judgment and best interests in decision-making, and the procedures for challenging the decision of a surrogate. These protocols should be in accordance with the CEJA preceding guidelines.

Policy H-85.952, "Advance Directives During Pregnancy," affirms the patient-physician relationship as the appropriate locus of decision making and the independence and integrity of that relationship, promotes awareness and understanding of the ethical responsibilities of physicians with respect to advance care planning, the use of advance directives, and surrogate decision making, regardless of gender or pregnancy status, set out in the Code of Medical Ethics, and recognizes that there may be extenuating circumstances which may benefit from institutional ethics committee review, or review by another body where appropriate.

Finally, AMA Policy H-140.826, "Use of Psychiatric Advance Directives," recognizes the potential for advance care planning to promote the autonomy of patients with mental illness and urges the mental health community to continue to study the role of advance care planning in therapeutic relationships and the use of psychiatric advance directives to promote the interests and well-being of patients, and support efforts to increase awareness and appropriate utilization of psychiatric advance directives.

DISCUSSION

Advance care planning is an important aspect of ensuring patient treatment preferences are respected in the event the patient is unable to communicate their wishes. Central to respecting patient autonomy at the end of life or during incapacity is the use of advance directives, a health care power of attorney, and other advance care planning instruments. However, laws governing these instruments may vary across states and this inconsistency can create confusion, complexity, and barriers to effective health care decision-making, ultimately undermining the very goals of advance care planning. A uniform approach among state laws could help minimize confusion and inconsistency and promote high-quality patient care and effective communication and decision-making between patients, families, and health care professionals, particularly in cases when medical decision-making may occur across state lines, amidst conflict between family members or when a patients' preferences have not been made clear. The UHCDA provides a framework for the creation, execution, and recognition of advance care planning tools, the delegation of health care decision-making, and the relevant duties of agents and health care providers. Indeed, existing AMA policy aligns with the goals of the UHCDA. However, inconsistencies between the UHCDA, AMA policy, and clinical practice raise concerns about whether broad endorsement of the UHCDA is appropriate for the AMA.

One critical criticism of the 2023 UHCDA centers around determinations of patient capacity to make health care decisions, and the lack of clear guidelines for complex medical scenarios. Specifically, under the UHCDA, the determination of capacity requires consideration of two criteria: (1) whether an individual is willing and able to communicate a decision and (2) whether the individual understands the nature and consequences of making or revoking a decision or instruction. In contrast, the widely accepted assessment of decisional capacity in clinical practice, which has been incorporated into state laws, assesses four skills: whether the individual is able to understand relevant information; appreciate the clinical circumstances; exhibit a rational process of decision making; and communicate a consistent choice.[2] While the approaches are not necessarily in conflict in all cases, the UHCDA approach could, particularly with regard to psychiatric care, conflict with the accepted medical standard for assessing capacity. This could lead to confusion among health care professionals and in application in the courts.

Additionally, some UHCDA provisions directly conflict with existing AMA policy. For example, AMA Policy H-140.970, "Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients," states that, in the absence of an advance directive, the patient's family should become the surrogate decisionmaker regarding decisions to forgo life-sustaining treatment, whereas the UHCDA first prioritizes "an adult the individual has identified, other than in a power of attorney for health care, to make a health-care decision for the individual if the individual cannot make the decision" before family. AMA policy also identifies when decisions to forgo life-sustaining treatment warrant institutional or judicial review, including when there is a dispute among family members and no designated decisionmaker, and when there is no available family willing to be the patient's surrogate decisionmaker. In contrast, the UHCDA instructs health care providers to comply with the decision of a majority of the family members when there is a dispute and authorizes non-family members to function as surrogate decisionmakers according to a priority list. AMA policy also advocates for use of institutional ethics committees, whereas the UHCDA makes no mention of ethics committees. The UHCDA also authorizes and promotes use of mental health advance directives, whereas AMA policy merely recognizes the potential benefit of mental health advance directives and urges further study.

The UHCDA also conflicts with AMA policies that vigorously support and advocate for appropriate physician supervision of non-physician clinical staff in all areas of medicine. Specifically, the UHCDA authorizes a "responsible health-care professional" to determine whether a patient lacks capacity when a physician, psychologist, physician assistant, advanced practice registered nurse, or social worker is unavailable, and a prompt decision is necessary to avoid loss of life or serious harm. The UHCDA does not require the "responsible health-care professional" to have any specific training, expertise, or license. AMA Policy H-160.949, "Practicing Medicine by Non-Physicians," expressly opposes state legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision.

It is critical to note that AMA does not endorse the actions of other organizations with which it does not completely and wholly agree. Though individuals may disagree about the appropriate weight to be given to the concerns and conflicts discussed in this report, the Board of Trustees (the Board) finds the lack of perfect alignment determinative. Therefore, the Board recommends against endorsement of the UHCDA. Additionally, adoption of the 2023 UHCDA by the ULC renders AMA Policy D-140.968, "Standardized Advance Directives," outdated and the policy should be rescinded.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 250-A-24 and the remainder of the report be filed.

1. That Policy D-140.968, "Standardized Advance Directives," be rescinded. (Rescind HOD Policy)

Fiscal Note: Less than $500

REFERENCES

[1] "About Us", Uniform Laws Commission, available at https://www.uniformlaws.org/aboutulc/overview
[2] Paul S. Appelbaum & Thomas Grisso, Assessing patients' capacities to consent to treatment, 319 NEJM 25, 1635-8 (Dec. 1988); Jacob M. Appel, The Statutory Codification of Decisional Capacity Standards, 51 J Am Academy Psych & Law 4, 506-519 (Dec. 2023).

REPORT 14 OF THE BOARD OF TRUSTEES (A-25)
A Public Health-Centered Criminal Justice System
(Reference Committee B)

EXECUTIVE SUMMARY

INTRODUCTION. Resolution 215-I-23, "A Public Health-Centered Criminal Justice System," was referred. This resolution asked that our American Medical Association support legislation that reduces the negative health impacts of incarceration by: a. advocating for decreasing the magnitude of penalties, including the length of prison sentences, to create a criminal justice model focused on citizen safety and improved public health outcomes and rehabilitative practices rather than retribution; b. advocating for legislation and regulations that reduce the number of people placed in prison conditions, such as preventing people who were formerly incarcerated from being sent back to prison without justifiable cause; and c. supporting the continual review of sentences for people at various time points of their sentence to enable early release of people who are incarcerated but unlikely to pose a risk to society. It also asked that our AMA recognize the inefficacy of mandatory minimums and three-strike rules and the negative consequences of resultant longer prison sentences to the health of incarcerated individuals, and support legislation that reduces or eliminates mandatory minimums and three-strike rules.

DISCUSSION. The United States (U.S.) incarcerates nearly two million people, far more than any other country in the world. The problem of mass incarceration in the U.S. is not just a function of the number of people in prison—or the larger number of people who cycle in and out of correctional facilities every year but also a function of the length of time the system incarcerates people. Retribution, deterrence, incapacitation, and rehabilitation are all concepts that have been central to sentencing theory, policy, and practice over the last two centuries. These principles have been backed by limited evidence of success—and evidence of harm. This report discusses the history of sentencing in the U.S., the use of mandatory minimums and three-strike penalties, the impact of longer sentencing on public safety, racial disparities observed in longer sentencing practices, and reforms that have reduced longer sentences without compromising public safety. This report also discusses sentencing reforms to address mass incarceration and summarizes AMA policy as it relates to the criminal justice system.

CONCLUSION. Experts argue that future reforms are still needed to address mass incarceration. This includes more expansive drug law reform such as addressing mandatory minimum sentences for drug offenses, repealing the 18:1 disparity between crack and powder cocaine, expanding alternative sentences, including the existing statutory safety valve, and reducing the number of people currently held in correctional facilities by making changes retroactive. The recommendations in this report support efforts to reduce the reliance on incarceration, particularly for non-violent offenders, acknowledges that rehabilitation and successful reentry into the community requires adequate support systems and services, and supports providing judges with the discretion to help ensure that sentences are fair and fit the crime. Further, the recommendations of this report build upon existing AMA policy centered around drug policy reform and lend way to adopting policies needed for public health centered-criminal justice system.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-A-25

Subject: A Public Health-Centered Criminal Justice System

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee B

INTRODUCTION

Resolution 215-I-23, "A Public Health-Centered Criminal Justice System," introduced by the Medical Student Section was referred. This resolution asked that that our American Medical Association:

> support legislation that reduces the negative health impacts of incarceration by: a. advocating for decreasing the magnitude of penalties, including the length of prison sentences, to create a criminal justice model focused on citizen safety and improved public health outcomes and rehabilitative practices rather than retribution, b. advocating for legislation and regulations that reduce the number of people placed in prison conditions, such as preventing people who were formerly incarcerated from being sent back to prison without justifiable cause, and c. supporting the continual review of sentences for people at various time points of their sentence to enable early release of people who are incarcerated but unlikely to pose a risk to society; and
>
> (1) recognize the inefficacy of mandatory minimums and three-strike rules and the negative consequences of resultant longer prison sentences to the health of incarcerated individuals, and (2) support legislation that reduces or eliminates mandatory minimums and three-strike rules.

BACKGROUND

The U.S. incarcerates nearly two million people, far more than any other country in the world.[1] The problem of mass incarceration in the U.S. is not just a function of the number of people in prison—or the larger number of people who cycle in and out of correctional facilities every year but also a function of the length of time the system incarcerates people. Retribution, deterrence, incapacitation, and rehabilitation are all concepts that have been central to sentencing theory, policy, and practice over the last two centuries.[1]

As of 2019, 57 percent of the U.S. prison population was serving sentences of 10 or more years.[1,2] As of 2020, one in seven people in U.S. correctional facilities was serving a life sentence.[1,3] In 2022, the Council on Criminal Justice, examining National Corrections Reporting system data, found that from 2005 to 2019 the percentage of people serving sentences of 10 or more years in state correctional facilities grew substantially, reaching 57 percent of the total population in 2019.[1,4] On any given day, there are nearly 1.7 million people serving sentences in prison and jail, almost 500,000 more detained in jail pretrial, another 4.4 million under some form of probation or parole control, and between 70 and 100 million marked with a record of arrest or conviction.[1,5,6,7] This level of incarceration reaches into more than 100 million U.S. households: half of all adults in

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the U.S. have had a family member detained at least overnight.[1,8] Black and Latinx people make up 58
percent of the U.S. prison population but just 31 percent of the nation's overall population.[1,9,10] Among those serving life and "virtual life" sentences—sentences of 50 years or more—nearly half are Black, and another 16 percent are Latinx.[1,11] One in five Black men in prison is serving a life sentence.[12] Black men receive harsher sentences and serve more time in prison compared to white men—in the federal system, for example, their sentences are 19.1 percent longer—even after controlling for factors like conviction history, education, and income.[1,12] In the same system, Black people are also 21.2 percent less likely to receive a sentence shorter than advised by the sentencing guidelines than white people.[1,12] In the last 20 years, however, racial disparities have dropped as the number of White people in prison continues to increase while the number of Black people drops.[1,13]

Incarceration and Health

It is well documented that justice-involved people have a higher prevalence of acute and chronic health conditions than the general U.S. population.[14] This includes higher rates of infectious diseases, mental health diagnoses, substance use disorders, traumatic brain injuries, hypertension, heart-related problems, diabetes, asthma, and stroke, along with overall lower life expectancy.[15,16,17] The higher prevalence of these acute and chronic conditions among incarcerated people has been partially attributed to pre-incarceration exposure to adverse structural determinants such as poverty and unstable housing.[15] However, the experience of incarceration itself is also associated with adverse health outcomes.[16-17] Violence—whether self-directed, interpersonal, or perpetrated by agents of the state—is also a significant documented harm of incarceration.[18] While men are more likely to experience interpersonal violence from another justice-involved person, women are more likely to be assaulted by staff.[18,19] Strikingly, transgender people are targeted at nearly 10 times the rate of other justice-involved people.[18,20] In addition to widespread violence and sexual assault inside carceral settings, other extreme human rights violations such as mass forced sterilizations, regular use of solitary confinement, and abandonment during natural disasters are known harms linked to incarceration.[18,21]

In addition to direct health consequences experienced by justice-involved people, the harms of the carceral system extend to families and communities of justice-involved people through mechanisms such as family separation and disruption of community cohesion.[22] For example, parental/caregiver incarceration is associated with food insecurity during childhood and a greater risk of living with mental health issues in childhood and adolescence.[23] If incarcerated pregnant people have children or give birth while incarcerated, the harm from incarceration is carried through generations even after release.[23] These detrimental consequences also extend to adult partners and relatives, inducing relationship strain and onset of depression and anxiety.[24] Some of the carceral system's harms are indirectly mediated through pathways such as added economic pressures (e.g., household income loss and paying for fees and fines) and housing precarity, which have been linked to adverse health outcomes.[25]

A Public Health Approach to Criminal Justice

A public health-centered approach to the criminal justice system is focused on prevention and early intervention and prioritizes addressing structural determinants such as poverty, education, employment, and environment that shape the prevalence of incarceration and increase the risk of adverse health outcomes.[26] These prevention strategies include providing equitable access to resources that communities need to thrive, including stable and supportive housing, affordable high-quality education starting in early childhood, well-paying employment, culturally responsive youth programs, and affordable and accessible health care (including access to mental health first

responders and within-community mental health services).[26,27] A public health approach emphasizes treatment for those facing mental health crises or substance use disorders rather than incarceration to help address underlying conditions. For those who are incarcerated, providing comprehensive health care services during incarceration, and linking people to services post release can help improve health and well-being. Rehabilitation and reentry programs are also vital to help individuals reintegrate into society post-release. It is also important to evaluate the effectiveness of these interventions to understand the impact not only on justice-involved individuals, but also on public safety and the overall health of communities. There is also a significant lack of support for women once they are released. There are fewer options for job training, fewer housing options, and often incarcerated women have less support systems when released compared to men.[28] Creating reentry programs tailored to women's needs is essential and these programs should focus on trauma-informed care, parenting support, and vocational training to address the unique challenges women face.[28]

Restorative Justice Approaches

Restorative justice is a nonpunitive, nonretributive process to address interpersonal harm that centers survivors of harm and brings together everyone affected to decide collectively how to heal and to repair harm.[29] Transformative justice builds upon this process by focusing not only on the individuals involved but also on the larger systems and structures that created the conditions for that harm to occur.[30] Although restorative and transformative justice processes vary widely in implementation, making evaluation of their effectiveness challenging, research on restorative justice shows it to be a promising solution to the problem of incarceration.[30] For example, one of the most comprehensive meta-analyses on restorative justice revealed higher levels of satisfaction among individuals involved in the process (including those who were harmed and those who did harm), a greater likelihood of adhering to restorative agreements, and decreased rates of recidivism relative to those who did not participate in a restorative justice process.[31] Another meta-analysis of restorative justice programs with young people less than 18 years of age showed a general trend of decreased reengagement with the legal system, a greater sense of fairness among both the young people who did harm and the people who were harmed, and greater satisfaction in comparison with those who did not participate in a program.[32] These outcomes suggest better mental well-being for all individuals involved when a restorative justice process is used as an alternative to the carceral system.[30,31] Preliminary evidence suggests that restorative justice approaches provide a more effective and less harmful means of accountability than continuing to invest in punitive paradigms.[18,30,31]

SENTENCING IN THE U.S.

Sentencing in criminal law refers to the process of determining the appropriate punishment or penalty for a person who has been convicted.[33] It typically involves taking into consideration factors, such as the nature and severity of the crime, the defendant's criminal history, and any mitigating or aggravating circumstances.[32] Retribution, deterrence, incapacitation, and rehabilitation are all concepts that have been central to sentencing theory, policy, and practice over the last two centuries.[32] The federal courts and some states have sentencing guidelines to guide judges in determining appropriate sentences and to encourage uniformity.[32]

Near the end of the 20th century, states and the federal government passed sentencing laws and policies that resulted in increasing incarceration rates in the U.S.[33] These laws fell into four main categories—mandatory minimums, "truth in sentencing," new and longer enhancements based on prior criminal convictions (such as "three-strikes" laws and other "habitual offender" laws), and laws that restricted parole release, such as life without parole sentences.[1,34] This report is focused

on mandatory minimum sentences, including three strike laws, as they fall within the purview of the original resolution.

MANDATORY MINIMUM PENALTIES & SENTENCING ENHANCEMENTS

All 50 states, the District of Columbia, and the federal government require a judge to order a set minimum period of incarceration if a person is convicted of certain crimes.[1,35] Mandatory minimums, limit judges' discretion to consider a person's individual circumstances.[1,34] On the federal level, the term "mandatory minimum penalty" requires, upon conviction of a federal criminal offense and the satisfaction of criteria set forth in that statute, the imposition of a specified minimum term of imprisonment.[36] Mandatory minimum penalties vary in length depending on the offense type and specified criteria, from two years for aggravated identity theft, to life in prison for certain drug trafficking offenses. The statutory criteria that trigger mandatory minimum penalties can be classified into at least one of three categories: (a) penalties triggered by offense characteristics or elements of the offense of conviction; (b) penalties triggered by reference to another underlying offense; or (c) penalties triggered by the offender's criminal history.[35]

Not all offenders convicted of an offense carrying a mandatory minimum penalty are sentenced to the minimum term of imprisonment specified in the statute of conviction.[35,37] Under the current system, a sentencing court can impose a sentence below an otherwise applicable statutory mandatory minimum penalty if: (1) the prosecution files a motion based on the defendant's "substantial assistance" to authorities in the investigation or prosecution of another person who has committed an offense; or (2) in certain drug trafficking cases, the defendant qualifies for the statutory "safety valve" contained in 18 U.S.C. § 3553(f).[35,36,38]

Unlike a substantial assistance departure—which applies to all types of federal offenses carrying a mandatory minimum penalty—the safety valve statute only applies in cases in which a defendant faces a mandatory minimum penalty after being convicted of a drug trafficking offense listed in the statute.[35,39] In addition, the safety valve only applies if the following five criteria are met:

- the defendant does not have more than one criminal history point, as determined under the sentencing guidelines;
- the defendant did not use violence or credible threats of violence or possess a firearm or other dangerous weapon (or induce another participant to do so) in connection with the offense;
- the offense did not result in death or serious bodily injury to any person;
- the defendant was not an organizer, leader, manager, or supervisor of others in the offense, as determined by the sentencing guidelines and was not engaged in a continuing criminal enterprise; and
- no later than the time of the sentencing hearing, the defendant has truthfully provided to the Government all information and evidence the defendant has concerning the offense or offenses that were part of the same course of conduct or of a common scheme or plan, but the fact that the defendant has no relevant or useful or other information to provide or that the government is already aware of the information shall not preclude a determination by the court that the defendant has not complied with this requirement.[35-38]

Where these criteria are met, judges shall impose a sentence without regard to the statutory mandatory minimum penalty for the covered offenses.[35,38] The drug trafficking guideline also provides for a 2-level decrease if the defendant meets the safety valve subdivision criteria.[40] This decrease applies regardless of whether the defendant was convicted of an offense carrying a mandatory minimum penalty.[41] It should also be noted that states have mandatory minimum

sentencing laws as well, but these vary state by state.[42] Successful state reforms to mandatory minimum sentencing are summarized in Appendix I. Ultimately, federal mandatory minimums result in longer incarceration because few ways around them exist, except via safety valve provisions or substantial assistance motions as mentioned above.

Three Strike Laws

Three strike laws are a criminal sentencing structure in which significantly harsher punishments are imposed on repeated offenders.[43] These laws generally mandate a life sentence for the third violation of violent felonies. These types of laws originated from the Violent Crime Control and Law Enforcement Act of 1994.[44] The federal three strikes statute punishes a defendant with "mandatory life imprisonment if he or she is convicted in federal court of a 'serious violent felony' and has two or more prior convictions in federal or state courts, at least one of which is a 'serious violent felony.'[43] The other prior offense may be a 'serious drug offense.'"[43] The "serious violent felony" includes murder, manslaughter, sex offenses, kidnapping, robbery, and any offense punishable by 10 years or more which includes an element of the use of force or involves significant risk of force.[43]

At the federal level, the First Step Act has eased the mandatory minimum sentencing imposed under the three strikes law.[44] Previously, a person with two or more prior convictions involving a "serious violent felony" or "serious drug felony" was punishable with life imprisonment without parole.[44] Now, this sentence is reduced to 25 years in prison and the sentence for the first offense is reduced from 20 years to 15 years in prison.[44] This reform has given more discretion to judges.[44] The Bureau of Prisons reports that the federal prison population is declining, thanks to the First Step Act.[45] However, a significant portion of the prison population resides in state correctional facilities.[44] Currently, 28 states have enacted the three strikes law.[46] Moreover, some states have a "two-strikes provision," where a subsequent strike-able offense is punishable with twice the term of its ordinary term.[45] In a few states, someone can be released on parole after serving a certain number of years in prison.[45]

ARGUMENTS IN SUPPORT OF MANDATORY MINIMUMS

Promotion of Uniformity in Sentencing and Avoidance of Unwarranted Disparity

Some view mandatory minimum penalties as promoting uniformity and reducing unwarranted disparities because such penalties require courts to impose similar sentences for similar offenses.[47,48] Congress enacted many mandatory minimum penalties, together with the then-mandatory guidelines system, as part of its effort in the 1980s to narrow judicial sentencing discretion and curb what it viewed as unduly disparate and lenient sentences.[49] According to some scholars, the importance of mandatory minimum penalties in ensuring uniformity has increased. The Department of Justice has observed that sentencing disparities have increased under the advisory guidelines system because for "offenses for which there are no mandatory minimums, sentencing decisions have become largely unconstrained as a matter of law."[50] This has led to greater variation in sentencing, which in turn "undermines the goals of sentencing to treat like offenders alike, eliminate unwarranted disparities in sentencing, and promote deterrence through predictability in sentence."[51] Furthermore, some prosecutors have charged offenses carrying mandatory minimum penalties to narrow the sentencing court's discretion.[52]

Protection of the Public through Certainty in Punishment, Deterrence, and Incapacitation

Law enforcement officials have historically urged the enactment of mandatory minimum penalties.[52] It is believed by some that mandatory minimum penalties deter crime by imposing certain, predictable, and generally severe punishment.[53] Because mandatory minimum penalties require a certain term of incarceration, they are viewed as "an effective means of alerting would-be offenders to the consequences of certain illegal conduct."[54] According to the Department of Justice, sentencing reforms in the 1980s, including the enactment and enhancement of many mandatory minimum penalties, helped reduce crime rates.[48] Some prosecutors and police officers report that the certainty of punishment provided by mandatory minimum penalties is "critical" to law enforcement efforts.[55] Furthermore, some believe that the severity of mandatory minimum penalties increases their deterrent effect by raising the "cost" of committing crime to would-be offenders.[56] In addition to their deterrent effect, some policymakers assert that mandatory minimum penalties reduce crime by incapacitating criminals and protecting the public from their potential future offenses.[57] For example, law enforcement officers have reported that incapacitation through mandatory minimum penalties has reduced methamphetamine- and firearm-related crime.[58]

Effective Law Enforcement Tool that Induces Pleas and Cooperation

The threat of a mandatory minimum penalty gives law enforcement leverage over defendants, who may be encouraged to cooperate in exchange for lesser charges or safety valve and substantial-assistance benefits.[59] Some have stated that the potential application of more severe penalties in federal court "has convinced a number of suspects to give up information."[60] Similarly, the Department of Justice views mandatory minimum penalties as an essential and critical tool in obtaining cooperation from members of "violent street gangs and drug distribution networks."[59]

Assistance to State and Local Law Enforcement

Another justification for federal mandatory minimum penalties relates to the relationship between state and federal law enforcement.[61] Due to the substantial concurrent state and federal jurisdiction in many drug and firearm cases, if a state sentence for a crime is inappropriately low, the existence of a substantially higher, federal mandatory minimum can help ensure a sentence that protects the public.[60] The prospect of being convicted under a federal statute carrying a mandatory minimum penalty can induce defendants to plead to state charges.[60]

ARGUMENTS IN OPPOSITION OF MANDATORY MINIMUMS

Contribution to Excessive Uniformity and Unwarranted Disparity

One of the weaknesses of mandatory minimums is that they apply one-size-fits-all sentences to defendants who are not equally liable.[62] According to the American Bar Association (ABA), "[t]reating unlike offenders identically is as much a blow to rational sentencing policy as is treating similar offenders differently."[63] Mandatory minimum penalties may result in arbitrary and disparate sentences because they rely on certain specified triggering facts.[64] For example, so-called "sentencing cliffs" occur when an offender's "conduct just barely brings them within the terms of the mandatory minimum.[65] In such a case, the offender is subject to a significantly higher sentence than an offender whose conduct fell just outside the scope of the mandatory minimum penalty, even though their conduct was only marginally different.[66] For example, a defendant convicted of trafficking 100 grams of heroin would be subject to the five-year mandatory minimum penalty while one who sold only 99 grams of the drug would not, meaning that these defendants are subject to substantially different sentences despite nearly identical conduct.[67] A majority of judges believe that mandatory minimum penalties contribute to sentencing disparity. In a survey of United States

District Judges on a range of sentencing issues, 52 percent of judges ranked mandatory minimum penalties among the top three factors contributing to sentencing disparity.[68] In contrast, 78 percent believed that the sentencing guidelines have reduced unwarranted sentencing disparities among similarly situated defendants.[67]

Excessive Severity and Disproportionality

Many scholars view current federal mandatory minimum penalties as producing sentences that are excessively harsh relative to the gravity of the offense committed, in part because "all sentences for a mandatory minimum offense must be at the floor or above regardless of the circumstances of the crime."[69] The Department of Justice has stated that there are real and significant excesses in terms of the imprisonment meted out for some offenders under existing mandatory sentencing laws, especially for some non-violent offenders.[70] The Department of Justice explained that "[m]andatory minimum sentencing statutes in the federal system now apply to a significant array of serious crimes; and they also, by and large, mandate very severe imprisonment terms."[69] This, in turn, has produced exponential growth in the federal prison population since the 1980s, and the federal Bureau of Prison's overcapacity "has real and detrimental consequences for the safety of prisoners and guards, effective prisoner reentry, and ultimately, public safety."[69] For this reason, the Department of Justice suggests some reforms of existing mandatory minimum sentencing statutes to eliminate excess severity in current statutory sentencing laws and to help address the unsustainable growth in the federal prison population.[69]

Lack of Individualized Sentencing

Critics often argue that mandatory minimum penalties conflict with the goal of individualized sentencing.[71] For instance, the Judicial Conference has long urged Congress "to reconsider the wisdom" of mandatory minimum penalties because they "block judges from considering the individual circumstances of particular cases."[72,73] Because mandatory minimum penalties may prevent a judge from considering all (or even most) of the pertinent facts and circumstances of the case (such as offender characteristics), the resulting sentence may be unfair or irrational.[70-72] Likewise, the American Bar Association has also called for the repeal of federal mandatory minimum penalties after concluding that they are "inconsistent with the notion of individualized sentencing within a guided discretion regime."[71,72] Moreover, there is significant agreement with the Judicial Conference and the ABA among judges and lawmakers, practitioners, scholars, and advocacy groups.[74]

Ineffectiveness as a Deterrent or as a Law Enforcement Tool to Induce Pleas and Cooperation

Some scholars counter the claims made by proponents of mandatory minimum penalties that these penalties serve as an effective deterrent to crime.[75] Research conducted by social scientists and public policy analysts has found little evidence to support the argument that mandatory minimums prevent crime.[76] In fact, many assert it is an increase in the certainty of punishment through the prosecution of more offenders that is the more cost-effective deterrent compared to the severity of punishment that mandatory minimum penalties or longer sentences provide.[77] Some also dispute the claims that mandatory minimum penalties are a useful law enforcement tool for the investigation and prosecution of criminals by inducing pleas and cooperation. Others have also argued that mandatory minimum penalties are inefficient investigative tools.[78] Some further believe that mandatory minimum penalties cause a "cooperation backlash" that occurs "when sentencing practices are viewed as overly severe" and "many citizens become reluctant to assist the law enforcement effort."[77] Therefore, while mandatory minimum penalties can increase cooperation by offenders who face those punishments, they can hinder the

willingness of citizens to cooperate with law enforcement at the early stages of investigation and arrest.[77]

Disproportionate Impact Across Demographic Groups

Some scholars express concerns that mandatory minimum penalties unfairly impact racial minorities and the economically disadvantaged.[79] This may be attributed in part to the fact that the most frequently applied mandatory minimum penalties are for drug offenses, which according to some, disproportionately impacts certain racial or ethnic groups.[80] While acknowledging that this disproportionate impact may be more a function of law enforcement priorities rather than sentencing policy, some assert that mandatory minimum penalties are being applied most frequently to a population that is not necessarily representative of all people violating such laws.[81] They argue that this perceived uneven application creates perceptions of unfairness that undermine the public's acceptance of the criminal justice system.[80] Some also view legally relevant factors, such as criminal history and prosecutorial discretion in charging decisions or plea agreements, as contributors to the demographically disparate impact of mandatory minimum penalties.[80] Studies show that racial minorities are more likely than whites to have a prior record, which may result from disproportionate processing by the criminal justice system.[82] Research likewise indicates that offenders in certain racial groups may be less likely to get the benefit of prosecutorial discretion in charging decisions or plea agreements.[81]

Limited impact on reducing crime rates

Evidence across the U.S. shows there is no discernable relationship between incarceration rates and crime rates: cities with high incarceration rates do not have lower crime rates than cities with low incarceration rates.[1,83] Mandatory minimums have been justified as an incapacitation strategy for people who have committed violent crimes based on the assumption that they are likely to continue to do so.[1,81,82] Research also shows that people "age out" of crime.[1,84] Violent crime, measured by arrest rates, is much more prevalent among younger people from their late teens to early twenties.[1,83] The rate of arrest for such crimes begins to sharply decline after this point and is more than halved by the mid-thirties.[1,85] This means that people who commit crimes, even if they once presented a danger to others, may be safely released much before the end of the 20-, 30-, and 40-year or life sentences they are now serving.[1,84] Additionally, a substantial body of research demonstrates that incarceration of any length is developmentally harmful for young people and contradicts safety, increasing the risk of future involvement with the criminal legal system rather than reducing crime.[1,86] Increases in the number and length of prison and jail sentences have not produced more public safety, because most justice-involved people are not a danger to the community.[1,84,85] A tiny fraction of people commit the majority of violent crimes in the U.S.—according to the data, 1 to 5 percent of people engaged in unlawful behavior commit 50 to 75 percent of all violent crimes.[1,87]

Counterproductive for public safety

Long-term sentences produce diminishing returns for public safety as individuals "age out" of the high-crime years; such sentences are particularly ineffective for drug crimes as drug sellers are easily replaced in the community; increasingly punitive sentences add little to the deterrent effect of the criminal justice system; and mass incarceration diverts resources from program and policy initiatives that hold the potential for greater impact on public safety.[1,82-86] Further, removing large numbers of people, mostly men, from their communities and placing them in correctional facilities for years at a time creates more harm than good.[1,88] Not only does the loss of these primary relationships cause trauma, but employers also lose employees, churches lose members, and

neighborhood groups lose contributors. [1,87] A meta-analysis of 116 studies found that custodial sentences not only do not prevent reoffending, but they can also actually increase it.[1,89] Data suggests that incarceration itself can be "criminogenic"—that the prison environment, separation from community, or even the process of returning to the community is so destabilizing that it increases the likelihood of continued encounters with the criminal legal system.[1,90]

Increases cost of incarceration

Scholars argue that if mandatory sentences for nonviolent and drug offenders were necessary for public safety, their cost would be justified.[91] However, as corrections spending has climbed, most experts have come to believe incarcerating huge numbers of low-level, nonviolent and drug offenders post-conviction is an inefficient and ineffective method of controlling crime.[90] While public safety benefits of incapacitating dangerous individuals justifies the costs, according to the Pew Center on the States, "most criminologists now consider the increased use of prison for nonviolent offenders a questionable public expenditure, producing little additional crime control benefit for each dollar spent."[92] A study looked at the cost effectiveness of mandatory minimum drug laws and asserted: "[I]f reducing consumption or violence is the goal, more can be achieved by spending additional money arresting, prosecuting, and sentencing dealers to standard prison terms than by spending it on sentencing (fewer) dealers to longer, mandatory terms."[93] As a result, many states have adopted evidence-based, cost-effective sentencing reforms. For instance, prosecutors in Michigan suggested to legislators that the state was "warehousing too many low-level nonviolent offenders with a minimal role in the drug trade for too long in costly prison beds."[94] As a result, Michigan repealed most of its drug-related mandatory minimums. Prison admittances fell and Michigan saved billions in tax dollars.[93] More importantly, the crime rate fell 27 percent in the decade after the repeal. Other states have moved in a similar direction.[93]

PROPOSED REFORMS TO ADDRESS LONG SENTENCING

Removing extensions of sentences based on prior convictions

Most states have prior conviction enhancements, which increase the probability and length of prison sentences for each felony conviction a person has on their record.[1,95] However, experts argue that sentence enhancements based on prior conviction history are problematic on at least three grounds: they do not promote safety, they are one of the major drivers of racial disparities in sentencing, and they punish people disproportionately for their behavior.[1,94] Policymakers often support prior record enhancements by using a deterrence argument: they claim that people will be deterred by knowing that if they commit a crime again, they will be punished more severely.[1,96] But increasing the severity of punishment based on a person's previous convictions does not effectively deter future criminal behavior as mentioned above.[1,97] Scholars argue that people who engage in repeated acts of serious harm—the 1 to 5 percent subset of the people who have committed violence— are perhaps the intended focus for proposed incapacitation, but suggest there are targeted ways to address these people, such as requiring specific findings of patterned harm at sentencing to extend sentences, as opposed to indiscriminately doing so for everyone based on prior records.[1,96]

Abolishing mandatory minimums for low-level nonviolent offenses and drug offenses

There is growing discourse about abolishing mandatory minimums and requiring prosecutors and judges to wrestle with the appropriateness of incarceration in each case, as well as the length of any carceral sentence.[1,98] Experts argue that states can remove all mandatory minimums by reviewing existing statutes and deleting each reference to a set minimum period of incarceration per crime or

class of crime and replace it with a more general statement that a judge may sentence someone to incarceration up to the maximum period of incarceration.[1,97]

Creating a "second-look" sentencing review

Second-look laws allow courts to reexamine a sentence after a person has served a period of time—10 to 15 years in most instances —to determine if the sentence still serves its original purpose.[1,99] These laws have increasingly become a viable way to reexamine needlessly long sentences and send people home from prison who can safely return to the community.[1,100] In the 2021 legislative session, second-look bills were introduced in 14 states; three, in Illinois, Maryland, and Oregon, passed.[1,101] The less restrictive versions of these bills allow justice-involved people to petition for relief; more restrictive versions reserve the petition power to district attorneys or the courts.[1,102] Although second-look laws may reduce the number of people currently incarcerated, they can suffer from the same pitfalls as parole boards.[1,101] For example, the California prosecutor-led second-look law that passed in 2019 has thus far resulted in about 100 releases in a state with a daily prison population of nearly 100,000 people.[1,103] The District of Columbia law, along with its later expansion to encompass people who were convicted of offenses that occurred up to age 26, has a better track record, with 67 people released in five years in a jurisdiction that has a daily justice-involved population of around 1,400.[1,104]

Expanding the existing statutory safety valve

Scholars argue that if Congress maintains mandatory minimum sentences, it should limit their use to exceptional cases and expand the statutory "safety valve" provision to allow courts more discretion.[1,105] Currently the safety valve provision permits a sentencing court to disregard a statutory minimum sentence for the benefit of certain low-level, nonviolent, cooperative defendants who have a minimal prior criminal record and were convicted of certain mandatory minimum controlled-substance offenses.[1,106] While the First Step Act of 2018 expanded relief for defendants with slightly more extensive prior criminal records, some have encouraged Congress to permit courts to invoke the safety valve in a broader set of circumstances.[1,107]

CURRENT AMA POLICY

The AMA has extensive policy addressing criminal justice system reform due to the intersections with health. Most relevant to this report is AMA Policy D-430.992 "Reducing the Burden of Incarceration on Public Health" which calls on the AMA to support efforts to reduce the negative health impacts of incarceration, through implementation and incentivization of adequate funding and resources towards indigent defense systems; implementation of practices that promote access to stable employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records; and housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings. This policy also calls on the AMA to partner with public health organizations and other interested parties to urge Congress, the Department of Justice, the Department of Health and Human Services, and state officials and agencies to minimize the negative health effects of incarceration by supporting programs that facilitate employment at a living wage, and safe, affordable housing opportunities for formerly individuals who are incarcerated, as well as research into alternatives to incarceration. AMA Policy H-80.993 "Ending Money Bail to Decrease Burden on Lower Income Communities" supports legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes.

AMA Policy H-95.907 "Address Disproportionate Sentencing for Drug Offenses" supports efforts to eliminate this sentencing disparity (from 18:1 to 1:1) and apply them retroactively to those already convicted or sentenced. AMA Policy H-100.955 "Support for Drug Courts" supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; encourages legislators to establish drug courts at the state and local level in the U.S.; and encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration. AMA Policy H-95.899 "Restorative Justice for the Treatment of Substance Use Disorders" acknowledges that inequitable sentencing structures, such as towards crack cocaine versus opioids, have contributed to unjust imprisonments. AMA Policy H-95.901 "Drug Policy Reform" states that the AMA supports elimination of criminal penalties for drug possession for personal use as part of a larger set of related public health and legal reforms designed to improve carefully selected outcomes. Further, AMA Policy H-430.980 "Compassionate Release for Incarcerated Patients" supports policies that facilitate compassionate release for incarcerated patients based on serious medical conditions and advanced age.

CONCLUSIONS

Incarceration in the U.S. rose at an unprecedented rate for nearly four decades beginning in 1973.[108] The initiatives, under the narrative of "tough on crime," involved enacting a range of sentencing policies designed to increase admissions to prison and to lengthen the amount of time served on a felony sentence.[107] Such policies were adopted by the federal government and every state to varying degrees. As a result of these changes, the combined prison and jail population of about 330,000 in 1972 has grown to over 1.9 million today.[109] The goal of mass incarceration was to improve public safety outcomes.[110] Evidence has shown that incarceration has an impact on crime, but the scale of that effect is much more modest than many policymakers or members of the public believe.[108,109] At best, the rise of incarceration may have produced about a quarter of the decline in crime that has occurred since the early 1990s.[111] Other studies have found this effect to be as low as five percent.[1,109,110] The second primary research finding on the effects of incarceration is that there are diminishing returns to public safety.[110] A key factor underlying this conclusion is that lengthy prison terms keep individuals behind bars long after they present a significant risk to public safety.[1,110] Further, incarceration has negative health impacts on those who are incarcerated with studies noting higher rates of infectious diseases, mental health diagnoses, substance use disorders, and overall lower life expectancy.[1,23,110] Birthing people in correctional facilities face even more unique issues such as issues related to breastfeeding, the possibility of being shackled while giving birth, lack of access to prenatal care, as well as the trauma of being separated from their newborns.[1,23,110]

There have also been efforts to address the length of prison terms in both the federal and state systems. At the federal level, the most impactful shift has been the decisions by the U.S. Sentencing Commission to revise drug offense guidelines downward, initially for crack cocaine offenses and subsequently for all drug offenses, and then to apply those revisions retroactively.[1,110] In state corrections systems, approaches to reduce sentence lengths have been relatively modest. While twenty-nine states have adopted reforms to mandatory sentencing procedures since 2000, many of these have been narrow in scope, and as a result the impact of reform may be limited.[112] Half of the states still maintain life sentencing policies of "three strikes and you're out" habitual offender laws, and more than half limit parole consideration (generally until eighty-five percent of a sentence has been served) due to the adoption of "truth in sentencing" laws that apply to many convictions.[113] Experts argue that future reforms are still needed to address mass incarceration, these include, but are not limited to removing prior conviction enhancements, providing for judicial discretion in sentencing, and adequate support systems and services for successful reentry into the

community.[1,112] Ongoing research is essential to assess the effects of sentencing reform on individuals who have been incarcerated and public safety.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 215-I-23, and the remainder of this report be filed.

1. Our AMA: (1) recognizes the negative impacts associated with prolonged incarceration, including on the physical and mental health of justice-involved individuals and their families, (2) supports efforts to reduce the reliance on incarceration, particularly for non-violent offenders, with recognition that rehabilitation and successful reentry into the community requires adequate support systems and services, (3) supports a system of continuous review of sentences for individuals who are incarcerated providing the opportunity for those who demonstrate rehabilitation and pose a minimal risk to society to be considered for early release, and (4) supports providing judges with the discretion to help ensure that sentences are fair and fit the crime, while protecting against unjust and inconsistent results. (New HOD Policy)
2. Our AMA supports additional research to assess the effects of sentencing reforms on the health impacts of individuals who have been incarcerated and public safety. (New HOD Policy)
3. That our AMA reaffirm the following policies: D-430.992 "Reducing the Burden of Incarceration on Public Health," H-95.899, "Restorative Justice for the Treatment of Substance Use Disorders;" H-95.901, "Drug Policy Reform," H-80.993, "Ending Money Bail to Decrease Burden on Lower Income Communities" (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than $1,000

APPENDIX I - Successful State Reforms to Mandatory Minimum Sentencing

California's Proposition 47	Proposition 47 which passed in 2014, reclassified several property and drug offenses as misdemeanors and led to retroactively reduced sentences.[114] Within three months, almost 9,000 people had been released from California correctional facilities; within one year, that became 13,000 people. Evaluations of Proposition 47 have shown that it led to an immediate 15 percent decline in total drug arrests and a 20 percent decline in property crime arrests, as well as a reduction in racial disparities in arrest rates.[111] Analyses of Proposition 47 impact on crime rates in California have found that the proposition's passage was not associated with a change in violent crime rates, although larceny theft increased modestly following passage.[111] Proposition 47 also reduced recidivism: two-year rearrest and reconviction rates were significantly lower for people released after serving sentences for Proposition 47 offenses compared to their pre-reform counterparts.[115]
New York's Rockefeller Drug Law Reform	In 2009, the New York State Legislature passed full repeal of New York's Rockefeller Drug law and replaced it with a different statutory structure.[116] This sentencing reform permitted drug treatment and alternative-to-prison programs instead of prison sentences and set shorter sentence lengths for those still permitted to be imprisoned for felony drug convictions.[113] An impact study of these reforms found that in the nine months prior to Rockefeller Drug Law repeal, Black and Latinx people were three times more likely than white people to receive a prison sentence following a felony drug arrest.[117] After the drug law reforms, they were twice as likely as white people to go to prison—a 33 percent reduction in a disparity that researchers concluded could not be explained by factors other than race.[114] A follow-up on both sample groups showed that those sentenced to diversion after the reforms had 43 percent fewer rearrests than those sentenced to incarceration.[114]
Illinois	From 1980 to 1983, Illinois corrections officials released 21,000 incarcerated individuals—or 10 percent of the prison population—to alleviate the state's severe prison overcrowding, brought about in part by a huge increase in prosecutorial staffing and the state's move from indeterminate to determinate sentencing.[118] The largest portion of people released were convicted of burglary (26 percent) and armed robbery (15 percent).[115] The average sentence reduction per person was about 105 days, or 12 percent.[115] For the people released early who did go on to commit crimes, these accounted for less than 1 percent (4,500 arrests) of all recorded arrests for the three-year period covering their releases.[115]

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-A-25

Subject:	Research Correcting Political Misinformation and Disinformation on Scope of Practice
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee B

INTRODUCTION

At the 2024 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-405.968, "Research Correcting Political Misinformation and Disinformation on Scope of Practice," which calls for the following:

> That our AMA Board of Trustees perform a comprehensive literature review on current research on correcting political misinformation and disinformation and conduct field research on ways to correct political misinformation and disinformation amongst policymakers as it pertains to scope of practice. (Directive to Take Action)
>
> That our AMA Board of Trustees report its findings and recommendations to the HOD on correcting political misinformation and disinformation and that our AMA incorporate these findings to the extent possible into our AMA's advocacy efforts on scope of practice. (Directive to Take Action)

This report will provide an overview of the current research on correcting political misinformation and disinformation, as well as highlight field research currently underway by our AMA based on learnings from this literature review.

BACKGROUND

The topic of how to correct misinformation and disinformation has garnered much attention over the last decade, particularly as the internet and social media platforms have increased the ability for misinformation and disinformation to spread.[1] Misinformation and disinformation can occur across various disciplines such as health, the environment, politics, and crime[2] and can include "inaccurate news, conspiracy theories, disinformation campaigns, propaganda, and slanted reporting."[3] Misinformation can be created and spread by individuals, organizations, government entities, politicians, corporations, and/or the media.[4] In contrast to disinformation, there does not need to be mal-intent or even intent to mislead for something to qualify as misinformation. Indeed, misinformation can even arise unintentionally, such as through reporting on evolving events like natural disasters where information changes as the event unfolds and new information becomes available.[5] The scientific process also lends itself to refinement over time, "this piecemeal approach to knowledge construction is the very essence of the scientific process, through which isolated initial findings are sometimes refuted or found not to be replicable."[6]

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For the purposes of this report, the Board of Trustees has been asked to focus its research on how best to correct political misinformation and disinformation. It is important to understand that the leading scholars on this issue caution that the issue is complex and there is no one-size fits all solution.[7] The ability to correct misinformation may depend on a variety of factors, such as the credibility of the source of information, whether the information aligns with one's personal beliefs, and whether the information aligns with one's social and political identities.[8] That said, studies do reveal some techniques that have shown promise in effectively correcting misinformation. In November 2023, the American Psychological Association published a Consensus Statement entitled*, Using Psychological Science to Understand and Fight Health Misinformation* (*APA Consensus Statement*). The *APA Consensus Statement* describes the body of research on the psychology of misinformation, noting that experts remain divided on many key issues, including "how to define misinformation clearly, how to quantify how many people are regularly exposed to it, what factors make people susceptible to believing and hearing it online and offline, and how best to counter the problem at scale."[9]

Defining Misinformation and Disinformation

There is not a commonly agreed upon definition for misinformation or disinformation. The *APA Consensus Statement* defines misinformation as "any information that is demonstrably false or otherwise misleading, regardless of its source or intention"[10] and goes on to distinguish between misinformation and disinformation, specifying that disinformation involves an explicit intent to deceive or manipulate others. The *APA Consensus Statement* elected to focus on the broader term of misinformation, noting the difficulty in proving motive, and thus the challenge in distinguishing between misinformation and disinformation.[11]

Other scholars in this area have offered the following definitions:

- Misinformation occurs when false information is shared, but no harm is meant;
- Disinformation occurs when false information is knowingly shared to cause harm; and
- Malinformation occurs when "genuine information is shared to cause harm, often by moving information designed to stay private into the public sphere."[12] Malinformation has also been defined as information that stems from the truth but is exaggerated in a way that misleads and causes potential harm.[13]

Theories for Correcting Misinformation

Much of the literature on corrective techniques focuses on misinformation not disinformation or malinformation. Misinformation corrective techniques may focus on correcting specific messages or teaching individuals how to spot manipulation techniques and stop the spread of misinformation.

The *APA Consensus Statement* describes the following four corrective techniques found in literature on this topic:

1. Debunking or fact-checking;
2. Inoculation theory or prebunking;
3. Literacy interventions; and
4. Nudging.

A separate meta-analysis comparing the effectiveness of techniques used to correct misinformation across science, health, politics, marketing, and crime focuses on the following common corrective techniques.

These techniques overlap with those in the *APA Consensus Statement* as noted below:

1. Appeals to consensus (similar to nudging);
2. Coherence (part of the corrective technique in debunking);
3. Source credibility (similar to literacy interventions);
4. Fact-checking (similar to debunking); and
5. Providing general warnings (similar to inoculation).

Debunking or Fact-Checking

Debunking or fact-checking is a common corrective technique used to state the inaccuracy of information, why it is incorrect, and often followed-up with the correct information. Unlike the inoculation or prebunking technique, which will be discussed below, this technique is used after misinformation has already been shared. Fact-checking is commonly used during political debates either in real-time or post-debate.

In general, studies have found that debunking alone is ineffective. One reason cited is because individuals tend to follow conversational norms and assume that speakers are truthful. Individuals may also continue to believe misinformation despite attempts to fact-check due to the "continued influence effect," in which misinformation retains its perceived truth despite attempts to correct.[14] In other words, fact-checking does not fully remove the false information from one's memory and familiarity with a message – even if it is incorrect – can increase its perceived truth. For example, one study found that debunking misinformation rarely eliminated one's reliance on misinformation, reducing references by only about 50 percent.[15] Studies also point to the importance of the tone of the correction, noting that authoritative retractions can be especially ineffective and may lead individuals to further entrench in the misinformation. The use of negative emotions in the correction has also been studied. For example, one study examining the use of emotions in corrective techniques related to tobacco found that the use of negative emotions was more effective than a simple correction; however, authors of the study caution that their findings are limited to the controlled setting in which they were examined and cannot be generalized.[16]

Research has found that the effectiveness of debunking increases when paired with other corrective methods, such as following up with correct information. According to several researchers, refuting the misinformation and replacing it with correct information has proven effective because it maintains the coherence of the story.[17] Indeed, leaving gaps in a narrative can limit the effectiveness of a corrective technique. Similarly, simple explanations are preferred over complex explanations.[18]

Inoculation Theory or Prebunking

Inoculation theory was originally developed by McGuire in the 1960s as a strategy to prevent misinformation from influencing individuals by building an individual's resistance to persuasion. Unlike fact-checking, inoculation or prebunking occurs before an individual receives the misinformation. The idea is to inoculate an individual by providing them with a weakened form of the misinformation, share why it is inaccurate, and provide clues on how one might be able to spot it in the future.[19] The theory has evolved to include both inoculating against specific messages and providing general mechanisms or forewarnings on how to spot common manipulation tactics.[20] Using inoculation techniques for specific issues typically involves two parts (1) identifying the threat, and (2) refutational preemption (prebunking). The threat component includes a warning that an individual will hear a specific piece of misinformation plus a less convincing version of the falsehood. This warning is then followed up with a refutational preemption or prebunking, i.e., the

correct information.[21] Noting the challenges with prebunking every piece of misinformation, researchers have turned to using inoculation to inform individuals on how to spot common manipulations techniques used to spread misinformation. These are often gamified and include platforms like "Bad News," (https://www.getbadnews.com/en) a role-playing game that teaches users manipulation techniques and awards them points for crafting a misinformation campaign that attracts followers, with the intent to make them better informed and able to spot misinformation in their daily lives.[22] Truth Labs for Education (https://inoculation.science/inoculation-videos/), is another example. Truth Labs for Education is a collaboration between Cambridge University, the University of Bristol, and Google Jigsaw that also has a series of videos aimed at inoculating individuals against common manipulation techniques used to spread misinformation. Similarly, Google has a series of videos (https://prebunking.withgoogle.com/) aimed at helping individuals spot manipulation techniques and providing guidance on how to successfully prebunk misinformation. Notably, there is overlap with these inoculation techniques and the literacy interventions and nudging techniques described below.

Inoculation has proven an effective technique in preempting the effect of misinformation. For example, one study found that inoculation of specific messages on climate change proved effective.[23] Researchers have also found that corrective actions including both a forewarning and preemptive refutation (prebunking) of the misinformation was most effective.[24] Since it would be nearly impossible to perform inoculation against each and every falsehood, studies have also measured the scalability of inoculation techniques across issues. The findings are promising. For example, studies have found that an individual who has been inoculated against one falsehood is less likely to be susceptible to misinformation in other contexts.[25] Similarly, a systemic review and meta-analysis confirmed this phenomenon finding that inoculation is "effective in creating more resistant attitudes against misinformation while improving truth discernment."[26] Studies have also found that inoculation can have long term effects – up to a week – and up to three months with brief reminders ("booster shots") of the inoculation.

Researchers, however, note that there are limitations with inoculation, including that most studies on the effectiveness of inoculation are done in controlled environments with only a few studies examining its effectiveness in correcting real-world misinformation.[27] In addition, most studies in this body of research focus on the effectiveness of inoculation techniques in improving the identification of misinformation. More research is needed on the effectiveness of inoculation in replacing misinformation with accurate information.

Literacy Interventions

Literacy intervention techniques are focused on improving an individual's ability to discern the accuracy of information and spot misinformation. As mentioned above, this technique often incorporates inoculation theories. The *APA Consensus Statement* describes this technique in terms of health literacy, media literacy, and digital literacy. Health literacy includes informing individuals how to evaluate health content for quality or accuracy. Media literacy includes the ability to evaluate the quality of print and online media and digital literacy includes the ability to properly execute tasks online.[28] These interventions often occur in formal settings, including schools, universities, and community centers.

In terms of the effectiveness of these approaches, the *APA Consensus Statement* describes mixed results, noting that there may be some short-term benefits, but that interventions may require a significant investment of time and resources (e.g., interventions lasting more than five hours were more likely to be effective than those lasting one hour).[29] In addition, the report notes that few

studies have focused on or shown a lasting effect of literacy interventions, challenging their long term impact.[30]

Nudging

Unlike the techniques described above, which are often focused on correcting misinformation, nudging is a technique used to encourage behavioral changes in individuals, such as encouraging them to correctly identify misinformation. Anti-misinformation nudges may include accuracy nudges, social-norm nudges, and motivational nudges.[31] Accuracy nudges encourage people to reflect on the importance of only sharing accurate information with others. Per the *APA Consensus Statement*, "social-norm nudges are geared toward news-sharing behavior and emphasize either injunctive norms (i.e., behaviors most people find acceptable or not) or descriptive norms about it (i.e., how other people respond in certain situations)."[32] Finally, motivational nudges "seek to motivate people to be as accurate as possible (e.g., paying them to correctly identify true and false news)."[33]

In general nudging is a systems-based technique aimed at correcting one's behavior rather than a technique used to correct misinformation related to specific topics or specific messages. For example, X and TikTok have, at times, integrated nudging techniques into their platform to encourage users to examine the veracity of the information and re-consider whether it should be shared with others.[34] Some have suggested that when inoculation is combined with nudging, the effectiveness of both techniques increases.[35]

In terms of the effectiveness of nudging, a meta-analysis described in the *APA Consensus Statement* "found that accuracy nudges were effective overall at improving sharing discernment, although this effect was both small and heterogeneous."[36] Similarly, a field study on X, when it was known as Twitter, found that social norm nudges were effective in improving the identification of misinformation.[37] Finally, motivational nudges, including paying people to correctly identify misinformation, were also found effective in both improving people's ability to accurately identify misinformation and reducing any partisan bias when reviewing information.

However, researchers also note mixed findings on studies of the effectiveness of nudging, as well as some general limitations. Notably, there is concern that effectiveness may be short-lived and wear off after several repetitions.[38] Nudging may also be less effective toward individuals who do not want to be nudged.[39]

DISCUSSION

The body of literature on techniques to correct political misinformation and disinformation provides guidance which may be applicable to correct myths often used by those supporting inappropriate scope of practice expansions. As noted in the literature, however, correction of political misinformation poses unique challenges, as research consistently shows people are more resistant to changing political beliefs compared to other domains. This resistance appears particularly strong among educated political partisans, suggesting that corrective techniques relying solely on increased education or providing additional information on a topic may be insufficient. This may be particularly true among legislators. Indeed, researchers have noted that an individual's worldview or ideology can play a key role in one's susceptibility to misinformation and the effectiveness of corrective techniques. Correcting political misinformation may also be faced with suspicion due to perceived motivations behind the misinformation and those correcting the misinformation.

Scholars have also shared limitations in this body of research. For example, much of the research has been done in a controlled setting, therefore, these techniques may not have the same level of effectiveness when replicated in a real-world environment. Finally, these theories are often tested on specific age groups or the general population, not policymakers or lawmakers, making it difficult to know whether these techniques will prove effective for this audience.

This literature review has been instrumental in providing the basis for our next step: assessing the effectiveness of these techniques to counter arguments related to scope of practice expansions. This step is currently underway and includes our AMA engaging in field research to test these techniques on specific messages often used by those supporting scope of practice expansions. Our AMA will incorporate findings from this field research into our scope of practice advocacy campaign. The cost necessary to implement Policy D-405.968, "Research Correcting Political Misinformation and Disinformation on Scope of Practice" including conducting the field research has already been approved and allocated by our AMA. With the directives having been accomplished, the Board of Trustees recommends rescinding this policy.

RECOMMENDATION

The Board of Trustees recommends the following recommendation be adopted and the remainder of the report be filed:

That our American Medical Association rescind Policy D-405.968, "Research Correcting Political Misinformation and Disinformation on Scope of Practice." (Rescind HOD Policy)

Fiscal Note: Less than $500.

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REPORT 17 OF THE BOARD OF TRUSTEES (A-25)
Antidiscrimination Protections for LGBTQ+ Youth in Foster Care Report
(Reference Committee B)

EXECUTIVE SUMMARY

Background: During the 2024 Annual Meeting, the House of Delegates (HOD) referred for report the second Resolve of Resolution 224 titled, Antidiscrimination Protections for LGBTQ+ Youth in Foster Care. The resolve recommended, "that our AMA support efforts by the Department of Health and Human Services and other appropriate stakeholders to establish a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data in the Adoption and Foster Care Analysis and Reporting System (AFCARS) only when strong privacy protections exist."

Discussion: LGBTQ+ youth, particularly transgender individuals, are disproportionately represented in the foster care system, facing significant challenges such as discrimination, mental health issues, and unstable placements. However, the lack of comprehensive data collection on sexual orientation and gender identity (SOGI) has hindered efforts to develop focused policies and interventions. Despite an unstable policy landscape, collecting SOGI data remains crucial.[i] Data collection enables child welfare agencies to better assess disparities, tailor services, and improve placement stability for LGBTQ+ youth.

This report explores considerations for integrating SOGI data into AFCARS, emphasizing the need for strong privacy protections. Creating a successful data strategy requires navigating political headwinds, concerns about privacy and data security, and varying state policies. To succeed, federal agencies can implement rigorous privacy measures, provide technical assistance to states, and ensure that SOGI data collection is voluntary and confidential. Moreover, ongoing collaboration between HHS, child welfare agencies, advocacy groups, and healthcare professionals is essential to establishing a sustainable reporting mechanism. Physicians and health care professionals play a key role by advocating for accurate data collection, safeguarding privacy, and ensuring that LGBTQ+ youth receive appropriate mental health and medical care.

Conclusion: Integrating SOGI data into AFCARS represents a critical step toward a more inclusive and equitable foster care system. With careful implementation, strong privacy protections, and support from healthcare professionals, this initiative can improve outcomes for LGBTQ+ youth and ensure that child welfare policies reflect the diverse needs of the children they serve.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-A-25

Subject:	Antidiscrimination Protections for LGBTQ+ Youth in Foster Care
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee B

BACKGROUND

During the 2024 Annual Meeting, the House of Delegates (HOD) Resolve 2 of Resolution 224-A-2-24 titled, Antidiscrimination Protections for LGBTQ+ Youth in Foster Care was referred for report.[ii] The resolve recommended:

> RESOLVED, that our AMA support efforts by the Department of Health and Human Services and other appropriate stakeholders to establish a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data in the Foster Care Analysis and Reporting System only when strong privacy protections exist.

Resolution 224-A-24 received mixed reviews when it was up for discussion in Reference Committee B. Testimony reflected that most LGBTQ+ groups believe that this data should be collected by the federal government "to enhance recruitment of foster homes, promote visibility for marginalized groups, help to analyze youth outcomes, and address disparities."[iii] However, there were serious concerns related to data privacy and overall child safety.[iv] Additional testimony highlighted the divide between which governmental body should collect SOGI data for LGBTQ+ youth, federal or state and local governments.[v]

DISCUSSION

The foster care system in the United States serves as a critical safety net for children and youth who are unable to remain in their homes due to abuse, neglect, or other family challenges. Administered at the state level with federal oversight and funding, the system provides temporary care and placement, aiming to ensure the safety, well-being, and permanency of children. (Permanency "is a permanent, stable living situation, ideally one in which family connections are preserved.")[vi] While the foster care system supports over 390,000 children annually, it faces significant challenges, including a shortage of foster families, disparities in outcomes for children of color and LGBTQ+ youth, and barriers to achieving permanency through reunification or adoption.[vii]

LGBTQ+ youth, particularly transgender individuals, are significantly overrepresented in the foster care system, with approximately 30 percent identifying as LGBTQ+ and five percent as transgender—far exceeding their representation in the general population.[viii] These youth face heightened risks of discrimination, mental health challenges, and disrupted placements due to systemic biases and lack of affirming care. Collecting sexual orientation and gender identity

(SOGI) data in the foster care system would be a critical step toward improving such outcomes for LGBTQ+ youth.[ix]

The U.S. Department of Health and Human Services (HHS) plays a central role in guiding and supporting efforts to collect SOGI data in child welfare. Within HHS, the Administration for Children and Families (ACF) oversees the Adoption and Foster Care Analysis and Reporting System (AFCARS), a national data system that tracks case-level information on children in foster care. Historically, AFCARS has not required the reporting of SOGI information.

However, recognizing the significant need for better data to serve LGBTQ+ youth, HHS and partnering agencies would make great strides in improving health outcomes by establishing a reporting mechanism for anonymized, aggregated SOGI data in AFCARS. These efforts would involve multiple interested parties – federal and state child welfare agencies, advocacy organizations, former foster youth, and experts in data collection and privacy – collaborating to design policies and practices that encourage SOGI data reporting.

A paramount concern in collecting SOGI information is ensuring strong privacy protections. Given the sensitive nature of sexual orientation and gender identity data, inappropriate disclosure can put youth at risk of stigma, discrimination, or even harm (for instance, some foster youth have been "outed" without consent, resulting in hostile reactions from caregivers).[x] Physicians and other healthcare professionals who care for foster youth understand the importance of confidentiality in maintaining trust; similarly, confidentiality is crucial when youth share SOGI information. The goal, therefore, is to develop data systems that yield valuable insights into LGBTQ+ foster youth's needs and the effectiveness of supportive interventions while rigorously safeguarding individual privacy. Federal guidance emphasizes that SOGI data collection must only proceed with measures to secure privacy, security, and civil rights – including robust consent practices and restrictions on data use.[xi] This report underscores the need for the establishment of a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data into AFCARS and overview of privacy protections considerations.

Unstable Policy Landscape around Collection of Data among LGBTQ+ Communities

In recent years, the policy landscape has evolved to explicitly support the inclusion of SOGI data in foster care reporting. In 2016, under the Obama Administration, HHS's ACF issued a groundbreaking final rule to update AFCARS after over two decades; this rule would have, for the first time, required state child welfare agencies to collect and report SOGI-related data.[xii] The 2016 rule specified that youth ages 14 and older would be asked to voluntarily self-report their sexual orientation, and that agencies would report the sexual orientation of foster/adoptive parents and legal guardians, as well as whether a youth's entry into care involved family conflict related to SOGI. The ACF explained that these data points were intended to "better support children and youth in foster care who identify as LGBTQ+" by ensuring placement resources and services could be tailored to their needs. This policy marked a significant recognition at the federal level that SOGI data are integral to child welfare planning.

However, the implementation of the 2016 AFCARS SOGI data requirements was halted and reversed under the first Trump administration. The rule's effective date was delayed multiple times in 2017–2018, and by 2019 HHS proposed rescinding the SOGI elements, citing a desire to reduce reporting burden and concerns that sexual orientation data were "too sensitive and private" for a government record.[xiii] In May 2020, a final rule was issued that eliminated the collection of sexual orientation data from AFCARS entirely.[xiv] This rollback was met with strong opposition from advocacy groups and some state officials, who argued that removing SOGI data "is a huge mistake

that will harm the children we serve," making LGBTQ+ youth and their outcomes "invisible" in national statistics.[xv] Massachusetts youth advocates responded by urging their state to collect and report SOGI data on its own, condemning the federal withdrawal as an "abandonment" of responsibility to LGBTQ foster youth.[xvi] The policy back and forth between 2016 and 2020 highlighted that, absent federal requirements, efforts to gather SOGI data would rely on state-level initiative or future policy changes.

The pendulum continues to swing regarding SOGI data collection. In June 2022, President Biden issued Executive Order 14075 on Advancing Equality for LGBTQI+ Individuals, which explicitly directs federal agencies to improve SOGI data collection while safeguarding privacy.[xvii] This order led to the creation of a Federal Evidence Agenda on LGBTQI+ Equity and an HHS-led SOGI Data Action Plan in 2023.[xviii,xix] The HHS SOGI Data Action Plan calls on the entire department to enhance the health and well-being of all Americans by systematically collecting SOGI data in its programs, "whenever data on other demographic characteristics are collected."[xx] In practice, this means HHS operating divisions and staff divisions would be reviewing their data systems (including those for foster care) to add SOGI variables where feasible.[xxi] The plan urges updating binary gender categories to be more inclusive and ensuring that SOGI questions would be incorporated into demographic data collection as soon as possible.[xxii] This renewed policy emphasis from HHS leadership signaled strong support for establishing a SOGI reporting mechanism in AFCARS. Additionally, various states and localities have enacted their own policies to gather SOGI data in social services – for example, California implemented a SOGI data collection law that added SOGI fields to statewide client databases – further building momentum for broader adoption.[xxiii] However, in January 2025, President Trump rescinded Executive Order 14075 and other key policies aimed at protecting LGBTQ+ individuals, reversing federal efforts to collect SOGI data in foster care, health care, and other social services while also limiting anti-discrimination protections across multiple agencies.[xxiv,xxv]

Benefits of Collecting SOGI Data in Foster Care

Collecting SOGI data within AFCARS stands to yield significant benefits for the well-being of children and adolescents in foster care, particularly those who are LGBTQ+. One of the clearest benefits is the ability to identify and address health inequities and needs more accurately. LGBTQ+ youth in care face distinctive health challenges – for example, higher rates of depression, suicidal ideation, and trauma related to identity-based rejection.[xxvi] If child welfare and health care professionals know how many individuals are affected and can correlate that with health outcomes, they can better allocate mental health services, counseling, and support programs. For instance, if data reveal that a substantial percentage of foster youth identify as transgender, agencies can ensure there are clinicians trained in gender-affirming care available for consultations. Similarly, if lesbian, gay, or bisexual youth in care show higher utilization of emergency mental health services, that could prompt focused preventive interventions (such as support groups or mentoring programs to build resilience). In short, what gets measured gets addressed – by capturing SOGI information, the foster care system can move from anecdotal awareness of LGBTQ+ youths' struggles to quantitative evidence that spurs more efficient and effective health care planning and resource allocation.[xxvii,xxviii]

From a social services perspective, SOGI data helps ensure that policies and practices are inclusive. For example, knowing the proportion of youth identifying as LGBTQ+ can inform recruitment of foster families.[xxix] Agencies might invest more in recruiting affirming foster homes or training existing foster parents on LGBTQ+ issues if data show a high need. Essentially, SOGI data allows for a more individualized approach in a system that often has to take broad steps to address various challenges.

Physicians who work with foster children (e.g., pediatricians in foster care clinics, child psychiatrists) would see direct benefits too. Providing affirming sexual health counseling would benefit all of their patients, and could help close gaps for foster children, particularly those who identify as LGBTQ+. If a physician is aware that a patient is part of a population at elevated risk for certain issues, they can institute procedures and/or create systems that prompt focused screening and intervention. For example, a primary care doctor knowing their foster patient is LGBTQ+ might increase their frequency of screening for depression or anxiety. On a systemic level, health care professionals can partner with child welfare to develop trauma-informed, LGBTQ+-affirming care models when the need is documented.[xxx] Furthermore, data might reveal positive outcomes where supportive policies are in place, thereby guiding best practices that health care professionals can advocate for, and health systems can scale up.

Finally, at a human level, asking SOGI questions in a respectful manner can itself send a message of inclusion to youth of all identities. Many LGBTQ+ youth in particular report feeling invisible or misunderstood in systems of care. When a caseworker or health care professional asks about their identity in a validating way and that information is used to support them, it affirms to the young person that they are seen and valued. This can build trust in the system. Over time, as data-driven improvements take root, one would hope to see tangible benefits: reductions in homelessness among LGBTQ+ youth who have aged out of the foster care system, fewer incidences of bullying or abuse in placements, better mental health status, and more stable, affirming placements – all of which contribute to healthier outcomes.

Privacy Protections for SOGI Data in Foster Care

Privacy laws are a critical component that ensure sensitive information is protected. Any state that receives a grant under the Child Abuse Prevention and Treatment Act (CAPTA), "must provide an assurance that it has in effect and is enforcing a state law that includes methods to preserve the confidentiality of all child abuse and neglect reports and records in order to protect the rights of the child and the child's parents or guardians, including requirements to ensure that the information is released only to certain individuals and entities."[xxxi,xxxii]

While foster care agencies are not considered "covered entities" under the Health Insurance Portability and Accountability Act (HIPAA), the principles of health information privacy are highly relevant to the collection of SOGI data. SOGI data can be considered sensitive, similar to health information, and should be safeguarded accordingly. Under HIPAA, any individually identifiable health information, including SOGI data in medical or counseling records must be protected and disclosed only for permitted purposes.[xxxiii] In April 2024, HHS reinforced these protections, preventing disclosure of health data for investigations related to gender-affirming care, further underscoring the expectation of privacy for SOGI-related information.[xxxiv]

Since AFCARS is an administrative database rather than a public health repository, any SOGI data collected would be subject to federal confidentiality rules, which also means federal laws such as the Privacy Act of 1974 applies to AFCARS data, requiring a System of Records Notice outlining its collection and use and restricting disclosure without consent. When properly anonymized and aggregated, SOGI data falls outside the scope of personally identifiable information and is not subject to HIPAA or Privacy Act restrictions. However, the initial collection of SOGI data—when attached to a youth's case—must be carefully managed under strict confidentiality rules.

Federal and State Legal Protections

In recent years, several federal directives have specifically addressed SOGI data privacy. Executive Order 14075, which as mentioned above was rescinded in early 2025, instructed agencies to safeguard privacy, ensure informed consent, and limit the use of SOGI information.[xxxv] The Trump administration also rescinded the March 2021 Department of Justice (DOJ) memo providing that DOJ would apply the Supreme Court's holding in *Bostock v. Clayton County*[xxxvi] (that Title VII of the Civil Rights Act of 1964 protects employees against discrimination and unjust termination based on their sexual orientation or gender identity) in the context of Title IX and, accordingly, Section 1557, weakening protections.

However, federal civil rights laws including Title VI of the Civil Rights Act continue to prohibit discrimination based on sex, which includes sexual orientation and gender identity; reinforcing the notion that SOGI data should be used to prevent disparities, not perpetuate discrimination.

State laws also impact SOGI data collection in foster care. Child welfare information, including SOGI details, is generally protected under state confidentiality statutes, limiting access to authorized parties such as case workers and health care professionals.[xxxvii] Some states have taken proactive steps to affirm LGBTQ+ youth rights. For instance, California's Foster Youth Bill of Rights (AB 175) ensures that youth are referred to by their preferred name and gender pronouns.[xxxviii] Additionally, California's AB 959 mandates SOGI data collection across state programs, leading to its inclusion in child welfare databases like Child Welfare Services/Case Management System.[xxxix]

However, some states have enacted laws hostile to LGBTQ+ rights, such as bans on gender-affirming care or restrictions on discussing LGBTQ+ issues in schools.[xl] In such states, there are concerns that SOGI data could be misused. While foster care data is not public, legal safeguards must ensure that access to SOGI data remains restricted and not subject to improper demands. No lawful basis currently exists for law enforcement or other agencies to access SOGI data from child welfare records simply to enforce anti-LGBTQ policies. To ensure both the protection of sensitive information and the effectiveness of data collection, it is crucial to establish a secure and standardized approach.

SOGI data collection at the federal level ensures consistency, comparability, and comprehensive national oversight. Federal agencies like the CDC and HHS generally have the infrastructure, resources, and reach necessary to gather or support standardized data across states, which is essential for identifying disparities and informing equitable public health and policy interventions. While state and local governments can complement these efforts with localized data collection, relying solely on them could risk inconsistency and incomplete data due to varying political climates and resource limitations. A federal framework with assistance to state and local governments and clear guidelines and privacy protections would strike a balance, ensuring LGBTQ+ populations are accurately represented and better served nationwide.

Addressing Privacy Concerns

Despite safeguards, privacy risks remain. A primary concern is the unintended disclosure of a youth's LGBTQ+ status, which can lead to stigma, discrimination, or even removal from supportive placements. Reports from the Government Accountability Office highlight cases where case workers or foster parents inappropriately disclosed a youth's SOGI information, leading to harm.[xli] Additionally, in politically charged environments, concerns persist that SOGI data could be

accessed for punitive purposes, similar to efforts in some states to obtain medical records related to gender-affirming care.[xlii]

To mitigate these risks, agencies must uphold strict need-to-know access policies, ensuring SOGI data is only accessible to those directly involved in the individual's care. Courts typically receive only information relevant to a proceeding, and SOGI data should not be included unless necessary. HHS has committed to publishing only anonymized and aggregated SOGI data, ensuring no individual can be identified.

Individual consent remains a fundamental protection. The scrapped 2016 AFCARS rule framed SOGI questions as voluntary for youth age 14 and older, a principle likely to carry forward in future implementation. Research suggests that youth are more likely to disclose SOGI information when assured of confidentiality.[xliii] Agencies can further enhance privacy by requiring explicit consent before sharing SOGI data with third parties, such as foster parents.[xliv]

From a security perspective, child welfare information technology systems already incorporate firewalls, encrypted databases, and role-based access to restrict data visibility.[xlv] Confidentiality agreements and mandatory staff training on LGBTQ+ cultural appropriateness reinforce ethical data handling.[xlvi,xlvii]

Challenges and Considerations

Implementing SOGI data collection in foster care could present several challenges that should be addressed.

Resistance and Pushback: Some interested parties, including state and local officials, argue that sexual orientation and gender identity are private matters and question their relevance to child welfare.[xlviii] Others cite concerns about workforce burden, including training, software updates, and data entry.[xlix] Political opposition has also hindered progress, with some fearing that collecting SOGI data may be misinterpreted as encouraging LGBTQ+ identification.[l] Additionally, religious objections from foster agencies and parents further complicate data collection efforts.[li,lii]

Ethical and Community Concerns: The voluntary nature of SOGI disclosure is crucial, as individuals in foster care may not yet feel comfortable identifying or may fear repercussions. LGBTQ+ advocacy groups generally support data collection for visibility and service improvements, but concerns about misuse persist. Another concern is if SOGI data is improperly accessed, LGBTQ+ youth in foster care could become targets for discrimination, harassment, or punitive actions, particularly in states with anti-LGBTQ+ policies. Given the vulnerability of foster youth, unauthorized disclosure of their SOGI status could lead to unsafe placements, rejection by caregivers, or even legal repercussions in hostile jurisdictions, underscoring the critical need for strict privacy protections.
Agencies must engage youth, community members, and organizations most impacted to ensure ethical data practices and accountability. Furthermore, collecting this data creates an obligation to use it effectively, rather than letting it sit unused.

Balancing Data Collection with Privacy: Protecting individual privacy is a top priority. Agencies must implement strict safeguards, ensuring that only authorized personnel access SOGI information. Training caseworkers on appropriate, sensitive questioning and confidentiality protocols is essential to prevent accidental disclosures or misuse. Agencies should also monitor for breaches and adjust policies as needed.

Resource and Operational Considerations: States differ in technical capacity, and under-resourced agencies may struggle to integrate new data fields. If HHS reinstates SOGI data requirements, funding and technical support will be needed. Ensuring accuracy is also a challenge, as incorrect data entry or assumptions by caseworkers could lead to harm. Systems should allow self-reporting and updates to reflect evolving identities.

Changing Political Winds: The collection of SOGI data has been subject to policy reversals, with one administration requiring it and another rescinding it. These shifts create uncertainty for states and child welfare workers. Establishing bipartisan professional consensus, supported by organizations like the American Academy of Pediatrics and the Child Welfare League of America, can help normalize SOGI data collection as a standard child welfare practice rather than a political issue.

To navigate these challenges, transparency is key. Agencies must clearly communicate why they are collecting SOGI data, how it will be used, and the protections in place. Engaging people and organizations most impacted, addressing concerns proactively, and demonstrating the benefits—such as improved services—can help build trust. For health care professionals, these challenges mirror the initial resistance to collecting other sensitive health data, underscoring the importance of careful implementation, privacy protections, and long-term commitment to better care for LGBTQ+ foster youth.

Current AMA policy

The AMA has adopted several policies to support LGBTQ+ individuals in health care, foster care, and legal protections. Below is a summary of these policies.

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation (H-315.967)

- Supports the voluntary inclusion of biological sex, gender identity, sexual orientation, and related data in medical records in a culturally sensitive way.
- Advocates for standardized data collection in medical research to improve patient care.
- Calls for collaboration with health IT vendors to ensure equitable treatment of patients regardless of gender identity.
- Supports the use of personal health records to reduce administrative burden.
- Urges the incorporation of best practices into electronic health records at no additional cost to physicians.

Protecting the Integrity of Public Health Data Collection (H-440.817)

- Advocates for the inclusion of sexual orientation and gender identity (SOGI) data in national and state health surveys, registries, and surveillance systems.
- Opposes the removal of SOGI data from such databases without a plan for updating demographic measures.

Medical Spectrum of Gender (D-295.312)

- Works to educate the medical community and the public on the diversity of gender identities.
- Supports policies that ensure access to quality healthcare for gender-diverse individuals.

- Affirms that an individual's gender, sex, and sexual orientation may not always align, recognizing gender identity as distinct from sex assigned at birth.

Opposing Mandated Reporting of People Who Question Their Gender Identity (H-65.959)

- Opposes laws requiring disclosure of patient information related to gender identity, gender dysphoria, intersex identity, or gender transition, including for minors.

Support of Human Rights and Freedom (H-65.965)

- Supports the dignity, equal rights, and non-discrimination of all individuals, including those of diverse gender identities and sexual orientations.
- Opposes hate crimes and advocates for legal protections against discrimination.

Encouraging LGBTQ+ Representation in Medicine (D-200.972)

- Advocates for targeted recruitment of LGBTQ+ students in medical education.
- Supports including SOGI data in demographic surveys to assess representation in medicine.
- Works with medical organizations to better understand and address the unique experiences of LGBTQ+ individuals in healthcare professions.

Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations (D-65.996)

- Encourages physicians to display a nondiscrimination policy in medical offices affirming inclusivity for all patients.

Nondiscrimination Policy (H-65.983)

- Affirms that the AMA does not and has never discriminated based on sexual orientation or gender identity.

LGBTQ+ Older Adults (D-65.979)

- Promotes awareness of aging-related LGBTQ+ health issues among the public, healthcare professionals, and policymakers.
- Supports cultural competency training for clinicians caring for LGBTQ+ older adults.
- Advocates for inclusive healthcare policies and practices in all settings.
- Calls for increased funding for research on LGBTQ+ aging and health disparities.

Health Care Needs of LGBTQ+ Populations (H-160.991)

- Encourages nonjudgmental recognition of LGBTQ+ identities in medical care.
- Supports physician education on LGBTQ+ health needs at all levels, from medical school to continuing education.
- Opposes conversion therapy.
- Collaborates with organizations to enhance physician competency in LGBTQ+ healthcare, including screening for conditions such as STIs and intimate partner violence.
- Promotes partnerships with LGBTQ+ communities to improve medical understanding and care.

Antidiscrimination Protections for LGBTQ+ Youth in Foster Care (H-60.895)

- Supports federal and state policies that protect LGBTQ+ youth from discrimination in the foster care system.
- Advocates for training child welfare professionals and foster caregivers to create safe and affirming placements.
- Promotes efforts to reduce violence against LGBTQ+ youth in foster care.
- Encourages recruitment of LGBTQ+-affirming foster families.
- Supports placing gender-diverse youth in homes that respect their identities.

Equal Access for Adoption in the LGBTQ+ Community (D-60.964)

- Advocates for equal adoption rights for LGBTQ+ individuals meeting federal criteria.
- Encourages government funding for child welfare agencies that provide inclusive adoption services.

Reducing Suicide Risk Among LGBTQ+ Youth (H-60.927)

- Partners with public and private organizations to reduce suicide rates and improve mental health for LGBTQ+ youth.

Promotion of LGBTQ+ Friendly and Gender-Neutral Intake Forms (D-315.974)

- Supports the development and implementation of inclusive medical documentation and forms to ensure accurate patient data collection.

Endorsing LGBTQ+ Research IRB Training (D-460.966)

- Advocates for standardized Institutional Review Board (IRB) training on research involving LGBTQ+ populations.

Nondiscrimination in Healthcare (H-65.976)

- Encourages medical institutions to include sexual orientation and gender identity in nondiscrimination policies for patients, employees, and healthcare workers.

Preventing Anti-Transgender Violence (H-65.957)

- Calls for increased public education on hate crimes against transgender individuals, particularly Black transgender women.
- Advocates for law enforcement data collection on transgender hate crimes and improved reporting.
- Supports stronger policies to prevent bias in law enforcement interactions with transgender individuals.
- Promotes increased access to mental health care and resources for LGBTQ+ individuals.

Youth and Young Adult Suicide Prevention (H-60.937)

- Recognizes youth suicide as a serious health crisis.
- Supports physician education on suicide prevention, screening, and intervention.
- Advocates for increased mental health resources, research, and targeted programs for high-risk populations, including LGBTQ+ youth.
- Calls for public awareness and policy action to address youth mental health crises, particularly post-COVID-19.

Conclusion

Integrating SOGI data into AFCARS is a critical step toward a more equitable child welfare system. This report highlights the importance of collecting SOGI data with strong privacy protections to improve policies, practices, and health outcomes for LGBTQ+ youth, who are overrepresented in foster care yet remain largely invisible in national data. While some federal protections have gone away, other protections like HIPAA, the Privacy Act, and confidentiality laws ensure privacy safeguards, while modern technology enables secure and anonymized data collection.

Establishing a secure and anonymized SOGI data reporting system aligns foster care systems with broader public health goals, advancing health equity for LGBTQ+ youth. With careful implementation, this initiative can build trust, ensure safer placements, and improve long-term outcomes. Achieving these goals requires ongoing collaboration among HHS, child welfare agencies, health care professionals, and the youth themselves. Supporting SOGI data collection while upholding the highest privacy standards, would be a vital step toward a more inclusive, responsive foster care system—one that truly serves and protects all children.

RECOMMENDATION

The Board therefore recommends that Resolve 2 of Resolution 224-A-24 be adopted and the remainder of the report be filed:

1. That our AMA support efforts by the Department of Health and Human Services and other appropriate stakeholders to establish a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data in the Adoption and Foster Care Analysis and Reporting System only when strong privacy protections exist. (New HOD Policy)

Fiscal Note: To be determined.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 21-A-25

Subject: Advocacy for More Stringent Regulations/Restrictions on Distribution of Cannabis (Res. 515-A-24)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 515-A-24, "Advocacy for More Stringent Regulations/Restrictions on Distribution of Cannabis," was adopted. This resolution resulted in Policy D-95.954, which directed the AMA "to study possible legislative, legal or regulatory means to make the cannabis industry responsible for increasing costs of medical and social care for people affected by the problems caused by cannabinoids similar to regulations for smoking cessation in the United States." Delegates' testimony, while limited, focused primarily on the need to cover the costs of treatment, effects of high-potency cannabis and cannabis-derived products, and medical impacts on individuals who use cannabis and cannabis-derived products. This report provides relevant background, discusses issues raised by the resolution, cites AMA policy, and makes recommendations.

BACKGROUND

As of the time of this report, cannabis was classified by the federal government as a Schedule I Controlled Substance. Without going into extensive detail, the Schedule I status has not prevented state-based legalization efforts. Almost every state has a robust legal and regulatory framework regulating cannabis. According to the National Conference of State Legislatures (NCSL), at least 47 states, the District of Columbia, and three territories (Guam, Puerto Rico, and the U.S. Virgin Islands) allow for the use of cannabis for medical purposes and/or low tetrahydrocannabinol (THC), and cannabidiol (CBD) products.[1] In general, each state defines the type(s) of qualifying medical condition(s) to authorize the personal use of cannabis for medical purposes. These laws have been adopted via legislative and/or ballot initiatives, and there are regulatory structures in each of these states, the District of Columbia, and the three territories, to implement the laws. All include requirements on cannabis growers, manufacturers, retailers, advertisers, home growers, and others. The NCSL also reports that at least 24 states and the District of Columbia allow for adult use of non-medical cannabis. The Board of Trustees (Board) notes that the AMA has worked closely with many medical societies on these laws.

Cannabis use is highly prevalent in the United States. In 2023, more than 43 million people over the age of 12 used cannabis in the past month, and 4.3 million people aged 12-20 used cannabis in the past month, according to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).[2] In 2022, nearly 62 million people used cannabis in the past year, according to SAMHSA.[3] "Teenage marijuana use is at its highest level in 30 years, and today's teens are more

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likely to use marijuana than tobacco," according to the American Academy of Child and Adolescent Psychiatry,[4] and the AMA Council on Science and Public Health (CSAPH) has detailed the clinical implications and public health effects of cannabis use in multiple previous reports.[5] The Board has provided the HOD with multiple reports concerning cannabis.[6] Finally, the AMA Cannabis Task Force also was instrumental in helping design and record a multi-episode podcast series on issues ranging from cannabis pharmacology to screening tools to counseling patients.[7]

Given the resolution's reference to tobacco, the Board notes that in 1998, more than 50 state and territory attorneys general entered into a Master Settlement Agreement (MSA)[8] with the nation's four largest tobacco companies: Philip Morris, R.J. Reynolds Tobacco Company, Brown & Williamson Tobacco Corporation, and Lorillard Tobacco Company. The state attorneys general claimed that the tobacco industry engaged in a wide range of culpable activity, including deceptive marketing and advertising about tobacco-related harms, youth impacts, and more. Additional states entered into similar agreements at the same time. Several dozen additional participating manufacturers also settled pursuant to the MSA. The MSA created a wide range of restrictions on tobacco-related marketing and advertising and other requirements. The MSA provided that states would receive approximately $206 billion over the first 25 years with additional funds to follow, but public health advocates have observed that much of the money does not go to tobacco cessation or prevention programs.[9] State attorneys general continue to sue the tobacco industry for ongoing deceptive acts.[10]

DISCUSSION

State Activity

States have taken a wide range of actions to restrict minors' exposure to legalized cannabis and cannabis-related marketing and advertising. States that have authorized cannabis for medical use or adult use restrict such use and sales to those 21 years of age and older. Also, marketing and advertising restrictions are common in states. This includes restrictions on content targeting children; print, radio and internet advertising; ads and promotions within a certain proximity to schools; content on public transportation; event sponsorship; and more.[11] The Board also points out that CSAPH Report 1 entitled, "Cannabis Therapeutic Claims in Marketing and Advertising," which was adopted at the 2024 Interim Meeting, provided significant background, research and analysis regarding cannabis-related advertising and marketing. The CSAPH recommendations in this report included asking the AMA to continue to monitor regulatory approaches concerning cannabis advertising and marketing. Without diving too deeply into the effects of these regulations, the Board wants to emphasize that not only is it continuing to monitor regulatory approaches as recommended by CSAPH, but also that the AMA has extensive policy (see below) – as well as model state legislation and other advocacy resources to help its national, state, and national medical specialty society partners enhance marketing and advertising restrictions relating to cannabis.

Social and Medical-Related Costs

The data varies for cannabis-related social and medical costs. One study of 248 individuals with cancer reported a median out-of-pocket cost of $80 per month for cannabis use.[12] Another study estimated that the cost for treating cannabis use disorder ranged between $3.5-$5.5 billion in the aggregate for hospital-related costs.[13] Cannabis use also has been linked to "increased risk of psychosis or schizophrenia in some users," as well as increased risks during pregnancy.[14] The American Lung Association has collected multiple reports showing additional adverse health effects, including increased risk of bronchitis, decreased immune system response, and more.[15] Other research shows that, "a marijuana comorbidity increases the cost of treating patients with

alcohol problems and mood disorder diagnoses, implying that there may be real health consequences associated with marijuana abuse and dependence."[16]

Cannabis use has been linked to a wide range of other costs, including how "cannabis use has been shown to be associated with cognitive decline, impaired educational or occupational attainment, risk of other substance use disorders, and poor quality of life."[17] A 2024 study from the U.S. Federal Reserve Bank in Kansas City found that substance use disorders and homelessness increased in states that authorized cannabis for adult use; increased economic benefits for the states; and increased in offenses for intoxicated driving and disorderly conduct.[18] Other economic benefits include the tax revenue on U.S. sales of cannabis, which have been approximately $1.5 billion per month for several years—with projections for 2025 ranging between $30-$45 billion.[19] The cannabis beverage industry also is growing, as well. In fact, from an estimated $1.2 billion in 2023, the market is projected to grow to nearly $4 billion by 2030.[20] Depending on the type of individual cannabis or cannabis-derived product, the out-of-pocket cost to consumers can vary from $10 up to $100 (or more) for products such as pre-rolls, vapes, flowers, edibles, beverages, tinctures, oils, or topical creams. Depending on the amount purchased, a single product could cost several hundred dollars.

Use of Cannabis Tax Revenue

States vary significantly regarding how they distribute cannabis tax revenue. The most common allocation categories are state general funds, public health efforts (i.e., substance abuse prevention, mental health, etc.), recidivism, education, police enforcement, and transportation. While some states allocate 50 percent or more of cannabis tax revenue to public health efforts, some states allocate less than 10 percent. Most states allocate at least a portion of cannabis tax revenue to public health efforts. AMA Policy H-95.923 entitled, "Taxes on Cannabis Products," specifically "encourages states and territories to allocate a substantial portion of their cannabis tax revenue for public health purposes, including substance abuse prevention and treatment programs, cannabis-related educational campaigns, scientifically rigorous research on the health effects of cannabis, and public health surveillance efforts." The Board believes that states need to be more purposeful with respect to these allocations. As a result, the Board strongly supports public health uses for cannabis-related revenue and therefore, recommends that states enact policies to ensure that <u>at least 50 percent</u> of cannabis tax revenues are directed to these purposes.

Who Comprises the Cannabis Industry?

Before being able to hold an industry "responsible," per the directive contained in Resolution 515, it is important to identify who that industry represents. For example, the "cannabis industry" includes companies that manufacture cannabis products.[21] The "industry" also includes cannabis growers[22] and cannabis dispensary chains.[23] Moreover, there are numerous businesses that also fall under the definition of "cannabis industry" that provide legal, marketing, financial, and other supports to the cannabis industry—just like any other product in the United States. Unlike the large tobacco manufacturers, whose products, marketing, and other business practices were largely consistent across the nation, each cannabis company, manufacturer, and retailer is subject to the specific state (and in some cases, local) laws and regulations.

Legal Status and Enforcement of Cannabis Laws

The unique legal status of cannabis also deserves attention. First, the Board is aware of policy considerations at work regarding the rescheduling of cannabis. As noted above, cannabis is a Schedule I Controlled Substance, and there is no interstate commerce in cannabis. Yet, most states

have authorized its use, and the federal government will generally not interfere in a state's regulatory authority governing retail or adult use if a state has authorized either or both. It is beyond the scope of this report to speculate about the implications of potential rescheduling or even the potential impacts of reclassifying hemp-derived cannabis products as cannabis. This is not to say that the federal government has not enforced the law.[24]

There also are multiple efforts already underway to hold the various players and entities that make up the "cannabis industry" responsible for cannabis-related harms. This includes state attorneys general that have been active in enforcing state laws regulating cannabis. For example:

- Colorado's attorney general filed suit against a cannabis company for alleged illegal marketing that exposed people under the age of 21 to high-potency cannabis products.[25]
- New York's attorney general successfully sued a cannabis dispensary operating without a license. [26]
- Connecticut's attorney general sued multiple companies for alleged violations of the state Unfair Trade Practices Act, including failure to comply with testing standards and misleading packaging designed to appeal to children.[27]
- The Missouri attorney general launched inquiries into multiple businesses that sell Delta-8 and Delta-9 goods on grounds that they potentially engaged in "deception, fraud, false promise, misrepresentation, unfair practices, and/or the concealment, suppression, or omission of material facts in connection with the sale or advertisement of CBD, Delta-8, and Delta-9 THC products."[28]
- The Nebraska attorney general filed suit against a business alleging violations for "failing to implement an age verification process, selling THC products to children, and selling products designed to appeal to children; Selling THC products which grossly understate or overstate the concentration of THC contained within the product and by failing to disclose which cannabinoids are contained in the product; Employing a purchase rewards program designed to increase sale frequency of addictive and psychoactive products, including to minors; and Selling THC products which are harmful when consumed."[29]
- The California attorney general filed suit against multiple companies, alleging the sale of "illegal inhalable hemp products in violation of Assembly Bill 45, failing to include warnings required by Proposition 65 for all commercial industrial hemp products, and engaging in unfair business practices."[30]

The Board emphasizes that these examples are just a snapshot into the legal actions taken by state attorneys general to enforce existing laws. In each case, the state lawsuit is based on specific state laws and regulatory requirements in effect. The Board believes that this is appropriate and commends the state attorneys general for these efforts.

There also are robust legal actions taken by the plaintiff's bar. This includes suits based on the federal Racketeer Influenced and Corrupt Organizations Act;[31] suits for deceptive marketing;[32] and product liability suits at the state and federal levels.[33] Furthermore, there are innumerable personal injury lawyers available to consider personal injury claims arising from cannabis use. The Board believes it is important to point out that there is no shortage of legal action already being taken to hold the cannabis industry responsible for alleged and real harms, as well as violations of state and federal laws.

AMA POLICY

The AMA has extensive policy regarding multiple aspects and issues concerning cannabis. This includes the AMA encouraging "states and territories to allocate a substantial portion of their cannabis tax revenue for public health purposes, including substance abuse prevention and treatment programs, cannabis-related educational campaigns, scientifically rigorous research on the health effects of cannabis, and public health surveillance efforts." (Policy H-95.923, "Taxes on Cannabis Products")

Related to the tobacco MSA, the AMA similarly "supports efforts to ensure that a substantial portion of any local, state or national tobacco litigation settlement proceeds be directed towards preventing children from using tobacco in any form, helping current tobacco users quit, and protecting nonsmokers from environmental tobacco smoke, and that any tobacco settlement funds not supplant but augment health program funding." (Policy H-495.983, "Tobacco Litigation Settlements")

The AMA also has complementary policy related to holding the pharmaceutical industry liable for actions related to "unethical and deceptive misbranding, marketing, and advocacy of opioids," which specifically calls on the AMA to support funds derived from opioid-litigation "be used exclusively for research, education, prevention, and treatment of overdose, opioid use disorder, and pain, as well as expanding physician training opportunities to provide clinical experience in the treatment of opioid use disorders." (Policy H-95-918, "Holding the Pharmaceutical Industry Accountable for Opioid-Related Costs") Importantly, the Board believes that these policies emphasize the need for the AMA to encourage policymakers that funds related to cannabis tax revenue—or proceeds from state attorneys general lawsuits for cannabis-related violations of law—these monies be directed to public health needs.

AMA policy also addresses multiple, additional legislative and regulatory issues. This includes advocating for "for regulations requiring point-of-sale warnings and product labeling for cannabis and cannabis-based products regarding the potential dangers of use during pregnancy and breastfeeding wherever these products are sold or distributed." (Policy H-95.936, "Cannabis Warnings for Pregnant and Breastfeeding Women")

The AMA broadly encourages states "to enforce cannabis-related marketing laws and to publicize and make publicly available the results of such enforcement activities." (Policy D-95.958, "Marketing Guardrails for the "Over-Medicalization" of Cannabis Use") The AMA also has created model state legislation and advocacy materials "to help states implement the provisions of AMA policies H-95.924, "Cannabis Legalization for Adult Use" and H-95.936, "Cannabis Warnings for Pregnant and Breastfeeding People" that currently do not have such model language, including regulation of retail sales, marketing and promotion (especially those aimed at children), misleading health claims, and product labeling regarding dangers of use during pregnancy and breastfeeding." (Policy D-95.956, "Cannabis Product Safety")

The Board further highlights AMA's considerable policy concerning restrictions on tobacco, including but not limited to Policy H-495.973, "FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products." Although there was limited testimony to provide specific direction, based on all of the above, the Board recommends using AMA's tobacco policy as a guide to further the AMA's cannabis-related policy and adopting new and reaffirming existing policy to respond to the directive in Resolution 515-A-24. Finally, the Board recommends that Policy D-95.954, "Advocacy for More Stringent Regulations/Restrictions on the Distribution of Cannabis," be rescinded having been accomplished with this report.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted, and the remainder of the report be filed:

1. That our American Medical Association (AMA) will advocate that any monies paid to the states, received as a result of a settlement or judgment, or other financial arrangement or agreement as a result of litigation for cannabis-related harms or violations of law, be used exclusively for research, education, prevention, and treatment of cannabis-related harms, as well as expanding physician training opportunities to provide clinical experience in the screening, diagnosis, and treatment of cannabis misuse and cannabis use disorder. (New HOD Policy)

2. That our AMA supports legislation and/or regulation of all cannabis products that:
    a. prohibits cannabis use in all places that tobacco use is prohibited, including in hospitals and other places in which health care is delivered;
    b. applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople;
    c. prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA;
    d. requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on all cannabis products;
    e. establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use;
    f. requires transparency and disclosure concerning product design, contents, and emissions; and
    g. prohibits the use of characterizing flavors that may enhance the appeal of such products to youth. (New HOD Policy)

3. That our AMA encourage state medical associations to strengthen existing cannabis marketing and advertising restrictions, including consideration of prohibitions on marketing and advertising to children. (New HOD Policy)

4. That our AMA support the review of conditions that states have approved to authorize cannabis for medical use and recommend the removal of those conditions without scientifically valid and well-controlled clinical trials supporting the use of cannabis. (New HOD Policy)

5. That Policy H-95.923, entitled “Taxes on Cannabis Products” be reaffirmed. (Reaffirm HOD Policy)

6. That Policy D-95.954, entitled “Advocacy for More Stringent Regulations/Restrictions on the Distribution of Cannabis,” be rescinded. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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AMERICAN MEDICAL ASSOCIATION

Resolution: 201
(A-25)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons, American Academy of Orthopaedic Surgeons, American College of Radiology

Subject: Inclusion of DICOM Imaging in Federal Interoperability Standards

Referred to: Reference Committee B

Whereas, the United States Core Data for Interoperability (USCDI), maintained by the Office of the National Coordinator for Health Information Technology (ONC), establishes standardized data elements that must be accessible, exchanged, and used across electronic health records (EHRs); and

Whereas, the Digital Imaging and Communications in Medicine (DICOM) standard is universally used in medical imaging and critical to the diagnosis and treatment of patients across numerous specialties; and

Whereas, imaging data are currently not a required component of the USCDI, thereby creating barriers to the seamless and timely exchange of DICOM images between healthcare systems, potentially leading to delayed care, repeat imaging, and increased healthcare costs; and

Whereas, federal electronic health record interoperability standards have made written imaging reports readily accessible between health systems, but DICOM-based imaging, the international standard for medical imaging, is not[1]; and

Whereas, current processes that include additional paperwork, navigating multiple proprietary image archive platforms and requesting physical compact discs by mail or hand delivery from patients and families[2] in order to share imaging between health systems are burdensome for patients, families, clinicians, and staff and inevitably result in delays[2]; and

Whereas, delays or barriers to accessing DICOM imaging results in delays in clinical care, suboptimal medical decision-making, and unnecessary duplication of imaging[3] with associated additional and unnecessary radiation exposure to the patient and financial and resource waste[4,5]; and

Whereas, the inclusion of DICOM imaging in federal interoperability standards would promote improved clinical decision-making, care coordination, patient safety, and outcomes by ensuring imaging is available at the point of care across institutions; and

Whereas, the American College of Radiology and other stakeholders are actively advocating for the incorporation of DICOM imaging into the USCDI; therefore be it

RESOLVED, that our American Medical Association support the addition of DICOM imaging to federal interoperability standards, namely the United States Core Data for Interoperability (USCDI), to promote standardized, interoperable image sharing across healthcare systems (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for policies and regulations requiring EHR and imaging archive system vendors to support the secure, efficient, and interoperable exchange of DICOM imaging data between healthcare entities. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/20/25

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RELEVANT AMA POLICY

EHR Interoperability D-478.972
Our American Medical Association will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System.
1. Our AMA supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange.
2. Our AMA will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges.
3. Our AMA will continue efforts to promote interoperability of EHRs and clinical registries.
4. Our AMA will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates.
5. Our AMA will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private.
6. Our AMA will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care.
7. Our AMA will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data.
8. Our AMA will review and advocate for the implementation of appropriate recommendations from the “Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care,” a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services.
Sub. Res. 212, I-15 Reaffirmed: BOT Rep. 03, I-16 Reaffirmed: Res. 221, I-16 Reaffirmed in lieu of: Res. 243, A-17 Reaffirmed: CMS Rep. 10, A-17 Appended: BOT Rep. 45, A-18 Reaffirmed: BOT Rep. 19, A-18 Appended: Res. 202, A-18 Appended: Res. 226, I-18 Reaffirmation: A-19 Reaffirmed: CMS Rep. 7, I-20 Reaffirmed: CMS Rep. 2, A-22

Consequences of Accepting Hospital and Health Care System Based EMRs/EHRs D-478.991
Our AMA will: (1) educate physicians regarding the potential adverse consequences of receiving EMRs/EHRs from hospitals and health care systems; and (2) encourage interoperability of information

systems used by hospitals and health care facilities. BOT Rep. 2, I-07Modified: CMS Rep. 01, A-17

Principles for Hospital Sponsored Electronic Health Records D-478.973

1. Our American Medical Association will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC).
2. Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production.
3. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs.
4. Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.

Information Technology Standards and Costs D-478.996

1. Our American Medical Association will:
    a. encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems.
    b. work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices.
    c. review the following issues when participating in or commenting on initiatives to create a NHII:
        i. cost to physicians at the office-based level;
        ii. security of electronic records; and
        iii. the standardization of electronic systems;
    d. continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records.
    e. continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.
2. Our AMA advocates that physicians:
    a. are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards.
    b. not be financially penalized for certified EHR technology not meeting current standards.

National Health Information Technology D-478.995

1. Our American Medical Associaion will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA:
    a. Advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology.
    b. Advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue.
    c. Advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.
    d. Advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services:

   a. Support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices.
   b. Develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will
   a. seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery.
   b. work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

AMERICAN MEDICAL ASSOCIATION

Resolution: 202
(A-25)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons, American Academy of Neurology

Subject: Preservation of the CDC Epilepsy Program Workforce and Infrastructure

Referred to: Reference Committee B

Whereas, the Centers for Disease Control and Prevention (CDC) Epilepsy Program has historically supported the epilepsy community through initiatives that improve public health, clinical care, education, and research; and

Whereas, this program has been instrumental in providing epidemiologic data[1], organizing educational conferences, funding epilepsy self-management programs, supporting local and national epilepsy initiatives, and contributing to key federal health reports; and

Whereas, the sudden and significant reduction in staff within the CDC Epilepsy Program has critically impaired its ability to function, placing ongoing and future projects in jeopardy; and

Whereas, loss of dedicated personnel disrupts collaborations between the CDC and professional, advocacy, and public health organizations, and may hinder evidence-based improvements in care and access for the 3.4 million Americans living with epilepsy; and

Whereas, the economic burden of epilepsy in the United States is estimated to exceed $15.5 billion annually, with direct costs (e.g., medical care, medications, hospitalizations) and indirect costs (e.g., lost productivity, unemployment, and caregiver burden) disproportionately affecting individuals with epilepsy and their families[2]; and

Whereas, people living with epilepsy are more likely to experience comorbid mental health conditions, stigma, social isolation, and barriers to education and employment[3]; and

Whereas, these challenges are particularly pronounced in underserved populations[4]; and

Whereas, discontinuation or interruption of the CDC Epilepsy Program's activities threatens the advancement of epilepsy care, limits access to essential public health data, and undermines the infrastructure necessary for coordinated national response to epilepsy-related challenges; and

Whereas, the American Medical Association has long supported funding and infrastructure for epidemiological research and public health surveillance; therefore be it

RESOLVED, that our American Medical Association advocate for the full restoration and continued support of the CDC Epilepsy Program, including its workforce and dedicated funding, to ensure its ability to support evidence-based public health initiatives in epilepsy (Directive to Take Action); and be it further

RESOLVED, that our AMA urge the Department of Health and Human Services and Congress to prioritize sustained funding and staffing for the CDC Epilepsy Program to promote ongoing

public health, clinical care advancement, and improved quality of life for people living with epilepsy. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/25

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2. Begley CE, Durgin TL. The direct cost of epilepsy in the United States: A systematic review of estimates. *Epilepsia*. 2015;56(9):1376–1387. doi:10.1111/epi.13084
3. Kobau R, Cui W, Kadima N, et al. Tracking psychosocial health in adults with epilepsy—Estimates from the 2010 National Health Interview Survey. *Epilepsy & Behavior*. 2014;41:66–73. doi:10.1016/j.yebeh.2014.08.141
4. Institute of Medicine. *Epilepsy Across the Spectrum: Promoting Health and Understanding*. Washington, DC: The National Academies Press; 2012. doi:10.17226/13379

RELEVANT AMA POLICY

D-440.922 Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems

1. Our American Medical Association will champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes.
2. Our AMA will develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress.
3. Our AMA will work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials.
4. Our AMA will advocate for
    a. consistent, sustainable funding to support our public health infrastructure.
    b. incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff.
    c. public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health.
    d. efforts to ensure equitable access to public health funding and programs. [Res. 407, I-20. Modified: CSAPH Rep. 2, I-21. Reaffirmed: CMS Rep. 5, A-2]

AMERICAN MEDICAL ASSOCIATION

Resolution: 203
(A-25)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons, American Society for Regional Anesthesia Pain Medicine

Subject: Supporting SUPPORT Act Modifications to Enhance Care of Patients with Chronic Pin

Referred to: Reference Committee B

Whereas, chronic pain remains a significant source of disability and healthcare expenditures in the United States; and

Whereas, a proportion of patients suffering from chronic pain are successfully managed on long term intrathecal therapy; and

Whereas, the sterile preservative-free mixtures of medications for intrathecal use are most often prepared by specialty compounding pharmacies; and

Whereas, for those patients who undergo pump refills in the office setting, the safest and most secure way to handle these syringes is to have the medication delivered to the managing physician's office; and

Whereas, the SUPPORT Act was passed to improve the access for patients to medications for the treatment of opioid use disorder (OUD); and

Whereas, Federal law restricts pharmacies from dispensing controlled medications to anyone except the end user. An exception to this prohibition was created by the SUPPORT act to allow direct dispensing to the practitioner, but only for medications used to treat OUD; and

Whereas, Section 3204 of the SUPPORT Act has been interpreted by DEA and DOJ as preventing pharmacies, including compounding pharmacies, from dispensing controlled substances for use in pain pumps directly to the prescribing physician; and

Whereas, this restriction raises the threat of prosecution of any physician whose practice directly receives these compounded medications for filling of intrathecal pumps; and

Whereas, the result of this has been to force patients to either receive and store the medication themselves, which is not adequately safe, or to coordinate delivery of the medication to their home with an appointment to have a healthcare provider to perform the refill at the patient's home as soon as the medication arrives; and

Whereas, The DEA and U.S. Department of Justice both recognize this issue but has stated in conversations with physicians and compounding pharmacies that the only solution is a legislative fix; therefore be it

RESOLVED, that our American Medical Association advocate for modifications to the SUPPORT Act that allow for the delivery of compounded syringes of medications intended for

the filling of intrathecal pumps directly to the prescribing physician's practice. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/25

REFERENCES

1. https://www.finance.senate.gov/imo/media/doc/930%20AM%20Edits%2009.26.18%20Final%20Opioid%20Sec-by-Sec%20BIPART%20BICAM.pdf?utm_source=article&utm_campaign=102618article

2. https://www.aans.org/advocacy/articles/neurosurgery-writes-u-s-attorney-general-re-intrathecal-pain-pumps-controlled-substances-act/

3. https://www.grassley.senate.gov/download/2025-02-04-wc-letter-to-senate-judiciary-committee-hearing-on-fentanyl

RELEVANT AMA POLICY

D-95.955 Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD)
1.Our American Medical Association advocates to ensure that patients who require a post-acute medical care setting are not discriminated against because of their history of substance use disorder.
2.Our AMA advocates that our federal, state, and local governments remove barriers to evidence-based treatment for substance use disorders, including medications for opioid use disorder, at skilled nursing facilities.
3. Our AMA advocates that Medicare and Medicaid, including managed care organizations, remove barriers to coverage and treatment for substance use and opioid use disorder, including medications for opioid use disorder, in skilled nursing facilities [Res. 219, I-23 Reaffirmed: Res. 217, I-24]

D-95.968 Support the Elimination of Barriers to Evidence-Based Treatment for Substance Use Disorders

1. Our American Medical Association will:
    a. advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities.
    b. develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medications for opioid use disorder (MOUD) and other evidence-based options as first-line treatments for this chronic medical disease.
2. Our AMA will support further research into how primary care practices can implement MOUD into their practices and disseminate such research in coordination with primary care specialties.
3. Our AMA Substance Use and Pain Care Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.
4. Our AMA will support increased access to affordable, accessible transportation for individuals to obtain evidence-based treatment for substance use disorders

Res. 222, A-18Appended: BOT Rep. 02, I-19Modified: Res. 228, A-23

H-160.889 Neuropathic Pain
Our AMA: (1) supports the designation of neuropathic pain as a disease state distinct from nociceptive pain, encompassing metabolic, toxic, mechanical, and other injuries to nerve cells, as well as neuroplastic and neuroimmune adaptations to nerve cells in response to chronic pain; (2) encourages research related to neuropathic pain, payer coverage of treatment options for neuropathic pain, and improved resources for patients suffering with neuropathic pain; (3) encourages physicians to engage in meaningful conversation with their patients about what is known about the pathology of neuropathic pain and to set appropriate expectations collaboratively with their patients; and (4) cautions that a neuropathic pain disease designation should only be used when appropriate, not overused, and that the cause of the neuropathic pain be carefully elucidated and documented [CSAPH Rep. 2, I-20]

H-410.950 Pain Management
Our American Medical Association adopts the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy:
Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of complications, and collaboration with other health care providers.

Invasive pain management procedures include interventions throughout the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post- operative course of care. Invasive pain management techniques include:

1. Ablation of targeted nerves.
2. Procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality.
3. Surgical techniques, such as laser or endoscopic diskectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators.

At present, invasive pain management procedures do not include major joint injections (except sacroiliac injections), soft tissue injections or epidurals for surgical anesthesia or labor analgesia.

When used for interventional pain management purposes such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and immediate medical judgment. These procedures are therefore within the practice of medicine, and should be performed only by physicians with appropriate training and credentialing.

Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations. Invasive pain management procedures employing radiologic imaging are within the practice of medicine and should be performed only by physicians with appropriate training and credentialing [BOT Rep. 16, A-13Reaffirmed: BOT Rep. 09, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(A-25)

Introduced by: American Academy of Ophthalmology

Subject: Protecting the Prescriptive Authority of Plenary Licensed Physicians

Referred to: Reference Committee B

Whereas, physicians holding a plenary license (MD/DO) are authorized under state and federal law to diagnose and treat all conditions and prescribe medications in the full scope of their license, irrespective of specialty designation; and

Whereas, reports from board-certified physicians in specialties such as ophthalmology and anesthesiology indicate growing instances in which pharmacists are refusing to dispense valid prescriptions—such as for sedatives, anxiolytics, or dermatologic agents—based on non-clinical objections that the medication falls “outside the prescriber's specialty”; and

Whereas, such refusals contradict American Medical Association policy opposing pharmacists’ authority to initiate, modify, or substitute medications outside a physician’s explicit direction, and amount to inappropriate intrusion into the practice of medicine; and

Whereas, pharmacists are not trained or licensed to make medical diagnoses and their scope of practice does not include the authority to override a physician’s clinical judgment or determine a patient’s treatment plan; and

Whereas, these denials disrupt patient care, compromise safety, delay medically necessary treatment, and may create liability and access issues, particularly for patients with urgent or chronic conditions; and

Whereas, AMA policy supports the right of patients to have legally valid prescriptions filled, and of physicians to prescribe, cancel, and manage medication therapy without interference; therefore be it

RESOLVED, that our American Medical Association study the national prevalence and patterns of pharmacists refusing to fill valid prescriptions from plenary licensed physicians, including impact on patient outcomes and prescriber autonomy (Directive to Take Action); and be it further

RESOLVED, that our AMA work with state medical boards, pharmacy boards, and appropriate federal agencies to protect the authority of plenary licensed physicians to prescribe all legal medications in accordance with their training and medical judgment (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm and publicize existing policy opposing unauthorized medication substitution, inappropriate pharmacy inquiries, and unauthorized treatment modification by pharmacists (Directive to Take Action); and be it further

RESOLVED, that our AMA support legislation or regulatory action requiring pharmacists and pharmacy chains to either fill a valid prescription or immediately refer the patient to an alternative dispensing pharmacy, with notification to the prescribing physician (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage interprofessional collaboration to clarify scope-of-practice boundaries, educate stakeholders on the legal authority of plenary licensure, and promote policies that ensure timely patient access to physician-directed therapy (New HOD Policy).

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/21/25

RELEVANT AMA POLICY

H-160.928 Drug Initiation or Modification by Pharmacists
Our AMA opposes pharmacists being given the authority to initiate or modify prescription drug treatment except on a case by case basis at the specific direction of a physician.[Res. 509, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19]

H-125.995 Therapeutic and Pharmaceutical Alternatives by Pharmacists
The AMA opposes legislative attempts at any level of government that would permit pharmacists, when presented with a prescription for a drug product, to:
(1) dispense instead a drug product that is administered by the same route and which contains the same pharmaceutical moiety and strength, but which differs in the salt or dosage form (pharmaceutical alternatives); and
(2) dispense a drug product containing a different pharmaceutical moiety but which is of the same therapeutic and/or pharmacological class (therapeutic substitution).
Our AMA will work with state medical associations to ensure that state pharmacy laws and medical practice acts are properly enforced so that treating physician's directions cannot be overruled or substituted without prior physician approval. [Res. 89, I-85; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CLRPD Rep. 2, I-95; Appended by Res. 501, A-98; Reaffirmed: CSAPH Rep. 2, A-08]

H-35.961 AMA Response to Pharmacy Intrusion Into Medical Practice
Our American Medical Association deems inappropriate inquiries from pharmacies to verify the medical rationale behind prescriptions, diagnoses, and treatment plans to be an interference with the practice of medicine and unwarranted. [CSAPH Rep. 8, A-23]

D-120.975 Preserving Patients' Ability to Have Legally Valid Prescriptions Filled
Our AMA will:
(1) work with state medical societies to support legislation to protect patients' ability to have legally valid prescriptions filled;
(2) enter into discussions with relevant associations (including but not limited to the American Hospital Association, American Pharmacists Association, American Society of Health System Pharmacists, National Association of Chain Drug Stores, and National Community Pharmacists Association) to guarantee that, if an individual pharmacist exercises a conscientious refusal to dispense a legal prescription, a patient's right to obtain legal prescriptions will be protected by immediate referral to an appropriate dispensing pharmacy; and
(3) in the absence of all other remedies, work with state medical societies to adopt state legislation that will allow physicians to dispense medication to their own patients when there is no pharmacist within a thirty-mile radius who is able and willing to dispense that medication. [Sub. Res. 6, A-05; Reaffirmed: CSAPH Rep. 1, A-15]

H-120.947 Preserving Patients' Ability to Have Legally Valid Prescriptions Filled
1. Our AMA reaffirms our policies supporting responsibility to the patient as paramount in all situations and the principle of access to medical care for all people; and supports legislation that requires individual pharmacists or pharmacy chains to fill legally valid prescriptions or to provide immediate referral to an appropriate alternative dispensing pharmacy without interference. In the event that an individual pharmacist or pharmacy chain refers a patient to an alternative dispensing source, the individual pharmacist or the pharmacy chain should return the prescription to the patient and notify the prescribing physician of the referral.
2. Our AMA supports the concept of advance prescription for emergency contraception for all women in order to ensure availability of emergency contraception in a timely manner. [Sub. Res. 6, A-05; Appended: BOT Rep. 18, I-06; Reaffirmed and Appended: BOT Rep. 2, A-08; Reaffirmed: CMS Rep. 01, A-18]

D-125.989 Substitution of Biosimilar Medicines and Related Medical Products
Our American Medical Association urges that State Pharmacy Practice Acts and substitution practices for biosimilars in the outpatient arena:
1. Preserve physician autonomy to designate which biologic or biosimilar product is dispensed to their patients;
2. Allow substitution when physicians expressly authorize substitution of a biologic or biosimilar product; and
3. In the absence of express physician authorization to the contrary, allow substitution of the biologic or biosimilar product when:
a. the biologic product is highly similar to the reference product, notwithstanding minor differences in clinically inactive components; and
b. there are no data indicating clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product; and
c. the prescribing physician has been adequately notified by the pharmacist. [Res. 918, I-08; Modified: CSAPH Rep. 1, I-11; Modified: CSAPH Rep. 4, A-14; Modified: CSAPH Rep. 05, A-24; Reaffirmed: CMS Rep. 04, I-24]

H-120.939 Physicians Should be Able to Cancel or Rescind Renewals of Prescriptions After the Prescription has Been Delivered to the Pharmacy
Our AMA will support legislation or regulations that:
(i) authorize physicians to cancel or rescind renewals of prescriptions previously written;
(ii) mandate pharmacies, including pharmacy benefit plans, to implement easy-to-use procedures to permit physicians to issue orders to cancel or rescind renewals of prescriptions previously written;
(iii) prevent such renewals from being filled or mailed to the patient; and
(iv) enable the pharmacy or pharmacy benefit plan to readily implement such renewal orders, when directed by the physician, regardless of the state of residence of the patient, the state of practice or licensure of the physicians, and the state of business operation of the pharmacy or the pharmacy benefit plan. [BOT Rep. 8, A-11; Reaffirmation A-15]

D-120.923 Automatic Pharmacy-Generated Prescription Requests
Our American Medical Association advocates that pharmacy-generated requests for changes to a prescription (quantity dispensed, refills, or substitutions) clarify whether these requests are generated by the patient or patient’s surrogates, or automatically by the pharmacy. [Res. 706, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(A-25)

Introduced by: American College of Lifestyle Medicine, Oregon Medical Association, Illinois

Subject: AMA Support for Continuance of the Section 1115 - Social Security Act, Medicaid Waiver Program

Referred to: Reference Committee B

Whereas, Section 1115 of the Social Security Act provides the USDHSS Secretary the authority to approve experimental, pilot or demonstration project that are likely to assist in promoting the objectives of the Medicaid program; and

Whereas, the purpose of this authority is to gives states additional flexibility to design, improve and evaluate state-specific policy approaches to better serve Medicaid populations[1]; and

Whereas, such waivers generally reflect priorities identified by the states and the CMS; and

Whereas, CMS additionally considers whether proposed waiver and/or expenditure authorities are appropriate and consistent with federal policies; and

Whereas, such demonstrations must be “budget neutral” to the Federal government (i.e., Federal Medicaid expenditures will not be more than federal spending without the demonstration); and

Whereas, such demonstrations are approved for an initial five-year period and can be extended for up to an additional three to five years[2]; and

Whereas, examples of such demonstrations have included care for seniors in Wisconsin, HIV/AIDs care in Maine, managed medical assistance in Florida, healthcare transformation and quality improvement in Texas as well as COVID-19 public health emergencies, 60 days post-partum related Medicaid coverage, transition-related strategies supporting community reentry for incarcerated persons in multiple states[3]; therefore be it

RESOLVED, that our American Medical Association work aggressively to advocate for, and assure, the continuance of the Section 1115 Medicaid Waiver Program as a critical safety net for our underserved and disadvantaged populations. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/18/25

REFERENCES

1. CMS. About Section 1115 Demonstrations. 2024. <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html>
2. National Association of Medicaid Directors. How 1115 Waivers Work. 2024. <https://medicaiddirectors.org/resource/how-1115-waivers-work>
3. Kaiser Family Foundation. Medicaid Waiver Tracker. January 14, 2025. <https://www.kff.org/report-section/section-1115-waiver-tracker-definitions/#:~:text=Pre%2DRelease%20Coverage:%20In%20April,eligibility%20and%20premium%20assistance%20programs>
4. Medicaid Cuts a Likely Result of Congressional Budget Negotiations https://www.medpagetoday.com/publichealthpolicy/medicaid/114286?xid=nl_mpt_DHE_2025-02-19&mh=0f2e4d4ae65ba05d0b0ffcb2474fd35c&zdee=gAAAAABm4wrEzP7mYhZ3X22RS_Fg3kGqnZ8Rtb2pHgPkTDZxOfjeBlCd7c1hO-ScyFx2mlWAh9ZTxLoVbKRmcAKSMZgGknWLRTIHO2QxS8d_RfNP8hTuzJw%3D&utm_source=Sailthru&utm_medium=email&utm_campaign=Daily%20Headlines%20Evening%20-%20Randomized%202025-02-19&utm_term=NL_Daily_DHE_dual-gmail-definition

RELEVANT AMA POLICY

Improving Medicaid and CHIP Access and Affordability H-290.954 Our American Medical Association opposes premiums, copayments, and other cost-sharing methods for Medicaid and the Children's Health Insurance Program, including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries**.**
Our AMA encourages the Centers for Medicare & Medicaid Services to amend existing Section 1115 waivers to disallow states the ability to charge premiums or copayments to Medicaid beneficiaries.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(A-25)

Introduced by: American College of Lifestyle Medicine, Oregon Medical Association, Illinois

Subject: AMA Support for Renewal of Section 1115 - Social Security Act, Medicaid Waiver Demonstration Projects Supporting Food and Nutrition Services

Referred to: Reference Committee B

Whereas, Section 1115 of the Social Security Act provides the USDHSS Secretary the authority to approve experimental, pilot or demonstration project that are likely to assist in promoting the objectives of the Medicaid program[1-2]; and

Whereas, segment populations of Medicaid recipients experience food insecurity; and

Whereas, changes in food prices over the past four years have increased beyond the rate of general inflation in the US, and this particular economic factor has significantly increased the number of food insecure individuals; and

Whereas, an additional food access issue has been the growing grocery store gap limiting healthy food options leading to negative health outcomes including predictors of obesity; and

Whereas, the US Department of Agriculture has determined that diet-related chronic diseases affect food insecure communities at a higher rate with almost 90% of health care spending linked to diet-related chronic disease; and

Whereas, deploying additional Medicaid funding for nutrition services and supports could improve health outcomes, reduce health disparities and be cost effective supplements to traditional Medicaid medical services; and

Whereas, under the 1115 Demonstration and Waiver, expanding eligibility for nutritional services to food insecure populations will test whether such additions will improve health outcomes and utilization of appropriate care[1-2]; and

Whereas, a number of states, such as New York, Massachusetts, Oregon, North Carolina, the District of Columbia, have provided such nutritional services to underserved and disadvantaged populations with support from a Section 1115 Waiver[3]; and

Whereas, such states have applied for extensions for their existing Section 1115 Waivers for food and nutritional services[4]; therefore be it

RESOLVED, that our American Medical Association aggressively advocate for, and support, the renewals and extensions of any and all Section 1115 Waivers supporting food and nutritional services as a counter to the issues of food insecurity in many of our Medicaid beneficiaries. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/18/2025

REFERENCES

1. CMS. About Section 1115 Demonstrations. 2024. <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html>
2. National Association of Medicaid Directors. How 1115 Waivers Work. 2024. <https://medicaiddirectors.org/resource/how-1115-waivers-work>
3. Kaiser Family Foundation. Medicaid Waiver Tracker. January 14, 2025. <https://www.kff.org/report-section/section-1115-waiver-tracker-definitions/#:~:text=Pre%2DRelease%20Coverage:%20In%20April,eligibility%20and%20premium%20assistance%20programs>
4. Medicaid Cuts a Likely Result of Congressional Budget Negotiations https://www.medpagetoday.com/publichealthpolicy/medicaid/114286?xid=nl_mpt_DHE_2025-02-19&mh=0f2e4d4ae65ba05d0b0ffcb2474fd35c&zdee=gAAAAABm4wrEzP7mYhZ3X22RS_Fg3kGqnZ8Rtb2pHgPkTDZxOfjeBlCd7c1hO-ScyFx2mlWAh9ZTxLoVbKRmcAKSMZgGknWLRTIHO2QxS8d_RfNP8hTuzJw%3D&utm_source=Sailthru&utm_medium=email&utm_campaign=Daily%20Headlines%20Evening%20-%20Randomized%202025-02-19&utm_term=NL_Daily_DHE_dual-gmail-definition

RELEVANT AMA POLICY

Improving Medicaid and CHIP Access and Affordability H-290.954

Our American Medical Association opposes premiums, copayments, and other cost-sharing methods for Medicaid and the Children's Health Insurance Program, including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries**.**

Our AMA encourages the Centers for Medicare & Medicaid Services to amend existing Section 1115 waivers to disallow states the ability to charge premiums or copayments to Medicaid beneficiaries.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(A-25)

Introduced by: American College of Surgeons

Subject: Abolishing Venue Shopping

Referred to: Reference Committee B

Whereas, Venue Shopping is a legal strategy where plaintiffs' attorneys file medical malpractice cases in jurisdictions known for awarding large monetary awards or settlements, even if the case has no connection to that location; and

Whereas, Venue Shopping has led to certain Courts being overwhelmed with lawsuits, delays in resolutions of disputes, and dramatically increased awards or settlements for plaintiffs' attorneys; and

Whereas, in 2002, more than 1,600 physicians were forced to participate in the Pennsylvania Joint Underwriter Association, the insurer of last resort, as the state of Pennsylvania was reduced to only two medical malpractice insurance carriers because of large (>40%) rate hikes, owing in large part to Venue Shopping; and

Whereas, Venue Shopping was rendered illegal in Pennsylvania in 2002 by The Medical Care Availability and Reduction of Error ("Mcare") act leading to a stabilization of the medical malpractice insurance market in Pennsylvania; and

Whereas, in August 2022, The Pennsylvania Supreme Court reversed the ban on Venue Shopping by passing a rule allowing plaintiffs to sue in any Pennsylvania county in which care occurred, where a defendant could be served, or where any transaction or occurrence giving rise to the suit took place; and

Whereas, the widespread use of telehealth greatly expands the footprint of care opening the door to even greater abuses of Venue Shopping; and

Whereas, immediately following the reversal of the ban on Venue Shopping, there was a four – fold increase in the number of malpractice lawsuits filed in Philadelphia County, and between January and April, 2023, 43% of 657 medical malpractice complaints initiated in Philadelphia County were based on care provided outside the city; and

Whereas, changes to malpractice law in Pennsylvania can herald similar changes in neighboring states and in the entire United States; therefore be it

RESOLVED, that our American Medical Association fiercely advocate against Venue Shopping in medical professional liability actions in collaboration with all interested state medical and specialty societies (Directive to Take Action); and be it further

RESOLVED, that our AMA urgently draft model state and federal legislation rendering venue shopping illegal in medical professional liability actions. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/14/25

REFERENCES

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(A-25)

Introduced by: American Psychiatric Association

Subject: Binding Arbitration in Health Insurance Contracts

Referred to: Reference Committee B

Whereas, binding arbitration clauses in health insurance contracts can have significant impacts on physicians; and

Whereas, these clauses typically require that disputes be settled outside the court system, with physicians bound by decisions made in arbitration, often not allowing for appeals. This limits the ability of the physician to seek legal recourse or challenge decisions that are unfavorable and contributes to a sense of powerlessness; and

Whereas, arbitration is often viewed as more cost-effective than court trials, it still involves expenses that can place a financial burden on physicians. Health insurers have significant bargaining power which could result in arbitration outcomes that favor insurers, potentially reducing reimbursement rates and leading to higher premium; and

Whereas, arbitration clauses in health insurance contracts often favor the insurer. Physicians, especially small practices or individual clinicians, have little negotiating power regarding the inclusion of arbitration clauses in their contracts; and

Whereas, the financial stress and operational challenges that arise from disputes over insurance claims and arbitration can affect how physicians interact with their patients; and

Whereas, current AMA policy (H-435.945) only addresses binding arbitration between patients and physicians, not physicians and insurance companies; therefore be it

RESOLVED, that our American Medical Association study the effects of binding arbitration in health insurance contracts with physicians. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/22/25

RELEVANT AMA POLICY

Binding Arbitration H-435.945
Our American Medical Association supports the utilization of pre-dispute binding arbitration that is agreed to by a patient and a physician prior to non-emergent treatment as an effective method of doctor-patient conflict resolution

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(A-25)

Introduced by: American Society of Addiction Medicine

Subject: Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Addiction Medications for Legitimate Medical Purposes

Referred to: Reference Committee B

Whereas, addiction medications, such as medications for opioid use disorder (MOUD), are lifesaving treatments for addiction;[1] and

Whereas, in 2023, fewer than 20% of people with OUD in the US received MOUD;[2] and

Whereas, several reasons exist for the underutilization of MOUD, including practitioners' fear of intrusion into clinical practice by the US Department of Justice (DOJ), including the Drug Enforcement Administration (DEA);[3-9] and

Whereas, practitioners fear they will be investigated or prosecuted for well-intentioned prescribing of controlled medications that violate ambiguous federal law; and

Whereas, federal regulations implementing the federal Controlled Substances Act (CSA) authorize the prescribing of controlled substances, like buprenorphine, for "a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice;"[10] and

Whereas, federal circuit courts are divided on whether a CSA violation requires proof of both a (1) lack of legitimate medical purposes and (2) deviation from the usual course of professional practice (i.e., a conjunctive standard),[11-12] or whether proof of just one of these two conditions is sufficient (i.e., a disjunctive standard);[13-19] and

Whereas, case law suggests "legitimate medical purpose" under the CSA means having the intention to improve a patient's health-related condition;[12,14,20-23] and

Whereas, a disjunctive standard allows for prosecution based solely on a violation of the "usual course of professional practice;"[13-19] and

Whereas, the phrase "usual course of professional practice" is amorphous and ambiguous, with the meaning potentially varying among well-intentioned practitioners due to the heterogeneity of state regulations governing the practice of addiction medicine,[24,25] as well as the heterogeneity of patients with substance use disorder (SUD),[26] practitioners who treat SUD, and practice settings; and

Whereas, DOJ personnel do not typically have the requisite medical expertise to accurately evaluate the totality of the circumstances that may explain differences in prescribing practices across practitioners; and

Whereas, the DOJ's expertise would best be utilized by focusing on practitioners prescribing for improper reasons – that is, without a legitimate medical purpose; and

Whereas, it is important to consider Congressional intent in passing the CSA, which was to prevent the trafficking or dealing of drugs, not to ensure good quality medical treatment;[27] therefore be it

RESOLVED, that our American Medical Association support legislative, regulatory, and other advocacy efforts that (1) advance the adoption of a conjunction standard in the context of "legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice" under the federal Controlled Substances Act and implementing regulations and (2) address relevant federal regulations to clarify that "legitimate medical purpose" means "for the purpose of preventing, treating, or managing a patient's health-related condition." (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

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3. Mendoza S, Rivera-Cabrero AS, Hansen H. Shifting blame: Buprenorphine prescribers, addiction treatment, and prescription monitoring in middle-class America. Transcultural Psychiatry. 2016;53:465-487. doi:10.1177/1363461516660884
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9. Jones CM, McCance-Katz EF. Characteristics and prescribing practices of clinicians recently waivered to prescribe buprenorphine for the treatment of opioid use disorder. Addiction. 2019;114:471-482. doi:10.1111/add.14436
10. 21 C.F.R. § 1306.04(a).
11. United States v. Feingold, 454 F.3d 1001, 1012 (9th Cir. 2006).
12. United States v. Smith, 573 F.3d 639 (8th Cir. 2009).
13. United States v. Ruan, 966 F.3d 1101 (11th Cir. 2020), vacated and remanded, 597 U.S. 450, 142 S. Ct. 2370, 213 L. Ed. 2d 706 (2022), and cert. granted, judgment vacated sub nom. Couch v. United States, 142 S. Ct. 2895, 213 L. Ed. 2d 1109 (2022), and adhered to in part, 56 F.4th 1291 (11th Cir. 2023).
14. United States v. Abovyan, 988 F.3d 1288 (11th Cir. 2021).
15. United States v. Heaton, 59 F.4th 1226, n17 (11th Cir. 2023).
16. United States v. Duldulao, 87 F.4th 1239 (11th Cir. 2023).
17. United States v. Armstrong, 550 F.3d 382 (5th Cir. 2008).
18. United States v. Nelson, 383 F.3d 1227 (10th Cir. 2004).
19. United States v. Naum, 832 F. App'x 137 (4th Cir. 2020), cert. granted, judgment vacated, 142 S. Ct. 2893, 213 L. Ed. 2d 1108 (2022).
20. City & Cnty. of San Francisco v. Purdue Pharma L.P., 620 F. Supp. 3d 936 (N.D. Cal. 2022). United States District Court, N.D. California.
21. United States v. Moore, 423 U.S. 122, 126, 96 S. Ct. 335, 46 L. Ed. 2d 333 (1975).
22. United States v. Tran Trong Cuong, 18 F.3d 1132 (4th Cir. 1994).
23. Ruan v. United States, 597 U.S. 450, 142 S. Ct. 2370, 213 L. Ed. 2d 706 (2022) (Alito, Thomas, & Barret, concurring).
24. Andraka-Christou B, Gordon AJ, Bouskill K, et al. Toward a Typology of Office-based Buprenorphine Treatment Laws: Themes from a Review of State Laws. *J Addict Med*. May 18 2021;16(2):192-207. doi:10.1097/ADM.0000000000000863

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27. United States v. Rosenberg, 515 F.2d 190 (9th Cir. 1975).

RELEVANT AMA POLICY

Protection for Physicians Who Prescribe Pain Medication H-120.960

Our AMA supports the following:
(1) the position that physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain should not be subject to the burdens of excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution. It is the policy of the AMA that state medical societies and boards of medicine develop or adopt mutually acceptable guidelines protecting physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain before seeking the implementation of legislation to provide that protection; (2) education of medical students and physicians to recognize addictive disorders in patients, minimize diversion of opioid preparations, and appropriately treat or refer patients with such disorders; and (3) the prevention and treatment of pain disorders through aggressive and appropriate means, including the continued education of doctors in the use of opioid preparations.

Our AMA opposes harassment of physicians by agents of the Drug Enforcement Administration in response to the appropriate prescribing of controlled substances for pain management.

DEA Regulations and the Ability of Physicians to Prescribe Controlled Medication Rationally, Safely, and Without Undue Threat of Prosecution D-120.979

Our AMA supports ongoing constructive dialogue between the DEA and clinicians, including physicians, regarding a proper balance between the needs of patients for treatment and the needs of the government to provide oversight and regulation to minimize risks to public health and safety.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(A-25)

Introduced by: American Society for Gastrointestinal Endoscopy, American Gastroenterological Association, The Society of Thoracic Surgeons

Subject: Impact of Tariffs on Healthcare Access and Costs

Referred to: Reference Committee B

Whereas, tariffs on foreign countries will add to the costs for medical equipment and devices, pharmaceuticals, and other healthcare-related goods in the United States, thereby raising the overall cost of healthcare delivery; and

Whereas, tariffs intended to encourage domestic production of medical equipment, devices, pharmaceuticals and other healthcare-related goods must account for the feasibility, capacity and timelines for such domestic production in order to prevent product shortages and increased healthcare costs; and

Whereas, in the short-term, tariffs on medical equipment, devices and supplies may not be appropriately accounted for in Medicare physician and hospital reimbursement, forcing health care providers to administer services at a financial loss; and

Whereas, elevated healthcare costs may result in reduced patient access to essential medical services; and

Whereas, the American Medical Association is committed to advocating for policies that ensure affordable and equitable access to healthcare for all individuals; therefore be it

RESOLVED, that our American Medical Association actively monitor and assess the impact of current and proposed tariffs on healthcare costs and patient access to medical services (Directive to Take Action); and be it further

RESOLVED, that our AMA engage with relevant stakeholders, including policymakers and industry leaders, to advocate for trade policies that do not adversely affect the affordability and availability of medical supplies and pharmaceuticals (Directive to Take Action); and be it further

RESOLVED, that our AMA support legislative efforts aimed at mitigating the negative effects of tariffs on the healthcare system, ensuring that patient care remains accessible and affordable (Directive to Take Action); and be it further

RESOLVED, that our AMA conduct a study evaluating the short- and long-term impacts of U.S. tariffs on the healthcare delivery system, including effects on cost, supply chains, patient outcomes, and healthcare disparities, and, given the urgency associated with the issue, report its findings no later than the November 2025 interim meeting of the House of Delegates. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(A-25)

Introduced by: California, Alabama, Colorado, Connecticut, Florida, Hawaii, Minnesota, Missouri, Nebraska, New Hampshire, New Mexico, North Dakota, Oklahoma, Oregon, Tennessee, Vermont, Washington, West Virginia, Integrated Physician Practice Section

Subject: Support for State Provider and Managed Care Organization Taxes to Sustain Federal Medicaid Matching Funding

Referred to: Reference Committee B

Whereas, the Medicaid program is a partnership between the federal government and the states to cover nearly 80 million low-income, vulnerable Americans – making it the largest source of health care coverage in the nation; and

Whereas, the federal government and the states share responsibility for financing Medicaid with the federal government guaranteeing federal matching payments to the states while the states are permitted to finance the non-federal share through state general funds, health-care related taxes (provider and managed care organization taxes) and local government funds; and

Whereas for two decades, all states except Alaska finance some of the state costs with taxes on health care providers (hospitals and nursing homes) and 20 states partially finance state costs with taxes on managed care organizations (MCOs) with 68% of state Medicaid funding coming from state general funds and 32% from local governments and provider/MCO taxes; Reliance on provider and MCO taxes have grown during economic downturns to cover higher state Medicaid costs; and

Whereas, under federal law and with the approval of state legislatures, states assess, usually voluntary, levies on hospitals, nursing homes and MCOs to generate state funds to match with federal Medicaid dollars, increasing the overall funding available to care for Medicaid patients, which has also increased all provider reimbursement rates; and

Whereas, federal rules set guidelines on how states can use provider and MCO taxes, ensuring they are 1) broad-based by applying to all providers or plans within a specific class and cannot be imposed only on providers or plans that primarily treat Medicaid patients; 2) uniform by applying to all providers or plans within a specific class (i.e., the tax cannot be higher on Medicaid revenue than non-Medicaid revenue; and 3) states cannot guarantee that providers or plans will receive their tax revenues back unless the tax revenues comprise 6% or less of net patient revenues from treating patients; and

Whereas, the provider and MCO assessments are applied to hospital, nursing home, and health plan revenues rather than directly to physician practices, do not impose costs on physicians or patients, and often result in increased physician and hospital reimbursement rates which improve Medicaid patients' access to care; and

Whereas, these financing mechanisms are structurally distinct from direct involuntary taxes on physician services, physician-owned facilities, or pass-through taxes - which are opposed by

AMA policy H-385.925, D-165.961, H 385.941 - because they do not create financial liabilities for physician practices but instead help to sustain funding for Medicaid patients and strengthen the viability of physicians and other providers; and

Whereas, recent Congressional proposals have suggested limiting or eliminating states' ability to use provider or MCO levies to finance their Medicaid programs – a cut of up to $630 billion nationally over ten years (CBO) - which would threaten health care coverage for millions of low-income children, pregnant women, veterans, the disabled and elderly, and would destabilize the provider safety net as well as the entire health care system; therefore be it

RESOLVED, that our American Medical Association support the use of broad-based, uniform Provider (hospital and nursing home) and Managed Care Organization (MCO) taxes to generate state funds to match with federal Medicaid funding that sustain or improve Medicaid patients' access to care while not financially burdening physician practices (New HOD Policy); and be it further

RESOLVED, that our AMA oppose federal proposals that would restrict or eliminate states' ability to assess Provider (hospital and nursing home) and Managed Care Organization Taxes to finance their Medicaid programs and protect patient access to care, as long as physician practices are not financially harmed (New HOD Policy); and be it further

RESOLVED, that our AMA amend policy H-385.925 as follows:
1. Our American Medical Association strongly opposes the imposition of a selective revenue tax on physicians ~~and other health care providers~~.
2. Our AMA will continue to work with state medical societies on issues relating to physician ~~and other provider~~ taxes, providing assistance and information as appropriate.
3. Our AMA strongly opposes the use of ~~provider~~ physician taxes or fees to fund health care programs or to accomplish health system reform.
4. Our AMA believes that the cost of taxes which apply to medical services should not be borne by physicians, but through adequate broad-based taxes for the appropriate funding of Medicaid and other government health care programs (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend policy D-165.961 as follows:
Our AMA will (1) proactively and vigorously oppose taxes on physician services, physician-owned facility taxes or "pass-through" taxes on physician medical services; and (2) work closely with national specialty societies and state medical societies to assist with advocacy efforts to combat existing and proposed taxes on physician services and physician-owned facilities (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend policy H-385.941 as follows:
Our AMA strongly: (1) opposes any attempt on the part of the federal or state governments or other entities to impose user fees, provider taxes, access fees, or bed taxes on physicians ~~and other health care providers~~ to subsidize or fund any health care program; (2) opposes any directive from the CMS to slow down the rate of payment of Medicare claims or reduce administrative services to patients, physicians, and other health care providers; and (3) urges Congress to appropriate sufficient funds to enable the CMS and its carriers to carry out their statutorily required functions. (Modify Current HOD Policy)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/22/25

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2. Kaiser Family Foundation. Medicaid Provider Taxes. 2023. https://www.kff.org/medicaid/state-indicator/provider-taxes

RELEVANT AMA POLICY

Selective Revenue Taxation of Physicians and Other Health Care Providers H-385.925
1. Our American Medical Association strongly opposes the imposition of a selective revenue tax on physicians and other health care providers.
2. Our AMA will continue to work with state medical societies on issues relating to physician and other provider taxes, providing assistance and information as appropriate.
3. Our AMA strongly opposes the use of provider taxes or fees to fund health care programs or to accomplish health system reform.
4. Our AMA believes that the cost of taxes which apply to medical services should not be borne by physicians, but through adequate broad-based taxes for the appropriate funding of Medicaid and other government health care programs.
Sub. Res. 258, A-92Reaffirmed: Res. 134, A-93Res. 207, I-93Reaffirmation A-99Reaffirmation A-00Appended Res. 132, A-01Reaffirmation A-05Consolidated and Renumbered: CMS Rep. 7, I-05Reaffirmed: CMS Rep. 6, I-11Reaffirmed: CMS Rep. 1, A-21

Physician Taxes D-165.961
Our AMA will (1) proactively and vigorously oppose taxes on physician services, physician-owned facility taxes or "pass-through" taxes on medical services; and (2) work closely with national specialty societies and state medical societies to assist with advocacy efforts to combat existing and proposed taxes on physician services and physician-owned facilities.
Res. 728, I-04Reaffirmation A-05Reaffirmed: CMS Rep. 1, A-15

Opposition to CMS User Fees H-385.941
Our AMA strongly: (1) opposes any attempt on the part of the federal or state governments or other entities to impose user fees, provider taxes, access fees, or bed taxes on physicians and other health care providers to subsidize or fund any health care program; (2) opposes any directive from the CMS to slow down the rate of payment of Medicare claims or reduce administrative services to patients, physicians, and other health care providers; and (3) urges Congress to appropriate sufficient funds to enable the CMS and its carriers to carry out their statutorily required functions.
Sub. Res. 201, A-98Reaffirmation A-05Reaffirmed: CMS Rep. 1, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(A-25)

Introduced by: Illinois

Subject: Setting Standards for Forensic Toxicology Laboratories Used in Litigation

Referred to: Reference Committee B

Whereas, forensic toxicology laboratories are called upon to analyze substances in bodily fluid matrices for litigation purposes; and

Whereas, litigation using bodily fluid matrices (e.g., workers' compensation arbitration, DUI legal actions) is often primarily dependent on the accuracy of drug/toxicology testing analyses (which is usually assumed to be reliable and precise); and

Whereas, the equipment utilized by forensic toxicology laboratories is similar to that used in hospital clinical chemistry laboratories for medical diagnostic and therapeutic purposes; and

Whereas, accreditation and licensure programs are designed to improve safety, promote a consistently high level of service, and advance the quality of laboratory services; laboratory licensure and accreditation are an assurance that the laboratory has met or exceeded a certifying agency's high standards of excellence; and

Whereas, proficiency testing is a regular, independent assessment of a laboratory's ability to generate accurate and precise test results and is a key component of a Quality Control Program which is used as an evaluation tool to guide performance improvement; Licensing and accrediting agencies incorporate proficiency findings into their overall compliance monitoring assessment of a laboratory; and

Whereas, there are a multitude of certification requirements for medical clinical chemistry laboratory accreditation and/or their personnel proficiency which may include but are not limited to Clinical Laboratory Improvement Amendments of 1988 (CLIA), College of American Pathologists (CAP) Laboratory Accreditation program (LAP), American Society for Clinical Pathology (ASCP), American Board of Clinical Chemistry (ABCC) – which are usually not achieved by forensic toxicology laboratories; and

Whereas, the laboratory director/certifying scientist of the forensic toxicology laboratories used by law enforcement and the judicial system may not be a licensed physician (with proper board certification) or a scientist with a relevant advanced graduate degree; and

Whereas, the University of Illinois Chicago (UIC) Analytical Forensic Testing Laboratory has been recently accused of providing flawed test results in cases of driving-under the influence of marijuana, many of them resulting in motorists being convicted and sent to jail; the lab has subsequently been the subject of allegations of a cover-up, and stopped doing tests for marijuana in law enforcement cases; and

Whereas, the UIC Analytical Forensic Testing Laboratory this same UIC laboratory lost the Racetrack Medication and Testing Consortium (RMTC) accreditation in early September 2024 due to non-compliance issue in racehorse blood bicarbonate testing; and

Whereas, any laboratory analysis of bodily fluids by forensic toxicology laboratories should have the same degree of accuracy and reliability as any hospital based clinical chemistry/toxicology laboratory; therefore be it

RESOLVED, that our American Medical Association pursue legislative or regulatory changes to require:

1. Forensic toxicology laboratories that analyze drugs in bodily fluids to follow the same protocols and obtain equivalent certifications as their clinical chemistry counterparts based in hospitals; and
2. CLIA – exempt forensic toxicology laboratories to obtain relevant accreditations and certifications such as CAP Forensic Drug Testing accreditation program (CAP FDT, formerly FUDT or Forensic Urine Drug Testing Accreditation Program]) the American Board of Forensic Toxicology Laboratory Accreditation Program (ABFT LAP), the American Society of Crime Laboratory Directors Laboratory Accreditation Board (ASCLD/LAB) or other related certification program (as their clinical chemistry counterparts in hospitals are required) which are publicly displayed; and
3. forensic toxicology laboratories to follow relevant state codes and regulations addressing testing of breath, blood, and urine for alcohol, other drugs, and intoxicating compounds; and
4. a Laboratory Director and/or Certifying Scientist who reviews all protocols and laboratory manuals and signs off on each result electronically to be a licensed physician (with proper and current board certification) or a scientist with an appropriate advanced graduate degree and certification; and
5. that results of laboratory proficiency testing and Quality Control Programs be available to the court and its litigants for review to assist in verifying forensic laboratory results. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/25

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3. https://isp.illinois.gov/Forensics/ForensicsLeadership
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5. https://www.thoroughbreddailynews.com/rmtc-kentucky-illinois-labs-reaccreditation-processes-extended/
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7. https://isp.illinois.gov/StaticFiles/docs/TrafficResources/Administrative%20Code%20Rules%202022_Complete%20Booklet.pdf
8. Bissell, Michael G. "Regulatory issues in accreditation of toxicology laboratories." Clinics in Laboratory Medicine 32, no. 3 (2012): 525-542.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(A-25)

Introduced by: Indiana

Subject: Emergency Department Designation Requires Physician on Site

Referred to: Reference Committee B

Whereas, due to the legislative efforts of the Indiana State Medical Association, new legislation was added to Indiana Code in 2023, IC 16-21-2-14.5, which requires that “a hospital with an emergency department must have at least one physician on site and on duty who is responsible for the emergency department at all times the emergency department is open” but this law does not account for freestanding emergency departments (FSEDs); and

Whereas, “freestanding health facilities” are specifically excluded from the statutory definition of “hospital” in Indiana Code, IC 16-18-2-179; and

Whereas, numerous models of freestanding emergency care exist around the country including independently operated FSEDs, specialty emergency hospitals, physician and proprietary owned facilities, off-campus hospital-affiliated emergency departments, and joint venture partnerships between FSEDs and hospitals; and

Whereas, the prevalence of FSEDs has grown exponentially from 1% in 2001 to 11% in 2016 of all emergency departments nationwide; and

Whereas, patients may assume that any and all facilities which are referred to as emergency departments (EDs) or emergency rooms (ERs) can provide emergency medical care by a physician; therefore be it

RESOLVED, that our American Medical Association create model legislation for all states, as a matter of truth and transparency in the scope of available emergency medical services, which requires that all facilities using the designation “emergency department” mandate the presence of at least one physician on-site and on-duty who is responsible for the emergency department at all times. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/16/25

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2. https://iga.in.gov/laws/2023/ic/titles/16#16-21-2-14.5
3. https://www.annemergmed.com/article/S0196-0644(19)30237-9/fulltext
4. https://iga.in.gov/laws/2023/ic/titles/16#16-18-2-179
5. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7234700/#

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(A-25)

Introduced by: Indiana

Subject: United Health Care and InterQual Monopoly

Referred to: Reference Committee B

Whereas, United Health care, through its Optum subsidiary, recently purchased Change Healthcare, which owns InterQual; and

Whereas, InterQual defines the medical criteria by which necessity of medical services is determined by payers; and

Whereas, United Health care now solely controls defining criteria of medical necessity and thereby qualification of medical services for payment across all payers; and

Whereas, multiple hospitals are struggling financially in part due to insurance company denials of payment for care; and

Whereas, many of these struggling hospitals are in medically underserved areas including rural hospitals; therefore be it

RESOLVED, that our American Medical Association oppose managed care utilization review systems and tools that have anticompetitive effects, create undue influence over medical necessity criteria, or negatively impact fair access to the delivery and payment of medical services. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/16/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 215
(A-25)

Introduced by: Minority Affairs Section

Subject: Support for Changing Standards for Minors Working in Agriculture

Referred to: Reference Committee B

Whereas, child labor regulations differ between agricultural and non-agricultural sectors, with agricultural work being exempt from certain provisions of the federal Fair Labor Standards Act (FLSA)[1]; and

Whereas, in non-agricultural work, the FLSA mandates that minors aged 14 and 15 are restricted to working no more than 3 hours on school days and 18 hours during a school week, agricultural workers of the same age face no such limitations on hours worked[2,3]; and

Whereas, children aged 16 and older are permitted to work in hazardous jobs in agriculture that involve dangerous machinery, exposure to pesticides, hazardous environments, and strenuous labor, while workers in all other industries must be 18 years and older to undertake similarly classified hazardous work[1,3]; and

Whereas, the safety of child workers in agriculture, beyond the small protections provided by federal law, is subject to the discretion of individual states, resulting in significant variability in child labor protections across the country[1,2]; and

Whereas, The National Children's Center for Rural and Agricultural Health and Safety in the United States reported that from 2001 to 2015, 48% of all fatal injuries to young workers occurred in agriculture with 33 children injured daily, and deaths occurring every 3 days[4]; and

Whereas, in North Carolina, which follows only federal regulations for child farmworkers, studies reveal significant risks: 29% of adolescent farmworkers experience musculoskeletal injuries, many are exposed to harmful pesticides linked to adverse health and neurodevelopmental effects, and all workers face heightened risks of heat-related illnesses due to strenuous work conditions and lack of regulatory protections[5-7]; and

Whereas, child farmworkers experience educational disruptions due to the demands of agricultural labor, leading to lower academic achievement and higher dropout rates compared to their peers in other industries[8]; and

Whereas, the physical and mental demands of agricultural work, combined with poor living conditions for many child farmworkers, contribute to significant mental health challenges, which are often unaddressed due to limited access to healthcare services[9]; and

Whereas, the Children's Act for Responsible Employment and Farm Safety Care Bill (CARE Act) was introduced in 2023 to amend the Fair Labor Standards Act to raise labor standards and

protections for child farmworkers to the same level set for all children in other occupations, strengthening existing regulations and their enforcement[3,10-13]; and

Whereas, the CARE Act closes loopholes in current law relating to age, work restrictions, and expanding workplace health and safety standards that protect against exposure to dangerous pesticides and unsafe equipment [3,10-13]; and.

Whereas, AMA policy H-60.962 covers the illegal employment of children but does not support the expansion of protection for all children legally working in agriculture; therefore be it

RESOLVED, that our American Medical Association strongly supports federal and state efforts to ensure that child labor protections uniformly apply to children working in agriculture, including raising the minimum age of employment, work hour restrictions, and extending workplace health and safety standards against exposures to hazardous substances and unsafe equipment. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/21/25

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RELEVANT AMA POLICY

H-10.984 Farm Related Injuries
Our AMA (a) emphasizes the need for more complete data on farm-related and other types of traumatic and occupational injuries; (b) reaffirms its support of regional medical facilities and programs having well-trained medical personnel and emergency care facilities capable of responding effectively to farm-related and other types of injuries; (c) advises manufacturers to improve machinery and farm implements so they are less likely to injure operators and others. Safety instructions should accompany each sale of a machine such as a power auger or tractor. Hazard warnings should be part of each power implement; (d) encourages parents, teachers, physicians, agricultural extension agencies, voluntary farm groups, manufacturers, and other sectors of society to inform children and others about the risks of agricultural injuries and about approaches to their prevention; (e) endorses the concept of making injury surveillance and prevention programs ongoing activities of state and local departments of public health; (f)encourages the inclusion of farm-related injury issues as part of the training program for medical students and residents involved in a rural health experience. [BOT Rep. U, A-91Reaffirmed: Sunset Report, I-01Reaffirmed: CSAPH Rep. 1, A-11Reaffirmed: CSAPH Rep. 1, A-21]

H-365.986 US Efforts to Address Health Problems Related to Agricultural Activities
Our AMA supports the endeavors of the U.S. Surgeon General and the National Institute of Occupational Safety and Health of CDC to address health problems related to agricultural activities. [Res. 212, A-91Reaffirmed: Sunset Report, I-01Reaffirmed: CSAPH Rep. 1, A-11Reaffirmed: BOT Rep. 7, A-21]

H-60.962 Enforcement of Child Labor Laws
Our AMA will work in conjunction with all appropriate organizations and specialty societies to enhance physician awareness of the problems and dangers associated with the illegal employment of children. [Sub. Res. 222, I-92 Reaffirmed by BOT Rep. 24, A-97 Reaffirmed: BOT Rep. 33, A-07 Reaffirmed: BOT Rep. 22, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 216
(A-25)

Introduced by: Medical Student Section, American Academy of Child & Adolescent Psychiatry

Subject: Support for Aging-Out Foster Youth with Mental Health and Psychotropic Needs

Referred to: Reference Committee B

Whereas, foster care youth are 62% more likely to have serious mental health issues from adverse childhood experiences (ACEs), experience polypharmacy, and have inadequate medical supervision and documentation[1-4]; and

Whereas, youth "age-out" of foster care at 18-25, as mandated by the Department of Children and Families (DCF), and are vulnerable to dependence on psychotropic medications, which can hinder future independence, compounded by their struggles to access and navigate healthcare services such as Medicaid despite eligibility [5,6,9]; and

Whereas, there is a lack of data on continued mental health services for former foster children with complex needs, and limited funding is allocated to support youths aging out of foster care, underscoring the need for better resources during their transition to adulthood[7,8]; and

Whereas, the John Chafee program, provides federal funding and oversight to support states, territories, and Indian tribal entities in helping youth transition out of foster care, including programs that offer education assistance, employment services, financial guidance, housing, and life skills training,[10,11]; and

Whereas, nearly 80% of eligible youths aging-out don't utilize the John Chafee program due to low awareness of offerings, inadequate time for navigating transition services, learned helplessness, and lack of trust, leading to adverse socioeconomic outcomes [5,12–14,16]; and

Whereas, despite the John Chafee program's expansion, existing federal and state funded programs lack comprehensive mental health support for aging-out foster youths, forcing community organizations to fill the gaps[7,8,10,14,15]; and

Whereas, California's use of the Chafee program, along with the state's Transitional Housing Program, successfully supports aging-out foster youth mental health, with 70% of these youth showing improved outcomes as they transition to adulthood[16]; and

Whereas, in Massachusetts, agencies overseeing Chafee funds have collaborated with the Department of Mental Health to increase access for transition-age youth to mental health and substance use treatment[17]; therefore be it

RESOLVED, that our American Medical Association support federal and state initiatives aimed at increasing funding and enhancing accessibility to services designed to help youths as they

transition out of foster care; especially for youths requiring mental health support and access to psychotropic medications. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/21/25

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RELEVANT AMA POLICY

H-60.897 Improved Foster Care Services for Children

Our American Medical Association will (a) encourage and support state, territorial, and tribal activities to implement changes to the child welfare system directed toward keeping children with their families when appropriate and the children's safety is assured, (b) support federal and state efforts to expand access to evidence-based treatment, counseling, mental health services, substance use disorder treatment, in-home parent skills-based services, and other services, (c) encourage and support state efforts expanding use of kinship and family foster care placement and state efforts to eliminate the use of non-therapeutic congregate foster care placement, (d) support both federal and state funding for improvements to the child welfare system which minimize harm to the child and help provide additional services to families that will safely prevent child separation from the family, (e) support government maintenance of a continuously

updated and comprehensive list of evaluated and tested prevention services and for families at risk for entry into the child welfare system. [Res. 216, A-23]

H-60.910 Addressing Healthcare Needs of Children in Foster Care
Our American Medical Association advocates for comprehensive, and evidence-based, trauma-informed care that addresses the specific mental, developmental, and physical health care needs of children in foster care. [Res. 907, I-17 Modified: Res. 420, A-23]

D-350.977 Addressing the Longitudinal Healthcare Needs of American Indian Children in Foster Care
Our American Medical Association (a) recognizes the Indian Child Welfare Act of 1978 as a model in American Indian and Alaska Native child welfare legislation, (b) supports federal legislation preventing the removal of American Indian and Alaska Native children from their homes by public and private agencies without cause, (c) will work with local and state medical societies and other relevant stakeholders to support legislation preventing the removal of American Indian and Alaska Native children from their homes by public and private agencies without cause, (d) supports state and federal funding opportunities for American Indian and Alaska Native child welfare systems, (e) will support the construction of health information systems to enhance information exchange between both tribal and non-tribal child welfare agencies and health care professionals, (f) will advocate for the designation of medical teams, and/or committees to longitudinally follow children in foster care, including to ensure the provision of continuity of care for children who are at the age of transition out of foster care, (g) will advocate for oversight of local, tribal, and state child welfare systems by physicians with expertise in pediatrics and child psychiatry, (h) will promote existing medical homes which provide continuity of care to children in foster care when feasible, (i) will support the appointment of a licensed pediatrician or family medicine physician (with substantial pediatric experience) in each state with experience in child welfare to the position of medical director of child welfare and a psychiatrist with substantial child and adolescent psychiatric experience to the position of psychiatric medical director of child welfare for each Title IV-E agency. [Res. 443, A-22Appended: Res. 930, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(A-25)

Introduced by: Medical Student Section

Subject: Regulation and Oversight of the Troubled Teen Industry

Referred to: Reference Committee B

Whereas, the Troubled Teen Industry includes youth residential programs such as treatment centers, wilderness programs, boot camps, and therapeutic boarding schools, housing about 120,000–200,000 adolescents as of 2020, with around 50,000 privately placed by parents[1-3]; and

Whereas, under the 2018 Family First Prevention Services Act, these programs are only required to follow federal and scientific standards if federally funded or state-run, however many are privately run, and are not held to these standards, leading to the use of unproven and potentially harmful practices[1,4]; and

Whereas, regulation of these programs is primarily left to state legislatures, leading to inconsistent oversight, while the out-of-state placement of many children further hinders effective monitoring and accountability by resource-limited non-profit organizations[3,5,6]; and

Whereas, many programs prioritize punitive methods over evidence-based treatments like cognitive behavioral therapy or trauma-informed care, leading to thousands of allegations of abuse, including false imprisonment, forced labor, solitary confinement, and physical and sexual abuse, all of which contribute to lasting trauma and, in some cases, death[1-2,7-11]; and

Whereas, the Troubled Teen Industry as a whole has a disproportionate impact on BIPOC children, children with disabilities and children who identify as part of the LGBTQ+ community[5,12]; and

Whereas, despite repeated efforts over the past decade, significant federal legislation, including the Stop Child Abuse in Residential Programs for Teens Act, has consistently failed to pass in Congress[13]; and

Whereas, H.R. 2955, the Stop Institutional Child Abuse Act, proposes the creation of a Federal Work Group on Youth Residential Programs to implement best practices for the health, safety, care, treatment, and placement of youth, but the bill has remained in committee since its introduction in April 2023[14]; and

Whereas, current advocacy for youth residential programs often does not extend to other aspects of the Troubled Teen Industry, such as wilderness therapy programs, which are less regulated due to their classification as shorter-term solutions[15]; and

Whereas, there are about 40 wilderness therapy programs in the U.S., part of the 2,000 "troubled teen" programs, and the New York Times reported at least 31 deaths in these programs since 1980, with many more cases reported since then[15,16]; and

Whereas, California has recently passed and will soon implement California's Accountability in Children's Treatment Act, which expanded current regulations on residential facilities to include short term residential therapeutic programs, like wilderness therapy programs[17]; and

Whereas, current AMA policy Youth Residential Treatment Program Regulation (H-60.896) specifically advocates for regulation of youth residential facilities which does not account for all aspects of the Troubled Teen Industry; therefore be it

RESOLVED, that our American Medical Association amend Policy H-60.896 "Youth Residential Treatment Program Regulation" by addition to read as follows:

Youth Residential and Other Treatment Program Regulation

1. Our American Medical Association recognizes the need for licensing standards for all youth residential treatment facilities (including private and juvenile facilities) as well as other treatment facilities (including wilderness therapy programs and other programs aimed at treating behavioral and mental health issues in youths) to ensure basic safety and well-being standards for youth.
2. Our AMA supports recommendations including, but not limited to, patient placement criteria and clinical practice guidelines, as developed by of nonprofit health care medical associations and specialty societies, as the standard for regulating youth residential treatment and other relevant youth programs.
3. Our AMA opposes the use of any non-evidence-based therapies and abusive measures in Youth Residential and Other Treatment Programs and supports that only appropriately qualified and certified child and adolescent medical and mental health professionals provide services to participants, and support oversight and review by licensed physicians, mental health professionals, and any other appropriate healthcare professionals
4. Our AMA supports efforts to improve information sharing between states on promising practices for preventing and addressing maltreatment in residential facilities.

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/21/25

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RELEVANT AMA POLICY

H-60.896 Youth Residential Treatment Program Regulation

1. Our American Medical Association recognizes the need for licensing standards for all youth residential treatment facilities (including private and juvenile facilities) to ensure basic safety and well-being standards for youth.
2. Our AMA supports recommendations including, but not limited to, patient placement criteria and clinical practice guidelines, as developed by of nonprofit health care medical associations and specialty societies, as the standard for regulating youth residential treatment programs. [Res. 218, I-23]

H-170.972 Role of Physicians in Improving Adolescent Health

The American Medical Association supports programs that encourage teen health and supports the involvement of medical students, residents, and other physicians in educational efforts to enhance teen health. [Res. 431, A-94; Reaffirmed and Modified: CSA Rep. 6, A-04; Modified: CSAPH Rep. 1, A-14; Reaffirmed: CSAPH Rep. 01, A-24]

H-95.965 Residential Treatment for Women with Substance Use Disorder

Our AMA encourages state medical societies to support an exemption in public aid rules that would allow for the coverage of residential drug treatment programs for women with child-bearing potential. [Res. 405, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21]

H-60.981 Adolescent Health

It is the policy of the AMA to work with other concerned health, education, and community groups in the promotion of adolescent health to: (1) develop policies that would guarantee access to needed family support services, psychosocial services and medical services; (2) promote the creation of community-based adolescent health councils to coordinate local solutions to local problems; (3) promote the creation of health and social service infrastructures in financially disadvantaged communities, if comprehensive continuing health care providers are not available; and (4) encourage members and medical societies to work with school administrators to facilitate the transformation of schools into health enhancing institutions by implementing comprehensive health education, creating within all schools a designated

health coordinator and ensuring that schools maintain a healthy and safe environment. [Res. 252, A-90; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17]

H-515.981 Family Violence-Adolescents as Victims and Perpetrators

1. Our American Medical Association:
    a. encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment.
    b. urges physicians to consider issues unique to adolescents when screening youths for abuse or neglect.
2. Our AMA encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs.
3. Our AMA will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development.
4. Our AMA will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment.
5. Our AMA urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs.
6. Our AMA encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence. [CSA Rep. I, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13; Reaffirmed: CSAPH Rep. 08, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 218
(A-25)

Introduced by: Medical Student Section, American College of Physicians, American College of Preventive Medicine, International Medical Graduates Section, Integrated Physician Practice Section

Subject: Distribution of Resident Slots Commensurate with Shortages

Referred to: Reference Committee B

Whereas, by 2036, the Health Resources & Services Administration (HRSA) projects an overall shortage of 139,940 physicians, with family medicine physicians, general internal medicine physicians, pediatricians, OBGYNs, and psychiatrists comprising 83% of the overall shortage[1]; and

Whereas, American Medical Association Policy H-200.949, “Principles of and Actions to Address Primary Care Workforce,” includes general internal medicine, family medicine, pediatrics, and OB/GYN as "primary care” specialties; and

Whereas, the National Health Service Corps considers general internal medicine, family medicine, pediatrics, OB/GYN, as well as psychiatry as specialties in shortage that preferentially receive scholarship support and loan repayment[2]; and

Whereas, preventive medicine physicians are another smaller primary care specialty not formally included in projections whose clinical scope can also help reduce the primary care shortage, in addition to their highly important role bolstering our public health workforce[3]; and

Whereas, our elderly population of over age 64 has been growing at the fastest rate since the 1800s, with an estimate of 55.8 million people, which represents a 38.6% increase in the last 10 years, resulting in increased demand for primary care services[4]; and

Whereas, primary care and psychiatry physician shortages are even more drastic than projected, because estimates like those from the HRSA assume that a large number of physician assistants and nurse practitioners will be hired instead of physicians to meet need[1]; and

Whereas, in both developing and developed countries, a sufficient primary care and psychiatry workforce has been associated with increased access to healthcare services, better health outcomes and decrease use in hospitalization and ED visits[6]; and

Whereas, based on HRSA data, the bipartisan Senate Finance Committee Medicare GME Working Group recently proposed allocating 25% of new Medicare GME slots to primary care and 15% to psychiatry, which are reasonable distributions considering that shortages in those fields are far more drastic[7]; and

Whereas, AMA action in the past has opposed allocating residency positions specifically to primary care and psychiatry, citing concerns about potential future shortages in other specialties

and emphasizing the need for flexibility to address regional demands and has also cosigned comments by the GME Advocacy Coalition, highlighting concerns about shortages across both primary care and specialties[8,9]; and

Whereas, the AMA's position does not align with the data on the extreme shortages in primary care and psychiatry, as the proposal's respective 25% and 15% slot allocations are far below their respective 53% and 30% shares of the physician shortage[1]; therefore be it

RESOLVED, that our American Medical Association support preferential distribution of new residency slots to general internal medicine, family medicine, preventive medicine, pediatrics, obstetrics and gynecology, and psychiatry, commensurate with their relative need and expected shortages. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/21/25

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RELEVANT AMA POLICY

H-200.949 Principles of and Actions to Address Primary Care Workforce
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
[CME Rep. 04, I-18; Reaffirmed: CMS Rep. 08, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 219
(A-25)

Introduced by: Medical Student Section

Subject: Opposing Unwarranted National Institutes of Health Research Institute Restructuring

Referred to: Reference Committee B

Whereas, in June 2024, the House Energy and Commerce Committee's National Institutes of Health (NIH) Reform Report proposed reducing the number of NIH institutes from 27 to 15, many of which are crucial for addressing specific medical conditions and public health challenges[1-3]; and

Whereas, in April 2025, a leaked draft of the 2026 budget proposal reveals that the current administration plans to go further by cutting the NIH's $47 billion budget to $26 billion and consolidate its 27 institutes and centers into just eight[14]; and

Whereas, recent terminations of long-term NIH contracts, as well as firing or reassignment of NIH institutes and centers' directors, have lacked transparency and clarity, indicating that reforms may proceed without input from physicians, scientists, researchers, academics and other interest and patient advocacy groups[4,5]; and

Whereas, the proposed restructuring and consolidation of the NIH may disproportionately affect research in pediatrics, maternal health and infectious diseases, shift funding away from rare diseases and health disparities, disrupt ongoing studies, reduce funding for specialized research—particularly for underrepresented groups—and redirect support from long-term to short-term projects[1,6]; and

Whereas, the current administration has not committed to maintaining total NIH funding or proportional funding across consolidated institutes and centers; and

Whereas, restructuring to larger research institutes does not necessarily improve productivity, as shown by the Fogarty International Center (FIC), which, despite having the smallest budget, publishes over 20 peer-reviewed manuscripts per $1 million and funds 500 projects at 100 U.S. universities, along with global partnerships in infectious disease, Alzheimer's research, and biodiversity that could be lost through consolidation[7-9]; and

Whereas, public investment in the NIH has generated $94.5 billion in economic activity in 2024 alone, yielding $2.56 for every $1 invested, and supports over 400,000 jobs which underscores its vital role in driving innovation, job growth, and supporting the biotech and pharmaceutical industries[10-12]; and

Whereas, previous NIH reform efforts created commissions to periodically advise additional reforms in the future, such as the Scientific Management Review Board, but have not been utilized in the current restructuring and reorganization[13]; therefore be it

RESOLVED, that our American Medical Association support efforts to promote the inclusion of direct input from allopathic and osteopathic physicians and the scientific community, particularly researchers and academics, in decisions pertaining to the restructuring of the NIH. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/22/25

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RELEVANT AMA POLICY

H-460.965 Viability of Clinical Research Coverages and Reimbursement

1. Our American Medical Association believes that legislation and regulatory reform should be pursued to mandate third party payer coverage of patient care costs (including co-pays/co-insurance/deductibles) of nationally approved (e.g., NIH, VA, ADAMHA, FDA), scientifically based research protocols or those scientifically based protocols approved by nationally recognized peer review mechanisms.
2. Our AMA believes that third party payers should formally integrate the concept of risk/benefit analysis and the criterion of availability of effective alternative therapies into their decision making processes.
3. Our AMA believes that third party payers should be particularly sensitive to the difficulty and complexity of treatment decisions regarding the seriously ill and provide flexible, informed and expeditious case management when indicated.
4. Our AMA believes that its efforts to identify and evaluate promising new technologies and potentially obsolete technologies should be enhanced.
5. Our AMA believes that its current efforts to identify unproven or fraudulent technologies should be enhanced.
6. Our AMA believes that sponsors (e.g., NIH, pharmaceutical firms) of clinical research should finance fully the incremental costs added by research activities (e.g., data collection,

investigators' salaries, data analysis) associated with the clinical trial. Investigators should help to identify such incremental costs of research.

7. Our AMA believes that supports monitoring present studies and demonstration projects, particularly as they relate to the magnitude (if any) of the differential costs of patient care associated with clinical trials and with general practice.
8. Our AMA believes that results of all trials should be communicated as soon as possible to the practicing medical community maintaining the peer reviewed process of publication in recognized medical journals as the preferred means of evaluation and communication of research results.
9. Our AMA believes that funding of biomedical research by the federal government should reflect the present opportunities and the proven benefits of such research to the health and economic well being of the American people.
10. Our AMA believes that the practicing medical community, the clinical research community, patient advocacy groups and third party payers should continue their ongoing dialogue regarding issues in payment for technologies that benefit seriously ill patients and evaluative efforts that will enhance the effectiveness and efficiency of our nation's health care system.
11. Our AMA believes that legislation and regulatory reform should be supported that establish program integrity/fraud and abuse safe harbors that permit sponsors to cover co-pays/coinsurance/ deductibles, otherwise not covered clinical care, and non-clinical ancillary costs in the context of nationally approved clinical trials.

[CSA Rep. F, I-89 Reaffirmed: Joint CMS/CSA Rep., I-92 Reaffirmed: BOT Rep.40, I-93 Reaffirmed: CSA Rep. 13, I-99 Reaffirmation A-00 Reaffirmed: CMS Rep. 4, A-02 Reaffirmed: CMS Rep. 4, A-12 BOT Action in response to referred for decision: Res. 813, I-15 BOT Action in response to referred for decision: Res. 823, I-15 Reaffirmation: I-18 Modified: Res. 226, A-22]

H-460.994 Support for Careers in Research

Our AMA: (1) supports joining with other public and private bodies in encouraging multiple approaches at local, state and national levels in support of the development of physician-investigators, and specifically encourages research and training grants without a pay-back provision; (2) encourages the several specialty boards through the Interspecialty Advisory Board to allow one or more years of clinical investigative training, as long as it has some relevance to that specialty, in lieu of a year of post-doctoral clinical experience, where appropriate; and (3) encourages the NIH to increase the stipends for NIH research traineeships and fellowships without reducing the actual number of available positions. [CSA Rep. G, A-80 Reaffirmed: CLRPD Rep. B, I-90 Reaffirmed: Sunset Report, I-00 Reaffirmation A-09 Reaffirmed: CSAPH Rep. 01, A-19]

H-460.975 Support for NIH Research Facilities

1. Our American Medical Association urges the enactment of federal legislation which would grant to the National Institutes of Health (NIH) funding authority to expand, remodel, and renovate existing biomedical research facilities and to construct new research facilities.
2. Our AMA urges that the authority be granted to the NIH Director and not fragmented at the categorical institute level.
3. Our AMA urges that institutions be required to match federal funding for this program in a systematic way.

[BOT Rep. S, I-88 Reaffirmed: Sunset Report, I-98 Reaffirmation A-00 Reaffirmed: BOT Rep. 6, A-10 Reaffirmed: BOT Rep. 7, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(A-25)

Introduced by: New England

Subject: Strengthening AMA Policy on Noncompete Clauses in Ownership Transitions

Referred to: Reference Committee B

Whereas, noncompete clauses (also known as restrictive covenants or covenants-not-to-compete) restrict physician mobility, impede patient continuity of care, and may force patients to seek alternative providers—thereby adversely affecting the quality and accessibility of care (AMA Code of Ethics 11.2.3.1); and

Whereas, such clauses have been shown to exacerbate healthcare workforce shortages, particularly in rural or underserved communities, by limiting physician ability to relocate or establish practices where needed; and

Whereas, numerous states have enacted outright bans on or strict limitations for physician noncompete agreements, including California, Delaware, New Hampshire, New Mexico, Rhode Island, Massachusetts, Minnesota, North Dakota, and Oklahoma; and

Whereas, pending legislation in several states, including Arkansas, Pennsylvania, Indiana, Maryland, and Louisiana, aims either to ban or further restrict the enforcement of physician noncompete clauses in employment contracts; and

Whereas, there is significant evidence that noncompete clauses become especially problematic in the event of ownership transitions, such as mergers, acquisitions (whether structured as a purchase of practice, stock acquisition, or asset sale), or reorganization, which can result in a material change in the employer that should not automatically transfer restrictive covenants unless explicitly agreed to in writing (as seen in Pennsylvania case law regarding assignment clauses and in cases like *Joyner Sports Medicine v. Stejbach*); and

Whereas, several states (e.g., Pennsylvania) prohibit the automatic assignment or transfer of noncompete clauses in the event of an ownership transfer, merger, or acquisition unless explicitly stated in the contract, thereby protecting physicians from being bound by covenants negotiated with a previous employer; and

Whereas, the National Labor Relations Board (NLRB) has argued that noncompete clauses may violate federal labor law by chilling employee mobility; and

Whereas, in 2024 the Federal Trade Commission (FTC) issued a rule banning noncompete clauses for employees in for-profit companies, although this ban was later struck down by a federal judge, reflecting ongoing concerns at the federal level about anti-competitive practices in employment; and

Whereas, case law, including *Valley Medical Specialists v. Farber* (Arizona) and *Mercy Health Sys. v. Bicak* (Arkansas), demonstrates that restrictive covenants can be overly burdensome when they impede patient choice and continuity of care, especially when applied following

dismissals or changes in ownership (Farber Case), thereby reinforcing the need for legislative and regulatory reform; and

Whereas, physicians who are dismissed by their employer, whether in the old or new ownership context, should not be penalized by noncompete clauses that were negotiated under different employment conditions (Connecticut Statute and Pennsylvania Act 67, 2023); and

Whereas, the disruption of patient continuity of care during ownership transitions is a serious public health concern that warrants strong advocacy and clear policy recommendations from the AMA; therefore be it

RESOLVED, that our American Medical Association strongly oppose the enforcement of noncompete clauses (restrictive covenants) following any material change in practice ownership or control, including but not limited to private equity acquisitions, hospital mergers, stock acquisitions, asset sales, or reorganizations, that do not receive explicit, renewed, and informed physician consent (New HOD Policy); and be it further

RESOLVED, that our AMA advocate at both the state and federal levels for legislative and regulatory solutions that prohibit the assignment or automatic transfer of noncompete clauses in the event of ownership transitions, mergers, or acquisitions, thereby preventing such clauses from being imposed on physicians without fresh contract negotiations (Directive to Take Action); and be it further

RESOLVED, that our AMA support policies that render any noncompete clause void if the physician is dismissed by the employer or group, whether under the old or new ownership, and support amendments to state laws to that effect (New HOD Policy); and be it further

RESOLVED, that our AMA support that all physicians be provided with clear, comprehensible disclosures regarding any noncompete or assignment clauses contained in contracts, including detailed explanations of how such clauses would (or would not) be applied in the event of a merger, acquisition, or other ownership change. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/15/25

RELEVANT AMA POLICY

H-160.885 Impact of Integration and Consolidation on Patients and Physicians
1) Our American Medical Association will continue to monitor the impact of hospital-physician practice and hospital-hospital mergers and acquisitions on health care prices and spending, patient access to care, potential changes in patient quality outcomes, and physician wages and labor.
2) Our AMA will continue to monitor how provider mix may change following mergers and acquisitions and how non-compete clauses may impact patients and physicians.
3) Our AMA will support efforts to collect relevant information regarding hospital-physician practice and hospital-hospital mergers and acquisitions in states or regions that may fall below the Federal Trade Commission (FTC)/Department of Justice review threshold.
4) Our AMA will encourage state and local medical associations, state specialty societies, and physicians to contact their state attorney general with concerns of anticompetitive behavior.
5) Our AMA will encourage physicians to share their experiences with mergers and acquisitions, such as those between hospitals and/or those between hospitals and physician practices, with the FTC via their online submission form.

H-265.987 Prohibiting Covenants Not-to-Compete
1) Our American Medical Association opposes all restrictive covenants between employers and physician employees and regularly update its state restrictive covenant legislative template.
2) Our AMA will continue to assist interested state medical associations and specialty societies in developing strategies for physician employee retention.

D-383.978 Restrictive Covenants of Large Health Care Systems
Our AMA, through its Organized Medical Staff Section, will educate medical students, physicians-in-training, and physicians entering into employment contracts with large health care system employers on the dangers of aggressive restrictive covenants, including but not limited to the impact on patient choice and access to care.

H-265.988 Prohibiting Covenants Not-To-Compete in Physician Contracts
1) Our American Medical Association support policies, regulations, and legislation that prohibits covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers.
2) Our AMA will oppose the use of restrictive covenants not-to-compete as a contingency of employment for any physician-in-training, regardless of the ACGME accreditation status of the residency/fellowship training program.
3) Our AMA will study and report back on current physician employment contract terms and trends with recommendations to address balancing legitimate business interests of physician employers while also protecting physician employment mobility and advancement, competition, and patient access to care - such recommendations to include the appropriate regulation or restriction of a) Covenants not to compete in physician contracts with independent physician groups that include time, scope, and geographic restrictions; and b) De facto non-compete restrictions that allow employers to recoup recruiting incentives upon contract termination.

AMA Code of Ethics 11.2.3.1 Restrictive Covenants
1) Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms.
2) Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care.
3) Physicians should not enter into covenants that: (a) Unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and (b) Do not make reasonable accommodation for patients' choice of physician.
4) Physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program.

D-215.980 Support Before, During, and After Hospital Closure or Reduction in Services
1) Our American Medical Association will work with appropriate federal and state bodies to assure that whenever there is a threatened, or actual, hospital closure a process be instituted to safeguard the continuity of patient care and preserve the physician-patient relationship. Such a process should: a) assure adequate capacity exists in the immediate service area surrounding the hospital closure, including independent health resources, physicians, and support personnel to provide for the citizens of that area; b) allow that in said circumstances, restrictive covenants, records access, and financial barriers which prevent the movement of physicians and their patients to surrounding hospitals should be waived for an appropriate period of time; and c) ensure financial reserves exist, and are sufficient to cover any previous contractual obligations to physicians, e.g., medical liability tail coverage.
2) Our AMA will proactively offer support to physicians, residents and fellows, patients, and civic leaders affected by threatened or actual healthcare facility closures, change in ownership, or significant reductions in services via provision of information, resources, and effective, actionable advocacy.

H-160.891 Corporate Investors
Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.

H-310.929 Principles for Graduate Medical Education
7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(A-25)

Introduced by: New England, Association for Clinical Oncology

Subject: Preservation of Medicaid

Referred to: Reference Committee B

Whereas, Medicaid provides healthcare coverage to 80 million Americans, including pregnant women, children, adults, seniors, people with disabilities, and many others[1]; and

Whereas, Medicaid coverage continues to improve health outcomes, with recent expansion linked to a 6% reduction in all-cause mortality, a 23% increase in self-reported excellent health, and 41% higher likelihood of having a usual source of care[2–9]; and

Whereas, Medicaid finances 40% of all births, insures 40% of individuals under 18 years of age, is the largest payer for behavioral health services, and is the largest payer of long-term care[10–13]; and

Whereas, rural physicians are more likely to serve patient populations who rely on Medicaid funding and would be disproportionately impacted by federal funding cuts[14]; and

Whereas, prior efforts to cut Medicaid spending via work requirements did not increase employment and led to increased medical debt, delayed care, and poorer medication compliance[15,16]; and

Whereas, the federal government finances 69% of Medicaid nationally, ensuring states can provide care without excessive fiscal burden[17]; and

Whereas, reductions to federal funding of Medicaid or changes to Medicaid eligibility at the federal level would lead to substantial loss of coverage for millions of Americans; and

Whereas, the U.S. Congress is considering cutting federal Medicaid spending by adopting a per-capita financing model, reducing the federal match rate, imposing work requirements on certain enrollees, and other policies that are likely to cause coverage reductions[18]; therefore be it

RESOLVED, that our American Medical Association make preservation of federal funding and eligibility for Medicaid one of its top and urgent legislative advocacy priorities, effective immediately, and request report back on the Board of Trustees' actions at I-25 (Directive to Take Action); and be it further

RESOLVED, that our AMA strongly oppose federal and state efforts to reduce eligibility and funding for all public health insurance programs, including Medicaid and CHIP. (New HOD Policy)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/15/25

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RELEVANT AMA POLICY

Medicaid Expansion D-290.979

1. Our American Medical Association, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.
2. Our AMA will: a. continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823. b. work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all.

Improving Medicaid and CHIP Access and Affordability H-290.954

1. Our American Medical Association opposes premiums, copayments, and other cost-sharing methods for Medicaid and the Children's Health Insurance Program, including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries.
2. Our AMA encourages the Centers for Medicare & Medicaid Services to amend existing Section 1115 waivers to disallow states the ability to charge premiums or copayments to Medicaid beneficiaries.

Pediatric Specialty Medicaid Reimbursement D-290.972
1. Our American Medical Association will make increasing Medicaid reimbursement for pediatric specialists a significant part of its plan for continued progress toward health equity.
2. Our AMA will advocate for payment parity with Medicare for the same or similar services provided to pediatric patients under Medicaid.
3. Our AMA will work with specialty societies to develop a value-based payment model that makes pediatric specialist practices sustainable and promotes access to care and health equity among the pediatric patients.
4. Our AMA will work with interested state parties to support the implementation of the value-based payment model for pediatric specialists in state Medicaid programs.
5. Our AMA will advocate for any demonstration projects undertaken to modernize Medicaid payment using value based payment models developed by the AMA and pediatric specialty societies be exempt from Medicaid demonstration project budget neutrality requirements.

Opposition to Medicaid Work Requirements H-290.961
Our AMA opposes work requirements as a criterion for Medicaid eligibility.

Federal Medicaid Funding H-290.963
1. Our AMA opposes caps on federal Medicaid funding.
2. Our AMA will advocate that Congress and the Department of Health and Human Services seek and take into consideration input from our AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors, and other stakeholders during the process of developing federal legislation, regulations, and guidelines on Medicaid funding.

Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations H-385.901
1. Our American Medical Association supports appropriate demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena.
2. Our AMA will extend ongoing payment reform research, education, and advocacy to address the needs of specialties and patient populations not served by current CMMI models or other Medicare-focused payment reform efforts.
3. Our AMA will support and work with national medical specialty societies that are developing alternative payment models for specific conditions or episodes, target patient populations including pediatric populations, and medical and surgical specialties and continue to advocate that the Centers for Medicare and Medicaid Services, including the Center for Medicare and Medicaid Innovation; state Medicaid agencies; and other payers implement physician-developed payment models.
4. Our AMA will consider improved Medicaid payment rates to be a priority given the critical impact these payment rates have on patient care and patient access to care.
5. Our AMA will support and collaborate with state and national medical specialty societies and other interested parties on the development and adoption of physician-developed alternative payment models for pediatric health care that address the distinct prevention and health needs of children and take long-term, life-course impact into account.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(A-25)

Introduced by: New York

Subject: Need for Separate H1B Pathway for IMG Doctors in the USA

Referred to: Reference Committee B

Whereas, International Medical Graduates (IMGs) constitute a significant portion of the U.S. physician workforce, particularly in underserved areas and critical specialties; and

Whereas, IMG doctors face significant barriers under the current H1B visa system, including delays due to visa caps and the lottery process, which impact their ability to provide consistent care; and

Whereas, the complexity and duration of the current H1B visa and its 3-year renewal process impose undue burdens on IMG doctors, potentially interrupting their work and patient care; and

Whereas, the U.S. is projected to face a shortage of up to 124,000 physicians by 2034, making it imperative to ensure that IMG doctors remain a stable and uninterrupted part of the healthcare workforce; and

Whereas, several countries, including Canada and the UK, have established streamlined visa pathways for foreign-trained physicians, recognizing their vital role in addressing healthcare workforce shortages; therefore be it

RESOLVED, that our American Medical Association advocate for an expedited H-1B visa application and renewal process for International Medical Graduate physicians. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/22/25

REFERENCES

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   AILA provides insight into the challenges of the 3-year H1B renewal process for professionals
2. U.S. Citizenship and Immigration Services (USCIS). H1B Visa Renewal Guidelines.
   Explains the process and potential delays associated with H1B visa renewals.
3. U.S. Department of Homeland Security. H1B Visa Cap and Lottery System.
   Details on the complexities of the H1B visa process, including visa caps and the lottery.
4. Migration Policy Institute. H1B Visas: A Primary Tool for Hiring High-Skilled Foreign Workers. This article discusses how H1B restrictions affect healthcare providers
5. Government of Canada. Federal Skilled Worker Program: Medical Professionals Stream.
   Canada's immigration pathways for foreign-trained physicians.
6. UK Home Office. Shortage Occupation List and Skilled Worker Visa Route for Doctors.
   The UK's visa process designed to attract healthcare professionals, including foreign-trained doctors.
7. Association of American Medical Colleges (AAMC). The Complexities of Physician Supply and Demand: Projections from 2019 to 2034.This report highlights the role of IMGs in addressing physician shortages in the U.S., especially in rural and underserved areas.
8. American Medical Association (AMA). IMGs in the U.S. Workforce. AMA statistics on the contribution of IMGs to the U.S. healthcare system

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(A-25)

Introduced by: New York

Subject: Preservation of Medicaid

Referred to: Reference Committee B

Whereas, Medicaid provides healthcare coverage to 80 million low-income Americans, including pregnant women, children, adults, seniors, people with disabilities, and LGBTQIA+ individuals[1]; and

Whereas, Medicaid improves health outcomes, with expansion linked to a 6% reduction in all-cause mortality, a 23% increase in self-reporting health as excellent, and 41% higher likelihood of having a usual care source[2–9]; and

Whereas, Medicaid finances 40% of all births (including nearly 50% of births in rural communities), insures 40% of individuals under 18 years of age, is the largest single payer for behavioral health services, including substance use disorder (SUD) treatment, and is the largest payer of long term care services in the United States[10–13]; and

Whereas, women physicians are more likely to serve patient populations who rely heavily on Medicaid funding and would be disproportionately impacted by federal funding cuts[14]; and

Whereas, previous efforts to cut Medicaid spending via work requirements did not increase employment and instead led to problems paying off medical debt, delayed care, and delayed taking medications due to cost[15,16]; and

Whereas, the federal government finances 69% of Medicaid nationally, ensuring states can provide care without excessive fiscal burden[17]; and

Whereas, reductions to federal funding of Medicaid or changes to Medicaid eligibility at the federal level would lead to substantial loss of coverage for millions of Americans; and

Whereas, U.S. Congress is considering cutting federal Medicaid spending by adopting a per-capita financing model, reducing the federal match rate, and imposing work requirements on certain enrollees —policies shown to force coverage reductions[18]; therefore be it

RESOLVED, that our American Medical Association strongly supports maintaining and expanding Medicaid coverage to ensure access to comprehensive healthcare for vulnerable populations (New HOD Policy); and be it further

RESOLVED, that our AMA opposes any state or federal efforts to impose work requirements as a condition of Medicaid eligibility (New HOD Policy); and be it further

RESOLVED, that our AMA opposes increasing cost-sharing requirements for Medicaid enrollees (New HOD Policy); and be it further

RESOLVED, that our AMA makes preservation of federal funding and eligibility for Medicaid an urgent and top legislative advocacy priority (Directive to Take Action); and be it further

RESOLVED, that our AMA strongly oppose federal and state efforts to restrict eligibility and funding for all public health insurance programs, including Medicaid and CHIP. (New HOD Policy)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/22/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(A-25)

Introduced by: New York

Subject: Support SAVE Plan and Public Service Loan Forgiveness (PLSF) Applications

Referred to: Reference Committee B

Whereas, the SAVE plan is an income-driven repayment plan that grants forgiveness on subsidized and unsubsidized federal loans after 120 months of qualifying payments[1]; and

Whereas, the SAVE plan provides an interest benefit preventing interest from accruing if the income-driven monthly payment does not cover the interest; and

Whereas, repayment length is based on the principal amount of the loan and level of study (graduate vs. undergraduate), with a cap of 25 years; and

Whereas, the average medical student graduates with $234,579 in medical school-associated debt[2]; and

Whereas, a federal court has placed an injunction on the SAVE plan, preventing borrowers from applying to SAVE and placing currently enrolled borrowers in involuntary forbearance[3]; therefore be it

RESOLVED, that our American Medical Association supports the reinstatement of the SAVE plan or a replacement program with similar income-based payments, interest benefits, and loan forgiveness and allows those with 120 qualifying payments to submit a PSLF application (New HOD Policy); and be further

RESOLVED, that this resolution be submitted to the American Medical Association for consideration and advocacy, ensuring that the AMA supports and promotes the reinstatement of the SAVE plan or a similar program at the national level. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(A-25)

Introduced by: New York

Subject: The Private Practice Physicians in the Community

Referred to: Reference Committee B

Whereas, I am a member and represent the endangered species of Medicine: The Private Practice Physicians which today comprise only 17% of practicing physicians. Recently the number has rapidly declined to near extinction levels. Many have gone into early retirement; others have joined the hospital or companies which offer employment opportunities; and

Whereas, there are several specific reasons for this decline, including the decline in reimbursements. This year a 2.83% cut in the physician payment schedule has occurred, the 5th straight year of cuts, a devastating decline in physician reimbursement that stretches beyond two decades; and

Whereas, private practice physicians are affected to a much larger degree than hospitalists as the hospital donors and state funding largely subtracts from the physician apportion; and

Whereas, hospitals and large group practices have greater market share due to ability to buy up practices in the community and claim enough member lives to negotiate higher reimbursement.The unregulated, unfettered urgent care and minute clinics also compete for business from the private physicians; and

Whereas, Direct care, concierge, and traditional personalized patient care in a private practice setting where the physician has greater flexibility and continuity with the patient fosters a stronger physician-patient relationship, which likely promotes better patient satisfaction and improved outcomes. The private practice physician has been the cornerstone and backbone of the healthcare system for the past few hundred years; and

Whereas, physicians have no reasonable labor protection, cannot unionize or strike unlike the hospitalists who can strike and unionize for better wages, are unable to share information about our contracts due to fear of accusations of “collusion”; and

Whereas, Corporate hospitals and large groups have taken over medicine with their bottom line agenda. In the year 2000 there were only a few hundred hospitalists, today there are 60,000 hospitalists, a number that is rapidly growing; therefore be it

RESOLVED, that our American Medical Association advocate for legislation, regulation or other policy mechanisms make it a priority to halt the constant yearly physician cutbacks in a climate of skyrocketing inflation and a high cost of living, in fact COLA should be built into ALL fee schedules (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate to The Centers for Medicare and Medicaid Services (CMS) and Congress to decrease the need for time consuming prior authorizations, decrease

the use of audits and recoupment and retrieving funds from physicians already burdened by ever increasing overhead and continual payment cutbacks. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(A-25)

Introduced by: Pennsylvania

Subject: Regulations for Algorithmic-Based Health Insurance Utilization Review

Referred to: Reference Committee B

Whereas, utilization review by health insurance companies was originally intended to involve comprehensive examination of patient records by medical experts to ensure fair and objective decisions[1]; and

Whereas, there is growing concern regarding the use of algorithmic systems in utilization review, which bypass traditional medical review steps and rely on automated processes to make claim denial decisions[1]; and

Whereas, the utilization of artificial intelligence (AI) and machine learning algorithms in utilization review processes by insurance companies raises concerns regarding their technical limitations, longitudinal unreliability, and propensity for biass[2]; and

Whereas, AI algorithms may exhibit limitations in accurately assessing complex medical data and making informed utilization review decisions, particularly in cases where the underlying data is incomplete, unrepresentative, ambiguous, or subject to interpretation[2]; and

Whereas, AI algorithms may exhibit bias in their decision-making processes, reflecting and perpetuating existing disparities and inequities in healthcare access and outcomes, particularly for marginalized and underserved populations[2]; and

Whereas, the opacity and lack of interpretability of AI algorithms may hinder the identification and mitigation of bias and may lead to an overreliance on algorithmic predictions, leading to possibly unfair and discriminatory utilization review practices by insurance companies[2]; and

Whereas, the utilization of algorithmic systems, such as Cigna's PXDX, has raised questions about the transparency, accountability, and fairness in their assessment of medical claims, as these systems lack human oversight and may lead to erroneous denials of medically necessary care[3,4]; and

Whereas, even after investigations by the U.S. Department of Labor, congressional committees, and journalists, the usage of algorithms in utilization review has not been transparently disclosed to physicians, patients, and the general public[3,4]; and

Whereas, insurance companies such as UnitedHealth have been found to use restrictive algorithms and medical staff coercion to limit Medicare patients' access to rehabilitation care, resulting in a lawsuit and pressure from US Representatives to prompt CMS oversight of use of AI in Medicare Advantage plans[5]; and

Whereas, the improper use of utilization management programs have been found to lead to inappropriate denials, thereby resulting in delays in patient care, clinician burnout, and

increased administrative burden to appeal such denials with a substantial portion of denials ultimately overturned in providers' favor[6]; and

Whereas, consumers facing wrongful insurance denials often encounter significant obstacles in navigating the appeals process, leading to low rates of appeal and potentially, underreporting of violations[6,7]; and

Whereas, the utilization of algorithmic systems in medical review processes may undermine patient trust in insurance providers and the healthcare system as a whole, leading to medical mistrust and dissatisfaction[6]; and

Whereas, the financial consequences of payment delays and denials for medically necessary care have placed significant strains on health systems with billions of dollars in delayed or potentially unpaid claims reported[1,6]; and

Whereas, delays in patient care have been linked to serious adverse events including hospitalizations, disabilities; and even deaths, as reported by physicians[6]; and

Whereas, there is extensive documentation of insurance companies violating numerous state laws aimed at protecting consumers from unfair insurance denials, including denials for life-saving cancer medications and necessary surgeries[7]; and

Whereas, state insurance departments tasked with enforcing these laws often lack the resources and manpower necessary to effectively conduct thorough audits or investigations into violations[7]; and

Whereas, The American Medical Association (AMA) has conducted extensive research on utilization management programs, like prior authorization, revealing their detrimental impact on patient care delays, administrative costs, and workflow disruptions, highlighting the urgent need for reform[8]; and

Whereas, surveys of practicing physicians have consistently indicated that prior authorization requirements interfere with patient care, and limit progress in reforming health plans[8]; and

Whereas, The American Medical Association House of Delegates adopted the following five policies since 2022 to address the use of AI in reviewing patient claims and prior authorization requests: H-285.998 Managed Care (2024); H-320.968 Approaches to Increase Payer Accountability (2024); H-390.849 Physician Payment Reform (2023); H-480.935 Assessing the Potentially Dangerous Intersection Between AI and Misinformation (2023), and H-480.939 Augmented Intelligence (2022); therefore be it

RESOLVED, that our American Medical Association advocate for state and federal oversight of and/or legislative activity to assure the transparency, patient safety, and biases involved in algorithm usage in utilization review by insurance companies (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm the following policies:
H-285.998 Managed Care (2024)
H-320.968 Approaches to Increase Payer Accountability (2024)
H-390.849 Physician Payment Reform (2023)

H-480.935 Assessing the Potentially Dangerous Intersection Between AI and Misinformation (2023)
H-480.939 Augmented Intelligence (2022). (Reaffirm HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/7/25

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RELEVANT AMA POLICY

Managed Care H-285.998

1. Introduction The needs of patients are best served by free market competition and free choice by physicians and patients between alternative delivery and financing systems, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing.
2. Definition "Managed care" is defined as those processes or techniques used by any entity that delivers, administers, and/or assumes risk for health care services in order to control or influence the quality, accessibility, utilization, or costs and prices or outcomes of such services provided to a defined enrollee population.
3. Techniques Managed care techniques currently employed include any or all of the following: (a) prior, concurrent, or retrospective review of the quality, medical necessity, and/or appropriateness of services or the site of services; (b) controlled access to and/or coordination of services by a case manager; (c) efforts to identify treatment alternatives and to modify benefits for patients with high cost conditions; (d) provision of services through a network of contracting providers, selected and deselected on the basis of standards related to cost-effectiveness, quality, geographic location, specialty, and/or other criteria; (e) enrollee financial incentives and disincentives to use such providers, or specific service sites; and (f) acceptance by participating providers of financial risk for some or all of the contractually obligated services, or of discounted fees.
4. Case Management Health plans using the preferred provider concept should not use coverage arrangements which impair the continuity of a patient's care across different treatment settings. With the increased specialization of modern health care, it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient. The physician is best suited by professional preparation to assume this leadership role. The primary goal of high-cost case management or benefits management programs should be to help to arrange for the

services most appropriate to the patient's needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient's care. Any health plan which makes available a benefits management program for individual patients should not make payment for services contingent upon a patient's participation in the program or upon adherence to treatment recommendations.

5. Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed. Physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field. A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for their decisions. All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to their patients. It is the responsibility of the patient and their health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan.

All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to their patient.

When inordinate amounts of time or effort are involved in providing case management services required by a third party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage."

Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services. Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring prior authorization are recommended by the physicians.

In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the AMA strongly opposes the use of this process.

Joint CMS/CLRPD Rep. I-91 Reaffirmed: CMS Rep. I-93-5 Reaffirmed: Res. 716, A-95 Modified: CMS Rep. 3, I-96 Modified: CMS Rep. 4, I-96 Reaffirmation A-97 Reaffirmed: CMS Rep. 3, I-97 Reaffirmed: CMS Rep. 9, A-98 Reaffirmed: Sub. Res. 707, A-98 Reaffirmed: CMS Rep. 13, I-98 Reaffirmed: Res. 717, A-99 Reaffirmation A-00 Reaffirmation A-02 Reaffirmation I-04 Reaffirmed in lieu of Res. 839, I-08 Reaffirmation A-09 Reaffirmed: Sub. Res. 728, A-10 Reaffirmation I-10 Reaffirmation A-11 Reaffirmed: Res. 709, A-12 Reaffirmed: CMS Rep. 07, A-16 Reaffirmed: CMS Rep. 08, A-17 Reaffirmed: CMS Rep. 04, A-18 Reaffirmation: A-19 Reaffirmed: CMS Rep. 4, A-21 Reaffirmation: A-22 Reaffirmation: A-23 Modified: Speakers Rep. 02, I-24

Approaches to Increase Payer Accountability H-320.968
Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

1. Disclosure Requirements. Our American Medical Association supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on:
    a. Coverage provisions, benefits, and exclusions.
    b. Prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services.
    c. Plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to their patient.
    d. Medical expense ratios.
    e. Cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)
2. Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to:
    a. Require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed.
    b. Require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review.
    c. Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review.
    d. Require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed.
    e. Require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay.
    f. Require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician.
    g. Require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than

the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

3. Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

BOT Rep. M, I-90 Reaffirmed by Res. 716, A-95 Reaffirmed by CMS Rep. 4, A-95 Reaffirmation I-96 Reaffirmed: Rules and Cred. Cmt., I-97 Reaffirmed: CMS Rep. 13 , I-98 Reaffirmation I-98 Reaffirmation A-99 Reaffirmation I-99 Reaffirmation A-00 Reaffirmed in lieu of Res. 839, I-08 Reaffirmation A-09 Reaffirmed: Sub. Res. 728, A-10 Modified: CMS Rep. 4, I-10 Reaffirmation A-11 Reaffirmed in lieu of Res. 108, A-12 Reaffirmed: Res. 709, A-12 Reaffirmed: CMS Rep. 07, A-16 Reaffirmed in lieu of: Res. 242, A-17 Reaffirmed in lieu of: Res. 106, A-17 Reaffirmation: A-17 Reaffirmation: I-17 Reaffirmation: A-18 Reaffirmation: A-19 Reaffirmed: Res. 206, I-20 Reaffirmation: A-22 Modified: Speakers Rep. 02, I-24

Physician Payment Reform H-390.849

1. Our American Medical Association will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
    a. Promote improved patient access to high-quality, cost-effective care.
    b. Be designed with input from the physician community.
    c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.
    d. Not require budget neutrality within Medicare Part B.
    e. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.
    f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
    g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
    h. Use adequate risk adjustment methodologies.
    i. Incorporate incentives large enough to merit additional investments by physicians.
    j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.
    k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
    l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.
    m. Include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society- developed clinical guidelines/standards.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

CMS Rep. 6, A-09 Reaffirmation A-10 Appended: Res. 829, I-10 Appended: CMS Rep. 1, A-11 Appended: CMS Rep. 4, A-11 Reaffirmed in lieu of Res. 119, A-12 Reaffirmed in lieu of Res. 122, A-12 Modified: CMS Rep. 6, A-13 Reaffirmation I-15 Reaffirmation: A-16 Reaffirmed in lieu of: Res. 712, A-17 Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17 Reaffirmation: A-19 Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19 Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19 Reaffirmed: Res. 212, I-21 Reaffirmed: Res. 240, A-22 Reaffirmation: A-22 Modified: CMS Rep. 04, A-23 Reaffirmed: Res. 214, A-23 Reaffirmation: A-23

Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935

1. Our American Medical Association will study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24.
2. Our AMA will work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice.
3. Our AMA will encourage physicians to educate our patients about the benefits and risks of consumers facing LLMs including GPTs.
4. Our AMA will support publishing groups and scientific journals to establish guidelines to regulate the use of augmented intelligence in scientific publications that include detailing the use of augmented intelligence in the methods, exclusion of augmented intelligence systems as authors, and the responsibility of authors to validate the veracity of any text generated by augmented intelligence.

Res. 247, A-23

Augmented Intelligence H-480.939

Our American Medical Association supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on
    a. clinical validation.
    b. alignment with clinical decision-making that is familiar to physicians.
    c. high-quality clinical evidence.
4. Payment and coverage for health care AI systems must
    a. be informed by real world workflow and human-centered design principles.
    b. enable physicians to prepare for and transition to new care delivery models.
    c. support effective communication and engagement between patients, physicians, and the health care team.
    d. seamlessly integrate clinical, administrative, and population health management functions into workflow.
    e. seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster

innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.

6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
    a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
    b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
    a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
    b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations:
    a. Identify areas of medical practice where AI systems would advance the quadruple aim.
    b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts.
    c. Outline new professional roles and capacities required to aid and guide health care AI systems.
    d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

BOT Rep. 21, A-19 Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(A-25)

Introduced by: Private Practice Physicians Section

Subject: Payment Recoupment—Let Sanity Prevail

Referred to: Reference Committee B

Whereas, insurance companies not only create barriers to care and payment, but manage to bamboozle physicians into retrospective recovery or claim recoupment with bolder and more outlandish schemes; and

Whereas, insurance companies often claim errors that are not the fault of the physician as the reason for recoupment; and

Whereas, insurance companies often try to cover up their mistakes and errors by imposing the costs on physicians for services legitimately performed for a medically necessary condition; and

Whereas, insurance companies recoup money for payments made “in error” due to a “coordination of benefits” error that is the fault of the insurance company; and

Whereas, medical practices are not debt collectors for insurance companies where debts belong to the patient or another insurance company; and

Whereas, claim recoupment is administratively costly to physician practices, has no meaningful due process, and is not overseen by any third party as claim-related appeals cannot be referred for outside appeals under most health plan provisions; and

Whereas, claim recovery or recoupment has a significant impact on the financial viability of medical practices with billions of dollars recurred in costs and billions unjustly stolen from physicians; and

Whereas, AMA policy D-385.944, “ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers” refers to the US Supreme Court holding in Rutledge v. PCMA, which gives the states the ability to regulate certain administrative aspects of health plans that do not relate to “a particular scheme of substantive coverage” which includes claim recoupment and payment recovery; therefore be it

RESOLVED, that our American Medical Association advocates for legislation and regulations compliant with the Supreme Court holding in *Rutledge v. PCMA* (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for legislation and regulations that stipulate that if payment recovery or recoupment is due to coordination of benefit failure, the payer seeks recovery from the patient and/or the correct insurance company or primary payer responsible for the claim (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for legislation and that whenever a health plan seeks recoupment or payment recovery for overpayment or wrong payment from a physician, a detailed and comprehensive explanation for the payment recoupment/recovery must be provided (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for legislation and regulation that if the reason for claim recovery or recoupment is not due to physician error, the health plan may not seek recovery from the physician and that health plans must seek resolution from the patient on whose behalf the insurance company paid the claim and who has a contract with the insurance company or the third party responsible for the payment involved in claim recovery or recoupment (Directive to Take Action); and be it further

RESOLVED, that our AMA report back at the 2026 Annual Meeting on the progress of the implementation of this resolution (Directive to Take Action).

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/22/25

RELEVANT AMA POLICY

ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers D-385.944
Our American Medical Association will study, and create resources for states, on the implication of *Rutledge, Attorney General Of Arkansas v. Pharmaceutical Care Management Association*, and any other relevant legal decisions from the last several years, in reference to potentially allowing more successful challenges to the actions of healthcare plans protected by the Employee Retirement Income Security Act of 1974 (ERISA) when the quality of care or healthcare outcomes are questioned.
Citation: Res. 224, I-23

Insurance Companies Use of Contractors to Recover Payments D-385.965
1. Our AMA will seek legislation to limit insurance companies, their agents, or any contractors from requesting payment back on paid claims to no more than 90 days after payment is made.
(a) Such legislation would require insurance companies, their agents, or any contractors to have a defined and acceptable process for physicians to dispute these maneuvers to get payment back on claims already processed, verified, and paid.
(b) Such legislation would ban insurance companies, their agents or contractors from using re-pricers and re-reviewers and to adhere to their own pricing and reviewing guidelines as agreed upon in their contracts with physicians.
2. Our AMA will pursue legislation to regulate self-insured plans in this regard and apply the same rules to Medicare and other federal plans.
Citation: Res. 215, A-09; Reaffirmed: BOT Rep. 09, A-19

Creating a Fair and Balanced Medicare and Medicaid RAC Program D-320.991
1. Our AMA will continue to monitor Medicare and Medicaid Recovery Audit Contractor (RAC) practices and recovery statistics and continue to encourage the Centers for Medicare and Medicaid Services (CMS) to adopt new regulations which will impose penalties against RACs for abusive practices.
2. Our AMA will continue to encourage CMS to adopt new regulations which require physician review of all medical necessity cases in post-payment audits, as medical necessity is quintessentially a physician determination and judgment.
3. Our AMA will encourage CMS to discontinue the denial of payments or imposition of negative action during an audit due to the absence of specific words in the chief complaint when the note provides adequate documentation of the reason for the visit and services rendered.
4. Our AMA will assist states by providing recommendations regarding state implementation of Medicaid RAC rules and regulations in order to lessen confusion among physicians and to ensure that

states properly balance the interest in overpayment and underpayment audit corrections for Recovery Contractors.
5. Our AMA will petition CMS to amend CMS' rules governing the use of extrapolation in the RAC audit process, so that the amended CMS rules conform to Section 1893 of the Social Security Act Subsection (f) (3) - Limitation on Use of Extrapolation; and insists that the amended rules state that when an RAC initially contacts a physician, the RAC is not permitted to use extrapolation to determine overpayment amounts to be recovered from that physician by recoupment, offset, or otherwise, unless (as per Section 1893 of the Social Security Act) the Secretary of Health and Human Services has already determined, before the RAC audit, either that (a) previous, routine pre- or post-payment audits of the physician's claims by the Medicare Administrative Contractor have found a sustained or high level of previous payment errors, or that (b) documented educational intervention has failed to correct those payment errors.
6. Our AMA, in coordination with other stakeholders such as the American Hospital Association, will seek to influence Congress to eliminate the current RAC system and ask CMS to consolidate its audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians.
7. Our AMA will: (A) seek to influence CMS and Congress to require that a physician, and not a lower level provider, review and approve any RAC claim against physicians or physician-decision making, (B) seek to influence CMS and Congress to allow physicians to be paid any denied claim if appropriate services are rendered, and (C) seek the enactment of fines, penalties and the recovery of costs incurred in defending against RACs whenever an appeal against them is won in order to discourage inappropriate and illegitimate audit work by RACs.
8. Our AMA will advocate for penalties and interest to be imposed on the auditor and payable to the physician when a RAC audit or appeal for a claim has been found in favor of the physician.
Citation: Res. 215, I-11; Appended: Res. 209, A-13; Appended: Res. 229, A-13; Appended: Res. 216, I-13; Reaffirmed: Res. 223, I-13; Appended: Res. 213, I-16; Reaffirmed: CMS Rep. 08, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(A-25)

Introduced by: Resident and Fellow Section, American Academy of Family Physicians, American College of Obstetricians and Gynecologists

Subject: CHIP Coverage of OTC Medications

Referred to: Reference Committee B

Whereas, the Children's Health Insurance Program (CHIP) is a joint federal and state program that provides health coverage to uninsured children in families with incomes too high to qualify for Medicaid, but too low to afford private coverage[1]; and

Whereas, CHIP was originally passed into law under the Balanced Budget Act of 1997, and was most recently extended through federal fiscal year 2027[2]; and

Whereas, in order for a child to be eligible for CHIP, they must be 1) under 19 years of age, 2) uninsured, 3) a citizen or meet immigration requirements, 4) a resident of the state where they are applying, and 5) eligible within the state's CHIP incoming range based on family income)[3]; and

Whereas, in 2009, the Children's Health Insurance Program Reauthorization Act (CHIRPA) amends the act to expand coverage to pregnant women, including coverage during the 60-day postpartum period[4]; and

Whereas, each state administers their own CHIP program with their own distinct rules and regulations, within federal guidelines, to meet the needs of their constituents[5]; and

Whereas, CHIP currently covers routine check-ups, immunizations, doctor visits, dental and vision care, inpatient and outpatient hospital care, lab and imaging services, emergency services, and prescription medications[6]; and

Whereas, since CHIP was enacted the uninsured rate for children 18 and under has fallen by 67.9% from 14.9 to 4.8%[7]; and

Whereas, 7.6 million children are currently enrolled in CHIP based on a 2021 report[8]; and

Whereas, CHIP beneficiaries can receive a range of prescription coverage; however, states may choose to limit coverage of over-the-counter (OTC) medications based on specific medication categories or require physician prescription for coverage of OTC medicines[9,10]; and

Whereas, CHIP currently imposes coverage limitations with respect to certain drug classes[11]; and

Whereas, the cost of medications, including OTC medications, are a significant contributor to overall cost for patients, especially for children with medical complexity[12]; and

Whereas, research has shown families who spent more on out-of-pocket costs for medications were more sensitive to high medication costs and had an immediate reduction in adherence when started on high-cost, long-term medications[13]; and

Whereas, the availability of OTC medication to treat mild conditions creates substantial savings for the US health system[14]; therefore be it

RESOLVED, that our American Medical Association advocate for expanding coverage of FDA-approved and/or medically necessary over-the-counter medications under the Children's Health Insurance Program (CHIP) for enrolled individuals, including by expanding medication classes covered under CHIP (Directive to Take Action); and be it further

RESOLVED, that our AMA oppose arbitrary limitations on the quantity of FDA-approved over-the-counter medications covered by the Children's Health Insurance Program for enrolled individuals (New HOD Policy); and be it further

RESOLVED, that our AMA oppose copayment requirements for over-the-counter medications for patients enrolled in CHIP. (New HOD Policy)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/21/25

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RELEVANT AMA POLICY:

Medicaid Payment for Over-The-Counter Drugs When They are the Drug of Choice H-125.990
The AMA supports over-the-counter drug benefits under Medicaid that provide physician-prescribed medications to enrollees. Cost-conscious OTC drug programs should satisfy the criteria contained in Policy 110.997 for AMA support of programs designed to contain the rising costs of prescription drugs and follow AMA Policy 125.991 on development and implementation of drug formularies. [CMS Rep. 12, A-94; Reaffirmed: CMS Rep. 7, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17]

Health Plan Coverage for Over-the-Counter Drugs H-185.956
Our AMA: (1) opposes mandated health plan coverage for over-the-counter (OTC) pharmaceuticals, including those that had previously been available only with a prescription; (2) encourages health insurers and health plans to cover medically necessary OTC drugs for which no prescription alternative exists; and (3) continues to support efforts to study the effects of converting medically necessary drugs from prescription to over-the-counter status on the costs and access to such medications.
[CMS Rep. 1, I-98; Renumbered: CMS Rep. 7, I-05; Reaffirmed: CMS Rep. 1, A-15]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(A-25)

Introduced by: Senior Physicians Section

Subject: Guaranteeing Timely Delivery and Accessibility of Federal Health Data

Referred to: Reference Committee B

Whereas, a memorandum was issued on January 21, 2025 to all thirteen Operating Divisions within the U.S. Dept. of Health & Human Services including the Food and Drug Administration, the Centers for Disease Control and Prevention, the Center for Medicare & Medicaid Services (CMS) and the National Institutes of Health, as well as other lesser-known health agencies[1]; and

Whereas, the CDC (Centers for Disease Control and Prevention) and the NIH (National Institutes of Health) had an almost three-month embargo imposed on data, which delayed physicians' access to essential information needed to provide timely and effective patient care; and

Whereas, lack of access to vital health data undermines the integrity and training of physicians, hindering their ability to provide optimal care to patients; and

Whereas, the CDC was established to minimize potential health risks while ensuring continuous, unrestricted access to critical data for both scientists and the general public; and

Whereas, tracking emerging infectious disease trends — including and not limited to those such as malaria, Zika, Chagas, tuberculosis, syphilis, H5N1 influenza virus (aka bird flu), gonorrhea and chlamydia — provides invaluable insights into how diseases spread, identifies vulnerable populations, and helps assess the effectiveness of prevention measures or treatments[2]; and

Whereas, judicial mandates and executive orders that directly delay or restrict access to important health data directly conflict with medical ethics, as they force physicians to wait for potentially harmful outcomes; therefore be it

RESOLVED, that our American Medical Association advocate for the immediate removal of restrictions on the CDC, NIH and other pertinent federal agencies' to disseminate critical health information, as withholding such critical information from physicians impedes their ability to deliver the highest standard of care and exposes all patients who are receiving care to less than optimal outcomes (Directive to Take Action); and be it further

RESOLVED, that our AMA promote the recognition of the CDC, NIH, and other federal agencies in their efforts to minimize the risks of emerging infections, beginning this year and continuing into the future. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/20/25

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RELEVANT AMA POLICY

H-440.813 Public Health Surveillance

1. Our American Medical Association recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats.
2. Our AMA recognizes the important role that physicians play in public health surveillance through reporting diseases and conditions to public health authorities.
3. Our AMA encourages state legislatures to engage relevant state and national medical specialty societies as well as public health agencies when proposing mandatory reporting requirements to ensure they are based on scientific evidence and meet the needs of population health.
4. Our AMA recognizes the need for increased federal, state, and local funding to modernize our nation's public health data systems to improve the quality and timeliness of data.
5. Our AMA supports the CDC's data modernization initiative, including electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from electronic health records to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws.
6. Our AMA will advocate for incentives for physicians to upgrade their EHR systems to support electronic case reporting as well as incentives to submit case reports that are timely and complete.
7. Our AMA will share updates with physicians and medical societies on public health surveillance and the progress made toward implementing electronic case reporting.
8. Our AMA will advocate for increased federal coordination and funding to support the modernization and standardization of public health surveillance systems data collection by the Centers for Disease Control and Prevention and state and local health departments.
9. Our AMA supports data standardization that provides for minimum national standards, while preserving the ability of states and other entities to exceed national standards based on local needs and/or the presence of unexpected urgent situations.
[CSAPH Rep. 1, I-19; Reaffirmed: Res. 219, A-21; Appended: Alt. Res. 402, A-21; Modified: CSAPH Rep. 2, I-21]

H-440.847 Pandemic Preparedness

In order to prepare for a pandemic, our American Medical Association:
1.urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, supplies, vaccine, drug, and data management capacity to prepare for and respond to a pandemic or other serious public health emergency.
2. urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, anti- microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people, without overreliance on unreliable international sources of production; and (b) to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to a pandemic or other serious public health emergency.
3. encourages states to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency.
4.urges the federal government to meet treaty and trust obligations by adequately sourcing medical and

personal protective equipment directly to tribal communities and the Indian Health Service for effective preparedness and to respond to a pandemic or other major public emergency.

5.urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of health care personnel in direct patient care settings;

6. supports the position that:

a. relevant national and state agencies (such as the CDC, NIH, and the state departments of health) continue to plan and test distribution activities in advance of a public health emergency, to assure that physicians, nurses, other health care personnel, and first responders having direct patient contact, receive any appropriate vaccination or medical countermeasure in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic.

b. such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers.

7. will monitor progress in developing a contingency plan that addresses future vaccine production or distribution problems and in developing a plan to respond to a pandemic in the United States.

8. will encourage state and federal efforts to locate the manufacturing of goods used in healthcare and healthcare facilities in the United States.

9. will support federal efforts to encourage the purchase of domestically produced personal protective equipment.

[CSAPH Rep. 5, I-12; Reaffirmation A-15; Modified: Res. 415, A-21; Reaffirmed: CSAPH Rep. 1, I-22; Appended: Res. 924, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(A-25)

Introduced by:	The Endocrine Society, American Association of Clinical Endocrinology, American Society for Reproductive Medicine, American Society for Metabolic and Bariatric Surgery, Obesity Medicine Association, American College of Physicians
Subject:	Advocating to Expand Private insurance Coverage of Anti-obesity Medications (AOM)
Referred to:	Reference Committee B

Whereas, the American Medical Association has declared that obesity is a disease[1]; and

Whereas, the Centers for Disease Control and Prevention (CDC) has reported that more than 2 in 5 U.S. adults have obesity[2]; and

Whereas, the CDC has reported health care for obesity is expensive for patients and the health care system. In 2019 dollars, annual medical costs for adults with obesity were $1,861 higher per person than adults with healthy weight. For adults with severe obesity, the excess costs were $3,097 per person. This accounts for nearly $173 billion in medical expenditures in 2019 dollars[3]; and

Whereas, the CDC has reported that many adults with obesity have other serious chronic diseases that are caused by obesity. For example, 58% of U.S. adults with obesity have high blood pressure, a risk factor for heart disease. Also, approximately 23% of U.S. adults with obesity have diabetes[4]; and

Whereas, clinical obesity across the lifespan continues to be a more serious problem with each passing year. Recent data show that obesity rates continue to be at record high levels with at least one in five adults in every U.S. state living with obesity[5]; and

Whereas, when combined with lifestyle and behavior changes, prescription medications help many people lose weight and maintain weight loss. On average, after 1 year, adults who take prescription medications as part of a lifestyle program lose 3% to 12% more of their starting body weight than people in a lifestyle program who do not take medication[6]; and

Whereas, Kaiser Family Foundation (KFF) analysis has found fewer than 20% of large employer firms currently do not cover GLP-1 drugs for weight loss and coverage in ACA Marketplace plans remains limited[7,8]; and

Whereas, tirzepatide has been shown to affect a mean weight reduction of 20.9% at 36 weeks and semaglutide has been shown to affect a mean weight reduction of 14.9% at 68 weeks 10[9,10]; therefore be it

RESOLVED, that our American Medical Association amend policy H-440.801, Advocacy Against Obesity-Related Bias by Insurance Providers, by addition to read as follows:

1. Our American Medical Association will urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to:
    a. Revise their policies to ensure that bariatric surgery is covered for patients who meet the appropriate medical criteria.
    b. Eliminate criteria that place unnecessary time-based mandates that are not clinically supported nor directed by the patient's medical provider.
    c. Ensure that insurance policies in their states do not discriminate against potential metabolic surgery patients based on age, gender, race, ethnicity, socioeconomic status.
    d. Advocate for the cost-effectiveness of all **obesity** treatment modalities in reducing healthcare costs and improving patient outcomes.
    e. Eliminate coverage exclusions for the pharmacologic treatment of obesity.
    f. Reduce the prior authorization burden for the coverage of anti-obesity medications, to include not requiring a new prior authorization for every dose change or requiring "step therapy".
    g. Support and cover chronic treatment with anti-obesity medications to maintain weight loss.
    h. Allow a patient's physician to prescribe anti-obesity medication and have it covered by insurance, without a requirement that patients must receive the prescription only from contracted disease management companies.
2. Our AMA will support and provide resources to state delegations in their efforts to advocate for the reduction of bias against patients that suffer from **obesity** for the actions listed. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

REFERENCES

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4. New CDC Data Show Adult Obesity Prevalence Remains High. Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, www.cdc.gov/media/releases/2024/p0912-adult-obesity.html.
5. New CDC Data Show Adult Obesity Prevalence Remains High. Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, www.cdc.gov/media/releases/2024/p0912-adult-obesity.html.

6. Prescription Medications to Treat Overweight & Obesity – NIDDK. National Institute of Diabetes and Digestive and Kidney Diseases, U.S. Department of Health and Human Services, www.niddk.nih.gov/health-information/weight-management/prescription-medications-treat-overweight-obesity.
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10. John P.H. Wilding, D.M., Rachel L. Batterham, M.B., B.S., Ph.D., et al. Once-Weekly Semaglutide in Adults with Overweight or Obesity. N Engl J Med 2021;384:989-1002.

RELEVANT AMA POLICY:

H-440.842 Recognition of Obesity as a Disease
Our American Medical Association recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention. [Res. 420, A-13Reaffirmed: CSAPH Rep. 08, A-23]

H-440.801 Advocacy Against Obesity-Related Bias by Insurance Providers
1. Our American Medical Association will urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to:
    a. Revise their policies to ensure that bariatric surgery are covered for patients who meet the appropriate medical criteria.
    b. Eliminate criteria that place unnecessary time-based mandates that are not clinically supported nor directed by the patient's medical provider.
    c. Ensure that insurance policies in their states do not discriminate against potential metabolic surgery patients based on age, gender, race, ethnicity, socioeconomic status.
    d. Advocate for the cost-effectiveness of all obesity treatment modalities in reducing healthcare costs and improving patient outcomes.
2. Our AMA will support and provide resources to state delegations in their efforts to advocate for the reduction of bias against patients that suffer from obesity for the actions listed. [Res. 224, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(A-25)

Introduced by: Washington State

Subject: Preventing Venue Shopping in Medical Liability to Protect Physician Practices and Access to Care

Referred to: Reference Committee B

Whereas, venue shopping in medical liability cases occurs when plaintiffs' attorneys select jurisdictions perceived to be more favorable for large verdicts, leading to increased healthcare costs and higher burnout for physicians; and

Whereas, physicians practicing in rural hospitals often have fewer resources, limited staff, and less advanced medical equipment compared to those within larger healthcare systems, and venue shopping may cause these physicians to reduce services, relocate, or retire, which especially impacts access to care in underserved areas; and

Whereas, Philadelphia, the preferred venue of plaintiffs, saw 544 medical malpractice cases filed in 2023 up from 275 cases in 2022, following reversal of Rule 1006(a.1) in January 2023, which stopped venue shopping and frivolous lawsuits; and

Whereas, higher rates of hospital closures and financial challenges increase health disparities that disproportionately affect maternal and infant care in rural areas; and

Whereas, the American Medical Association advocates for a balanced and fair legal process that protects physicians from unnecessary liability risks and ensures continued access to quality care for our patients; therefore be it

RESOLVED, that our American Medical Association advocate that claims be filed in the county where the alleged medical liability occurred (Directive to Take Action); and be it further

RESOLVED, that our AMA study and report on the impact of venue rule changes on medical liability case filings, healthcare costs, and access to care, particularly in rural and underserved areas (Directive to Take Action); and be it further

RESOLVED, that our AMA work with state medical societies to develop model legislation that protects against venue shopping while ensuring fair access to the legal system for patients with legitimate claims. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/9/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(A-25)

Introduced by: Women Physicians Section

Subject: Preservation of Medicaid

Referred to: Reference Committee B

Whereas, Medicaid provides healthcare coverage to 80 million low-income Americans, including pregnant women, children, adults, seniors, people with disabilities, and LGBTQIA+ individuals[1]; and

Whereas, Medicaid improves health outcomes, with expansion linked to a 6% reduction in all-cause mortality, a 23% increase in self-reporting health as excellent, and 41% higher likelihood of having a usual care source[2–9]; and

Whereas, Medicaid finances 40% of all births (including nearly 50% of births in rural communities), insures 40% of individuals under 18 years of age, is the largest single payer for behavioral health services, including substance use disorder (SUD) treatment, and is the largest payer of long term care services in the United States[10–13]; and

Whereas, women physicians are more likely to serve patient populations who rely heavily on Medicaid funding and would be disproportionately impacted by federal funding cuts[14]; and

Whereas, previous efforts to cut Medicaid spending via work requirements did not increase employment and instead led to problems paying off medical debt, delayed care, and delayed taking medications due to cost[15,16]; and

Whereas, the federal government finances 69% of Medicaid nationally, ensuring states can provide care without excessive fiscal burden[17]; and

Whereas, reductions to federal funding of Medicaid or changes to Medicaid eligibility at the federal level would lead to substantial loss of coverage for millions of Americans; and

Whereas, U.S. Congress is considering cutting federal Medicaid spending by adopting a per-capita financing model, reducing the federal match rate, and imposing work requirements on certain enrollees —policies shown to force coverage reductions[18]; therefore be it

RESOLVED, that our American Medical Association make preservation of federal funding and eligibility for Medicaid an urgent and top legislative advocacy priority, effective immediately at the conclusion of the Annual 2025 House of Delegates Meeting (Directive to Take Action); and be it further

RESOLVED, that our AMA strongly opposes federal and state efforts to restrict eligibility and funding for all public health insurance programs, including Medicaid and CHIP. (New HOD Policy)

Fiscal Note: Moderate – between $5,000 - $10,000

Date Received: 04/21/2025

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RELEVANT AMA POLICY

Medicaid Expansion D-290.979

1. Our American Medical Association, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.
2. Our AMA will:
    a. continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823.

b. work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all.

[Res. 809, I-12 Reaffirmed: CMS Rep. 02, A-29 Reaffirmed: CMS Rep. 5, I-20 Reaffirmed: CMS Rep. 3, A-21 Reaffirmed: CMS Rep. 9, A-21 Reaffirmed: CMS Rep. 3, I-21 Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21 Appended: Res. 122, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(A-25)

Introduced by: Young Physicians Section

Subject: Increasing Transparency of AMA Medicare Payment Reform Strategy

Referred to: Reference Committee B

Whereas, the American Medical Association House of Delegates (HOD) recently identified Medicare payment reform as the top priority through a referendum; and

Whereas, since this resolution, the AMA has consistently communicated via emails and position statements that Medicare payment reform remains the top priority; and

Whereas, despite these communications, there appears to have been relatively little progress in advancing Medicare payment reform when compared to the extent of communication; and

Whereas, the continued need of substantial progress on Medicare payment reform necessitates an in-depth analysis to identify potential barriers and opportunities for enhancement of the current strategy; therefore be it

RESOLVED, that our American Medical Association provide a summary of findings and actionable recommendations from both internal and external advocacy consultants regarding Medicare payment reform. The report must primarily focus on barriers identified, gaps in the current strategy, and specific recommendations for improving and accelerating advocacy efforts (Directive to Take Action); and be it further

RESOLVED, that our AMA share with its members comprehensive reports on our Medicare payment reform advocacy efforts, including consultant findings on major barriers, strategy gaps, and recommendations for improvement, at both the Interim and Annual Meetings beginning at I-25, and more frequently as legislative dynamics dictate. (Directive to Take Action)

Fiscal Note: $108,308

Received: 04/21/2025

REFERENCES

American Medical Association, 2024. Medicare Physician Payment Reform Has Never Been More Urgent. Accessed 10/04/2024. https://www.ama-assn.org/about/leadership/medicare-physician-payment-reform-has-never-been-more-urgent

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(A-25)

Introduced by: International Medical Graduates Section

Subject: Protection for International Medical Graduates

Referred to: Reference Committee B

Whereas, the American Medical Association recognizes the contributions of international medical graduates (IMG) to US healthcare, to medical education, residency and fellowship programs, and patient care, especially in underserved areas[(1)]; and

Whereas, the majority of IMGs spend a large portion of their careers requiring non-immigrant visas, immigrant visas or other protective immigration statuses; and

Whereas, the AMA recognizes that immigrant status is a public health issue (D-350.975) and social determinant of health (H-65.938) significantly affecting persons physical and mental wellbeing with limited support systems (https://www.nydailynews.com/2021/07/17/nyc-doctor-suicides-raise-concerns-about-treatment-of-resident-physicians-at-bronx-hospital/); and

Whereas, immigration status is a tool that can be weaponized systemically to push IMGs to accept abusive contracts and discriminatory conditions, discourages IMGs from reporting and seeking help; and

Whereas, unannounced visits by Immigration and Customs Enforcement (ICE) agents to medical offices and hospitals can disrupt patient care, create undue anxiety, and interfere with the physician-patient relationship[(2)]; therefore be it

RESOLVED, that our American Medical Association supports the designation of medical or mental healthcare facilities, such as a hospital, doctor's office, health clinic, vaccination or testing site, urgent care center, site that serves pregnant individuals, or community health center as a protected area, avoiding, when possible, targeted immigration enforcement, in order to preserve the continuity of patient care and medical education (New HOD Policy); and be it further

RESOLVED, that our AMA work with relevant stakeholders to develop a confidential mechanism through which IMG physicians can report workplace immigration related interviews, enforcement actions, or audits, in order to identify and address potential instances of unfair treatment or targeting of IMG physicians. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/22/25

REFERENCES

1. D-255.980 Impact of Immigration Barriers on the Nation's Health | AMA [Internet]. [cited 2025 Feb 7]. Available from: https://policysearch.ama-assn.org/policyfinder/detail/Visa?uri=%2FAMADoc%2Fdirectives.xml-D-255.980.xml
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4. H-255.988 AMA Principles on International Medical Graduates | AMA [Internet]. [cited 2025 Feb 7]. Available from: https://policysearch.ama-assn.org/policyfinder/detail/IMG?uri=%2FAMADoc%2FHOD.xml-0-1790.xml

RELEVANT AMA POLICY

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.
   (Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 210, A-23)

Visa Complications for IMGs in GME D-255.991

1. Our American Medical Association will work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates.
2. Our AMA work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
   Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.
   (Res. 844, I-03; Reaffirmation A-09; Reaffirmation I-10; Appended: CME Rep. 10, A-11; Appended: Res. 323, A-12; Reaffirmation: A-19; Reaffirmed: Res. 234, A-22)

Disruptive Visits to Medical Offices by Government Investigators and Agents H-175.977

1. Our American Medical Association supports legislation and/or other appropriate means to ensure that State and Federal investigators, and/or agents, give a physician written notice prior to a visit to a medical office, so that such visit may be scheduled upon mutual agreement at a time when patients are not present in the medical office.
2. Our AMA, in any circumstances which lawfully permit a visit to a medical office without notice, such as a search warrant, arrest warrant or subpoena, investigators and/or agents should be required to initially identify themselves to appropriate medical staff quietly and confidentially that allows the physician an opportunity to comply in a manner that is
least disruptive and threatening to the patients in the medical office.
3. Our AMA encourages physicians to report incidents of inappropriate intrusions into
their medical offices to the AMA's Office of the General Counsel and consider development of a hotline for implementation.
(Res. 211, A-99; Reaffirmation I-01; Reaffirmed: BOT Rep. 22, A-11; Reaffirmed: BOT Rep. 7, A-21)

AMA Principles on International Medical Graduates H-255.988

1. Our American Medical Association supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement: completion of medical school and residency training outside the U.S.;
extensive U.S. medical practice; and evidence of good standing within the local medical community.

13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine.
15. Our AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
16. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
17. Our AMA membership outreach to IMGs to include using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; publicizing its many relevant resources to all physicians, especially to nonmember IMGs; identifying and publicizing AMA resources to respond to inquiries from IMGs; and expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
18. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
19. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
20. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
21. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
22. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
23. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
24. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
25. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
26. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.
    (BOT Rep. Z, A-86; Reaffirmed: Res. 312, I-93; Modified: CME Rep. 2, A-03; Reaffirmation I-11; Reaffirmed: CME Rep. 1, I-13; Modified: BOT Rep. 25, A-15; Modified: CME Rep. 01, A-16; Appended: Res. 304, A-17; Modified: CME Rep. 01, I-17; Reaffirmation: A-19; Modified: CME Rep. 2, A-21; Modified: CME Rep. 1, A-22; Modified: CCB/CLRPD Rep. 1, A-22; Reaffirmed: CME Rep. 03, A-23)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(A-25)

Introduced by: Association for Clinical Oncology, American College of Rheumatology

Subject: CMS Payment Monitoring Following Government Staff Reductions

Referred to: Reference Committee B

Whereas, the Department of Health and Human Services (HHS) is implementing a large-scale restructuring, including a significant reduction in its workforce and plans to eliminate 10,000 employees in addition to 10,000 HHS employees who have already departed (20,000 total), thereby reducing the workforce from approximately 82,000 to 62,000; and

Whereas, the Centers for Medicare & Medicaid Services (CMS) initially eliminated 300 CMS positions, including at the Office of Program Operations and Local Engagement (OPOLE), which works with providers and health plans that serve Medicare recipients to ensure they're in compliance with CMS requirements and helps manage case work for Medicare Advantage (MA) and the Patient Protection and Affordable Care Act (ACA) Marketplace patients, which could impact providers' and patient access; and

Whereas, HHS also announced that it would consolidate the department's 28 divisions into 15 (including agencies such as CMS and the Food and Drug Administration (FDA), and HHS offices such as the Office of the Assistant Secretary of Legislation (ASL)), cut five of the 10 regional offices, and centralize core administrative functions; therefore be it

RESOLVED, that our American Medical Association will monitor federal staffing reductions with a focus on those at the Centers for Medicare & Medicaid Services (CMS) (Directive to Take Action); and be it further

RESOLVED, that our AMA offers a method whereby providers can report CMS payment delays and/or new or additional obstacles to timely receipt of reimbursement to our AMA, and that our AMA should use the information collected to inform advocacy efforts to protect physicians from unreasonable CMS payment delays and notify CMS of slowing payments and/or obstacles. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/22/25

REFERENCES

1. HHS's Restructuring: What Happens Next? - McDermott+
2. Layoffs begin at US health agencies | AP News
3. Widespread firings start at federal health agencies including many in leadership: Shots - Health News: NPR

RELEVANT AMA POLICY

Congressional Oversight Hearings and Legislative Reform of CMS H-330.910
Our AMA will: (1) seek immediate and periodic Congressional oversight hearings of the CMS on issues related to the administration of the Medicare and Medicaid programs and additionally will seek legislation to reform CMS; and (2) undertake and support activities that would hold state and federal agencies, their contractors, and employees dealing with health care issues to the same level of accountability as are physicians.

Physician Payment Reform H-390.849

1. Our American Medical Association will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
    a. Promote improved patient access to high-quality, cost-effective care.
    b. Be designed with input from the physician community.
    c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.
    d. Not require budget neutrality within Medicare Part B.
    e. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.
    f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
    g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
    h. Use adequate risk adjustment methodologies.
    i. Incorporate incentives large enough to merit additional investments by physicians.
    j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.
    k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
    l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.
    m. Include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society- developed clinical guidelines/standards.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

Reference Committee C

Report(s) of the Council on Medical Education

01 Council on Medical Education Sunset Review of 2015 House of Delegates' Policies
02 International Applicants to U.S. Medical Schools
03 Unmatched Graduating Physicians
04 Access to Restricted Health Services When Completing Physician Certification Exams
05 Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine (Res. 309-A-24)
06 Reporting of Total Attempts of USMLE Step 1 and COMLEX-USA Level 1 Examinations
07 Designation of Descendants of Enslaved Africans in America
08 Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes

Resolutions

301 Examining ABMS Processes for New Boards
302 AMA Study of Lifestyle Medicine and Culinary Electives to Reduce Burnout and Bolster Career Satisfaction in Trainees
303 Support for the Establishment of an Indigenous-Led Medical School in the United States
304 Addressing Professionalism Standards in Medical Training
305 Curricular Structure Reform to Support Physician and Trainee Well-Being
306 Innovation and Reform of Medical Education
307 Disclosure of Individual Physician Volunteers Participation in Committee Decision-making to other Organizations, Stakeholders and Joint Providers
308 Streamlining Annual Compliance Training Requirements for Physicians
309 Increasing Education on Physician-Led Care and Advocacy in Residency Training
310 Protections for Trainees Experiencing Retaliation in Medical Education
311 Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter
312 Selection of IMG Residents Based on Merit

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-A-25

Subject:	Council on Medical Education Sunset Review of 2015 House of Delegates' Policies
Presented by:	Krystal Tomei, MD, MPH, Chair
Referred to:	Reference Committee C

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification; and (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its ten-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

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RECOMMENDATION

The Council on Medical Education recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Fiscal Note: $1,000.

APPENDIX: RECOMMENDED ACTIONS

	Policy Number	Title	Text	Recommendation
1	D-275.957	An Update on Maintenance of Licensure	Our American Medical Association will: 1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue. 2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOL issues. 3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician workforce. 4. Work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL. 5. Explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may help shape and support MOL for physicians. 6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians. 7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards. 8. Encourage rigorous evaluation of the impact on physicians of any future proposed	**Rescind – no longer relevant.** Federation of State Medical Boards (FSMB) is not advancing Maintenance of Licensure (MOL) and has archived their MOL policies.

			changes to MOL processes, including cost, staffing, and time.	
2	D-275.973	Essentials for Approval of Examining Boards in Medical Specialties	Our AMA approves the twelfth revision of the Essentials for the Approval of Examining Boards in Medical Specialties.	**Rescind – no longer relevant.** AMA is no longer part of the American Board of Medical Specialties (ABMS) approval process. "Essentials" policy is now called "Admission of new medical specialty boards to membership in the ABMS" (policy 1.8, adopted Oct 2023).
3	D-275.975	Sharing of Medical Disciplinary Data Among Nations	Our AMA will, in conjunction with the Federation of State Medical Boards, support the efforts of the International Association of Medical Regulatory Authorities in its current efforts toward the exchange of information among medical regulatory authorities worldwide.	**Retain – still relevant.** FSMB was a founder of the International Association of Medical Regulatory Authorities (IAMRA) and its Secretariat continues to be supported by FSMB.
4	D-295.315	Enhancing the AMA's Role in Premedical Education	Our AMA will: (1) update its "Becoming a Physician" website with most relevant information to enhance usage and usability, and support the concept and explore the feasibility of enhancing current AMA online resources for premedical students; (2) explore the feasibility of developing innovative online "premedical" engagement activities that are affordable to students and cost-effective for our AMA and have value to medical school admissions personnel; and (3) explore the feasibility of developing resources to enhance premedical student advising and mentoring by physicians and others.	**Rescind – accomplished.** Program/website is now defunct.
5	D-305.965	Alternative Funding for Continuing Medical Education	1. Our AMA will seek funding for quality, unbiased continuing medical education for all physicians. 2. Our AMA supports physician autonomy by partnering with relevant organizations to encourage medical organizations or institutions that employ physicians and offer financial support towards continuing medical education (CME) to avoid prioritizing institutional goals over individual physician educational needs in the choice of CME coursework.	**Rescind clause (1) – accomplished.** **Retain clause (2) – still relevant.** (1) The House action was communicated to the Association of American Medical Colleges (AAMC), American Hospital Association, Medical Group Management Association, and Veterans Affairs as well as medical schools, residency program directors, directors of medical education at U.S. teaching hospitals, and other interested groups via the Med Ed Update newsletter.
6	D-310.952	Mitigation of Physician Performance Metrics on Trainee Education	Our American Medical Association will ask the Accreditation Council for Graduate Medical Education and other organizations to use data to evaluate the impact of supervising physicians? performance metrics on trainees? learning experience.	**Rescind – accomplished.** Accreditation Council for Graduate Medical Education and AAMC were notified of the House action. It was also shared with medical schools, residency program directors, directors

				of medical education at U.S. teaching hospitals, and other interested groups via AMA Med Ed Update newsletter.
7	D-405.984	Confidentiality of Enrollment in Physicians (Professional) Health Programs	1. Our American Medical Association will work with other medical professional organizations, the Federation of State Medical Boards, the American Board of Medical Specialties, and the Federation of State Physician Health Programs, to seek and/or support rules and regulations or legislation to provide for confidentiality of fully compliant participants in physician (and similar) health programs or their recovery programs in responding to questions on medical practice or licensure applications. 2. Our AMA will work with The Joint Commission, national hospital associations, national health insurer organizations, and the Centers for Medicare and Medicaid Services to avoid questions on their applications that would jeopardize the confidentiality of applicants who are compliant with treatment within professional health programs and who do not constitute a current threat to the care of themselves or their patients.	**Retain – still relevant.**
8	H-225.960	Voluntary Use of Hospitalists and Required Consent	It is the policy of our AMA that the use of a hospitalist physician as the physician of record during a hospitalization must be voluntary and the assignment of responsibility to the hospitalist physician must be based on the consent of the patient's personal physician and the patient.	**Retain – still relevant.**
9	H-255.983	Graduates of Non-United States Medical Schools	The AMA continues to support the policy that all physicians and medical students should be evaluated for purposes of entry into graduate medical education programs, licensure, and hospital medical staff privileges on the basis of their individual qualifications, skills, and character.	**Rescind – duplicative.** Addressed by more recent policies that provide greater clarity on the assessment of students and physicians entering GME. • H-275.934 • D-310.945 • H-295.895 Also, title is inaccurate since it is about "non-U.S." graduates while policy is much broader.
10	H-255.989	A Program for Exchange Visitor Physicians	(1) It is the AMA's policy to separate the issues involved in the support of alien physicians participating in exchange visitor physician programs for purposes of education, training and/or research followed by return to their native lands from the issues involving U.S. citizens who are graduates of foreign medical schools and	**Retain – still relevant. Amend title and clause (1) to update language as follows:** ~~A PROGRAM FOR~~ EXCHANGE PROGRAMS FOR VISITOR PHYSICIANS

			alien physician graduates of foreign medical schools who seek permanent residence in the United States. (2) The AMA urges government and private funding of the physician exchange visitor program under the auspices of an appropriate organization that will: consider the range and type of medical education and health care needs of those foreign nations sending exchange visitor physicians; the means to evaluate the level of knowledge and needs of prospective participants in graduate medical education programs; and identify truly outstanding public health, geographic medicine, basic medical science, and clinical training programs to answer the needs of the visitor's native land.	(1) ~~It is the~~ AMA~~'s policy to separate the issues involved in the~~ supports ~~of alien~~ non-citizen physicians participating in exchange visitor physician programs for purposes of education, training and/or research followed by return to their ~~native~~ home ~~lands~~ country. This is separate from the issues involving U.S. citizens who are graduates of foreign medical schools and ~~alien~~ non-citizen physician graduates of foreign medical schools who seek permanent residence in the U.S.~~ United States~~.
11	H-255.994	Physician Exemption from Medical School Standards and Performance Evaluation Requirements	Our AMA recommends to medical licensing boards that those physicians who are international medical graduates currently duly licensed by any licensing jurisdiction in the U.S. should not be denied endorsement of their licenses, or denied admission to reexamination when this is required by law, solely because they are unable to provide documentation of graduation from a school meeting "equivalent standards and performance evaluation requirements" to those of programs accredited by the Liaison Committee on Medical Education.	**Retain – still relevant.**
12	H-275.917	An Update on Maintenance of Licensure	AMA Principles on Maintenance of Licensure (MOL): 1. Our American Medical Association (AMA) established the following guidelines for implementation of state MOL programs: A. Any MOL activity should be able to be integrated into the existing infrastructure of the health care environment. B. Any MOL educational activity under consideration should be developed in collaboration with physicians, should be evidence-based and should be practice-specific. Accountability for physicians should be led by physicians. C. Any proposed MOL activity should undergo an in-depth analysis of the direct and indirect costs, including physicians' time and the impact on patient access to care, as well as a risk/benefit analysis, with particular attention to unintended consequences. D. Any MOL activity should be flexible and offer a variety of compliance options for all physicians, practicing or non-practicing, which may vary depending on their roles	**Rescind clauses (1), (2), (3B-D) – no longer relevant.** FSMB is not advancing MOL and has archived their MOL policies. **Retain clause (3A) – still relevant. Amend title and clause to update language as follows:** ~~AN UPDATE ON MAINTENANCE OF LICENSURE~~ ACCEPTANCE OF AMA PRA CREDIT AS EVIDENCE OF CONTINUING MEDICAL EDUCATION ~~3.~~ Our AMA will~~:~~ ~~A. C~~ continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major continuing medical education (CME) credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance

			(e.g., clinical care, research, administration, education). E. Any MOL activity should be designed for quality improvement and lifelong learning. F. Participation in quality improvement activities, such as chart review, should be an option as an MOL activity. 2. Our AMA supports the Federation of State Medical Boards Guiding Principles for MOL (current as of June 2015), which state that: A. Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice. B. Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing MOL requirements should remain within the purview of state medical boards. C. Maintenance of licensure should not compromise patient care or create barriers to physician practice. D. The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements. E. Maintenance of licensure processes should balance transparency with privacy protections (e.g., should capture what most physicians are already doing, not be onerous, etc.). 3. Our AMA will: A. Continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format, and continue to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME as part of the process for MOL. B. Advocate that if state medical boards move forward with a more intense or rigorous MOL program, each state medical board be required to accept evidence of successful ongoing participation in the	Improvement CME (PICME) format, and continue to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME ~~as part of the process for MOL~~.

			ABMS MOC and AOA-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL, if performed, C. Advocate that state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians to choose which programs they participate in to fulfill their MOL criteria. D. Oppose any MOL initiative that creates barriers to practice, is administratively unfeasible, is inflexible with regard to how physicians practice (clinically or not), does not protect physician privacy, or is used to promote policy initiatives about physician competence.	
13	H-295.859	Guidelines for Students Shadowing Physicians	Our American Medical Association: (1) encourages physicians in both private practice and academic settings to provide shadowing opportunities to students interested in a career in medicine--particularly those from underrepresented populations--as part of the physician's commitment to the future of the profession; (2) encourages physicians to adopt the most appropriate shadowing model to the needs of the practice/institution and the student(s); and (3) endorses the clinical shadowing guidelines for students from the Association of American Medical Colleges as one model for such students and will help disseminate this document to K-12 students, premedical students, health professions advisors, hospitals, and physicians.	**Retain clauses (1), (2) - still relevant.** **Rescind clause (3) – accomplished.** House action was communicated to medical students, medical schools, residency program directors, directors of medical education at U.S. teaching hospitals, health professions advisors, and other interested groups via the MedEd Update newsletter, Medical Student Section (MSS) listserv, and National Association of Advisors for the Health Professions listserv. AMA policy avoids language to "endorse." AAMC's guidance document has not been updated since 2013. They conducted a clinical shadowing survey in 2016 and shared the results, which was meant to serve as updated guidance.
14	H-295.860	Promoting Transparency in Medical Education and Access to Training	Our American Medical Association: (1) strongly encourages medical schools and graduate medical education training programs to communicate with current and prospective medical students, residents and fellows how affiliations and mergers among health care organizations may impact health care delivery, medical education and training opportunities at their respective institutions; and (2) will work with the Accreditation Council for Graduate Medical Education and other appropriate stakeholders to support transparency within medical education, recommending that	**Retain – still relevant.**

			medical schools and graduate medical education training programs communicate with current and prospective medical students, residents and fellows how affiliations and mergers among health care organizations may impact health care delivery, medical education and training opportunities.	
15	H-295.862	Alignment of Accreditation Across the Medical Education Continuum	1. Our AMA supports the concept that accreditation standards for undergraduate and graduate medical education should adopt a common competency framework that is based in the Accreditation Council for Graduate Medical Education (ACGME) competency domains. 2. Our AMA recommends that the relevant associations, including the AMA, Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM), along with the relevant accreditation bodies for undergraduate medical education (Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation) and graduate medical education (ACGME, AOA) develop strategies to: a. Identify guidelines for the expected general levels of learners' competencies as they leave medical school and enter residency training. b. Create a standardized method for feedback from medical school to premedical institutions and from the residency training system to medical schools about their graduates' preparedness for entry. c. Identify areas where accreditation standards overlap between undergraduate and graduate medical education (e.g., standards related to the clinical learning environment) so as to facilitate coordination of data gathering and decision-making related to compliance. All of these activities should be codified in the standards or processes of accrediting bodies. 3. Our AMA encourages development and implementation of accreditation standards or processes that support utilization of tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the	**Rescind clause (1)- accomplished.** Liaison Committee on Medical Education (LCME) standards do require that schools include a competency framework as the basis for their educational program objectives. **Rescind clause (2) – accomplished.** The AMA has been an active member of the Foundational Competencies for Undergraduate Medical Education initiative. Regarding (2b). AAMC developed such a tool. **Retain clause (3) – still relevant. Amend to update language as follows:** 3. Our AMA ~~encourages~~ supports the development and implementation of ~~accreditation standards or processes that support utilization of~~ tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum. **Rescind clause (4) – no longer relevant.** Addressed by newer policy H-275.916. **Rescind clause (5a) – accomplished.** Addressed by AMA ChangeMedEd initiative (formerly called Accelerating Change in Medical Education). **Rescind Clause (5b) – accomplished.** Addressed by AMA's longstanding collaboration with ACGME.

			defined competencies across the continuum. 4. Our AMA supports the concept that evaluation of physicians as they progress along the medical education continuum should include the following: (a) assessments of each of the six competency domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice; and (b) use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the medical education continuum. 5. Our AMA encourages study of competency-based progression within and between medical school and residency. a. Through its Accelerating Change in Medical Education initiative, our AMA should study models of competency-based progression within the medical school. b. Our AMA should work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Next Accreditation System support competency-based progression in residency. 6. Our AMA encourages research on innovative methods of assessment related to the six competency domains of the ACGME/American Board of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum. 7. Our AMA encourages ongoing research to identify best practices for workplace-based assessment that allow performance data related to each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice.	**Rescind clauses (6), (7) – accomplished.** HOD actions were communicated to the Accreditation Council for Graduate Medical Education, American Osteopathic Association, Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, American Board of Medical Specialties, Commission on Osteopathic College Accreditation and Liaison Committee on Medical Education. Also, they were shared with medical schools, residency program directors, directors of medical education at U.S. teaching hospitals, and other interested groups via MedEd Update. **Amend title as follows:** ~~ALIGNMENT OF ACCREDITATION ACROSS THE MEDICAL EDUCATION CONTINUUM~~ TOOLS TO SUPPORT ACHIEVEMENT OF COMPETENCIES ACROSS LEARNING CONTINUUM
16	H-295.907	The Impact of the Changing Health Care Environment on Graduate Medical Education	Our American Medical Association will encourage the Accreditation Council for Graduate Medical Education to review the impact of the changing health care environment on the feasibility of meeting accreditation standards related to patient volume, number of procedures to be performed, residency program size, and the	**Rescind – accomplished.**

			requirement for the presence of residency programs in other disciplines.	
17	H-295.926	Support for Development of Continuing Education Programs for Primary Care Physicians in Non-Academic Settings	The AMA: (1) supports development, where appropriate, of programs of education for medical students and faculty in non-academic settings, making use of telecommunications as needed; (2) encourages that medical schools provide faculty development programs that are designated for *AMA PRA Category 1 Credit*"; and (3) encourages that teaching continue to be accepted for *AMA PRA Category 2 Credit*" when not designated for *AMA PRA Category 1 Credit*" .	**Retain – still relevant.**
18	H-295.953	Medical Student, Resident and Fellow Legislative Awareness	1. The AMA strongly encourages the state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students. 2. Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum. 3. Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows. 4. Our AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows.	**Retain clauses (1), (2), (4) – still relevant**. **Rescind clause (3) – accomplished**. Program is now defunct.
19	H-295.980	Clinical Training in STD for Medical Students/ Physicians in Training	The AMA urges medical schools to provide supervised training in sexually transmitted diseases for all medical students and physicians in training.	**Retain – still relevant. Amend title to update language as follows:** CLINICAL TRAINING IN ~~STD~~SEXUALLY TRANSMITTED INFECTIONS ~~FOR MEDICAL STUDENTS/ PHYSICIANS IN TRAINING~~ The AMA urges medical schools to provide supervised training in sexually transmitted ~~diseases~~ infections for all medical students and physicians in training.
20	H-300.959	Physician Participation in the AMA Physician's	It is policy that: (1) the AMA, state medical societies, and specialty societies in the AMA House of Delegates publicize and promote physician participation in the AMA	**Retain – still relevant. Amend to update language as follows:**

		Recognition Award	Physician's Recognition Award; and (2) that all physicians participate in the AMA Physician's Recognition Award as a visible demonstration of their commitment to continuing medical education.	~~It is policy that:~~ AMA encourages (1) ~~the AMA,~~ state medical societies~~,~~ and specialty societies in the AMA House of Delegates to publicize and promote physician participation in the AMA Physician's Recognition Award (PRA); and (2) ~~that~~ all physicians to participate in the AMA Physician's Recognition Award (PRA) as a visible demonstration of their commitment to continuing medical education.
21	H-300.969	Uniform Standards for Continuing Medical Education	The AMA (1) will continue its efforts to develop uniform standards for continuing medical education; and (2) will solicit input from all state medical associations, medical licensure boards, and national specialty organizations concerning the development of the most appropriate uniform standards for continuing medical education.	**Rescind – duplicative.** Clause (1) is addressed by newer policies H-300.976 "Unification of Education Credits" and 9.2.6 "Continuing Medical Education." Clause (2) was accomplished during simplification and alignment process in 2017.
22	H-305.942	The Ecology of Medical Education: The Infrastructure for Clinical Education	The AMA recommends the following to ensure that access to appropriate clinical facilities and faculty to carry out clinical education is maintained: (1) That each medical school and residency program identify the specific resources needed to support the clinical education of trainees, and should develop an explicit plan to obtain and maintain these resources. This planning should include identification of the types of clinical facilities and the number and specialty distribution of full-time and volunteer clinical faculty members needed. (2) That affiliated health care institutions and volunteer faculty members be included in medical school and residency program resource planning for clinical education when appropriate. (3) That medical school planning for clinical network development include consideration of the impact on the education program for medical students and resident physicians. (4) That accrediting bodies for undergraduate and graduate medical education be encouraged to adopt accreditation standards that require notification of changes in clinical affiliations, in order to ensure that changes in the affiliation status of hospitals or other clinical sites do not adversely affect the education of medical students and resident physicians.	**Retain – still relevant.**
23	H-305.971	Discrimination Against Resident Candidates Based on	Our American Medical Association urges residency programs to use the qualifications of residency applicants as a basis for filling available positions, and not the eligibility or	**Retain – still relevant.**

		Graduate Medical Education Medicare Funding	level of future Medicare graduate medical education funding.	
24	H-310.917	Securing Funding for Graduate Medical Education	Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.	**Retain – still relevant.**
25	H-310.966	Residency Interview Costs	1. It is the policy of the AMA to pursue changes to federal legislation or regulation, specifically to the Higher Education Act, to include an allowance for residency interview costs for fourth-year medical students in the cost of attendance definition for medical education. 2. Our AMA will work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, in consideration of the following strategies to address the high cost of interviewing for residency/fellowship: a) establish a method of collecting data on interviewing costs for medical students and resident physicians of all specialties for study, and b) support further study of residency/fellowship interview strategies aimed at mitigating costs associated with such interviews.	**Retain – still relevant.**

26	H-310.993	Resident Participation on Hospital Committees	The AMA encourages hospitals with graduate medical education programs to include residents on hospital executive, fiscal and other committees.	**Retain – still relevant.**
27	H-310.994	Curriculum Orientation of Medical Staff Membership in Teaching Programs	Our American Medical Association believes that teaching programs in hospitals with residencies throughout the US should incorporate information on the privileges and responsibilities of medical staff membership into their education program's orientation materials.	**Retain – still relevant.**
28	H-310.995	Anonymity for Resident Inquiries to Residency Review Committees	Our American Medical Association supports a detailed procedure to guarantee anonymity of a resident physician who initiates an inquiry by a residency review committee into the conduct of a residency program, to protect residents from reprisals and program directors from unfounded complaints. The procedure includes a mechanism for the resident who elects to forward a complaint to the residency review committee (RRC), outlines options for RRC action; and identifies possible final actions open to the RRC.	**Retain – still relevant.**
29	H-350.969	Medical Education for Members in Underserved Minority Populations	Our AMA: (1) actively opposes the reduction of resources and opportunities used to increase the number of minority medical and premedical students in training; (2) uses its influence in states and local communities to increase the representation of minority group members in medical education, as long as domestic health care disparities exist between minority populations and the greater population at-large; and (3) supports the need for an increase in the participation of under-represented minorities as investigators, trainees, reviewers, and subjects in peer review biomedical research at all levels.	**Retain – still relevant.**
30	H-350.970	Diversity in Medical Education	Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.	**Retain – still relevant.**

31	H-435.954	Impact of US Medical Liability Premiums on Clinical Medical Education	Our AMA opposes increases in medical liability insurance premiums based solely on preceptor or volunteer faculty status.	**Retain – still relevant. Amend title to update language as follows:** ~~IMPACT OF~~ US MEDICAL LIABILITY PREMIUMS ~~ON CLINICAL MEDICAL EDUCATION~~ AND FACULTY STATUS
32	H-475.985	Protecting the Integrity of General Surgery as a Specialty	Our American Medical Association policy is that general surgery is a single specialty, distinct from other surgical specialties and that general surgery should be recognized as such by state regulatory agencies.	**Retain – still relevant.**

REPORT 2 OF THE COUNCIL ON MEDICAL EDUCATION (A-25)
International Applicants to U.S. Medical Schools (Resolution 301-A-24)

EXECUTIVE SUMMARY

Resolution 301 was introduced at the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates. The resolution asked that the AMA encourage additional medical schools to consider applications from and to admit international students to their programs alongside domestic students; amend policy H-255.968 "Advance Tuition Payment Requirements for International Students Enrolled in U.S. Medical Schools" by addition and deletion; and advocate for increased scholarship and funding opportunities for international students accepted to or currently attending United States medical schools.

To understand the issues better, this report will provide background information and data related to international student application and visa processes, student payment and financial aid, and funding for medical schools. Furthermore, this report will discuss impediments for international students as well as resources available to them and explore the building of a representative workforce.

In sum, the topic of international students applying and entering U.S. medical schools is complex. While many governmental policies include much broader issues and concerns than the admission of international students into medical school (e.g., visa processes, financial aid, funding, administrative changes, voter/public interest), some barriers can be addressed.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-A-25

Subject: International Applicants to U.S. Medical Schools

Presented by: Krystal Tomei, MD, MPH, Chair

Referred to: Reference Committee C

INTRODUCTION

Resolution 301 entitled "Fairness for International Medical Students" was referred at the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD) and asked that our AMA:

- Encourage additional medical schools to consider applications from and to admit international students to their programs alongside domestic students (New HOD Policy); and be it further
- Amend policy H-255.968 "Advance Tuition Payment Requirements for International Students Enrolled in U.S. Medical Schools" by addition and deletion to read as follows:

  Advance Tuition Payment Requirements for International Students Enrolled in U.S. Medical Schools H-255.968

  Our AMA:

  - supports the autonomy of medical schools to determine optimal tuition requirements for international students;
  - encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the U.S. of the limited options available to them for tuition assistance;
  - supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR); and
  - supports efforts to re-evaluate and minimize the use of pre-payment requirements specific to international medical students; and
  - encourages medical schools to explore alternative means of prepayment, such as a letter of credit, ~~for four years~~ for covering the costs of medical school. (Modify Current HOD Policy); and be it further
- Advocate for increased scholarship and funding opportunities for international students accepted to or currently attending United States medical schools.

The reference committee received mixed testimony on this item. Concerns were raised regarding the Student and Exchange Visitor Program (SEVP), federal regulations regarding international students, limited funding opportunities for international students, the criteria of the F visa program to enter the U.S, the Form I-20 "Certificate of Eligibility for Nonimmigrant Student Status," Title IV federal financial aid funding, and the relationships between medical schools and their parent institutions. Also, testimony recommended that the American Association of Colleges of

Osteopathic Medicine (AACOM) be included along with AAMC. Given the complexities raised, the Reference Committee recommended that this item be referred. The HOD also moved to refer. This report was written in response to that directive.

BACKGROUND

To better understand policy proposed in this resolution, several of the foundational topics raised by the author are described.

International student application and visa processes

Applicants to U.S. medical schools

For the purpose of this report, "international" medical school applicants are commonly understood to be individuals who are neither U.S. citizens nor hold permanent resident status in the U.S.[1] According to the AAMC, some U.S. MD-granting medical schools do accept a small number of international applicants. In 2019, 48 schools (out of 155) indicated that they accept applications from international applicants per the AAMC Medical School Admission Requirements™ (MSAR™) guide.[2,3] The 2019 cycle for MD-granting programs in the U.S saw 53,371 total applicants[4] with 21,969 (41%) matriculated into medical school; 325 out of 1,890 foreign applicants who applied to such programs were accepted.[2] Among the 325 students accepted, 272 matriculated into medical school, including those who applied via the American Medical College Application Service® (AMCAS®) and Texas Medical & Dental Schools Application Services (TMDSAS).[2] Related policies vary across schools and can be researched on an allopathic school's website or within the MSAR's section on "Application Deadlines and Requirements." Additional data can be found on the AAMC website. Similar data from AACOM and osteopathic medical schools were not available.

The National Center for Education Statistics offers the College Navigator search engine to identify educational institutions. The first step to studying in the U.S. is to apply to a school approved by the U.S. Immigration and Customs Enforcement (ICE) Student and Exchange Visitor Program (SEVP). This program ensures the government has necessary data related to nonimmigrant students and exchange visitors, provides approval and oversight to authorized schools, and issues guidance to both students and schools regarding the requirements for maintaining their status. If a student is accepted, they are registered in the SEVP platform called Student and Exchange Visitor Information System (SEVIS).[5] For a school to be accepted into SEVP, it must complete the online "Petition for Approval of School for Attendance by Nonimmigrant Student," (Form I-17) in SEVIS and pay all required fees.[6]

Most U.S. medical schools use AMCAS to facilitate and streamline the student application process. Since AMCAS does not accept foreign transcripts or verify foreign coursework (unless the coursework was accepted by an accredited U.S., U.S. Territorial, or Canadian postsecondary institution), individual medical schools may ask an applicant for their transcript with the understanding that some courses may not be accepted.[2] For DO-granting medical schools, the AACOM oversees the American Association of Colleges of Osteopathic Medicine Application Service (AACOMAS).[1] Likewise, admission policies for international students vary across DO schools. Once admission to a SEVP-approved school is secured, an international student can apply for their student visa.

Although not legally U.S. citizens or permanent residents, the admission process and barriers for Deferred Action for Childhood Arrivals (DACA) applicants were determined not to be the intent of the referral and beyond the purview of this report.

Applicant race/ethnicity data

AAMC provides data on the number of applicants to U.S. MD-granting medical schools, to include a breakdown by race/ethnicity and state of legal residence (if known). Such data provides insight into the diversity, or lack thereof, of the incoming students and includes non-citizen and non-permanent residents. AAMC data for the academic year 2024-2025 totals 51,946 applicants and includes 1,852 non-U.S. citizen and non-permanent residents.[7] More detailed R/E data on U.S. citizens is available. 2024 AACOM data totals 22,107 applicants and includes 470 non-U.S. citizens and non-permanent residents.[8] Likewise, more detailed R/E data on U.S. citizens is also available. While much is known about the countries of origin of international medical graduates (IMGs),[9] race/ethnicity data on international student applicants is not as readily available. AAMC indicated that recent international applicants were from 112 countries; among them, matriculants were from 67 countries.[10] Similar data from AACOM or ECFMG were not available.

Visa entry to U.S.

The Immigration and Nationality Act allows the admission of different classes of foreign national nonimmigrants who seek temporary admission to the U.S.[11] The Department of State's Bureau of Consular Affairs oversees the student visa process. Non-citizen students must have a student visa to travel to the U.S. to study. The course of study and the type of school determines which type of visa is needed. For the F visa, the student must be entering the U.S. to attend university or college, high school, private elementary school, seminary, conservatory, or another academic institution, including a language training program. For the M visa, the student must be entering the U.S. to attend a vocational or other recognized nonacademic institution, other than a language training program.[5] J visas are non-immigrant visas for individuals approved to participate in exchange visitor programs in the U.S.[12]

The student must submit the Online Visa Application (Form DS-160), along with a photo and fee, and must schedule an interview at the U.S. Embassy or Consulate in the country where they live. Wait times for interviews at the consulate vary by location, time of year, and visa type and range from the same day to over a year (e.g., Kolkata, India). Additional documentation may be required at the interview including intent to depart the United States upon completion of the course of study and how the applicant will pay for all educational, living, and travel costs.[5] A visa does not guarantee entry into the United States; rather, the Department of Homeland Security's U.S. Customs and Border Protection officials at the port-of-entry have authority to permit or deny entry. Students in the U.S. with F visas must depart within 60 days after the program end date listed on the Form I-20, including any authorized practical training.[5] The same process described above can be used to apply to renew a visa. More detailed information is provided on the student visa website.

The visa system allowing international students to enter the U.S. is governed by federal immigration policy and law. For example, the current federal administration starting in 2025 has ordered the Departments of State, Justice, and Homeland Security to ensure visa applicants "do not bear hostile attitudes" toward U.S. "citizens, culture, government, institutions, or founding principles" and "are vetted and screened to the maximum degree possible."[13] How this executive order will be implemented may impact the opportunities of international students to enter and stay in the U.S. for study.

Student payment and financial aid receipt

According to the AAMC, the majority of medical students pay for their education through student loans. Further, the mean education debt for indebted medical school graduates in 2023 was $206,924, with 70 percent of all students having education debt.[14] MD school-specific information is provided in the AAMC Tuition and Student Fees workbooks, which contain tuition, fees, and health insurance costs reported by accredited medical education programs from academic year 1995 to present.[15]For DO students, the average graduate indebtedness in 2023-2024 was $259,196.[16]

While domestic students may have government financial assistance options, most international medical students need to secure private loans or institutional loans (if available from the enrolled medical school) and, if available for foreign study, financial aid from the student's country of citizenship. The application process for private loans varies from lender to lender. Some medical schools may require international applicants to show proof of financial means to pay for all four years of medical school or may require such applicants to have the full amount in an escrow account as some international medical schools require of U.S. applicants.[2]

The U.S. Department of Education (DOE) oversees federal student aid and determines eligibility for "non-citizens." This designation includes U.S. nationals (including natives of American Samoa or Swains Island), U.S. permanent residents, or individuals with an Arrival-Departure Record (I-94) from U.S. Citizenship and Immigration Services. The latter includes those designated as "Refugee," "Asylum Granted," "Cuban-Haitian Entrant (Status Pending)," "Conditional Entrant" (if issued before April 1, 1980), T-visa holders (victims of human trafficking; T-2, T-3, or T-4), or "Parolee." For the parolee designation, an individual must be paroled into the U.S. for at least one year and must be able to provide evidence from the United States Citizenship and Immigration Services of intention to become a U.S. citizen or permanent resident. If applicable, federal student aid such as Direct Unsubsidized Loans and Direct PLUS Loans may be available if eligibility requirements are met.[17]

According to Harvard Medical School, "Since federal financial aid programs require that the recipient be a citizen or permanent resident of the United States, the programs used to fund international or Deferred Action for Childhood Arrivals (DACA)-eligible MD student financial aid awards come from private and institutional sources. International and DACA-eligible MD students fill out the standard financial aid application materials and receive financial aid award determinations in a similar manner as U.S. citizens and permanent residents. International and DACA-eligible MD students who qualify for need-based institutional funding are first offered a standard loan package which consists of a combination of loans from institutional and/or private sources. A variety of private loan options are available to MD students regardless of financial need with options to borrow with or without a U.S. co-signer."[18]

The Council on Medical Education studied "Medical Student Debt and Career Choice" (CME 4-N-21) and "Financing Medical Education" (CME 2-A-23), both of which provide greater detail into cost, debt, and financial resources.

Funding medical schools

While considering how an international student will pay for school, it is also important to understand the mechanisms in which schools are funded and how they use their funding to aid students. A medical school is part of a larger academic institution that may be public or private. Funding may come from several sources, including but not limited to student tuition fees, federal

and/or state monies, philanthropy, clinical revenue, faculty practice plans, industry, grants, and private payers. There may be stipulations on each of these forms of funding and how it is to be spent. Such stipulations may or may not address international student fees. For example, governmental funding for medical schools is partially based on a desire to train more students in or from a certain jurisdiction. A state government may demand that state universities and their medical schools give priority to residents of their state when it comes to admission as well as tuition subsidies. This may also pertain to private universities in their state, especially when they receive government support. Thus, funding for international students will be secondary to supporting additional students from the state that is providing taxpayer funds to universities and their medical schools.

Governmental funding is also driven by law. The Higher Education Act (HEA) of 1965 regulates the relationship between the federal government, colleges and universities, and students. Title IV of the HEA authorizes a variety of programs and provisions to assist students in accessing financial aid in a postsecondary education. These programs are often the primary sources of federal aid to support such education.[19] The regulated entity could be the university, including their medical school or the medical school as a stand-alone entity. "Under the HEA 90/10 rule, proprietary institutions of higher education (IHEs) must derive at least 10 percent of their total tuition and fees revenue from non-Title IV sources (or, conversely, no more than 90 percent of their tuition and fees revenue from Title IV funds) during a fiscal year."[21] Further, the DOE issued rule changes which took effect starting in 2023.[20] "The HEA and accompanying regulatory provisions specify how revenues are to be calculated. If an IHE fails to meet the rule's requirement in a single year, its certification to participate in the Title IV aid programs becomes provisional for two institutional fiscal years. If an IHE fails to meet the rule's requirements in two consecutive years, it loses its eligibility to participate in the Title IV programs for at least two institutional fiscal years. The rationale behind the 90/10 rule is twofold: (1) reducing fraud, waste, and abuse at proprietary IHEs and (2) if a proprietary IHE is of sufficient quality, it should be able to attract a specific percentage of revenues from non-Title IV sources."[21] The impact on school funding could also affect accreditation. This rule may explain why some medical schools require international students to pay up front or show proof of ability to pay, as default of payment can threaten a school's Title IV funding, thereby impacting the availability of financial aid for all students attending their school. Of note, the current federal administration is considering changes to the DOE; the impact of such changes remains to be seen.[22]

The Council on Medical Education has studied medical education, as mentioned above, as well as medical schools in its report "For-Profit Medical Schools or Colleges" (CME 1-I-19).

DISCUSSION

Each of these topics illuminate the complexity of this issue. They also raise further concerns related to heterogeneity, fairness, and involvement of international students as well as the challenges and resources available to them.

Building a representative workforce

According to the AAMC, their 10-point strategic plan called "A Healthier Future for All" is focused on supporting the capacity building of pathway programs to expand the U.S. medical school applicant pool in order to diversify the physician workforce.[23] Likewise, AACOM addresses similar points in their strategic plan.[24]

The Council on Medical Education has addressed issues of equity in some recent reports. For example, two reports of relevance are "Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education" (CME 3-I-23) and "Promising Practices Among Pathway Programs to Increase Diversity in Medicine" (CME 5-J-21).

Focus on pathway programs, while important, centers on underrepresented U.S. students who face systemic barriers to medical school admission. Consideration can also be given to the potential contribution of international students in advancing related efforts in U.S. medical schools.

Impediments for international students

As described above, international students face significant challenges, including but not limited to the following:

- Medical school application forms, processes, interviews, and deadlines: Cost, language barriers, detailed forms, and deadlines may inhibit international students in their ability to successfully apply and be accepted to a U.S. medical school.
- Visa application forms, processes, interviews, and deadlines: the cost, detailed forms and documentation, deadlines, and immigration policies may prevent some international students from entry into the U.S. for study. Further, wait times for interviews at some consulates can be prolonged, resulting in a significant lag between admission and receipt of an F-visa.
- Pre-payment or proof of ability to pay: Financial capacity is challenging for most medical students, let alone international students who face non-citizenship required fees and may also have financial hardships. In addition, applicants for a student visa may be required by the consular officer to provide documentation of how they will pay for all educational, living, and travel costs. "This evidence of financial ability includes but is not limited to family bank statements, documentation from a sponsor, financial aid letters, scholarship letters, or letter from an employer showing annual salary."[25] Data on how many medical schools also require this proof was not readily available.
- Limited financial aid options: Given their non-citizen status, international students often struggle with knowing where/how to identify possible resources, let alone how to apply for them. Countries often do not provide financial aid to their citizens studying in the U.S.
- Public interest: Voters often demand that their tax dollars should go primarily toward educating their own citizens who reside in their state and that state universities and their medical schools prioritize their own citizens in admissions and financial aid. This may apply as well to private medical schools receiving state support. With competition for medical school admission already high in the U.S., including for U.S. applicants identifying as historically minoritized, increasing admissions to international students may decrease government and public support for medical schools including funding for all medical students.
- Federal immigration policy: The President and current federal administration is prioritizing an "America First" agenda that purports security and safety concerns related to immigrants, migrants, and asylum seekers, which may adversely impact the entry of international persons for study in the U.S.[26] The AMA is monitoring changes in federal immigration law and regulations and its potential impact on the physician workforce.

Resources for international students

Despite the challenges, a number of resources are available to aid such students in their ability to study medicine in the U.S. This is in addition to the financial aid office at each medical school. These resources include, but are not limited to:

- AAMC offers information on "Applying to Medical School as an International Applicant" as well as the Financial Information, Resources, Services, and Tools (FIRST) program. FIRST provides free resources to students, including publications, videos, webinars, infographics, and charts to help students and residents make informed financial decisions related to their education.
- Federal Student Aid website provides detailed information on eligibility and options.
- Sallie Mae provides guidance on financial aid and how to control costs associated with medical school.
- F-1 Doctors is a peer-led mentorship platform for international applicants to U.S. medical (and dental) schools and U.S. residency programs. The platform currently hosts over 140 mentors from over 30 countries, providing free guidance on applying to such U.S. schools and programs.[27]

In the AMA, the IMG Section is a member group that convenes on and advocates for relevant issues affecting international medical graduates. The section also provides students with information on how to become certified by the Educational Commission for Foreign Medical Graduates (ECFMG)/Intealth and how to navigate practicing medicine in the U. S. as well as access to mentoring consults. The AMA Medical Education unit produced a 2022 issue brief on Support for IMGs practicing in the U.S. In the last five years, the Council on Medical Education published the following reports related to IMGs:

- Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict (CME 8-A-23)
- Financial Burdens and Exam Fees for International Medical Graduates (CME 3-A-23)
- Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice (CME 4-JUN-21)
- Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses (CME 2-JUN-21)

Also, the AMA Medical Student Section is a member group that convenes on and advocates for relevant issues impacting medical students in the U.S. The AMA and AMA Foundation (AMAF) can consider additional ways they can support international applications and students within their own programs and initiatives, such as the AMAF medical student scholarships.

RELEVANT AMA POLICIES

The AMA has many policies in support of medical students, medical education, and medical schools. Such policies are accessible in the AMA Policy Finder. Regarding international medical students, related policies include:

- Advance Tuition Payment Requirements for International Students Enrolled in U.S. Medical Schools H-255.968
- Clinical Skills Assessment During Medical School D-295.988

SUMMARY

The topic of international students applying to and entering U.S. medical schools is complex. While many governmental policies discussed include much broader issues and concerns than the

admission of international students into medical school (e.g., visa processes, financial aid, funding, administrative changes, voter/public interest), some of the barriers can be addressed with the above resources.

RECOMMENDATIONS

The Council on Medical Education recommends the following be adopted, and the remainder of the report be filed:

That our AMA:

1. Supports all U.S. medical schools in (a) considering international applicants; (b) investigating additional financial aid opportunities, including scholarships, for international medical school applicants; and (c) re-evaluating their pre-payment requirements specific to international applicants.
2. Recognizes the federal government's current programs that allow for the entry of qualified international medical students into the U.S. and encourages the maintenance and/or improvement of such programs.
3. Supports relevant parties to include international medical students and applicants in data collection, philanthropy, and financial assistance programs.

(New HOD Policy)

Fiscal note: $1,000

APPENDIX: RELEVANT AMA POLICIES

Advance Tuition Payment Requirements for International Students Enrolled in U.S. Medical Schools H-255.968

1. Our American Medical Association supports the autonomy of medical schools to determine optimal tuition requirements for international students.
2. Our AMA encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance.
3. Our AMA supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR).
4. Our American Medical Association encourages medical schools to explore alternative means of prepayment, such as a letter of credit, for four years of medical school.

Clinical Skills Assessment During Medical School D-295.988

1. Our American Medical Association will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.
2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.
3. Our AMA will work to:
   a. ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners.
   b. encourage a significant and expeditious increase in the number of available testing sites.
   c. allow international students and graduates to take the same examination at any available testing site.
   d. engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization.
   e. include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.
4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.
5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.
6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would:
   a. Identify areas of satisfactory or better performance.

b. Identify areas of suboptimal performance.
c. Give students who fail the exam insight into the areas of unsatisfactory performance on the examination.

7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.

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REPORT 3 OF THE COUNCIL ON MEDICAL EDUCATION (A-25)
Unmatched Graduating Physicians (Resolution 306-A-24)

EXECUTIVE SUMMARY

Resolution 306 was introduced at the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates. The resolution asked that the "Board of Trustees study the role these unmatched physicians can play in providing care to our patients, their impact of lessening the impact of physician shortages, and provide recommendations on how to enroll these graduating physicians with a uniform title, privileges, geographic restrictions, and collaboration choices, and report to the House of Delegates (HOD) at the next Interim meeting." The Reference Committee received mixed testimony on this item and it was ultimately referred by the HOD.

To examine if unmatched physicians without residency education would contribute meaningfully to addressing a physician workforce shortage and increase access to care, this report will provide background information and data related to physician education standards and graduate medical education as well as the physician workforce shortage. It will also review the quantity of unmatched U.S. medical graduates, reasons for being unmatched, and the Accreditation Council for Graduate Medical Education position on the unmatched.

Finally, this report will discuss concerns and considerations from the resolution author and physician community, implications for international medical graduates, and the AMA's own efforts and resources in this space.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-A-25

Subject: Unmatched Graduating Physicians (Res 306-A-24)

Presented by: Krystal Tomei, MD, MPH, Chair

Referred to: Reference Committee C

INTRODUCTION

At the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 306 was referred and asked that our "Board of Trustees study the role these unmatched physicians can play in providing care to our patients, their impact of lessening the impact of physician shortages, and provide recommendations on how to enroll these graduating physicians with a uniform title, privileges, geographic restrictions, and collaboration choices, and report to the HOD at the next Interim meeting."

The author purported many concerns in Resolution 306, demonstrating the complexities of the problem. These concerns include:

- Graduate medical education (GME) shortage (e.g., lack of funding; lack of residency slots)
- Unmatched physicians (e.g., a Missouri state law allowing physicians without residency training to practice and other similar state laws; lack of support/experiences for unmatched medical students so they can go on to match)
- Workforce (e.g., physician shortage in primary and specialty care; a decrease in practicing physicians; not enough medical students, residents, and fellows to meet the needs of patients)
- Scope of practice (e.g., physician assistants [PAs], advanced practice providers [AAPs], and nurse practitioners [NPs] have replaced physicians in shortage areas; state allowances for non-physician extenders to practice)

The reference committee received mixed testimony on this item. Testimony in opposition raised concerns about the multifactorial and nuanced problem of the physician shortage, variances in state laws related to non-physician providers, patient safety, physician education, lack of physician mentors, and circumvention of Accreditation Council for Graduate Medical Education (ACGME) standards by not participating in an accredited GME program. For these reasons, the reference committee recommended that resolution 306 be not adopted; however, the HOD final action moved for referral. This report is written in response to that directive.

BACKGROUND

To examine if unmatched physicians without residency education would contribute meaningfully to addressing a physician workforce shortage and increase access to care, the following issues and facts need to be considered.

Physician workforce shortage

The physician workforce shortage and maldistribution by geography and specialty is impacting access to care. In 2023, the Association of American Medical Colleges (AAMC) conducted a study entitled "The Complexities of Physician Supply and Demand: Projections From 2021 to 2036." The resulting report predicts that by the year 2036, the U.S. will face a physician shortage of up to 86,000 physicians.[1] While the physician shortage is a multifactorial and nuanced problem, the report asserts that the main drivers of the physician shortage are population demographics, retiring physicians, and the needs of groups that have been historically and intentionally excluded.

- Demographics: The study projects the U.S. population will grow by 8.4 percent overall, along with a growth in the aged 65 and older subpopulation by 34.1 percent leading to a significant increase in demand for primary care and for the specialists they most often need.
- Retirement: Currently, 42 percent of the clinical physician workforce is over age 55 (20 percent are aged 65 or older and 22 percent are between age 55 and 64). Thus, a substantial number of physicians will reach retirement age within the next decade.
- Underserved: The U.S. would have already needed 202,800 more physicians (as of 2021) to care for underserved communities in order to provide care at the same rate as other populations.[1]

These forecasts suggest worsening health inequities, particularly for the aging and underserved populations. AAMC offers projected data on physician demand through 2036 by patient race and ethnicity as well as urban-rural location. Of note, the AMA recently issued a brief on "Defining "rural" for the physician workforce."

Physician education standards and graduate medical education

For almost a century, successful completion of GME in the United States has been the established standard for physician education in the United States for independent practice and now for many countries around the world. Beginning in 1914, the AMA published the first list of hospitals approved for GME, and in 1927, the AMA Council on Medical Education and Hospitals began publishing the names of all the approved hospitals with GME programs in various specialties in the "Essentials of Approved Residencies and Fellowships." In the mid-20th century, the AMA played a key role with specialty boards in establishing residency review committees (RRCs), beginning with the RRCs for internal medicine and surgery in 1953. In 1956, the Federation of State Medical Boards recommended GME as a requirement for a full, unrestricted license to practice medicine. In 1972, the AMA helped found the Liaison Committee on Graduate Medical Education to accredit residency programs and, in 1981, was one of the five parent organizations establishing the ACGME.[2] In 2020, osteopathic and allopathic GME were unified into a single accreditation system to standardize GME for all physicians in the United States.[3]

GME is not only a critical part of the education of physicians in preparation for independent practice in a clinical specialty, GME is also a period of assessment for each trainee to ensure they are competent to practice. At completion of a GME program in the U.S., the residency director attests (per the 2024 ACGME Guide to the Common Program Requirements) that the resident has "demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice."[4] Allowing unmatched physicians to practice without GME would be a significant change in professional standards for patient care.

How many unmatched U.S. medical graduates are there?

Physicians applying for residency or fellowship enter a match to determine in which program they will train. The Council on Medical Education provides greater detail on the match processes and alternatives in their 2024 report, The Current Match Process and Alternatives (CME 2-A-24).

The National Residency Matching Program (NRMP) publishes annual results and reports on various data topics. According to the NRMP's report, "2024 Main Residency Match® By the Numbers," there were 41,503 total positions, and 38,941 of them were filled (93.8 percent), leaving 2,562 unfilled.[5] For PGY-1 positions, there were 38,494 total positions, and 35,984 of them were filled (93.5 percent), leaving 2,510 unfilled. In both instances (total positions and PGY-1 only), the percentages of filled spots went up 0.5 percent from the previous year.[5] See Appendix A for more report highlights or visit the NRMP® website for the complete data. Further Match data shows a match rate of 93.5 percent for U.S. MD seniors (an all-time high), 92.3 percent for U.S. DO seniors, 67 percent match rate for U.S. citizen international medical graduates (IMGs), and 58.5 percent match rate for non-U.S. citizen IMGs.[6]

Regarding IMGs in 2024, "19,050 U.S. citizen and non-U.S. citizen students and graduates of international medical schools (IMGs) registered for the Match, 1,668 more than 2023. Of the 4,751 U.S. IMGs who submitted rank order lists of programs, 3,181 matched to a PGY-1 position for a match rate of 67.0 percent. Of the 10,021 non-U.S. citizen IMGs who submitted rank order lists of programs, 5,864 matched to a PGY-1 position for a match rate of 58.5 percent. In 2024, the overall number of registered applicants was 50,413, the highest in the history of the Match. The number of registered non-U.S. citizen IMGs was 12,787, 1,986 more than last year."[7]

A total of 2,655 positions went unfilled in the 2024 NRMP Match, which included the 2,562 mentioned above as well as 93 additional positions in programs that did not submit a rank order list. Also, some unfilled programs had submitted a rank order list but chose not to participate in the Supplemental Offer and Acceptance Program® (SOAP®)to fill their unfilled positions. Among the 2,655 mentioned above, 97 percent (2,575) were placed in the SOAP offered by the NRMP during Match Week.[7] The SOAP is a process whereby eligible unmatched or partially matched applicants in The Match can apply for and be offered positions that went unfilled after the matching algorithm was processed. At the conclusion of SOAP, 176 positions still remained unfilled from 109 SOAP-participating programs. The matching and SOAP processes combined filled 99.6 percent of positions available through the Match, resulting in 0.4 percent unfilled positions."[7] This data does not include other match processes outside the NRMP. See Appendix A for a graph of NRMP Match data.

Reasons U.S. medical graduates are unmatched

Data provided by medical schools to the Liaison Committee on Medical Education (LCME) in the LCME Part II Annual Medical School Questionnaire offers insight into reasons medical school graduates did not match into a residency program. In 2023, 20,484 graduates accepted a residency position, and the total number of potential graduates who reported not entering residency training in 2023-2024 was 309 and their reasons given were:

- Research/pursuing additional degree or training: 113
- Did not find a residency position: 80
- Changing careers: 56
- Other: 56
- Family responsibilities/childcare: 4[8]

The LCME does not have additional details about the reasons. It is possible that those who "did not find a residency position" may not have found one in their desired specialty or geography even if

other positions were available. Data on osteopathic medical school graduates not entering residency training were not available.

Notably, 80 U.S. LCME medical graduates reported being unable to find a residency position, while the NRMP reported 176 unfilled residency positions after the SOAP. It is likely that the unmatched physicians had preferences for residency positions that were not met by the available vacant positions.

Regarding osteopathic medical schools, American Association of Colleges of Osteopathic Medicine's (AACOM) UME-GME Task Force Residency Match Working Group sent a survey to medical school advisers and deans in 2018-2019 to assess reasons why students did not match. The results indicated low board scores and lack of parallel plans were the main reasons students did not match.[9]

ACGME statement on those who are unmatched

The ACGME issued a statement of note in 2020 regarding "Unmatched US (Domestic, non-IMG) Allopathic and Osteopathic Medical Graduates, and International Medical Graduates with valid Educational Commission for Foreign Medical Graduates (ECFMG) certification Scenarios." It reads, "ACGME-accredited Sponsoring Institutions that permit programs to appoint unmatched/ uncommitted graduates, consistent with their programs'/ Sponsoring Institutions' match participation agreements, must offer at least 1 year of appointment in an ACGME-accredited program (if eligible per ACGME requirements). Any such appointments must be reviewed and approved in advance by the Sponsoring Institution's Graduate Medical Education Committee (GMEC). Enrollment in preliminary year positions, categorical positions, and positions in Transitional Year programs may be appropriate in this circumstance.

1. If the program would be within its approved complement, appointment in an ACGME-accredited program may proceed.
2. If the program would not be within its approved complement, Review Committee approval of a temporary complement increase must be obtained prior to appointment in an ACGME-accredited program. Approval of temporary complement increases, when required, must be obtained by programs of Sponsoring Institutions that have declared pandemic emergency status (Stage 3)."[10]

DISCUSSION

Concerns and considerations

Ultimately, Resolution 306 seeks to determine if unmatched physicians can have a significant impact on the physician shortage by creating opportunities for these physicians to practice.

There is a common misperception that there are not enough GME positions for graduates of U.S. medical schools. However, the data provided in this report proves otherwise, with the number of U.S. medical graduates who are unable to obtain a residency each year being very small (under 100) compared to the overall number of physicians entering GME (almost 40,000) and would have a very small potential impact on the physician workforce. For U.S. medical school graduates who are seeking a residency position but who remain without a residency position, there is likely a mismatch between their preferences and the residency positions available to them. Similarly, unmatched physicians may have preferences that may result in a lack of interest in some practice opportunities.

Residency is mandatory for medical licensure in the U.S. Thus, guidance for unmatched physicians is usually focused on getting them into a residency, which means applying for SOAP to attempt to match into unfilled positions or taking a year to prepare to reapply for The Match. Given AAMC predictions, it would be most advantageous to the health of the public if trainees choose to pursue the specialties of most need and seek employment in areas of most need. Should unmatched physicians decide not to reapply, they can pursue other careers in health care that contribute to the health of patients. Depending on their skills and interests, such employment paths include medical writing, consulting, administration, research, education, entrepreneurship, technology, or government agencies.

For DO students looking to strengthen their application, the National Board of Osteopathic Medical Examiners (NBOME) suggests that unmatched graduates also "consider applying to take COMLEX-USA Level 3 under the alternate pathway attestation, which permits candidates to obtain eligibility with endorsement by their COM dean."[11] Completion of Level 3 may be a way for DO applicants to strength their application while reapplying. Equivalent information for MD students was not available on the National Board of Medical Examiners website, although it is widely accepted that passing Step 3 can strength an application while reapplying.

There is little evidence to suggest that U.S. unmatched physicians can address the physician shortage. Without completing a residency, it is unlikely that they could provide the quality of care of a physician who completed an ACGME-accredited residency program. Residents cannot bill for their services and must be under supervision of fully licensed physicians, including in-person supervision during the first 6 months of residency. Thus, it would seem unmatched physicians should need at least this level of supervision, if not more. Further, hospital medical staff, medical groups, and/or payors should not grant privileges to unmatched physicians without residency training. For privileges, these entities often require completion of ACGME residency training.[12]

While ACGME accreditation standards call for structured supervision and longitudinal assessment in GME, an alternate pathway for unmatched physicians to enter practice lacks detailed guidelines for and enforcement of appropriate clinical supervision to assure patient safety and assess competence. In addition, a shortage of physicians in underserved areas able to supervise may lead to subquality oversight of unmatched physicians in these communities. Related, the AMA recently issued a brief on "The role of supervision in assessment of physician competency."

Also, the resolution implies that unmatched physicians should be granted practice privileges that are potentially greater than those who did match and entered GME. This issue could create distrust between physicians in residency programs and unmatched physicians.

In recent years, there has been movement toward creating positions for these individuals where they may function similarly to a non-physician provider. At least ten states have passed laws to provide this opportunity. For example, the Medical Association of the State of Alabama introduced a bill that was signed into state law in 2023 entitled the "Physician Workforce Act."[13] It creates a Bridge Year Graduate Physician Program. This program allows unmatched physicians to gain experience and skills under the supervision of licensed physicians. These individuals will receive a one-year renewable permit to practice medicine under an Alabama-licensed physician.[14] Since it is a new program, data is limited. While it seems that Alabama seeks to eventually get these individuals into residency positions, some states do not offer an end goal whereby these individuals may remain under supervision much like a non-physician provider. It calls into question the consequences for unmatched physicians who are unable to secure a desired GME position for years. It is unclear if this role is truly transitional, how long they will be allowed to continue in such a role, and how the medical community can prevent exploitation of unmatched physicians.

For example, a St. Louis physician was recently sentenced to prison for employing physician assistants and unmatched physicians to see patients but billing health plans as if he was the one providing direct care. The Department of Justice concluded that "under Missouri law, this is expressly illegal, especially since many of the assistants were not qualified to provide unsupervised care. While they had completed medical school, they did not finish a required residency. …Further, when hiring the assistants, the physician would market the roles as 'residency prep' and a 'stepping stone' toward full qualification."[15]

In 2023, the urology program at Case Western Reserve University School of Medicine in Ohio introduced a pilot program designed to afford an unmatched student a mentored and supervised year as a "Resident Team Assistant (RTA)," with support for research projects, attendance of educational didactic conferences, and experience within their subspecialty that reflects an experience similar to a one-year acting internship. Their responsibilities were limited by the lack of a training permit, but their duties were aligned to the needs of an ACGME-accredited residency program with educational exposure and resources afforded by such a position. This individual successfully matched the next year.[16]

An example of support for DO students who did not initially match into a residency program is a program at the Rocky Vista University (RVU) College of Osteopathic Medicine. In 2021, this institution launched the Predoctoral Internship (PDI) and Master's Predoctoral Internship (MPDI), both designed to aid students who did not match into a residency program to reenter the match process and successfully match. According to RVU, "The PDI and MPDI are rigorous, milestone-based programs designed to develop personalized experiences to meet the individual needs of an unplaced student to prepare them to reenter the match process and successfully match to a residency program. The key difference between the PDI and MPDI, outside of the curriculum structure, is that a student in the MPDI program will also be concurrently enrolled in an accredited master's program of their choice at a different institution. … The successes of these programs have spurred conversations about ways the university can incorporate components of the PDI and MPDI programs into the core curriculum of the COM to mitigate the need for such programs to exist."[17] The programs included 11 participants and achieved a 100 percent success rate for those re-entering the Match, while also helping to reduce anxiety and increase support throughout the process.[17] Additional information about the RVU innovation is available on the school's website and here. AACOM offers a toolkit to aid such students reentering the residency application and match process.[9]

A great concern about creating a pathway for unmatched physicians to enter practice absent completion of an ACGME accredited residency in order to ameliorate the physician shortage would essentially create a two-tiered health care system, further clouding the distinction in training and ability between physicians and non-physician providers. However, examples of successful programs to provide unmatched graduates with structured educational clinical experiences have shown greater success in truly assisting these graduates with a later successful match. Key parties are encouraged to consider the need and utility of programs to support unmatched physicians.

Another potential etiology of unmatched students underlies the decision of some residency programs to choose not to participate in the SOAP. These programs will only accept applicants who matched during the main residency Match. Understanding the decision of these residency programs to keep their positions unfilled rather than considering unmatched applicants for those positions may elucidate opportunities to increase the slots available for unmatched students. Programs need to actively indicate their participation in the SOAP each year; if overlooked it may result in programs with unfilled positions inadvertently not being available in the SOAP. Key

parties are encouraged to investigate processes to enable all unfilled residency positions to be available in the SOAP.

IMGs

Resolution 306 did not specify "U.S." unmatched physicians. Thus, it can be interpreted to include IMGs and open the door to broader implications. Regarding IMGs, the AMA is an active member of the newly formed Advisory Commission on Additional Licensing Models, co-chaired by the Federation of State Medical Boards (FSMB), Intealth™, and the ACGME. This Commission, established in March 2024, released draft preliminary recommendations on eligibility requirements for public comment through December 6, 2024. Notably, requiring GME training is recommended for the IMGs in any additional licensing pathway. More information is expected in 2025.

AMA efforts and resources

GME, matching, and the physician shortage are areas of significant concern of the AMA and often addressed in its Advocacy efforts. See Appendix B for a list of relevant accomplishments in the last two years alone.

In addition to the report cited earlier, the Council on Medical Education has actively addressed concerns related to GME and the physician workforce in reports such as:

- Guiding Principles and Appropriate Criteria for Assessing the Competency of Physicians Across the Professional Continuum, CME 1-I-21
- Optimizing Match Outcomes, CME 3-A-21
- Expanding UME Without Concurrent GME Expansion, CME 3-A-18
- Options for Unmatched Medical Students, CME 5-A-17
- Standardizing the Allopathic Residency Match System and Timeline, CME 6-A-17
- Addressing the Increasing Number of Unmatched Medical Students, CME 3-A-16

FREIDA™ is the AMA's Residency & Fellowship Database® that enables unmatched students to research residencies from more than 13,000 programs both during and following SOAP.

AMA media coverage and educational resources in the last two years include:

- Powerful Senate committee takes up physician shortage (Aug 2024)
- AMA president sounds alarm on national physician shortage (Oct 2023)
- Match: Which specialties place most residents through SOAP (Feb 2024)
- What if you don't match? 4 things you should do (March 2024)
- What's exacerbating the physician shortage crisis—and what's needed to fix it (May 2024).

REVANT AMA POLICIES

The AMA has strong policy in support of GME, medical licensure, board certification, and competent patient care – all of which illuminate the importance of completion of a residency. See Appendix C for full policies. To support an alternative to residency training that allows for insufficiently supervised patient care would go against longstanding AMA policy.

AMA policy D-310.977 entitled "National Resident Matching Program Reform" addresses the unmatched in clauses 11-15 and 17 to read as follows:

11. Our AMA will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs.
12. Our AMA will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
13. Our AMA will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program.
14. Our AMA will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions.
15. Our AMA encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match.
17. Our AMA encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.

Also, AMA Policy H-200.954 entitled "US Physician Shortage" addresses the underlying issue of this resolution — the physician shortage. Additional related policies are located in the AMA Policy Finder and include:

- Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
- Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929
- Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986
- Financing of Medical Education Programs D-305.973
- Fixing the VA Physician Shortage with Physicians D-510.990
- The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
- Residents and Fellows' Bill of Rights H-310.912

SUMMARY

This report examined issues surrounding physicians who do not secure entry into an accredited residency program by graduation. It addressed concerns related to competency to perform patient care as well as the growing physician shortage, both of which were raised by the resolution author. Based on the data and analysis in this report, changing professional standards to permit the small number of unmatched physicians without GME training to practice is a problematic and negligible response to physician workforce shortages and lack of access to care. Successful completion of a

residency is a key tenant of medical education and licensure and is highly supported by AMA policy. However, there may be more that key parties can do to support and prepare applicants to succeed is securing a GME position in their residency applications and The Match (or other match processes). Such parties should evaluate their roles and efforts.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted in lieu of Resolution 306-A-24, and the remainder of the report be filed:

1. Encourage relevant parties to examine the root causes for physicians who do not secure entry into an accredited residency program by graduation and evaluate each of their efforts to address them including informing medical students and their advisers how to obtain GME training opportunities. Such parties include but are not limited to medical schools, residency programs, Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, National Resident Matching Program , Intealth, and Accreditation Council for Graduate Medical Education . (New HOD Policy)

2. Encourage relevant parties to evaluate opportunities that have successfully matched previously unmatched physicians into residency positions, so students can be better counselled on opportunities that improve their chances of matching into a residency program. (New HOD Policy)

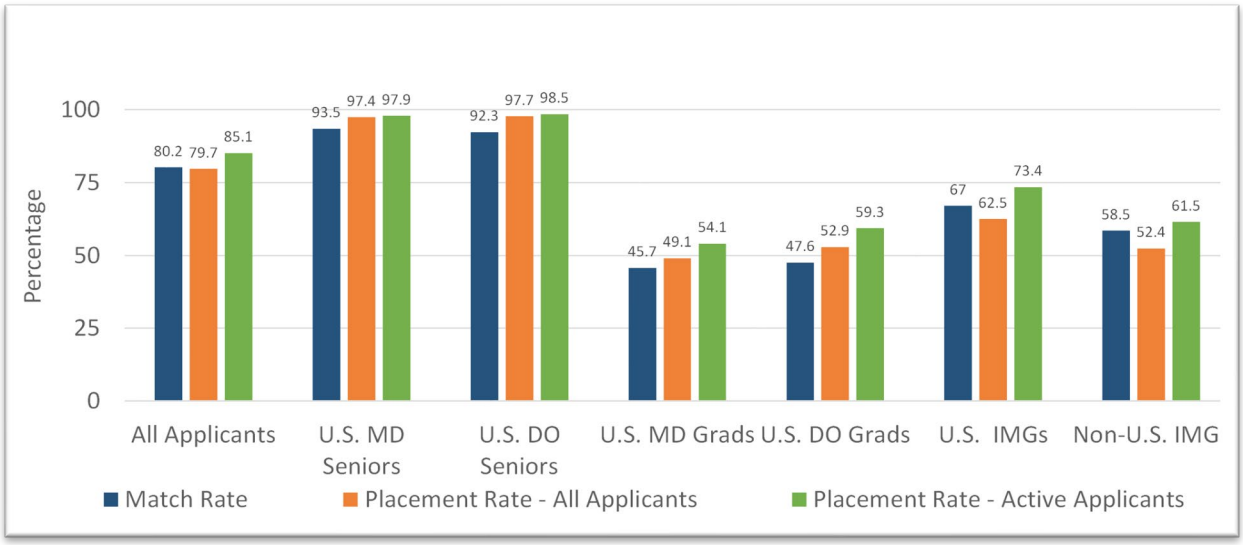
3. Reaffirm AMA policies D-310.977 "National Resident Matching Program Reform" and H-200.954 "U.S. Physician Shortage." (Reaffirm HOD Policy)

Fiscal note: $1,000

APPENDIX A:

PGY-1 Match and Placement Rates by Applicant Type, 2024

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National Resident Matching Program, Results and Data: 2024 Main Residency Match. Reprinted with permission from NRMP, 2025.

APPENDIX B: AMA ADVOCACY EFFORTS IN LAST TWO YEARS

- June 24, 2024: comments were submitted on the Senate Finance Committee's draft policy proposal and specific questions for consideration on policies related to the Medicare Graduate Medical Education (GME) program. If workforce barriers for physicians are reduced and additional investments in GME are made, it will help to increase the number of physicians in the U.S., which will lead to healthier communities and ultimately a healthier country as access to much-needed medical care increases.
- June 10, 2024: comments were submitted to the Centers for Medicare & Medicaid Services (CMS) on the Fiscal Year 2025 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System (LTCH PPS), supporting the expansion of resources and the removal of barriers to the training and retention of obstetric care physicians, especially in rural and underserved areas. We also recommended that CMS consider increasing support for programs that integrate comprehensive approaches to maternity care and highlight the importance of social determinants of health (SODH) in maternal and infant outcomes. The AMA also supported the allocation of Graduate Medical Education (GME) slots to strategically address the most pressing needs within the health care system, including the shortage of mental health professionals. We urged CMS to adopt a distribution framework that considers the specific needs of communities and the capacity of institutions to provide high quality education and training to residents.
- May 16, 2024: Statement for the Record was submitted to the U.S. Senate Committee on Finance as part of the hearing entitled, "Rural Health Care: Supporting Lives and Improving Communities." The statement covered a number of issues, including recommendations on ways to increase and retain the physician workforce, especially in rural communities.
- October 19, 2023: Statement for the Record was submitted to the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health as part of the hearing entitled "What's the Prognosis? Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors." This statement covers a number of issues including GME and workforce issues that the AMA would like addressed to strengthen the physician workforce.
- October 5, 2023: letter was sent by request from the House Committee on Ways and Means' for information (RFI) commenting on ways to improve health care in rural and underserved areas. A number of subject areas were covered including needed improvements for workforce issues and scope of practice considerations.
- March 20, 2023: comments were submitted to the Senate Committee on Health, Education, Labor and Pensions responding to their request for comment concerning health care workforce shortages. We discussed rural hospitals, physician burnout, prior authorization, loan repayment and scholarship programs, support for physician led teams, and physician payment.
- On July 29, 2022: information was provided regarding the Department of Health and Human Services' (HHS) Initiative To Strengthen Primary Health Care.
- May 22, 2023: letter was signed in support of the Resident Physician Shortage Reduction Act of 2023 (S. 1302). This bipartisan legislation is crucial to expanding the physician workforce and to ensuring that patients across the country are able to access quality care from physicians.
- On May 9, 2023: letter was sent in strong support of H.R. 2389, the "Resident Physician Shortage Reduction Act of 2023." This bipartisan legislation would gradually raise the number of Medicare-supported graduate medical education (GME) positions by 2,000 per

year for seven years, for a total of 14,000 new slots. A share of these positions would be targeted to hospitals with diverse needs including hospitals in rural areas, hospitals serving patients from health professional shortage areas (HPSAs), hospitals affiliated with historically Black medical schools, hospitals in states with new medical schools or branch campuses, and hospitals already training over their caps.

APPENDIX C: RELEVANT AMA POLICIES

National Resident Matching Program Reform D.310.977

1. Our American Medical Association will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies.
2. Our AMA will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match.
3. Our AMA will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match.
4. Our AMA will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match.
5. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians.
6. Our AMA does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process.
7. Our AMA will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements.
8. Our AMA will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants.
9. Our AMA encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas.
10. Our AMA will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including:
    a. Analysis of time-based implications of the ACGME milestones for residency programs.
    b. The impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies.
    c. The impact on financial aid for medical students with variable time lengths of medical education programs.
    d. The implications for interprofessional education and rewarding teamwork.
    e. The implications for residents and students who achieve milestones earlier or later than their peers.
11. Our AMA will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs.
12. Our AMA will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;

13. Our AMA will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program.
14. Our AMA will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions.
15. Our AMA encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match.
16. Our AMA supports the movement toward a unified and standardized residency application and match system for all non-military residencies.
17. Our AMA encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.
18. Our AMA encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency.
19. Our AMA will work with appropriate stakeholders to study options for improving transparency in the resident application process.
20. Our AMA encourages the piloting of innovations to the residency application process with aims to reduce application numbers per applicant, focus applicants on programs with reciprocal interest, and maximize residency placement. With support from the medical education community, successful pilots should be expanded to enhance the standardized process.
21. Our AMA will continue to engage the National Resident Matching Program® (NRMP®) and other matching organizations on behalf of residents and medical students to further develop ongoing relationships, improve communications, and seek additional opportunities to collaborate including the submission of suitable nominees for their governing bodies as appropriate.

US Physician Shortage H-200.954

1. Our American Medical Association explicitly recognizes the existing shortage of physicians in many specialties and areas of the US.
2. Our AMA supports efforts to quantify the geographic maldistribution and physician shortage in many specialties.
3. Our AMA supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US.
4. Our AMA encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations.
5. Our AMA encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations.
6. Our AMA encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations.

7. Our AMA will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas.
8. Our AMA will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification.
9. Our AMA will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need.
10. Our AMA continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
11. Our AMA continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
12. Our AMA will:
    a. promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians;
    b. work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and
    c. monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
13. Our AMA will work to augment the impact of initiatives to address rural physician workforce shortages.
14. Our AMA supports opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas.

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association recommends that:
    a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
    b. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
    c. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
    d. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
    e. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
    f. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.

g. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
h. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
i. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
j. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
k. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
l. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
3. Our AMA will:
   a. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and
   b. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
4. Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.
5. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs.

Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929

1. It is AMA policy that:

A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.

B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.

C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.

D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.

E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.

F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be

opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.
G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.
H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.
I. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.
3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.
4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publicly report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.
5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986

1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.
2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.

Financing of Medical Education Programs D-305.973

1. Our American Medical Association will work with the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes:
   a. Ensure adequate Medicaid and Medicare funding for graduate medical education.
   b. Ensure adequate Disproportionate Share Hospital funding.
   c. Make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions.
   d. Revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings.
   e. Stabilize funding for pediatric residency training in children's hospitals.
   f. Explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need.

g. Identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties.
h. Act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose.

2. Our AMA will work with other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions.

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.

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

1. Our American Medical Association will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).

7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA:
    a. recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed.
    b. will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda.
    c. will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative

pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.

19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will:

a. encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans.
b. strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation.
c. encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.
35. Our American Medical Association will ask federal agencies that fund graduate medical education (including but not limited to the Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the Department of Defense, the Health Resources and Services Administration, and others) to issue an annual report detailing the quantity of total GME funding for each year including how Direct GME funds are allocated on a per resident or fellow basis, for the previous year.

Residents and Fellows' Bill of Rights H-310.912

1. Our American Medical Association continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows:
   a. Adequate financial support for and guaranteed leave to attend professional meetings.
   b. Submission of training verification information to requesting agencies within 30 days of the request.
   c. Adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period.
   d. Health insurance benefits to include dental and vision services.
   e. Paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year.
   f. Stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA:
   a. will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds.

b. encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement).
c. encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:
   RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
   Residents and fellows have a right to
   A. An education that fosters professional development, takes priority over service, and leads to independent practice.
      With regard to education, residents and fellows should expect:
      1. A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations;
      2. Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities;
      3. Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value;
      4. 24-hour per day access to information resources to educate themselves further about appropriate patient care; and
      5. Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.
   B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.
      With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.
   C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
      With regard to evaluation and assessment processes, residents and fellows should expect:

1. Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work;
2. To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion;
3. Access to their training file and to be made aware of the contents of their file on an annual basis; and
4. Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.
With regard to the workplace, residents and fellows should have access to:
1. A safe workplace that enables them to fulfill their clinical duties and educational obligations;
2. Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit;
3. Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.
1. With regard to contracts, residents and fellows should receive:
   a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance.
   b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
2. With regard to compensation, residents and fellows should receive:
   a. Compensation for time at orientation.
   b. Compensation, including salary and benefits, commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
3. With regard to benefits, residents and fellows must be fully informed of and should receive:
   a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program.
   b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues.
   c. Confidential access to mental health and substance abuse services.
   d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks.
   e. Leave in compliance with the Family and Medical Leave Act.

f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience:
1. A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME.
2. At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations
With regard to reporting violations to the ACGME, residents and fellows should:
1. Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official.
2. Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process.
3. Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.
10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).
11. The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.
12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles, including resident/fellow empowerment and peer-selected representation in institutional leadership.
13. Our AMA encourages development of accreditation standards and institutional policies designed to facilitate and protect residents/fellows who seek to exercise their rights.
14. Our AMA encourages the formation of peer-led resident/fellow organizations that can advocate for trainees' interests, as outlined by the AMA's Residents and Fellows' Bill of Rights, at sponsoring institutions.

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REPORT 4 OF THE COUNCIL ON MEDICAL EDUCATION (A-25)
Access to Restricted Health Services When Completing Physician Certification Exams (Res. 307-A-24)
(Reference Committee C)

EXECUTIVE SUMMARY

AMA Policy D-275.944, Access to Reproductive Health Services When Completing Physician Certification Exams calls on our AMA to "study the impact of laws restricting reproductive healthcare and gender-affirming care on examinees and examiners of national specialty board exams and existing alternatives to in-person board examinations."

The title of this report was modified to "Access to Restricted Health Services When Completing Physician Certification Exams" to reflect the report's wider scope for potentially restricted health services.

This report reviews the history and context of national specialty board examinations, and examples of current format, location, and accommodation information for these exams. The report also reviews information available on legal restrictions on health care and any known impacts to patients or physicians at the time of the report's writing. It then estimates how many board examinees could specifically be impacted. This report may not reflect legal or social changes occurring after its initial drafting.

Finally, the report discusses the challenges and nuances involved in equity and assessing safety within rapidly changing sociopolitical environments, including differing assessments and perceptions of risk to personal safety. The report recommends amending existing AMA policy on access to reproductive health care during board certification exams with new AMA policy to support the physical and psychological safety of board examination candidates when taking certification examinations.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-A-25

Subject: Access to Restricted Health Services When Completing Physician Certification Exams (Res. 307-A-24)

Presented by: Krystal Tomei, MD, MPH, Chair

Referred to: Reference Committee C

Resolution 307-A-24, "Access to Reproductive Health Services When Completing Physician Certification Exams," was introduced by the California delegation at the 2024 Annual Meeting of the American Medical Association (AMA). Alternate language was proposed in Reference Committee C to reduce the risk of unintended consequences from implementation, while supporting the original resolution's intentions as an urgent issue regarding the potential for personal health and/or legal risk in states with laws restricting health services, particularly reproductive and gender-affirming care.

Alternate Resolution 307 was adopted by the House of Delegates, becoming AMA Policy D-275.944, Access to Reproductive Health Services When Completing Physician Certification Exams. The first resolve was already implemented, and states: "Our American Medical Association will encourage national specialty boards who hold in-person centralized mandatory exams for board certification to provide alternate options when those exams take place in states with laws banning or restricting abortion, gender-affirming care, or reproductive healthcare services such that travel to those states would present either a limitation in access to necessary medical care, or threat of civil or criminal penalty against the examinees and examiners."

The second resolve states that the AMA will "study the impact of laws restricting reproductive healthcare and gender-affirming care on examinees and examiners of national specialty board exams and existing alternatives to in-person board examinations." This report is that study. The title has been modified to "Access to Restricted Health Services When Completing Physician Certification Exams" to reflect the report's wider scope for potentially restricted health services.

BACKGROUND

National specialty board examinations are one mechanism by which specialty boards determine whether a physician has the knowledge and skills to practice safely and effectively in their area of specialization, both initially and on a continuing basis. As discussed in Council on Medical Education Report 4-I-23, "Recognizing Specialty Certifications for Physicians," the history of specialty board examinations is as follows:

"In 1933, the [AMA] established the American Board of Medical Specialties (ABMS) to bring order to the proliferation of specialty boards and address conflicts arising between specialty boards. Other entities later emerged as certification boards and have varying standards for obtaining initial board certification and maintaining continuing certification over time. AMA support of these entities is contingent with the certification program meeting accepted standards that include offering an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty."[1]

Historically, there has been discrimination against osteopathic board certification,[2] which is changing over time,[3] and some osteopathic boards, such as Obstetrics & Gynecology and Emergency Medicine, are open to MDs as well as DOs.[4] AMA policy Medical Specialty Board Certification Standards H-275.926 opposes discrimination against physicians based solely on lack of ABMS or equivalent American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certification. However, in the current health care system, board certification is "no longer as discretionary as it once was."[5]

Current Examination Locations

Each entity engaged in specialty board examination has different procedures for examination, and this varies between specialties. As a non-comprehensive example of differences—not representing the hundreds of possibilities for board certification—the following table compares a few different entities and specialty board examinations within these entities' standards, based on data publicly available in December 2024:

Umbrella Entity	**Specialty**	**Types of exams for board certification**	**Location of in-person exams**
American Board of Medical Specialties (ABMS)	American Board of Obstetrics & Gynecology (ABOG)	In-person certifying exam	Dallas, TX
American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS)	American Osteopathic Board of Obstetrics & Gynecology (AOBOG)	Written AOBOG exam (or ABOG qualifying exam) and in-person oral exam	Chicago, IL
American Board of Physician Specialties (ABPS)	Obstetrics & Gynecology	Initial certification not offered,[6] recertification requires ABOG or AOBOG initial certification	N/A
ABMS	American Board of Pediatrics (ABP)	In-person computer-based exam	Prometric testing centers (multiple locations)
AOA-BOS	American Osteopathic Board of Pediatrics (AOBP)	Written exam	N/A (remotely proctored)
ABMS	American Board of Emergency Medicine (ABEM)	Written qualifying exam and in-person certifying exam[7]	Written exam at Pearson-Vue testing centers; Raleigh, NC certifying exam in 2026[8]
AOA-BOS	American Osteopathic Board of Emergency Medicine (AOBEM)	Written and oral exam	N/A (remotely proctored)

Examiners and Examinees

When safety concerns arise, attention to concerns from both board examiners and examinees is important. However, differences exist between examinees and examiners. If they wish to be board certified, examinees must take mandatory examinations to achieve board certification for their career within a specific time frame. Examiners are also examinees (board certified, with varying requirements for continuing certification) but in the role of examiner are typically optional volunteers who choose to participate for a variety of reasons, such as leadership and professional development, deeper involvement in the specialty, and credit toward continuing certification. This report will focus primarily on initial board certification and examinees due to the disproportionate impact, though the needs of both groups are important, deserve attention, and often overlap.

Pre-Existing General Accommodations

For all specialty boards in the United States, reasonable accommodations must be provided in alignment with the Americans with Disabilities Act, a federal civil rights law prohibiting discrimination against people with disabilities in everyday activities.[9] A 2024 article on structural bias in board examinations points out, however, that "society often overlooks individuals who do not qualify for federally protected disability benefits but are nevertheless unable to overcome hurdles equitably."[10] In practice, accommodations—disability-related and otherwise—vary between specialties.[11] A non-comprehensive sample of current accommodation policies (as of December 2024) is below:

According to ABMS Standards for Initial Certification, "Test accommodations must be offered to candidates with documented disabilities (e.g., learning and reading disabilities; physical disabilities; visual impairments) to comply with the Americans with Disabilities Act; Member Boards may also offer accommodations in other situations (e.g., extra break time for nursing mothers). Applicants should be provided with information describing the documentation to be submitted with the request for accommodations and the timeframe within which an accommodation decision will be made. Procedures for responding to these requests should be equitable and consistent and should include a mechanism for handling candidate appeals of these decisions."[12]

According to AOA Testing Accommodation Policies & Procedures, "Reasonable and appropriate accommodations are provided in accordance with the Americans with Disabilities Act (ADA) for individuals with documented disabilities, as well as to those requiring accommodations for use/availability of specific personal items, nursing/breastfeeding and/or related to religious observation. All requests for accommodation must be submitted at least 90 days before the applicable examination."[13] Materials also note a procedure for late requests.

Pre-Existing Security Policies

Some boards offer additional information about security for test-takers, such as ABOG, which noted on their website in February 2025, for instance: "ABOG always has security measures in place both during examination weeks as well as during off-examination timeframes. While we do not want to publicize every security measure taken, below are some of the security features you can expect during the Certifying Examination:

- No ABOG site (hotel meeting room for registration, building where the examinations are held, exam floors, etc.) is designated to the public as ABOG spaces by signage.
- ABOG staff is trained in security/emergency protocols including but not limited to fire evacuation, CPR and first aid, and active shooter response.

- The elevators in the ABOG building are badge access only. Only ABOG staff members can move freely about the building.
- The stairwells in the ABOG building are locked and can only be accessed with a code which is changed frequently.
- Additional security personnel are on-site during exam weeks in a number of high-traffic locations.
- Security cameras are live throughout the ABOG building."[14]

Alternatives to In-Person Board Examinations

Each specialty board decides on the best format and location for its respective examinations. During the height of the COVID-19 pandemic, several ABMS member boards pivoted from postponing their oral exams to converting to a virtual format.[15] Later research in 2023 found that the American Board of Emergency Medicine (ABEM)'s virtual oral exam had "substantial validity evidence and reliability to support ongoing use… to make confident and defensible certification decisions,"[16] and good satisfaction with comparable passing rates for the virtual general surgery certifying exam through the American Board of Surgery.[17] Research on the American Board of Anesthesiology's virtual exam, however, demonstrated both pros and cons of the virtual format and prompted a return to an in-person exam due to standardization and security concerns, as well as imperfect technology.[18]

Decisions about relocation, meanwhile, also vary between specialties. Some specialty boards partner with nationwide companies that already offer multiple testing locations, depending on the exam type, while others contract with one specific physical location only. Rapidly changing laws and political climates also offer difficulties as state policies on important issues may shift more rapidly in the future than in-person contracts and logistical planning reasonably allows for.

ABMS offered the following information highlighting some of the considerations Member Board Executives are taking into account when looking at existing and alternative test sites:

- Not all assessments measure the same things: "When ABMS Member Boards were required to move from in-person exams to virtual during COVID, data collected demonstrated that not all content or constructs could be tested equally in a virtual environment as in-person."
- "High variability in the content and components of assessments across specialties. Each Member Board designs assessments critical to the skills, knowledge, and behaviors that are specific to each specialty and sub-specialty."
- "Inability to include low fidelity simulations in remote exams."
- "Consistency to ensure, within each Member Board, every candidate is tested in the same way."
- "Ensuring exam security."
- "Increased exam costs to create and support alternate in-person testing facilities that are equal to existing assessment sites in equipment, staffing, timing and security. Projections by some Member Boards who have explored these options would result in a 4-fold increase in costs for all candidates."
- "How specific laws could impact individuals traveling from out-of-state during participation in certifying exams."

"All Member Boards," ABMS stated, "are committed to providing testing environments that minimize the stress to candidates and are exploring options for alternative test sites with respect to the above."[19]

Restricted Health Care and Safety Concerns

As described later in this report, some states in the U.S. currently have laws restricting reproductive and/or gender-affirming health care. National specialty board examination testing location concerns, for the purposes of this report, center multiple arenas, including but not limited to potential risks (physical and legal) to:

- pregnant examiners and examinees
- examiners and examinees who provide reproductive care
- transgender or gender non-conforming examiners and examinees
- examiners and examinees who are primary caregivers of and travel with transgender or gender non-conforming children
- examiners and examinees who provide gender-affirming care

These concerns regarding potential risks are also diverse in terms of levels of legal authorization and overt versus covert threat, including but not limited to:

- states with proposed bills that have not been implemented into law, but wherein overall societal hostility and violence toward people seeking and/or providing reproductive and/or gender-affirming care may be heightened;
- states with implemented laws against reproductive and/or gender-affirming care, but with no known examples of criminal or civil penalties enacted;
- states with implemented laws against reproductive and/or gender-affirming care, with known examples of actual criminal or civil penalties;
- states with implemented laws against reproductive and/or gender-affirming care, with known examples of physical harm to patients due to inadequate care;
- states with officials in authority who seek notoriety from threatening or harming individuals engaged in providing and/or receiving reproductive and/or gender affirming care.

Proposed bills fluctuate quickly and will not be tracked in this report. However, several of the below sections describe current state laws at the time of this writing, as well as known examples of additional tangible actions that have been taken, with acknowledgment that a social climate of hatred and fear has significant negative impacts on people, whether or not overt legal actions occurred against them.[20] As one of the goals of specialty board examination, as stated by ABMS, is consistency within each Member Board, ensuring every candidate is tested in the same way, such health and safety considerations are also relevant to the disproportionate impact some test-takers may experience in states with restrictions on health care.

Legal Restrictions to Reproductive Health Care

According to the New York Times abortion ban tracker, sourced from the Center for Reproductive Rights, the Guttmacher Institute, and KFF (formerly known as the Kaiser Family Foundation), as of December 3, 2024, the 13 states with the most restrictive laws for reproductive health care are: Idaho, South Dakota, Oklahoma, Texas, Arkansas, Louisiana, Indiana, Kentucky, Tennessee, Mississippi, Alabama, West Virginia, and Missouri.[21] Though Missouri voted to enshrine abortion

rights in the constitution at the end of 2024, ongoing regulatory complexities mean this medical procedure remains unavailable in that state.[22] However, according to Guttmacher, 27 states are predominantly restrictive toward reproductive health care.[23] The remaining 23 states have some protections, either paired simultaneously with restrictions, or primarily protective. Within restrictive states, many also have laws deemed "targeted regulation of abortion providers (TRAP)" laws, imposing standards beyond what the medical profession has deemed necessary for patient safety in order to make providing reproductive care more difficult.[24] Private litigation against physicians and health care workers is currently possible under Texas' SB8.[25] Although some states have proposed prison sentences for physicians who perform abortions past gestational limits,[26] to date no physician has been criminally prosecuted for this reason.[27]

Though no specific board exam related examples are publicly known, potential risks to pregnant examinees or examiners in emergency situations in states with abortion bans may include life-threatening delays in and/or inadequate care.[28,29] In response to this concern, ABOG's website states: "ABOG has a partnership with UT Southwestern to provide medical care in unanticipated, urgent, or emergency situations for examination candidates, examiners, or staff. [University of Texas Southwestern] is in close proximity to the ABOG offices and offers high standards of obstetrical care in medical emergencies." In July 2024, the Texas Medical Board clarified that "imminence of death or impairment of a major bodily function is not required" for legal emergency reproductive care.[30] However, nationwide more generally, laws tend to create situations of "hesitant medicine" that negatively impact the patient-physician relationship and destabilize decision-making within health care,[31] and many broader anecdotes exist about the dangers.[32]

At least one Texas woman was also arrested and indicted on murder charges following a self-managed abortion in 2022, though charges were later dropped and current Texas law exempts patients seeking abortions from criminal charges.[33]

Potential legal risks to examinees or examiners who provide reproductive health care may not currently be problematic for out-of-state test takers within Texas. ABOG, in regards to the Texas location of their specialty board exam, notes: "Any candidate taking a Certifying Exam, whether it be virtual or physically in Texas, should not be at legal risk. SB8 only applies to abortions performed in Texas. More importantly, SB8 text specifically references and pertains to the performance or induction of an abortion: '… a physician may not knowingly perform or induce an abortion on a pregnant woman' beyond the point in time when a fetal heartbeat is detected. Additionally, civil liability for aiding and abetting applies only to abortions performed in Texas. This should mean that the action for which a plaintiff is filing a lawsuit must be proven to be tied to a specific abortion performed. Care of patients on a case list and ensuing discussion with examiners during the Certifying Exam are not subject to SB8."[34] The only current, known instance of a suit against a physician related to SB8 was dismissed after a ruling that a bystander not directly impacted by an abortion service provided cannot sue the abortion provider.[35] Dallas and several other cities chose in 2022 to deprioritize using city resources to investigate abortions,[36] and several elected city prosecutors vowed in 2023 not to prosecute individuals who seek or provide abortion care.[37]

Fears remain, however. Unrelated to board examinations, in December 2024, the Texas Attorney General sued a New York physician for allegedly providing telemedicine and mailing abortion pills to a patient who lived in Texas—however, enforcement, even in the event the plaintiff wins, is ambiguous due to New York's shield laws.[38] In Indiana, a physician was publicly targeted by the state's Attorney General and reprimanded and fined by the Indiana Medical Licensing Board after publicly recounting a case where an abortion was provided to a young patient who was a victim of rape.[39] While there is reason for physicians to be concerned about legal repercussions in many

states, no known successful prosecutions of physicians resulting in criminal or civil penalties have thus far taken place. AMA advocates for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion (Preserving Access to Reproductive Health Services D-5.999).

In November 2023, the Attorneys General of New York, Arizona, California, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, North Carolina, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and Wisconsin collectively began correspondence with ABOG regarding concerns around OB/GYN specialty exam required travel to Texas and has engaged with ABOG on the possibility of establishing testing exemptions related to restrictive laws under certain circumstances. At the time of this writing, this is under consideration by ABOG.[40]

Legal Restrictions to Gender-Affirming Care and Facilities

According to the American Civil Liberties Union (ACLU) "Mapping Attacks on LGBTQ Rights in U.S. State Legislatures in 2024," seven states have official, active laws restricting LGBTQ+ rights within health care specifically as of December 2024. These states are: Idaho, New Hampshire, Ohio, South Carolina, Tennessee, Utah, and Wyoming.[41] The Human Rights Campaign"Attacks on Gender Affirming Care by State" notes 26 states with law or policy banning gender affirming care when states with litigation proceedings challenging the bans are included.[42] Related to other health impacts, according to the Movement Advancement Project's "Equality Maps: Bans on Transgender People's Use of Public Bathrooms & Facilities According to Their Gender Identity,"[43] both Florida and Utah currently make it a criminal offense in certain circumstances for transgender people to use bathrooms or facilities consistent with their gender identity, and these two states, as well as North Dakota, Louisiana, Mississippi, Alabama, and Ohio ban transgender people from using bathrooms consistent with their gender identity in some or all government-owned buildings and locations, including some colleges. K-12 school bathroom bans are even more extensive, though outside the direct scope of this report regarding physicians and travel. Restrictions such as these can lead to significant physical health impacts,[44] and bathroom discrimination is associated with poorer mental health outcomes.[45]

No specific board exam related examples are publicly known regarding enforcement of the above policies. Several non-comprehensive general examples of enforcement thus far include the following: in 2022, Texas Attorney General office and governor encouraged the Texas Department of Family and Protective Services to consider gender-affirming care to constitute child abuse,[46] and some investigations have taken place for this reason,[47] prompting fear for parents or caregivers of transgender children. Physicians who provide transgender care have in some cases been threatened with violence.[48] There are no known arrests of physicians providing gender-affirming care, but Texas Attorney General Ken Paxton has, at the time of this writing, sued three Texas physicians for providing gender-affirming care to minors.[49]

DISCUSSION

Little data currently exists on the impact of these issues on board examiners and examinees directly, and state laws restricting reproductive and gender affirming care have been only recently enforced against patients and physicians. The most obvious impact is a threat to physical safety due to inappropriate or reduced access to care and facilities, which has been demonstrated more broadly in research discussed above, though no public anecdotes exist related to taking board exams. In terms of criminal or civil liability, many laws have not currently been officially enforced at all,

serving instead to perpetuate bias and fear without direct legal action. While there is genuine reason for physicians to be concerned about legal repercussions in many states, few actual successful prosecutions of physicians resulting in criminal or civil penalties have taken place.

In some cases, legal restrictions may be intended primarily to have an overall "chilling effect,"[50] which has unfortunately been "successful" to some degree. For instance, research has found that there is a lower OB/GYN supply in abortion-ban states, despite minimal tangible state-level changes in the 2 years post-*Dobbs*.[51] The difficult balance becomes balancing legitimate psychological and physical safety concerns with strategies to counter the chilling effect of a fear-driven political climate, particularly encouragement for providers of gender-affirming care and providers of reproductive care to continue delivering high-quality, legal patient care in defiance of disinformation and social pressure, when feasible and appropriate. This is a challenging balance, and policy around the concept tends to focus around high-risk public health crises and emphasizes institutional responsibility as well, such as AMA's Pandemic Ethics and the Duty of Care H-140.821, which includes statements such as: "The duty to treat is foundational to the profession of medicine but is not absolute. The health care work force is not an unlimited resource and must be preserved to ensure that care is available in the future. For their part, physicians have a responsibility to protect themselves, as well as a duty of solidarity to colleagues to share risks and burdens in a public health crisis. So too, health care institutions have responsibilities to support and protect health care professionals and to apportion the risks and benefits of providing care as equitably as possible."

Hypothetical risk during direct patient care is also different than hypothetical risk during certification exams, when educational environments should ideally remain as physically and psychologically safe as possible for appropriate learning.[52,53]

Numbers of Impacted Examiners or Examinees

The numbers of those who could be directly impacted by physical safety concerns (i.e., pregnant examiners and examinees, transgender examiners and examinees) are not readily available for a variety of reasons within most medical education demographic information. These reasons include privacy and discrimination concerns, particularly in a political climate when this information may be misused against individuals, as well as the tendency for gender-related data collection to focus on a male/female binary based on birth sex, despite the problematic nature of this framing.[54] Some respondents within binary male/female gender demographic questions are likely transgender but this disaggregation is not available.

ABMS board certification data does list those who chose not to report their gender, which may partially include but is not limited to non-binary or gender non-conforming people. As of June 2024 data, the number of ABMS active diplomates in the United States who did not report gender was 59,498 individuals, or about six percent of the 957,915 active U.S. diplomates, though this does not accurately reflect actual transgender information. Not specific to physicians, approximately 1.1 percent of the U.S. population openly identifies as transgender, with an additional 1.5 percent neither trans, cis male, nor cis female, for a total of 2.6 percent, according to a Jan-Apr census pulse 2024.[55] This nationwide data is likely underreported, although within medicine, transgender and gender non-conforming physicians are likely to be underrepresented compared to general proportions within the overall U.S. population.[56] In general, transgender medical students and physicians already experience significant barriers,[57] signaling a need for systemic and individual responses to improve gender equity within medical education.[58]

Approximations of pregnancy or potential for pregnancy are also highly problematic to calculate, especially because gender is not inherently tied to pregnancy and health information is unknown. Regarding pregnancy, in 2020, research focusing on "reproductive age women" approximated that 3.9% of this population subset was pregnant at any given time.[59] Compared loosely to ABMS diplomate data for "female" diplomates under age 45 (131,331 individuals), this may be approximately 5,121 people pregnant at any given time, though this data describes those who hold board certification status through ABMS, not those taking exams.

Within the field of OB/GYN specifically, according to 2024 National Resident Matching Program (NRMP) data,[60] applicants who obtained a position and ranked their preferred specialty as OB/GYN were approximately 90 percent "female" in 2024.[61] There were 1,533 matches into OB/GYN, 1,103 of which were MD seniors.[62] An additional six positions were filled with SOAP, for a total of 1,539 filled residency positions. Thus, approximately 1,385 individuals (who may be more likely to be capable of pregnancy) matched into residency in 2024 alone. Approximately 54 of these individuals may be pregnant at any given time based on above pregnancy likelihood calculations. These individuals may sit for board exams in the near future in one state with restrictive laws (Texas), if specialty certified by ABOG (not if certified by AOBOG). Note, however, that laws restricting reproductive care may also feel or be threatening to anyone capable of pregnancy, regardless of actual pregnancy status.

Anyone practicing gender-affirming care or reproductive care may also have legal or safety concerns, particularly when treating patients who travel from out of state or via telemedicine or simply for being a known practitioner in general, regardless of their own personal experiences. Regardless of identity, the majority of providers of adolescent gender-affirming care in one study, for instance, reported receiving harassment and targeted threats.[63] Fear and harassment have increased even for those not directly impacted,[64] and some research suggests worsened negative impacts in states with restrictive laws.[65]

Social Injustice, Safety, and Educational Equity

One limitation regarding navigating safety, risk, and equity during certification exams is the difficulty of navigating safety threats for examinees and examiners across the many domains where genuine safety concerns arise in the face of systemic oppression. This is true for rapidly shifting legal landscapes, where bills are introduced but may not be implemented into law or laws may be enacted, challenged in courts, modified, and so on. Threats are particularly difficult to react to when significant but generally extrajudicial. For example, police murder of unarmed Black Americans has significant spillover effects on the sense of safety and mental health of Black Americans in the U.S. in general.[66] Experiences of racism and oppression negatively impact cognitive function due to trauma[67] already setting up inequity within education and testing compared to those with more social privilege, i.e., anyone less likely to be targeted by oppression, who need not use as many resources preparing oneself for the possibility of experiencing life-ending systemic violence. Certain areas of the U.S. may also informally be more dangerous for visibly Black examinees and other learners of color, depending on a variety of factors, even without overtly discriminatory laws in place.

For gender and LGBTQ+ rights specifically, it is also difficult to tackle a much wider problem with individualized testing location changes alone, as it is a systemic problem that continues to proliferate. Transgender people, for instance, particularly transgender women of color, have long been subject to violence, discrimination, and arrest for existing,[68] and genuine safety concerns or health inequities (such as inappropriately gendered restroom facilities) may exist in any public

location in the U.S., even in locations without overtly hostile laws—though those locations are on the face of it the most apparently dangerous.

Exemptions and other strategies for examiner and examinee safety, therefore, may be best understood as broadly as feasible within a social justice lens through a variety of thoughtful strategies as requested by those most impacted by injustice, rather than solely focused on the direct enforcement of specific hostile laws or an individual burden of proof at any given time.

RELEVANT AMA POLICY

AMA has robust policy in support of both gender-affirming and reproductive care, and already encourages "national specialty boards who hold in-person centralized mandatory exams for board certification to provide alternate options when those exams take place in states with laws banning or restricting abortion, gender-affirming care, or reproductive healthcare services such that travel to those states would present either a limitation in access to necessary medical care, or threat of civil or criminal penalty against the examinees and examiners" (Access to Reproductive Health Services When Completing Physician Certification Exams, D-275.944). AMA continues to advocate for the physician-patient relationship, as well as the improvement of medical education in other ways. Additional examples are listed in Appendix A.

SUMMARY

Concerns related to potential risk, both physical and legal, for those who provide and/or receive evidence-based reproductive and/or gender-affirming health care are genuine and can be particularly challenging to alleviate when comprised of a rapidly shifting blend of formal legal restrictions, ambiguity in enforcement, fear-provoking social contexts, and informal, extrajudicial threat. The AMA, through its Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted, as well as several other avenues, remains committed to engaging with issues related to federal and state policies on reproductive and gender-affirming care that may impact both physicians and patients, including but not limited to national specialty board examiners and examinees. AMA policy also encourages national specialty boards who hold in-person centralized mandatory exams for board certification to provide alternate options when those exams take place in states with laws banning or restricting abortion, gender-affirming care, or reproductive health care services. Although research is not yet available on the specific impacts of reproductive and gender-affirming care restrictions on board examiners and examinees, the Council on Medical Education supports the work of AMA's task force and continues to closely monitor these rapidly evolving issues.

RECOMMENDATION

The Council on Medical Education recommends that the following be adopted, and the remainder of the report be filed:

1. That our AMA amend D-275.944 "Access to Reproductive Health Services When Completing Physician Certification Exams," by deletion and addition as follows:

   "2. ~~Our AMA will study the impact of laws restricting reproductive healthcare and gender-affirming care on examinees and examiners of national specialty board exams and existing alternatives to in-person board examinations.~~

Our AMA supports the physical and psychological safety of board examination candidates when taking certification examinations."

Fiscal note: $1,000

APPENDIX A: RELEVANT AMA POLICY

Access to Reproductive Health Services When Completing Physician Certification Exams D-275.944

1. Our American Medical Association will encourage national specialty boards who hold in-person centralized mandatory exams for board certification to provide alternate options when those exams take place in states with laws banning or restricting abortion, gender-affirming care, or reproductive healthcare services such that travel to those states would present either a limitation in access to necessary medical care, or threat of civil or criminal penalty against the examinees and examiners.
2. Our AMA will study the impact of laws restricting reproductive healthcare and gender-affirming care on examinees and examiners of national specialty board exams and existing alternatives to in-person board examinations.

Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted G-605.009

1. Our American Medical Association will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
    a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities.
    b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines.
    c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities.
    d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements.
    e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance.
    f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need.

g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.
h. Work with interested parties to encourage the development of institution-level guidance and protection for physicians practicing in states with restrictions potentially interfering with the patient-physician relationship.

3. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care.

Medical Specialty Board Certification Standards H-275.926

1. Our American Medical Association opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Our AMA opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
3. Our AMA continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet accepted standards for certification that include both
    a. a process for defining specialty-specific standards for knowledge and skills and
    b. offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.
4. Our AMA opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
5. Our AMA advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
6. Our AMA encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
7. Our AMA encourages continued advocacy to federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other interested parties to define physician board certification as the medical profession establishing specialty-specific

standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification.

Accommodating Lactating Individuals Taking Medical Examinations H-295.861

1. Our American Medical Association urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give breastfeeding individuals additional break time and a suitable environment during examinations to express milk.
2. Our AMA encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump.

Clarification of Evidence-Based Gender-Affirming Care H-185.927

1. Our American Medical Association recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice.
2. Our AMA will work with state and specialty societies and other interested stakeholders to:
    a. advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence;
    b. oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care;
    c. support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, genderaffirming care and patients who seek and/or receive such care, as well as their parents and guardians; and
    d. communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence.
3. Our AMA will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers.

Principles for Advancing Gender Equity in Medicine H-65.961

Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;

8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

Effects of Work on Pregnancy H-420.960

1. Our American Medical Association supports the right of employees to work in safe workplaces that do not endanger their reproductive health or that of their unborn children.
2. Our AMA supports workplace policies that minimize the risk of excessive exposure to toxins with known reproductive hazards irrespective of gender or age.
3. Our AMA encourages physicians to consider the potential benefits and risks of occupational activities and exposures on an individual basis and work with patients and employers to define a healthy working environment for pregnant people.
4. Our AMA encourages employers to accommodate increased physical requirements of pregnant people; recommended accommodations include varied work positions, adequate rest and meal breaks, access to regular hydration, and minimizing heavy lifting.
5. Our AMA acknowledges that future research done by interdisciplinary study groups composed of obstetricians/gynecologists, occupational medicine specialists, pediatricians, and representatives from industry can best identify adverse reproductive exposures and appropriate accommodations.

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

1. Our American Medical Association supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality.
2. Our AMA commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes.
3. Our AMA encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties.
4. Our AMA encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine.
5. Our AMA encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal.

6. Our AMA continues to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

Encouraging LGBTQ+ Representation in Medicine D-200.972

1. Our American Medical Association will advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident, and provider diversity.
2. Our AMA encourages the inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables, including but not limited to governmental, AMA, and the Association of American Medical Colleges surveys, given respondent confidentiality and response security can be ensured.
3. Our AMA will work with the Association of American Medical Colleges to disaggregate data of LGBTQ+ individuals in medicine to better understand the representation of the unique experiences within the LGBTQ+ communities and their overlap with other identities.

Access to Basic Human Services for Transgender Individuals H-65.964

Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one's gender identity.

Support for Access to Preventive and Reproductive Health Services H-425.969

Our American Medical Association supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

Support for Access to Preventive and Reproductive Health Services H-425.969

Our American Medical Association supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-A-25

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

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

This resolution originally stated the following:

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

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

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

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

Testimony also discussed AMA's own history of discrimination, with only recent efforts to rectify this, and suggested a restorative justice informed approach to address past and current harms. In addition, testimony noted that AΩA recently secured new leadership six months prior and requested time for that leader to demonstrate AΩA's commitment to diversity, equity, and belonging. Reference Committee C recommended that D-310.945 be reaffirmed in lieu of Resolution 309 and noted that calling for disaffiliation from AΩA could induce reputational risk to the AMA when amicable relationships are needed to encourage and assist such groups to

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collaborate with us to build a diverse physician workforce. In the full House of Delegates meeting, the complexities of Resolution 309 were emphasized, and the resolution was referred for study.

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

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

BACKGROUND

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

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

Updated Information Since 2022

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

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

One institution's November 2023 study described holistic review of applicants within one neurosurgery program with the intention of reducing bias and shifting the focus away from traditional metrics such as USMLE scores and AΩA status, which no longer predict rank lists in this program.[2] Actual diversity impacts, if any, were not directly studied due to a lack of retrospective data. Another study published in November 2023 explored natural language

processing in an effort to reduce bias in medical student clerkship assessments, researching the use of a statement provided to clinical performance assessors that included the following language: "As medical educators, we value diversity and inclusion and strive to treat our students fairly and equitably. Data show that, despite our intentions, bias continues to impact student assessment. This leads to persistent inequities in grades, residency attainment, and Alpha Omega Alpha Honors Society achievement."[3] Results on the impact on narrative language use at two institutions were inconsistent, which the authors suggested may be related to the optionality of the module.

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

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

DISCUSSION

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

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

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

targeting specific organizations whose impacts are unknown as in the case of SSP and whose practices may shift over time after a recent commitment to change as in the case of AΩA.

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

RELEVANT AMA POLICY

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

SUMMARY

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

RECOMMENDATION

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

Fiscal note: $1,000

APPENDIX A: RELEVANT AMA POLICY

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

1. Our American Medical Association will encourage medical schools, medical honor societies, and residency/fellowship programs to work toward ethical, equitable, and transparent recruiting processes, which are made available to all applicants.

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

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

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

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

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

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

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

Competency-Based Portfolio Assessment of Medical Students D-295.318

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

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

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

Continued Support for Diversity in Medical Education D-295.963

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

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

1. Our American Medical Association supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality.
2. Our AMA commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes.
3. Our AMA encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties.
4. Our AMA encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine.
5. Our AMA encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal.
6. Our AMA continues to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-A-25

Subject:	Reporting of Total Attempts of USMLE Step 1 and COMLEX-USA Level 1 Examinations (Res 315-A-24)
Presented by:	Krystal Tomei, MD, MPH, Chair
Referred to:	Reference Committee C

INTRODUCTION

At the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 315 entitled "Cease Reporting of Total Attempts of USMLE Step 1 and COMLEX-USA Level 1 Examinations," was referred. The resolution asked our AMA to "advocate that NBME and NBOME cease reporting the total number of attempts of the Step 1 and COMLEX-USA Level 1 examinations to residency and fellowship programs and licensure."

Resolution 315 received mixed testimony as well as commentary from the National Board of Osteopathic Medical Examiners (NBOME). Testimony against reporting addressed personal stories related to failing the United States Medical Licensing Examination (USMLE®) Step 1, stressing perceived possible impact on career advancement. On the other hand, testimony in favor of reporting addressed the value of transparency to inform holistic review, enhance precision education, and determine residency program resource needs to support learners in their programs. Also, concerns were raised regarding public safety perceptions and scope of practice when advocating for increased numbers of exam attempts. Further, testimony noted current state laws requiring the reporting of exam attempts for licensure. Given the concerns, the reference committee recommended that Resolution 315 not be adopted; however, the HOD moved to refer the item for study. This report was written in response to that directive.

It should be noted that while the Resolved statement in Resolution 315 addressed both allopathic (USMLE) and osteopathic (COMLEX-USA) medical school exams, the Whereas statements only addressed Step 1.

BACKGROUND

USMLE® Step 1

The USMLE is a joint program of the Federation of State Medical Boards (FSMB) and National Board of Medical Examiners (NBME) and pertains to students enrolled in MD schools. It is comprised of three exams — Step 1, Step 2 Clinical Knowledge (CK), and Step 3. Step 1 is usually taken at the end of the second year of medical school. It assesses whether the examinee "understands and can apply important concepts of the sciences basic to the practice of medicine, with special emphasis on principles and mechanisms underlying health, disease, and modes of therapy. It ensures mastery of not only the sciences that provide a foundation for the safe and competent practice of medicine in the present, but also the scientific principles required for maintenance of competence through lifelong learning."[1] The exam is administered by Prometric at

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its various locations. Beginning in 2022, the results of Step 1 are reported as pass/fail only. Examinees receive a Step 1 Score Report. It does not provide performance feedback; however, examinees who fail will receive information to help assess how close they scored in relation to the passing standard. This report is provided to the examinee; in some circumstances, medical schools may receive scores and pass/fail outcomes for their students. The total number of attempts allowed per Step exam is four.[2]

If an examinee needs to reschedule their exam due to an unforeseen circumstance, they do so through the Prometric website which states, "The fee to reschedule an exam varies by testing organization, as does the amount of time you have to do so without penalty. Please check the procedures specific to the organization whose exam you are taking for rescheduling timeliness and penalties."[3]

It is policy of the USMLE program that a student's complete examination history of all Steps and its components be reported on the USMLE transcript. This includes all passes, failures, and incomplete attempts for each Step and its components.[4] Communication with NBME staff indicated that no exceptions are made to this policy.

USMLE Step 1 examinee performance data since the implementation of pass/fail scoring is provided in the table below:[5]

US/Canadian Schools	**2022 Number Tested**	**2022 Percent Passing**	**2023* Number Tested**	**2023* Percent Passing**
MD Degree	24,317	91%	25,146	90%
1st Takers	22,828	93%	23,100	92%
Repeaters**	1,489	71%	2,046	70%
DO Degree	4,722	89%	4,913	86%
1st Takers	4,659	89%	4,798	87%
Repeaters**	63	67%	115	60%
Total	29,039	91%	30,059	90%
Non-US/Canadian Schools	**2022 Number Tested**	**2022 Percent Passing**	**2023* Number Tested**	**2023* Percent Passing**
1st Takers	22,030	74%	22,611	72%
Repeaters**	2,926	45%	3,530	47%
Total	24,956	71%	26,141	68%

Table reprinted with permission from NBME, 2025.
* Represents data for examinees tested in 2023 and reported through March 13, 2024.
** "Repeaters" represents examinations given, not number of examinees.

COMLEX-USA® Level 1

The Comprehensive Osteopathic Medical Licensure Exam (COMLEX-USA®) is offered by the National Board of Osteopathic Medical Examiners (NBOME) and pertains to students enrolled in DO schools. It is also comprised of three exams — Level 1, Level 2 Cognitive Evaluation (CE), and Level 3. Level 1 is taken after the end of the second year of medical school prior to the clerkship training. The exam assesses "competency in the areas of knowledge related to practicing medicine. It tests the medical knowledge and clinical skills that are considered essential for an osteopathic physician to practice medicine without supervision."[6] Starting in May 2023, the exam is offered by Pearson VUE. Level 1 is reported as pass/fail. In addition, examinees receive a "formative performance profile that compares both total examination performance and performance

in individual content areas to the performance of other first-time test-takers who passed the examination."[7] It is only provided to the examinee and their school; the NBOME cautions against using the profile for any other purpose and discourages residency programs from requesting it. Like USMLE, the switch to pass/fail was instituted in 2022, and examinees are allowed a total of four attempts per Level exam.

If an examinee needs to reschedule their exam due to an unforeseen circumstance, it is done through their NBOME account. The NBOME website states the examinee has "up to 24 hours before your scheduled exam date to reschedule or cancel your appointment. You may reschedule or cancel your appointment more than 30 days before your scheduled date at no charge. Failure to reschedule or cancel within 24 hours and failure to appear at the testing center will cause your exam to be deemed a 'No Show,' and a fee will be assessed."[8]

The certified COMLEX-USA transcript contains scores and/or pass/fail status for all COMLEX-USA examinations taken and score interpretation annotations/notes and is sent directly to either participating state medical boards or the Federation Credentials Verification Service (FCVS).[9]

COMLEX-USA Level 1 examinee performance data since the implementation of pass/fail scoring is provided in the table below:[10]

Years	First Time Takers	First Time Pass Rate	Repeat Test Takers	Repeat Pass Rate
2023-2024	9,222	93.0%	822	80.8%
2022-2023	8,798	90.6%	861	75.6%

Table reprinted with permission from NBOME, 2025. Data accessed 12/06/24. NBOME website indicates data is updated automatically every 5 minutes.

DISCUSSION

Author's concerns

The resolution raised concerns about Step 1 overall as well as concerns related specifically to the pass/fail scoring system. In general, the author conveyed that Step 1 is an inadequate indicator of future professional competence as a physician. Also, they noted issues regarding stress (i.e., burnout, social isolation, suicidal ideation, substance use) and inequities (i.e., performance disparities related to gender and age).

In addition to the concern about reporting of total number of attempts, on which the Resolved statement is based, the author also noted other concerns about pass/fail. The author cited declining pass rates since the introduction of the new scoring system. The author surmised that examinees experience heightened pressure to pass on the first attempt, and that pass/fail scoring has placed an increased emphasis on Step 2 exam results and extracurricular activities.

Other concerns and considerations

Process assistance: The process of preparing for and taking (and rescheduling/retaking) the Step 1 or Level 1 exam can be daunting. While NBME, NBOME, Prometric, and Pearson VUE all offer a bounty of information on their websites, some students may benefit from more direct assistance. MD and DO schools may consider if they can better advise and assist student examinees with arranging their Step 1 or Level 1 exam.

Financial assistance: Registering for the exam (and rescheduling, if necessary) can be costly for students. In August 2024, USMLE announced the "NBME is introducing a new fee assistance program for students with demonstrated financial need who meet the required criteria to use towards the registration cost of the USMLE Step exams. This program will provide aid to approximately 1,300 medical students to cover their fees for USMLE Step 1 or Step 2 Clinical Knowledge (CK) examinations."[11] NBOME states, "If for some reason beyond your control you are unable to get to your COMLEX-USA examination or complete it, you may qualify to have all or part of your rescheduling or cancellation fees waived that would otherwise be incurred. Additionally, we may be able to assist you with other fees you have incurred. For example, you may qualify for assistance if your flight is cancelled on your way to take your COMLEX-USA examination, your examination is cancelled though force majeure, you had a family emergency, or (knock on wood) you are ill on the day of your scheduled administration."[12] While the cost burdens on the examinees is clear, there is also a financial cost incurred to the testing center for arranging exam administration and security when an examinee cancels without sufficient notice, which may raise the overall cost of the exam.

Test accommodations: Both NBME and NBOME state on their websites that they provide reasonable and appropriate accommodations in accordance with the Americans with Disabilities Act for examinees who provide the required documentation.[13,14] Thus, it is incumbent on the examinee to read and adhere to the processes and related deadlines. However, further assistance and flexibility may be needed, whether from the organizations themselves or the medical schools, to aid such students and ensure their comprehension and timeliness.

Test offerings: While NBME, NBOME, Prometric, and Pearson VUE all indicate some levels of flexibility in the availability and scheduling of exams, there may be sensitivities around the school curriculum and cycles that can be further considered in order to provide the most optimal scheduling for students. There are anecdotes that students are delaying taking Step 1 or Level 1. Medical schools should advise students and provide them opportunities to take the exam at the most appropriate stage of their medical school curriculum for passing.

Reporting of total attempts

While the Resolved statement of Resolution 315 is focused on ceasing reporting of total number of exam attempts, it is important to fully explore this issue. For the residency application process, students may be reticent to disclose why they rescheduled or retook an exam for fear of judgment and exclusion. These concerns need to be addressed by relevant parties (medical schools and residency programs) to communicate to students that disclosure allows faculty the opportunity to provide support and assistance to improve their success on the numerous future exams students will encounter in their medical education.

As discussed in the reference committee hearing, disclosure of the total number of exam attempts may be an important data point for residency program directors. In the spirit of holistic assessment, knowing if and why a student took Step 1or Level 1 more than once can help to determine the support the applicant needs as a resident. The path to licensure and board certification involves several examinations, and if the applicant has difficulty with passing such exams, faculty need to be aware so problems can be quickly identified and mitigated. Conversely, denying applicant performance information to program directors only masks problems that may lead to failure to complete residency.

The primary purpose of the USMLE is for licensure by state medical boards. State medical licensing boards have their own criteria for the number of attempts per Step or Level exam, which

may be in state law. This information is provided by the FSMB and can be found at https://www.fsmb.org/step-3/state-licensure/. Applicants should consider in advance which state(s) they wish to practice in and review this information in preparation for their exams.

Another consideration is public transparency. When it comes to government agencies, including state licensing boards, the public demands transparency including disclosure about licensing decisions. While it is unlikely that individual patients may ask if a physician ever failed a Step or Level exam, advocates and journalists often demand that performance information on license holders should be available to foster public accountability.

The significance of Step 1 passage as it relates to Match rates has been studied. The National Resident Matching Program® (NRMP®) provides data on such correlations. They also offer information from program director surveys; 2024 results indicate that "program director key considerations for interviewing included USMLE Step 1 pass."[15] Additional information is provided on their website. While past studies have indicated that a high Step 1 score is a significant predictor of passing a specialty board exam,[16] it may be too soon to show correlation between today's pass/fail scoring and board passage.

RELEVANT AMA POLICIES

AMA policy H-275.953(2)(c) "The Grading Policy for Medical Licensure Examinations" states that "Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students." Given that it supports the reporting of each attempt, it thereby implies support in knowing the total number of attempts. Therefore, Resolution 315's desire to cease total reporting may conflict with current policy. However, this policy does support holistic review of applicants; such review may include an understanding of not only the total number of attempts but why. H-275.953(1) states that "selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection." It supports that for holistic review to be truly beneficial to students and programs, program directors should want to understand why a student failed or needed to reschedule licensing exams.

Further, policy D-200.985(9) "Strategies for Enhancing Diversity in the Physician Workforce," asserts that "Our AMA will recommend that medical school admissions committees and residency/ fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities." It infers the notion that holistic review works better with more data. Such holistic assessment also aligns with the AMA's efforts related to precision education and competency-based medical education, both addressed in its ChangeMedEd initiative.

Additional policies of relevance are located in the AMA Policy Finder and include:

- Clinical Skills Assessment During Medical School D-295.988
- Discouraging the Use of Licensing Exams for Internal Promotion in Medical Schools H-275.958
- Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934

SUMMARY

Resolution 315-A-24 raised important considerations related to the implications of total reporting of exam attempts, whether it be USMLE® Step 1 or COMLEX-USA® Level 1. As discussed, the culture shift toward holistic assessment in residency applications should ease some concerns. Regarding licensure, such disclosure is state-mandated in most cases and would need to be considered further by such relevant parties to determine its pertinence. Medical schools and residency programs can consider how they may play a stronger role in assisting examinees and applicants.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted in lieu of Resolution 315-A-24, and the remainder of the report be filed:

1. Encourage the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME) to continue evaluating barriers for students related to testing centers (e.g., rescheduling, cost, etc.). (New HOD Policy)

2. Encourage medical schools to assist examinees in scheduling of USMLE® and COMLEX-USA® exams and consider opportunities for flexibility. (New HOD Policy)

3. Encourage communication and transparency between residency programs and applicants involving the rescheduling or retaking of the USMLE® Step 1 and COMLEX-USA® Level 1 exam. (New HOD Policy)

4. Reaffirm policies H-275.953 "The Grading Policy for Medical Licensure Examinations" and D-200.985 "Strategies for Enhancing Diversity in the Physician Workforce." (Reaffirm HOD Policy)

Fiscal note: $1,000

APPENDIX: RELEVANT AMA POLICIES

The Grading Policy for Medical Licensure Examinations H-275.953

1. Our American Medical Association's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring:
   a. Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.)
   b. Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of their numerical scores.
   c. Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.
3. Our AMA will:
   a. promote equal acceptance of the USMLE and COMLEX at all United States residency programs.
   b. work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores.
   c. work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.
4. Our AMA will work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination of the United States Level 1 scores and students who received Pass/Fail scores.

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our American Medical Association, 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.
   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 and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
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 unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order 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.

Clinical Skills Assessment During Medical School D-295.988

1. Our American Medical Association will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.
2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.
3. Our AMA will work to:
    a. ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners.
    b. encourage a significant and expeditious increase in the number of available testing sites.
    c. allow international students and graduates to take the same examination at any available testing site.
    d. engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization.

   e. include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.
4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.
5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.
6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would:
   a. Identify areas of satisfactory or better performance.
   b. Identify areas of suboptimal performance.
   c. Give students who fail the exam insight into the areas of unsatisfactory performance on the examination.
7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.

Discouraging the Use of Licensing Exams for Internal Promotion in Medical Schools H-275.958
It is the policy of the AMA to encourage the discontinuation of the use of the USMLE Step 1 Exam as a requirement for the promotion of medical students to the clinical phase.

Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934
Our American Medical Association adopts the following principles:
1. Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training.
2. All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all state-required licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement for completing one year of accredited GME in the U.S.: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.
3. There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA.
4. Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians.
5. Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements.

6. There should be no reporting of actions against medical students to state medical licensing boards.
7. Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems. as well as gaps in student knowledge and skills.
8. The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 7-A-25

Subject:	Designation of Descendants of Enslaved Africans in America (Resolution 218-A-24)
Presented by:	Krystal Tomei, MD, MPH, Chair
Referred to:	Reference Committee C

Resolution 218-A-24, "Designation of Descendants of Enslaved Africans in America," was introduced by the Michigan delegation at the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates and was referred. The original resolution stated:

RESOLVED, that our American Medical Association work with appropriate organizations including, but not limited to, the Association of American Medical Colleges to adopt and define the term Descendants of Enslaved Africans in America and separate it from the generic terms African American and Black in glossaries and on medical school applications. (Directive to Take Action)

Reference Committee B heard mixed testimony on Resolution 218, indicating that it is important to disaggregate data to make sure everyone is recognized and that the data influencing policies, programs, and solutions are accurate. However, testimony also highlighted that over the last four years, our AMA has been working with the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education through the Physician Data Initiative (PDI) to establish best practices for data sharing and standards for sociodemographic data, including race, ethnicity, and more. Reference Committee B also heard that the Office of Management and Budget recently concluded an extensive national consultation process concerning updating race and ethnicity standards, which our AMA provided comments on. The process found that further research is needed to fully understand the implications of a designation for "Descendants of Enslaved Africans in America," because individuals and civil rights groups disagreed on whether or how to implement this potential revision. Due to the need for more time to understand the resolution's nuances and implications and to collaborate with partners through the PDI, Resolution 218 was referred for study by the House of Delegates.

BACKGROUND

The AMA recognizes racism as a public health threat.[1] Medical education must strive to alleviate systemic and institutional racism, including but not limited to, anti-Black racism, which has been perpetuated by the AMA itself.[2] For this reason, it is also important for the AMA to act based on priorities established by affected communities and civil rights organizations, particularly when questions of individual and group identity are raised. This is a better approach than the AMA determining itself how subsections of underrepresented groups define and understand themselves. This report reviews some of the basic history and current conversations surrounding the disaggregation of "Descendants of Enslaved Africans in America" and related terms, both outside of and within medical education, with the observation that Black and/or African American viewpoints on these considerations are not monolithic.

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The Context for Defining "Descendants of Enslaved Africans in America"

Defining and disaggregating subsections of Black and African American people according to whether they had enslaved African ancestors or not is a challenge, particularly when narrowly defined within the continental U.S. The authors of this resolution stated that "Descendants of Enslaved Africans in America are the only people in U.S. history to be classified as nonhuman and property" and "the only people for whom it was illegal to attend school or learn how to read or write in the United States." There have been discussions of reparations for systemic harms to Black Americans. According to the University of California, San Francisco's "Medical Reparations: A Resolution Paper,"[3] there are multiple viewpoints for the appropriate recipients of reparations:

> "Some have argued that reparations in the form of compensation should be exclusively paid to those whose families were wronged by slavery because slavery was the original wrong, inflicting the original harm. Thus those who are descendants of slaves have been living in a position of deficit that needs to be addressed and rectified."
>
> "Others have argued that the legacies of slavery in the US have impacted all Black Americans, thus reparations should be focused on eliminating anti-Black Racism and providing compensation to all Black Americans (including those whose families were never slaves). In other words, reparations should not only compensate descendants of slaves but also funding efforts to root out and eradicate ongoing forms of institutional racism, namely the lack of people of color at every level of the socio-economic hierarchy."

Differing Viewpoints on Definitions and Categorization

When emphasis is on defining and disaggregating descendants of enslaved Africans in America (and other related terms) into a separate category from Black and African American demographic questions, stances on this are varied. For example, NAACP's work on reparations describes them as for "every descendant of an enslaved African American and [every] Black person [who is] a descendant of those living in the United States including during American slavery until the Jim Crow era," and acknowledges evidence of systemic racism still present today.[4] The National African American Reparations Commission (NAARC) focuses on "people of African descent" and "the benefit of Black America as a whole."[5] The National Coalition of Blacks for Reparations in America (N'COBRA) is "a mass-based coalition organized for the sole purpose of obtaining reparations for African descendants in the United States," and in terms of definitions, states: "Within the broadest definition, all Black people of African descent in the United States should receive reparations in the form of changes in or elimination of laws and practices that allow them to be treated differently and less well than White people."[6]

While none of these organizations focus on distinct racial identity for descendants of enslaved Africans, other groups do. A well-known variation on this phrasing is "American Descendants of Slavery" (ADOS), which, according to those who claim the term, emerged in 2016 for the purpose of "categorizing Black Americans with generational roots in the United States as American descendants of slavery (ADOS), distinct from African or Caribbean immigrants."[7] The ADOS Foundation "[insists] upon a specific group designation" for "descendants of chattel slavery in the United States of America." Even those who may under certain conditions be considered to "qualify" as ADOS may struggle with the wording or believe that it does not reflect the depth of their own experience.[8] On the other hand, some find value and meaning in the term and suggest genealogical lineage as a possible alternative to the current nationwide ban on race-based admissions in higher education.[9]

The discussion of descendants of enslaved Africans existed well before 2016.[10] People have many reasons for using the term ADOS or variations of this acronym to refer to Black and African American people experiencing the violent, harmful legacy of slavery via direct experiences of their known ancestors in the U.S. Though not reflective of every individual who identifies with ADOS, some have raised concerns about the primary organization associated with the ADOS-specific acronym, the ADOS Advocacy Foundation. For example, a *New York Times* article raised concerns about the movement's anti-migrant rhetoric within some ADOS discussions, public use of and defense of a Nazi slogan, and alleged affiliations with white supremacist groups, as well as reported fears by Black scholars of messaging co-optation by white supremacists, even when individual ADOS supporters are well-intentioned.[11] The ADOS Advocacy Foundation's website itself states: "Although our justice claim for reparations is sacred to ADOS, we are fiercely committed to advocating for policies that eliminate the divides faced by black citizens with immigrant backgrounds. We recognize the lived experience of racism and discrimination among all black people in America, and we invite all people from all backgrounds to join this cause."[12]

Groups like the Institute of the Black World 21st Century (IBW21) recognize the impacts of slavery and support reparations but reject the use of ADOS in the context of the 2016 movement, expressing the opinion that use of the term in this context could "further marginalize and oppress Black communities."[13] Given the variation of views on the purpose of self-identification of Black descendants of slavery within the Black community, it is problematic for organizations outside the community to impose their own definitions of identity.

Concerns with Medical Education Definition and Enactment of Lineage-Specific Terms

Systemic oppression and anti-Black racism continue in the U.S. to this day in a variety of forms,[14] and many forms of this violence do not inherently depend upon an awareness of a Black person's specific ancestry.[15] The history of anti-Black racism in the U.S., including within medical education, is complex and systemic, and there are challenges inherent in institutionally establishing categories based on descendancy. As one scholar points out, "for good or for ill, the social and political history of this country has defined the Black race using the rule of hypodescent."[16] This is also known as the one-drop rule, which asserts that even one drop of blood from a Black ancestor makes one Black. This establishes wide-ranging, pervasive anti-Black racism in opposition to supposed white "racial purity." Hickman warns against viewing "racial injustice in the drawing of the boundaries around the Black race rather than in racism itself,"[17] while also acknowledging a diversity of experiences within those racialized as Black within the U.S.

There are problems inherent in the AMA delineating and defining a specific category for Black identity. The AMA as an organization has only recently begun to address its own history of racism, and only 4.3 percent of AMA member physicians and medical students[18] identify as "non-Hispanic Black" compared to 13.6 percent "non-Hispanic" Black people in the U.S.[19] Implementation issues would also arise with doing so. Some people who "qualify" for whatever definition is chosen may choose the label, but the label may not be claimed by all those who "qualify" to claim the terms. Some prefer terms like Descendants of Enslaved Africans in America. Some may actively oppose these terms or prefer others, and some may be uncertain. The term does not necessarily capture clear or objective data if it were to be used. The scope of slavery definitions in the Americas is also ambiguous—for example, a family history of slavery in the continental U.S., versus the wider "Americas," or slavery in places that are now considered U.S. territory, such as Puerto Rico.

Finally, in the background of the original resolution, concerns were raised regarding lying about race on medical education applications. Verification of self-reported demographic information is problematic regardless of which categorization is used. Self-reported descendancy from enslaved

Africans is not inherently more objective than any other self-reported experience. It would be inappropriate, resource intensive, and likely intrusive and exclusionary for already underrepresented populations if medical education institutions attempted to collect and verify genealogical records. These records may or may not also be known to individuals or accurately represent someone's direct lived experience within systemic racism.

Federal Efforts and the Office of Management and Budget (OMB) Revisions

In March 2024, the Office of Management and Budget (OMB) finalized revisions to Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (SPD 15).[20] This process included the following:

> "*Summary of Public Input*. The [Federal Register Notice] asked, "How can Federal surveys or forms collect data related to descent from enslaved peoples originally from the African continent? For example, when collecting and coding responses, what term best describes this population group (e.g., is the preferred term 'American Descendants of Slavery,' 'American Freedmen,' or something else)? How should this group be defined? Should it be collected as a detailed group within the 'Black or African American' minimum category, or through a separate question or other approach?"
>
> "The majority of the public input on this subject expressed support for adding a category or question to identify descendants of persons enslaved in the United States. There was support for terms including: Foundational Black American, American Descendant of Slavery, American Freedman or Freedman, Black American, African-American, and Negro or American Negro; however, there was disagreement about which term is preferred. Commenters described the importance of collecting these data and the value for data users and policymakers, pointed to existing research that shows differences in outcome measures, like income and wealth, and stated that descendants of persons who were enslaved in the United States are ethnically distinct from African immigrants."
>
> "Other commenters, including civil rights groups, opposed the collection of these data. Commenters expressed concern about the difficulty of verifying that identification is accurate, the usefulness or necessity of the data, the exclusion of other groups of historically enslaved people, and the creation of confusion that could make the Black or African American community harder to count. Related, there was also concern about potential harm to the full and accurate count of the Black or African American population, particularly Black or African American immigrants. The comments noted the lack of in-depth research and engagement with the diverse Black or African American community on terminology, definition, and data collection and coding protocol, as well as implications on the counts of other Black or African American diasporic populations."
>
> "*Working Group's Final Recommendation*. The Working Group did not recommend disaggregation of the Black or African American category by descent from persons who were enslaved in the United States. They identified the disaggregation of Black or African American population groups as a priority area for future research and noted that additional stakeholder engagement is also needed."
>
> "*OMB Decision*. OMB concurs with this recommendation and the Working Group's determination that further research is needed."

Physician Data Initiative Recommended Standards

In 2024, a partnership between the AMA, the Accreditation Council for Graduate Medical Education (ACGME), and the Association of American Medical Colleges (AAMC) released recommended standards[21] for data collection and reporting in race and ethnicity as well as language proficiency.[22]

The "short version" of the race and ethnicity standards asks "How do you self-identify?" and offers the following options:

"Please check as many categories as may apply:

□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Hispanic or Latino
□ Middle Eastern or North African
□ Native Hawaiian or Pacific Islander
□ White
□ Some other race or ethnicity: [write-in]"

The "long version" asks "How do you self-identify? Please check as many categories and subcategories as may apply:" and within the Black or African American category, offers the following options:

□ African
□ African American
□ Afro-Caribbean
□ Ethiopian
□ Haitian
□ Jamaican
□ Nigerian
□ Somali
□ Some other Black or African American: [write-in]"

DISCUSSION

People targeted for anti-Black racism have diverse experiences and histories that may be ambiguous to define, including potential histories of dehumanization, state violence, and enslavement within and outside of the continental United States. Narratives of "choice" in immigration are also not always clear cut for many individuals and their past family experiences. When speaking of "chosen" immigration in contrast to those with family history of being enslaved in the continental US, not all those called "immigrants" have an experience based in free will, either: they may also have family contexts of chattel slavery (i.e., enslavement outside continental U.S. before ancestors arrived to the U.S.), traumatic refugee circumstances, imprisonment, forced unpaid labor, and/or human trafficking.

While specifically defining and verifying family history of enslavement in the U.S. for the purposes of one aspect of reparations may be valuable to consider, this would be inappropriate for the AMA, AAMC, or medical schools to determine and define this, and this work should be led and determined by the affected communities and civil rights groups. Some individuals and groups

may choose to identify with these family experiences as part of a racial or ethnic identity distinguished from or in addition to an overall identity of being Black or African American. Individuals' feelings on this concept vary.

There may also be value in disaggregating and exploring health inequities for subsets of racial/ethnic groups based on the known traumatic experiences of one's ancestors, such as chattel slavery. However, populations of medical education learners or applicants are not the appropriate group to study to determine this information in a comprehensive way. There are also limitations on self-reporting and verification of any genealogical information in medical education demographics and varying opinions within the affected communities about the benefits or harms of this delineation.

It also remains important to avoid single narratives of divisions between Black, African, and/or African American lineages of "immigrants" or "non-immigrants," as experiences of ancestral and/or current slavery and/or oppression are highly complex issues. Current Physician Data Initiative recommendations include space for people to self-identify as they prefer, without imposing specific definitions.

RELEVANT AMA POLICY

The AMA has several policies related to racial justice and diversity within medical education. A selection of these are listed in Appendix A.

SUMMARY

The AMA and medical education have a responsibility to oppose systemic and institutional racism, including but not limited to anti-Black racism and the legacy of chattel slavery, which have resulted in inequities in health outcomes. Black and/or African American viewpoints on designations like "Descendants of Enslaved Africans in America" are highly complex and non-monolithic. Support should be given to ongoing collective work, led by civil rights groups and by communities most affected by anti-Black racism, to determine the appropriate means of identifying and addressing the harmful ramifications of slavery and racism on these communities. AMA is not an appropriate institution to define and designate how underrepresented individuals should identify themselves, and the current Physician Data Initiative recommendations include write-in space for people to self-identify as they prefer, without imposing specific definitions.

RECOMMENDATIONS

The Council on Medical Education therefore recommends that the following be adopted in lieu of Resolution 218-A-24, and the remainder of the report be filed:

1. Our AMA acknowledges that anti-Black racism, including but not limited to direct experiences and/or family histories of slavery, results in significant and ongoing harm to Black people and communities. (New HOD Policy)
2. Our AMA will raise awareness of the Physician Data Initiative's work to disaggregate racial/ethnic identification categories on demographic forms and offer opportunities for individuals to self-identify. (New HOD Policy)

Fiscal note: $2,000

APPENDIX A: RELEVANT AMA POLICY

Racism as a Public Health Threat H-65.952

1. Our American Medical Association 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 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.
    b. How to prevent and ameliorate the health effects of racism.
4. Our AMA:
    a. supports the development of policy to combat racism and its effects.
    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.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Immigration Status is a Public Health Issue D-350.975

1. Our American Medical Association declares that immigration status is a public health issue that requires a comprehensive public health response and solution.
2. Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.
3. Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.
4. Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities.

Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category "race" can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.

4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.

Continued Support for Diversity in Medical Education D-295.963

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

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our American Medical Association, 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.
    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 and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
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 unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order 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.

<u>Diversity in the Physician Workforce and Access to Care D-200.982</u>

1. Our American Medical Association will continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools.
2. Our AMA will continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs.
3. Our AMA will continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

<u>Underrepresented Student Access to US Medical Schools H-350.960</u>

1. Our American Medical Association 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.

2. Our AMA 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.
3. Our AMA recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination.
4. Our AMA is committed to promoting truth and reconciliation in medical education as it relates to improving equity.
5. Our AMA recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations.
6. Our AMA will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine.
7. Our AMA will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school.
8. Our AMA will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants.
9. Our AMA will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine.
10. Our AMA will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979,
    a. encouraging state and local governments to make quality elementary and secondary education available to all.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 8-A-25

Subject:	Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes (Res. 243-A-24)
Presented by:	Krystal Tomei, MD, MPH, Chair
Referred to:	Reference Committee C

Resolution 243-A-24, "Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes," was introduced by the Minority Affairs Section at the 2024 Annual Meeting of the American Medical Association (AMA) House of Delegates and was referred. The resolution asked the following:

"RESOLVED, that our American Medical Association add 'Enrolled Member of a Federally Recognized Tribe' on all AMA demographic forms (Directive to Take Action); and be it further

"RESOLVED, that our AMA advocate for the use of 'Enrolled Member of a Federally Recognized Tribe' as an additional category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education (Directive to Take Action); and be it further

"RESOLVED, that our AMA support the Association of American Medical Colleges (AAMC) inclusion of 'Enrolled Member of a Federally Recognized Tribe' on all AAMC demographic forms (New HOD Policy); and be it further

"RESOLVED, that our AMA advocate for the Accreditation Council for Graduate Medical Education (ACGME) to include 'Enrolled Member of a Federally Recognized Tribe' on all ACGME demographic forms. (Directive to Take Action)"

Reference Committee B testimony noted AMA's work with the AAMC and the ACGME through the Physician Data Initiative (PDI) to establish best practices for data sharing and standards for sociodemographic data, including race, ethnicity, and more. Testimony also discussed that the Office of Management and Budget (OMB) recently concluded an extensive national consultation process concerning updating race and ethnicity standards, to which AMA provided comments. Testimony highlighted that the OMB ultimately decided to "remove the phrase 'who maintains tribal affiliation or community attachment' in the American Indian/Alaska Native (AI/AN) definition... to improve estimates of the AI/AN population in Federal statistics." However, testimony also indicated the possible value in collecting data about members of federally recognized tribes because it is a legal designation, not a racial category, and therefore not subject to the recent U.S. Supreme Court decisions banning the use of race in holistic college admissions processes. Testimony indicated it would be beneficial to study the implications of this designation to ensure that AMA policy is more comprehensive and does not exclude AI/AN individuals because their tribe is not federally recognized. Testimony also noted that more time is needed to understand the nuances and implications of this resolution and to collaborate with partners through the PDI to fully consider the short and long-term implications of these changes. Resolution 243 was referred for study.

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BACKGROUND

According to the U.S. Department of the Interior, Indian Affairs, "A federally recognized tribe is an American Indian or Alaska Native tribal entity that is recognized as having a government-to-government relationship with the United States, with the responsibilities, powers, limitations, and obligations attached to that designation, and is eligible for funding and services from the Bureau of Indian Affairs. Furthermore, federally recognized tribes are recognized as possessing certain inherent rights of self-government (i.e., tribal sovereignty) and are entitled to receive certain federal benefits, services, and protections because of their special relationship with the United States. At present, there are 574 federally recognized American Indian and Alaska Native tribes and villages."[1]

Federally recognized tribal enrollment in the United States is a legal and political category in relation to the U.S. government, rather than a racial or ethnic identity.[2] The U.S. does not grant sovereign status to these tribes but rather chooses whether or not to acknowledge the continued existence of a tribe's inherent sovereignty. Many tribes remain unacknowledged by the federal government, with some of these recognized only by states,[3] or not at all. Native Hawaiians, for instance, are not federally recognized as a sovereign tribe or tribes.[4] Recognition itself may be linked to the process of colonization. For example, Patty Ferguson-Bohnee, JD, associate dean, clinical professor of law, and faculty director of the Indian Legal Program at Arizona State University, indicated in a 2021 presentation that, "The inclusion of a federal acknowledgement requirement poses a direct threat to the right and sovereignty of all tribes and creates a particular challenge for non-BIA listed tribes by attempting to link tribal sovereignty to federal acknowledgement… The Federal Acknowledgement Process persists in functioning as a barrier to historically well documented tribes seeking to achieve federal recognition."[5] These concerns are a natural consequence of the current social structure: "Because the foundation of colonial governments requires those entities to ignore the inherent rights of Indigenous Peoples, these governments—such as the United States government—have a tendency to ignore some Indigenous Peoples, and recognize others."[6]

Various U.S. government actions over time have also broken treaties with many tribes,[7] including actions to terminate federal recognition of tribal sovereignty.[8] As noted by the U.S. National Archives, "From 1953 until 1970, Congress initiated 60 separate termination proceedings against American Indian tribes, and over three million acres of tribal lands were relinquished as a result. Although the Nixon administration repudiated termination in 1970 and shifted federal Indian policy toward self-determination, the effect of termination was nevertheless devastating for many tribes."[9]

The United Nations Declaration on the Rights of Indigenous Peoples does not directly determine or define tribal status or Indigenous identity, stating in Article 9, "Indigenous peoples and individuals have the right to belong to an indigenous community or nation, in accordance with the traditions and customs of the community or nation concerned," and in Article 33, "Indigenous peoples have the right to determine their own identity or membership in accordance with their customs and traditions."[10]

Demographic Definitions and the Indian Health Service

The original resolution's interest in including additional categorization of Indigenous medical education learners and physicians was in part driven by the Indian Health Service's (IHS) role, referred to in the resolution, as "a health care system for federally recognized American Indians and Alaska Natives in the United States," noting significant physician vacancies as well as the IHS

Physician Scholarship program's requirement for applicants to be enrolled members of federally recognized tribes.[11] Indeed, while earlier IHS scholarship opportunities (such as for pre-medicine) are also eligible for both descendants and members of either federal or state recognized tribes in the 2025-2026 scholarship cycle, health professions scholarships, including for physicians-in-training, are restricted to enrolled members of federally recognized tribes—no descendants of members, nor members of state recognized tribes.[12]

While tribes and groups eligible for IHS health care are restricted to those federally recognized, individual patient eligibility for IHS is complex. Though it generally defaults to federal recognition, there are several exceptions where patients who are not enrolled members of a federally recognized tribe may receive services at the time of this writing, including but not limited to: non-enrolled membership in an AI/AN federally recognized group evidenced by other "reasonable" factors, children of otherwise eligible patients, spouses if the appropriate tribal organization deems them eligible, people who are pregnant under some circumstances, and others. IHS employees are not required to be AI/AN, although IHS does by law provide preference to AI/AN applicants,[13] and determines this via Bureau of Indian Affairs (BIA) standards.[14]

Physician vacancies in IHS have been attributed to issues such as matching local market salaries and housing scarcity,[15] as well as lack of GME funding[16] and management concerns.[17] AI/AN people experience significant challenges based on wider systemic oppression in education in general and therefore are underrepresented in high school and college degrees as well as in the physician workforce.[18]

Tribal Enrollment Data and Data Sovereignty

There are currently 574 AI/AN tribes federally recognized by the U.S. government. While the BIA maintains a list of tribal leaders,[19] AI/AN nations maintain their own enrollment records and processes.[20] Racial or ethnic self-identity, or status as an Indigenous person per one's own community or nation's customs and traditions, would not and likely should not be defined by broad medical education groups like the AMA. Enrollment in a federally recognized tribe is a verifiable legal and political status, and any data collected on this would therefore need to be verified. As discussed in a presentation by the American Indian Health Commission for Washington State, available on the U.S. Bureau of Justice Assistance website, tribal data sovereignty is of the utmost importance: "Tribal Nations' inherent sovereign authority to administer the collection, ownership, and application of their own data is rooted in a tribal nation's right to govern their people."[21] Collecting and reporting on alleged federally recognized tribal enrollment without each tribal nation's permission or verification would be a direct violation of tribal sovereignty and inappropriate.[22] Hypothetical collection of this data would require meaningful partnerships with the appropriate and specific tribal leaders in each of the potential 574 federally recognized tribes to ascertain if collection and verification of this data within medical education is even a desirable priority for each nation, and if so, the resources and data privacy and dissemination agreements needed.

Office of Management and Budget Revisions

In March 2024, OMB finalized revisions to Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (SPD 15).[23] Previously, the demographic data standards on AI/AN included the phrase "who maintain tribal affiliation or community attachment," and the removal of this phrase was supported by the National Congress of American Indians and several other relevant organizations.[24]

This was removed in the final recommendations, such that, within a combined question for race and ethnicity, AI/AN is defined as follows: "American Indian or Alaska Native. Individuals with origins in any of the original peoples of North, Central, and South America, including, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, and Maya." The standards allow for minimum category data collection with no write-ins, but they also allow for a write-in field for "additional details." The OMB stated this is "especially critical for the American Indian or Alaska Native category, which does not have required detailed categories under these standards." The revised standards do not collect information on federal recognition.

Physician Data Initiative Recommended Standards

In 2024, a partnership between the AMA, ACGME, and AAMC released recommended standards[25] for data collection and reporting in race and ethnicity as well as language proficiency, "driven by the importance of a diverse physician workforce and a more equitable health system."[26]

The "short version" of the race and ethnicity standards asks, "How do you self-identify?" and offers the following options:

"Please check as many categories as may apply:

□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Hispanic or Latino
□ Middle Eastern or North African
□ Native Hawaiian or Pacific Islander
□ White
□ Some other race or ethnicity: [write-in]"

The "long version" asks "How do you self-identify? Please check as many categories and subcategories as may apply:" and within the AI/AN subsection states:

"□ American Indian or Alaska Native
    □ Tribal affiliation: [write-in]"

DISCUSSION

No current standards support broad official medical education collection of federal tribal enrollment recognition status, and significant concerns arise related to accurately collecting this data. It is especially concerning regarding tribal data sovereignty, and the potential consequences to state recognized tribal members and other Indigenous learners who are not federally or state recognized.

There may also be privacy concerns within certain forms of disaggregation in medical education. For instance, according to the AAMC, in 2023, there were only 90 total AI/AN self-reported applicants to U.S. MD-granting medical schools, and 57 Native Hawaiian or Other Pacific Islander (though some Indigenous applicants may have been aggregated under other ethnic categories, such as multiracial.)[27] Based on some AI/AN organizational recommendations, it may be valuable to disaggregate data on those who indicate multiple ethnicities, without disaggregating based on federal recognition of enrollment in specific tribes. For instance, the National Congress of

American Indians "has recommended applying the approach used by the U.S. Census Bureau to report data on AI/AN alone… and AI/AN in combination with other races and ethnicities."[28]

Given significant underrepresentation of AI/AN medical education learners and physicians, it is valuable to work directly with tribes on admissions pathways, scholarships, and other programs.[29] AMA policy acknowledges "long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect."[30] Rather than broadly attempting to collect and verify federal enrollment data from any applicant, the focused work of engaging directly with tribes to create programs to reduce inequities may be beneficial. Although federally recognized tribes tend to have more legal protections in the U.S., where legal and feasible, this work should ideally also include tribes and communities that are not federally recognized. This is in alignment with AMA's stance that "Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs."[31] AMA policy also supports AI/AN access to health care both within and outside of IHS.[32]

Any collection or reporting on enrollment status, whether federally recognized or not, must be in direct collaboration with tribes as sovereign nations with inherent rights to self-determine priorities and data strategies. This should be undertaken on a case-by-case basis in response to each tribe's communicated needs, as collection of delineated enrollment data within medical education may or may not be relevant to each nation's priorities.

RELEVANT AMA POLICY

The AMA has policy related to Indigenous peoples and medical education. Some examples are as follows:

- H-350.981, "AMA Support of American Indian Health Career Opportunities," continues to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations. This includes training a workforce from and for these tribal nations.
- H-350.976, "Improving Health Care of American Indians and Alaska Natives," recommends that the federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives.
- H-270.950, "Indian Health Service Licensing Exemptions," works with interested parties to evaluate existing regulatory and licensure opportunities and barriers to physician participation in health care services for Native Americans, Alaska Natives, and Native Hawaiians.
- H-350.939, "Health Care Access for American Indians and Alaska Natives," supports the federal government continuing to enhance and develop alternative pathways for American Indian and Alaska Native patients to access the full spectrum of health care, including within and outside of the established Indian Health Service (IHS) system.

- H-350.950, "Tribal Public Health Authority," supports the use of data-sharing agreements between local and state public health departments and American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers.
- H-350.977, "Indian Health Service," supports efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level.
- H-460.884, "Indigenous Data Sovereignty," recognizes that American Indian and Alaska Native (AI/AN) Tribes and Villages are sovereign governments that should be consulted before the conduct of research specific to their members, lands, and properties.

SUMMARY

Attending to the health care workforce needs of AI/AN and Indigenous populations is very important, as is respect for tribal data sovereignty. It would not be appropriate nor feasible for the AMA to collect and verify federal tribal enrollment data as part of medical education demographic information. It would also not be appropriate for the AMA to advocate for other medical education organizations to do so unless in direct collaboration with each of the relevant sovereign nations and led by the communicated priorities and needs of these tribal governments.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted in lieu of Resolution 243-A-24, and that the remainder of this report be filed.

1. That AMA Policy H-460.884, "Indigenous Data Sovereignty," be amended by addition:

   4. Our AMA recognizes that data collection on tribal membership, including for medical education and workforce, should recognize and respect Tribal data sovereignty and include Tribal consultation. (Modify HOD Policy)

2. That our AMA reaffirm Policy H-350.981, "AMA Support of American Indian Health Career Opportunities." (Reaffirm HOD Policy)

Fiscal note: $1,000

APPENDIX A: RELEVANT AMA POLICY

AMA Support of American Indian Health Career Opportunities H-350.981

Our American Medical Association policy on American Indian health career opportunities is as follows:

1. Our American Medical Association, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
2. Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees.
3. Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population.
4. Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations to include training a workforce from and for these tribal nations.
5. Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.
6. Our AMA acknowledges the significance of the Morrill Act of 1862, the resulting land-grant university system, and the federal trust responsibility related to tribal nations.

Improving Health Care of American Indians and Alaska Natives H-350.976

1. Our American Medical Association recommends that all individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens.
2. Our AMA recommends that the federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives.
3. Our AMA recommends that state and local governments give special attention to the health and health-related needs of nonreservation American Indians and Alaska Natives in an effort to improve their quality of life.
4. Our AMA recommends that American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
5. Our AMA recognizes practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives.
6. Our AMA monitors Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care.
7. Our AMA supports consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the

development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs.

8. Our AMA recommends strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
9. Our AMA recommends a team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
10. Our AMA will continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
11. Our AMA recommends that state and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside.
12. Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian and Alaska Native health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians and Alaska Natives.
13. Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

<u>Indian Health Service Licensing Exemptions H-270.950</u>

Our American Medical Association will work with interested parties to evaluate existing regulatory and licensure opportunities and barriers to physician participation in health care services for Native Americans, Alaska Natives, and Native Hawaiians.

<u>Health Care Access for American Indians and Alaska Natives H-350.939</u>

1. Our American Medical Association supports the federal government continuing to enhance and develop alternative pathways for American Indian and Alaska Native patients to access the full spectrum of health care, including within and outside of the established Indian Health Service (IHS) system.
2. Our AMA supports collaborative research efforts to better understand the limitations of IHS health care, including barriers to access, disparities in treatment outcomes, and areas for improvement.
3. Our AMA encourages studies between the IHS and the CDC to better evaluate regional health outcomes, and potential treatment deficiencies among American Indian and Alaska Native populations, including with respect to cancer care.
4. Our AMA supports federal and other efforts to increase funding for and provide technical assistance to develop and expand accessible specialty care services at IHS, Tribal, and Urban Indian Health Programs and associated facilities, including by contracting with other physician practices.

<u>Tribal Public Health Authority H-350.950</u>

1. Our American Medical Association will support the Department of Health and Human Services issuing guidance, through the Centers for Disease Control and Prevention and the Indian Health Service, on Public Health and Tribal-affiliated data-sharing with American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers.
2. Our AMA will support the use of data-sharing agreements between local and state public health departments and American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers.

Indian Health Service H-350.977

The policy of the American Medical Association 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. Our 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. Personnel:
    a. Compensation scales 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 specialty and primary care service in remote areas;
    c. In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers and other federal health agencies, thus increasing both the available staffing 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 without detracting from physician compensation;
    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 burnout; 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 supports 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.
8. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate, but incremental, loan forgiveness when they practice in an Indian Health Service, Tribal, or Urban Indian Health Program.
9. Our AMA supports reform of the Indian Health Service (IHS) Loan Repayment Program eligibility for repayment with either a part-time or full-time employment commitment to IHS and Tribal Health Programs.

Indigenous Data Sovereignty H-460.884

1. Our American Medical Association recognizes that American Indian and Alaska Native (AI/AN) Tribes and Villages are sovereign governments that should be consulted before the conduct of research specific to their members, lands, and properties.
2. Our AMA supports that AI/AN Tribes and Villages' Institutional Review Boards (IRBs) and research departments retain the right to oversee and regulate the collection, ownership, and management of research data with the consent of their members, and that individual members of AI/AN Tribes and Villages retain their autonomy and privacy regarding research data shared with researchers, AI/AN Tribes and Villages, and governments, consistent with existing protections under 45 CFR 46.
3. Our AMA encourages:
    a. the use and regular review of data-sharing agreements for all studies between academic medical centers and AI/AN Tribes and Villages be mutually agreed upon and aligned with AI/AN Tribes' and Villages' preferences.
    b. the National Institutes of Health and other stakeholders to provide flexible funding to AI/AN Tribes and Villages for research efforts, including the creation and maintenance of IRBs.

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[31] AMA Support of American Indian Health Career Opportunities H-350.981

[32] Health Care Access for American Indians and Alaska Natives H-350.939

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(A-25)

Introduced by: American College of Cardiology, American Society of Echocardiography, American Society of Nuclear Cardiology, Heart Rhythm Society, Society for Cardiovascular Angiography & Interventions, Society of Cardiovascular Computed Tomography, Society for Cardiovascular Magnetic Resonance

Subject: Examining ABMS Processes for New Boards

Referred to: Reference Committee C

Whereas, certification of clinical competence is a cornerstone of the medical profession; and

Whereas, the American Board of Medical Specialties (ABMS) was established in 1933 as an independent body “to serve the public and medical profession by improving the quality of health through setting professional standards for lifelong certification in partnership with Member Boards;” and

Whereas, the ABMS recently updated their standards for continuing certification, which address the six core competencies and a more holistic approach; and

Whereas, the American College of Cardiology, the American Heart Association, the Heart Failure Society of America, the Heart Rhythm Society and the Society for Cardiovascular Angiography & Interventions broadly supported an independent cardiovascular board by collaborating to establish a new, independent American Board of Cardiovascular Medicine (ABCVM); and

Whereas, the ABCVM prepared a comprehensive application that sufficiently demonstrated how each of the ABMS standards for both initial and continuing certification would be met; and

Whereas, despite strong professional advocacy and an application that met/exceeded the standards, the ABMS chose to not recognize that cardiology is deserving of a separate board; and

Whereas, AMA policy supports the creation and existence of certification entities that meet accepted standards for assessment of knowledge and skills in a medical specialty; therefore be it

RESOLVED, that our American Medical Association supports the creation and recognition of practice competency certification mechanisms for physicians, when the oversight bodies for such certification meet established criteria (New HOD Policy); and be it further

RESOLVED, that our AMA Council on Medical Education examine ABMS processes for new boards to determine whether the ABCVM met the necessary requirements to be recognized as an independent board, with report back to the AMA Board of Trustees (BOT) and the AMA HOD. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 4/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(A-25)

Introduced by: American College of Lifestyle Medicine

Subject: AMA Study of Lifestyle Medicine and Culinary Electives to Reduce Burnout and Bolster Career Satisfaction in Trainees

Referred to: Reference Committee C

Whereas, the American Medical Association reports that, as of 2021, nearly 63% of physicians reported symptoms of burnout, up from 38% in 2020, and that large-scale change is needed to address the physician burnout crisis;[1] and

Whereas, the AMA recognizes that physician well-being is influenced by both organizational and individual factors;[1] and

Whereas, the AMA successfully fought for passage of the Dr. Lorna Breen Health Care Provider Protection Act of March 2022, which provides essential physician wellness resources to address persistently high rates of burnout-related suicide among physicians by encouraging urgent attention from researchers, health leaders and policy makers to develop and evaluate specific interventions to protect physicians' mental health;[1] and

Whereas, the United States will be short by as many as 86,000 physicians by 2036, according the Association of American Medical Colleges, due to early retirement, two in three doctors experiencing burnout during the pandemic, and fewer students gravitating to medical careers;[2] and

Whereas, the AMA has advocated for an all-hands-on-deck approach to solving for the projected physician shortage;[2] and

Whereas, the well-being of providers is considered an essential component of meeting the Quintuple Aim;[3] and

Whereas, the AMA Code of Ethics states that it is the ethical responsibility of a provider to attend to their self-care and well-being;[4] and

Whereas, self-care can help prevent burnout, enhance empathy, and improve attitudes among primary care providers;[5] and

Whereas, suboptimal care for patients may be one of the unintended consequences of provider burnout;[6] and

Whereas, research has shown an association between lifestyle medicine competencies, self-care, and self-reported increase in career satisfaction;[7] and

Whereas, individual risk-reduction intervention to combat burnout through lifestyle interventions can target primordial, primary, secondary, and tertiary prevention;[6] and

Whereas, Lifestyle Medicine Interest Groups have been established across more than 100 medical schools, the Lifestyle Medicine Residency Curricula (LMRC) has been adopted by 368 residency programs across over 170 locations, and LM Fellowship curricula enrollment has grown exponentially;[8,9] and

Whereas, Congressional 2022 bipartisan resolution H. Res.1118 calls for meaningful education on health professional education on nutrition and diet;[10] and

Whereas, an expert panel of 22 nutrition subject matter experts and 15 residency program directors reached consensus on recommended nutrition competencies, the level of medical education at which they should be included, and recommendations for monitoring implementation and evaluation of these competencies;[10] and

Whereas, academic medical schools in the Teaching Kitchen Collaborative have developed elective curricula to teach culinary and other lifestyle self-care skills, an established concept of lifestyle medicine, in affordable, culturally diverse, and time-efficient ways to medical students and test efficacy on dietary habits, physical activity, and overall health and well-being;[11] and

Whereas, the Culinary Medicine Curriculum developed at Stanford University Medical School for medical students has been distributed by the American College of Lifestyle Medicine and has been downloaded over 10,000 times as of March 2024, demonstrating the vast interest in lifestyle and culinary medicine knowledge and skills;[12] therefore be it

RESOLVED, that our American Medical Association study the impact and outcomes of teaching elective and affordable culinary and lifestyle self-care skills to medical students, residents, and fellows to reduce burnout and bolster career satisfaction. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 4/18/25

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RELEVANT AMA POLICY

Healthy Lifestyles H-425.972
Our AMA: (A) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the Journal of the American Medical Association in 2010; (B) will urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (C) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management.

2.Our AMA supports policies and mechanisms that incentivize and/or provide funding for the inclusion of lifestyle medicine education and social determinants of health in undergraduate, graduate and continuing medical education.

Programs on Managing Physician Stress and Burnout H-405.95
1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.

Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout D-460.96
1. Our American Medical Association will monitor and report on the research regarding technology, measures, and effective use of personal and biological data to assess professional workforce wellbeing and inform organizational interventions to mitigates burnout.
2. Our AMA will develop ethical guidelines on the collection, use, and protection of personal and biological data obtained to improve professional workforce wellbeing.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(A-25)

Introduced by: Minority Affairs Section

Subject: Support for the Establishment of an Indigenous-Led Medical School in the United States

Referred to: Reference Committee C

Whereas, American Indian and Alaska Native (AI/AN) individuals remain deeply underrepresented in the U.S. physician workforce, comprising only 0.4% of active physicians despite representing approximately 2.9% of the U.S. population, contributing to persistent healthcare workforce shortages and access challenges in Tribal and urban AI/AN communities[1-4]; and

Whereas, AI/AN communities experience disproportionately high rates of chronic illness, mental health conditions, substance use disorder, and maternal morbidity, in part due to structural inequities, limited access to culturally concordant care, and the intergenerational impact of historical trauma[5-7]; and

Whereas, increasing the number of physicians from AI/AN communities and those trained to serve Indigenous populations is a critical strategy to promote health equity, improve care delivery, and strengthen trust between healthcare systems and AI/AN patients[9]; and

Whereas, significant barriers continue to prevent AI/AN students from entering and succeeding in medical education, including geographic isolation, financial hardship, limited mentorship, and experiences of systemic racism and discrimination[9]; and

Whereas, although the partnership between the Oklahoma State University College of Osteopathic Medicine and the Cherokee Nation represents a historic advancement by establishing a medical school campus on Tribal land, the distinct knowledge systems and healing philosophies of Indigenous cultures have yet to be systematically integrated and reconciled within the curriculum of an accredited U.S. medical school[10-11]; and

Whereas, the creation of an Indigenous-governed medical school would provide a culturally safe, community-anchored environment to recruit, educate, and retain AI/AN students and faculty, while serving as a center for excellence in Indigenous health education and healing traditions[12-13]; and

Whereas, the Indigenous School of Medicine (ISOM), a 501(c)(3) nonprofit organization founded by Indigenous physicians and educators from institutions including Johns Hopkins, Mayo Clinic, and Yale University, is developing a fully accredited U.S. allopathic medical school that integrates Indigenous healing knowledge with Western biomedical training and prioritizes Tribal governance and sovereignty[14]; and

Whereas, our American Medical Association has existing policies supporting AI/AN health equity, including: H-350.977 (Support of the Indian Health Service), CME Report 5-A-18 (Study

on American Indian and Alaska Native Students in Medical School), and CME Report 3-A-24 (Reimbursement for Traditional Indigenous Healing Practices); and

Whereas, the development of an Indigenous-led medical school aligns with national efforts to address physician workforce shortages, diversify medical education, and promote culturally responsive care models[15-17]; and

Whereas, multiple federal agencies, philanthropic foundations, and academic institutions are increasingly supporting Indigenous-led initiatives in health and education, presenting a timely opportunity for multisector collaboration and advocacy[18-21]; therefore be it

RESOLVED, that our American Medical Association support efforts to establish a fully accredited, allopathic, Indigenous-governed medical school in the United States, with a governance and leadership structure grounded in Tribal sovereignty and cultural integrity, and guided by principles of accountability to Indigenous Nations, inclusion of Indigenous leadership, and alignment with community-defined values and priorities (Directive to Take Action); and be it further

RESOLVED, that our AMA work collaboratively with Tribal Nations, Indigenous-led organizations, academic institutions, and relevant governing bodies to explore the feasibility, infrastructure, and resource needs for such an institution (Directive to Take Action); and be it further

RESOLVED, that our AMA support initiatives to develop culturally centered medical curricula, recruit Indigenous faculty and leadership, and facilitate pathways to institutional accreditation that reflect the values and priorities of Tribal communities (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for funding and resource development, including through partnerships with academic, philanthropic, health system, and governmental stakeholders, to support sustainable development and operation of an Indigenous-led medical school. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/21/25

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RELEVANT AMA POLICY

H-350.977 Indian Health Service

The policy of the American Medical Association 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. Our 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. Personnel:
    a. Compensation scales 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 specialty and primary care service in remote areas;
    c. In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers and other federal health agencies, thus increasing both the available staffing 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 without detracting from physician compensation;
    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 burnout; 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 supports 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.
8. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate, but incremental, loan forgiveness when they practice in an Indian Health Service, Tribal, or Urban Indian Health Program.
9. Our AMA supports reform of the Indian Health Service (IHS) Loan Repayment Program eligibility for repayment with either a part-time or full-time employment commitment to IHS and Tribal Health Programs. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Appended: Res. 305, A-23; Reaffirmed: BOT Rep. 09, A-23; Reaffirmed: CMS Rep. 03, A-24; Reaffirmed: Res. 244, A-24; Reaffirmed: BOT Rep. 31, A-24; Modified: CMS Res. 305, A-24]

H-350.976 Improving Health Care of American Indians and Alaska Natives

1. Our American Medical Association recommends that all individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens.
2. Our AMA recommends that the federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives.
3. Our AMA recommends that state and local governments give special attention to the health and health-related needs of nonreservation American Indians and Alaska Natives in an effort to improve their quality of life.
4. Our AMA recommends that American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
5. Our AMA recognizes practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives.
6. Our AMA monitors Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care.
7. Our AMA supports consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs.
8. Our AMA recommends strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
9. Our AMA recommends a team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
10. Our AMA will continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

11. Our AMA recommends that state and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside.
12. Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian and Alaska Native health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians and Alaska Natives.
13. Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. [CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09, A-23; Modified: CMS Rep. 03, A-24; Reaffirmed: Res. 244, A-24]

D-350.976 AMA Support of American Indian Health Career Opportunities

1. Our American Medical Association will work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, Association of American Indian Physicians, and Association of Native American Medical Students to increase representation of American Indian physicians in medicine by promoting effective practices in recruitment, matriculation, retention and graduation of American Indian medical students.
2. Our AMA will Convene key parties, including but not limited to the Association of American Indian Physicians (AAIP) and American Indian/Alaska Native (AI/AN) tribes/entities such as Indian Health Service and National Indian Health Board, to discuss the representation of AI/AN physicians in medicine and promotion of effective practices in recruitment, matriculation, retention, and graduation of medical students. [BOT Action in response to referred for decision: Res. 308, A-22; Modified: BOT Rep. 31, A-24; Reaffirmed: BOT Rep. 31, A-24]

H-350.981 AMA Support of American Indian Health Career Opportunities

Our American Medical Association policy on American Indian health career opportunities is as follows:

1. Our American Medical Association, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.
2. Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees.
3. Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population.
4. Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations to include training a workforce from and for these tribal nations.
5. Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.
6. Our AMA acknowledges the significance of the Morrill Act of 1862, the resulting land-grant university system, and the federal trust responsibility related to tribal nations. [CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: CME Rep. 1, A-22; BOT Action in response to referred for decision: Res. 308, A-22; Modified: BOT Rep. 31, A-24]

H-200.951 Strategies for Enhancing Diversity in the Physician Workforce

1. Our American Medical Association supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality.

2. Our AMA commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes.
3. Our AMA encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties.
4. Our AMA encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine.
5. Our AMA encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal.
6. Our AMA continues to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations. [CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21; Reaffirmed: BOT Rep. 31, A-24]

H-295.874 Educating Medical Students in the Social Determinants of Health and Cultural Competence
Our AMA: (1) Supports efforts designed to integrate training in social determinants of health, cultural competence, and meeting the needs of underserved populations across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models. [CME Rep. 11, A-06; Reaffirmation A-11Modified in lieu of Res. 908, I-14; Reaffirmed in lieu of Res. 306, A-15; Reaffirmed: BOT Rep. 39, A-18; Modified: CME Rep. 01, A-20]

H-160.883 American Indian and Alaska Native Language Revitalization and Elder Care
1. Our American Medical Association recognizes that access to language concordant services for American Indian and Alaka Native (AI/AN) patients will require investment in Indigenous languages in North America.
2. Our AMA supports federal-tribal funding opportunities for American Indian and Alaska Native language revitalization efforts, especially those that increase health information resources and access to language-concordant health care services for American Indian and Alaska Native elders living on or near tribal lands.
3. Our AMA supports the development of best practices for AI/AN elder care to ensure this group is provided culturally-competent healthcare outside of the umbrella of the Indian Health Service. [Res. 215, A-24]

H-350.939 Health Care Access for American Indians and Alaska Natives
1. Our American Medical Association supports the federal government continuing to enhance and develop alternative pathways for American Indian and Alaska Native patients to access the full spectrum of health care, including within and outside of the established Indian Health Service (IHS) system.
2. Our AMA supports collaborative research efforts to better understand the limitations of IHS health care, including barriers to access, disparities in treatment outcomes, and areas for improvement.

3. Our AMA encourages studies between the IHS and the CDC to better evaluate regional health outcomes, and potential treatment deficiencies among American Indian and Alaska Native populations, including with respect to cancer care.
4. Our AMA supports federal and other efforts to increase funding for and provide technical assistance to develop and expand accessible specialty care services at IHS, Tribal, and Urban Indian Health Programs and associated facilities, including by contracting with other physician practices. [Res. 242, A-24]

H-350.957 Cultural Leave for American Indian Trainees
Our American Medical Association recognizes the importance of cultural identity in fostering trainee success and encourages residency programs, fellowship programs, and medical schools to accommodate cultural observances for trainees from American Indian, Alaska Native, and Native Hawaiian communities. [Res. 323, A-22]

H-295.897 Enhancing the Cultural Competence of Physicians
1. Our American Medical Association continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence and cultural humility, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.
6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.
7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula. [CME Rep. 5, A-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-11; Appended: Res. 304, I-16; Modified: CME Rep. 01, A-17; Appended: Res. 320, A-17; Reaffirmed: CMS Rep. 02, I-17; Appended: Res. 315, A-18; Modified: Res. 322, A-22]

H-350.960 Underrepresented Student Access to US Medical Schools
1. Our American Medical Association 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.
2. Our AMA 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.
3. Our AMA recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination.
4. Our AMA is committed to promoting truth and reconciliation in medical education as it relates to improving equity.
5. Our AMA recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations.
6. Our AMA will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine.
7. Our AMA will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school.

8. Our AMA will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants.
9. Our AMA will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine.
10. Our AMA will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979,
    a. encouraging state and local governments to make quality elementary and secondary education available to all. [Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21; Appended: Res. 305, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(A-25)

Introduced by: Medical Student Section, International Medical Graduates Section, LGBTQ+ Section, Minority Affairs Section

Subject: Addressing Professionalism Standards in Medical Training

Referred to: Reference Committee C

Whereas, professionalism is ambiguously defined as a set of standards of beliefs about how one should operate in the workplace or as “the state or practice of doing one’s job with skill, competence, ethics and courtesy,” of which its largely subjective nature may create opportunities for harm and discrimination[1-3]; and

Whereas, medical education centers the importance of professionalism in course syllabi, clinical evaluations, and residency reference letters, resulting in the subjective grading of professionalism having direct effects on medical students' future career[4-6]; and

Whereas, the American Medical Association Code of Medical Ethics centers professionalism around maintaining the patient-physician relationship, public trust, ethical behavior, privacy and confidentiality, with no consistent incorporation of cultural diversity[27-31]; and

Whereas, biases and Eurocentric standards in defining professionalism have led to unfair evaluations of students, particularly underrepresented minorities, and it is crucial to establish a uniform, equitable definition of professionalism that respects diverse identities and promotes fair assessments[7-9]; and

Whereas, professionalism standards frequently reference "appropriateness" in areas such as speech and dress without clearly defining what is considered appropriate, leaving subjective interpretation to administrations whose judgments can vary significantly, resulting in inconsistent and potentially biased enforcement[2,3]; and

Whereas, the phenomenon of racial weathering and the pressure to conform to dominant cultural norms within medical institutions disproportionately impacts students from underrepresented backgrounds and of color in medical schools, leading to significant physical and mental health challenges[10-17]; and

Whereas, previous encounters of professionalism violations have not explicitly addressed the concerns for which an individual was unprofessional, but rather the concept itself was cited as the reason, which allows a method of weaponization as institutions do not have to acknowledge their rationale[2;] and

Whereas, physicians and trainees are in unique positions as community leaders to advocate for our patients and for humanity[19-21]; and

Whereas, even in contemporary times, the advocacy of individuals has been met with

penalization and seen as exhibiting “unprofessional behavior”, even though the right to advocate is protected under the Supreme Court ruling of Healy v James (1972)[22-24]; and

Whereas, emphasis on professionalism discourages open communication between doctors and patients by forcing trainees to become overly concerned with projecting a certain image rather than engaging in authentic human centered interactions, limiting diversity and inclusion of diverse perspectives originally encouraged in medical practice[13,25-27]; therefore be it

RESOLVED, that our American Medical Association supports regular institutional review, including review by Diversity, Equity and Inclusion (DEI) offices or other appropriate entities, of professionalism policies in medical school and residency programs, ensuring that they do not lead to discriminatory practices (New HOD Policy); and be it further

RESOLVED, that our AMA supports the Accreditation Council for Graduate Medical Education (ACGME), the Association of American Medical Colleges (AAMC), and American Association of Colleges of Osteopathic Medicine (AACOM) to establish guidelines for residency programs and medical school professionalism policies that encourage institutions to outline actions that constitute a violation (New HOD Policy); and be it further

RESOLVED, that our AMA advocates for AAMC, ACGME, and AACOM to support measures that prevent medical schools and residency programs from using professionalism violations as a means to stop student advocacy measures. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Date Received: 04/10/2025

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RELEVANT AMA POLICY

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

1. Our American Medical Association will continue to encourage work in support of the Coalition for Physician Accountability's Undergraduate Medical Education-Graduate Medical Education Review Committee "Recommendations for Comprehensive Improvement of the UME-GME Transition."
2. Our AMA will encourage and support UME institutions' investment in
    a. developing more valid, reliable, and unbiased summative assessments for clinical clerkships, including development of assessors' awareness regarding structural inequities in education and wider society, and
    b. providing standardized and meaningful competency data to program directors.
3. Our AMA will encourage institutions to publish information related to clinical clerkship grading systems and residency match rates, with subset data for learners from varied groups, including those that have been historically underrepresented in medicine or may be affected by bias.
4. Our AMA will encourage UME institutions to include grading system methodology with grades shared with residency programs. [CME Rep. 04, A-23]

Decreasing Bias in Evaluations of Medical Student Performance D-295.307
Our American Medical Association will work with appropriate stakeholders to promote efforts to evaluate methods for decreasing the impact of bias in medical student performance evaluation as well as reducing the impact of bias in the review of disciplinary actions. [Res. 309, A-22; Reaffirmed: CME Rep. 04, A-23]

Fostering Professionalism During Medical School and Residency Training D-295.983
(1) Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training. This planning effort should include the following elements:
(a) Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics.
(b) Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism.
(c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees' acquisition of professionalism.
(d) Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism.
(2) Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism, to include an evaluation of professional behavior, carried out at regular intervals and employing methods shown to be valuable in adding to the information that can be obtained from observational reports. An ideal system would utilize multiple evaluation formats and would build upon educational experiences that are already in place. The results of such evaluations should be used both for timely feedback and appropriate interventions for medical students and resident physicians aimed at improving their performance and for summative decisions about progression in training. [CME Rep. 3, A-01; Reaffirmation I-09; Reaffirmed: CME Rep. 01, A-19; Modified: CME Rep. 01, A-20]

Professionalism in the Use of Social Media E-2.3.2
Physicians and medical students should be aware that they cannot realistically separate their personal and professional personas entirely online and should curate their social media presence accordingly. Physicians and medical students therefore should:
(a) When publishing any content, consider that even personal social media posts have the potential to damage their professional reputation or even impugn the integrity of the profession.
(b) Respect professional standards of patient privacy and confidentiality and refrain from publishing patient information online without appropriate consent. [AMA Principles of Medical Ethics: I,II,IV, Issued: 2016]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(A-25)

Introduced by: Medical Student Section, American College of Lifestyle Medicine

Subject: Curricular Structure Reform to Support Physician and Trainee Well-Being

Referred to: Reference Committee C

Whereas, the urgency of the COVID-19 pandemic disrupted the in-person structure of medical education and required rapid and novel adaptations to existing medical school curricula to incorporate online distance learning[1-3]; and

Whereas, studies have found that most students felt online learning provided insufficient opportunities for interaction and was less effective than face-to-face learning, and that medical students preferred a curriculum with 42% online learning and 58% on-site learning[3,4]; and

Whereas, a cross-sectional study comparing online-only, hybrid, and on-site only learning of evidence-based medical curricula demonstrates that a hybrid model offers increased learning motivation, autonomy, and satisfaction, while also increasing the efficiency of delivery of the material, which in turn increases students' understanding of the material[5]; and

Whereas, a 2022 AAMC survey found that 70% of medical students used non-institutional videos and other online content (3rd party resources) daily or weekly for medical information[6]; and

Whereas, distance learning may reduce the financial burden of medical school (for example, reduced transportation costs), reduce the impact of socioeconomic barriers on academic performance, and increase the accessibility of medical education, particularly for students with disabilities[7]; and

Whereas, the impact of distance learning on various knowledge-based and behavioral-based core competencies of medical education remains unknown, including its impact on medical student mental health and burnout[8]; and

Whereas, 42% of physicians report feeling burned out, exacerbated by factors such as bureaucracy, long working hours, insufficient compensation, and a lack of clinical autonomy[9-11]; and

Whereas, the prevalence of burnout among residents is significantly associated with difficulty meeting professionalism milestones, with up to half of residents reporting burnout or emotional exhaustion, and nearly half of medical students report burnout symptoms following matriculation [12-17]; and

Whereas, the Liaison Committee on Medical Education (LCME) mandates that medical schools support their medical students through the development and institution of "programs to promote

their well-being and to facilitate their adjustment to the physical and emotional demands of medical education"[18]; and

Whereas, inflexible burnout prevention programs that include mandatory assignments, punitive measures, and suboptimal scheduling of sessions fail to accommodate individual needs, are likely to be ineffective, and can paradoxically increase stress and workload among physicians and medical students [19-21]; and

Whereas, evidence-based burnout prevention programs prioritize flexibility, participant autonomy, mindfulness, leisure time, and self-care and allow individuals to choose activities that best suit their needs and schedules, leading to increased effectiveness, improved job satisfaction, better relationships with others, and reduced burnout among medical professionals[20-22,26,27]; and

Whereas, integrating effective burnout prevention programming into medical education curricula can lead to a reduction of student anxiety, increased ability to complete required sessions, and improved psychological well-being while completing coursework[22-25,28]; therefore be it

RESOLVED, that our American Medical Association promote a systems approach to student well-being and support research into the impact (beneficial or deleterious) of various educational structures and processes, including but not limited to, the use of third-party resources and distance learning, upon learner well-being and self-efficacy (New HOD Policy); and be it further

RESOLVED, that our AMA discourage physician, resident/fellow, and medical student burnout prevention programs which impose inflexible requirements, mandatory assignments, or punitive measures, except where required by law (New HOD Policy); and be it further

RESOLVED, that our AMA support evidence-based burnout prevention programs that:
a) prioritize personal time for participants;
b) facilitate voluntary participation in activities relating to personal values, leisure, hobbies, group and peer engagement, and self-care; and
c) are integrated directly into medical school and residency program curricula, and;
D) provide multiple options to complete any expectations or activities flexibly (New HOD Policy); and be it further

RESOLVED, that our AMA support the implementation of evidence-based evaluation strategies in the ChangeMedEd Initiative for the ongoing assessment and improvement of burnout prevention programs. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 04/10/2025

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RELEVANT AMA POLICY

D-310.968 Physician and Medical Student Burnout

Our American Medical Association recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.

Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical

student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
Our AMA will continue to:
address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight.
develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being. [CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19; Reaffirmation: A-22; Reaffirmed: Res. 802, I-24]

D-345.983 Study of Medical Student, Resident, and Physician Suicide
Our American Medical Association will explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies.
Our AMA will monitor progress by the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events.
Our AMA will support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services.
Our AMA will collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and substance use disorders, and attempted and completed suicide among physicians, residents, and medical students.
Our AMA will work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the collection of current wellness initiatives that institutions have in place to inform and promote meaningful mental health and wellness interventions in these populations. [CME Rep. 06, A-19; Modified: Res. 326, A-22]

H-295.993 Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs
Our AMA: (1) recognizes the need for appropriate mechanisms to include medical students and resident physicians in the monitoring and advocacy services of state physician health programs and wellness and other programs to prevent impairment and burnout; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available student assistance programs and other related services. [Sub. Res. 84, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed and appended: CME Rep. 4, I-98; Reaffirmed: CME Rep. 2, A-08; Modified: CME Rep. 01, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(A-25)

Introduced by: Medical Student Section

Subject: Innovation and Reform of Medical Education

Referred to: Reference Committee C

Whereas, in 1904, the American Medical Association created a Council on Medical Education to standardize the preliminary requirements for entry into medical school[1]; and

Whereas, since 1930, medical school prerequisites have remained largely static, besides the addition of a math/calculus requirement and the expansion of organic chemistry from one semester to one year, despite substantial pushback from many scholars, who frequently compare them to hazing rituals[2-8]; and

Whereas, chemistry courses, particularly organic chemistry, disproportionately dissuade students from pursuing medicine, particularly underrepresented minorities and women[7,9]; and

Whereas, the sheer volume of requirements disproportionately impacts lower socioeconomic status (SES) students, resulting in reduced study time, a lower GPA, and reduced time to participate in extracurricular activities, culminating in a discriminatory system that ultimately favors the wealthy[10]; and

Whereas, students with low prerequisite GPAs often take post-baccalaureate courses to compensate, despite data showing that these programs, which commonly attract older, underrepresented, and social science majors, do not improve performance on preclinical medical school exams[11]; and

Whereas, required pre-medical courses, including physics and chemistry, often function as "weed-out" courses and are assessed on the MCAT regardless of coursework, limiting students' ability to explore other important topics for physicians, such as social justice, ethics, or personal interests[12,13]; and

Whereas, community college and associate degrees (AS/AA) are a large source of education throughout the United States, but almost all medical schools require a bachelor's degree (BS/BA) to apply[14]; and

Whereas, requiring a BS/BA for medical school admission imposes significant academic, administrative, and financial burdens, with the average cost of attendance for a 4-year public in-state institution in 2024 being $108,584, over three times the cost of a 2-year in-district program at $34,878[15]; and

Whereas, permitting admission with an AS/AA degree could reduce barriers for students of lower socioeconomic status, who are more likely to attend 2-year programs, fostering a more equitable, affordable, and inclusive path to medicine[15-17]; and

Whereas, the AMA has made it a priority to address medical education costs and student debt through policy H-305.92518; and

Whereas, many community colleges offer all mandatory prerequisites for medical school, and students can take remaining prerequisites at local universities at a lower total cost than pursuing a four-year BS/BA[19]; and

Whereas, AS/AAs degree programs are audited and accredited by the same governing bodies that accredit BS/BA degree programs and are held to the same accreditation standards as BS/BA programs, ensuring equivalent educational quality[20]; and

Whereas, all applicants, regardless of their degree, would still take the Medical School Admissions Test (MCAT), a universal standardized admission assessment tool[21]; and

Whereas, some students initially enroll in a less expensive AS/AA program due to uncertainty of their career path, and then have to return to school later and pay for more courses than necessary, further delaying their entry to medical school[22]; and

Whereas, permitting applicants with alternative degrees to apply to medical school allows them to allocate more time to clinical and research experience while meeting all pre-medical prerequisites and demonstrating academic rigor, especially with the expansion of research opportunities at community colleges[23]; and

Whereas, 31% of dental schools and 96% of pharmacy schools do not require a BS/BA as there is no national admissions requirement[24,25]; and

Whereas, considering students with AS/AA degrees is more closely aligned with the holistic review process that promotes equity and diversity in the medical profession[26]; and

Whereas, physicians and trainees are increasingly concerned by the disproportionate focus of standardized exams on less prevalent conditions compared to conditions such as diabetes and cardiovascular disease, highlighting the need to shift to more clinically relevant examination content that better aligns with competencies for effective patient care[27-31]; and

Whereas, despite medical curricula covering USMLE Step 1 content, clerkship directors report insufficient student preparation in areas like life-cycle stages, epidemiology, and systems of care, while students feel unprepared to apply preclinical knowledge during clinical clerkships due to a disconnect between preclinical and clinical curricula[31-35]; and

Whereas, preclinical exams emphasizing knowledge that is decontextualized and not integrated with clinical knowledge in practice contribute to the difficult transition of medical students between preclerkship and clerkship years[35,36]; and

Whereas, a comparison of pre-clerkship and post-clerkship for both basic sciences test scores and USMLE Step 1 scores showed a significant increase in scores after clerkship, underlying a lack of knowledge that is filled during the clerkship[36-38]; and

Whereas, Step 1 is widely known as an inaccurate predictor of clinical success and shows no strong correlation with residency exam performance, and poor integration of basic sciences with clinical practice undermines the relevance of these subjects, hindering knowledge retention and application[39,40]; and

Whereas, test performance is positively correlated with perceived relevance of examination material, and the evolving landscape of medical practice necessitates that standardized exams be regularly reviewed and updated to ensure valid assessment of knowledge and skills relevant to current clinical practice as indicators of competency[41]; and

Whereas, AMA Policies H-275.929 and H-275.924 set a precedent for revising national standardized exams and continuing certification to ensure they have predictive validity and are relevant to clinical practice, with the AMA Council on Medical Education actively working with the American Board of Medical Specialties to reform maintenance of certification to enhance clinical relevance[42]; and

Whereas, as rising tuition and living costs have led to an average medical student debt of $202,453, accelerated three-year programs, which are increasingly common, help students save on tuition, enter the workforce earlier, and address the projected shortage of 21,100 to 55,200 primary care physicians by 2032[43-48]; and

Whereas, by shortening preclinical curriculum and starting clinical exposure earlier, three-year students meet all graduation requirements while achieving similar clinical performance ratings during key clerkships and maintaining similar outcomes in residency milestones and performance[46,49]; and

Whereas, many three-year medical programs prioritize residency positions in primary care, psychiatry, and under-resourced or rural areas, reducing the time, stress, and cost of a pplying to residency, while also achieving high enrollment of underrepresented groups and significantly higher primary care placement rates compared to the national averages of 9% for allopathic and 23% for osteopathic schools[46,50-54]; and

Whereas, some schools have adopted or are considering a 12-month preclinical curriculum, reducing live lectures in response to students' use of asynchronous online resources, which transitions students to clerkships 6 to 12 months earlier and allows three-year programs to maintain or increase clinical exposure[55-57]; therefore be it

RESOLVED, that our American Medical Association collaborate with AMA’s ChangeMedEd Initiative to study the following topics and report back with recommendations on ways to innovate the structure, content, and timing of medical education:

a) Expansion of three-year pathways and pathways prioritizing residency seats for students entering primary care, OBGYN, psychiatry, and practice in under-resourced, rural, and IHS areas;
b) Re-evaluation of premedical prerequisites for clinical readiness (including organic chemistry, calculus, and calculus-based physics versus high-school physics) and expectation of a bachelor’s degree for medical school;
c) Medical school acceptance of prerequisite credit earned in high school or community college or via placement/test-out examinations, to prevent pressure to repeat coursework;
d) Options to shorten preclinical education to better reflect clinical readiness and emphasize clinical exposure, including external asynchronous study aids, placement/test-out examinations, and completion of preclinical education prior to medical school;
e) Possibility of merging the MCAT and USMLE Step 1/COMLEX Level 1;
f) Changes to standardized exams to better reflect clinical readiness, including adjusting frequency of questions based on their proportional relevance to clinical knowledge

expected for a general medical degree, while still including content on less common concepts. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

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RELEVANT AMA POLICY

H-295.871 Accelerating Change in Medical Education: Strategies for Medical Education Reform
Our AMA continues to recognize the need for transformation of medical education across the continuum from premedical preparation through continuing physician professional development and the need to involve multiple stakeholders in the transformation process, while taking an appropriate leadership and coordinating role. [CME Rep. 13, A-07; Reaffirmed: CME Rep. 01, A-17]

D-295.317 Competency Based Medical Education Across the Continuum of Education and Practice
1. Our American Medical Association Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients.
2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation.
3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents' compensation and lifetime earnings. [CME Rep. 3, A-14; Appended: CME Rep. 04, A-16; Reaffirmed: CME Rep. 04, A-23]

H-200.949 Principles of and Actions to Address Primary Care Workforce
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation’s current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution’s mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice. [CME Rep. 04, I-18; Reaffirmed: CMS Rep. 08, A-2]

H-275.929 Oppose Additions to United States Medical Licensure Examination and Comprehensive Osteopathic Medical Licensure Examination
Our American Medical Association opposes additions to the United States Medical Licensing Examination and Comprehensive Osteopathic Medical Licensure Examination that lack predictive validity for future performance as a physician. [Res. 308, A-04; Reaffirmed: CME Rep. 2, A-14; Modified: CME Rep. 01, A-24]

H-275.924 Continuing Board Certification
Our American Medical Association Principles on Continuing Board Certification
(1) Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content…(4) Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones). (5) CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities… (12) CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care. (13) The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice. (14) CBC should be used as a tool for continuous improvement… (18) CBC activities and measurement should be relevant to clinical practice. (19) The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care. (20) Any assessment should be used to guide physicians' self-directed study. (21) Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner. (22) There should be multiple options for how an assessment could be structured to accommodate different learning styles… (27) Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes. [CME Rep. 16, A-09; Reaffirmed: CME Rep. 11, A-12; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 919, I-13; Appended: Sub. Res. 920, I-14; Reaffirmed: CME Rep. 2, A-15; Appended: Res. 314, A-15Modified: CME Rep. 2, I-15; Reaffirmation A-16; Reaffirmed: Res. 309, A-16; Modified: Res. 307, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 319, A-17; Reaffirmed in lieu of: Res. 322, A-17; Modified: Res. 953, I-17; Reaffirmation: A-19; Modified: CME Rep. 02, A-19; Reaffirmed: Res. 310, I-22; Reaffirmed in lieu of: Res. 302, A-24; Reaffirmed in lieu of: Res. 316, A-24]

H-305.925 Principles of and Actions to Address Medical Education Costs and Student Debt
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 “20/220 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. Our 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.
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. [CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21;

Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21; Reaffirmation: A-22; Appended: CME Rep. 02, A-23; Appended: Res. 311, A-23; Reaffirmed: Res. 314, A-24; Reaffirmed: Res. 215, I-24; Reaffirmed: BOT Rep. 07, I-24]

D-200.985 Strategies for Enhancing Diversity in the Physician Workforce

1. Our American Medical Association, 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.
    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 and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
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 unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order 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; Modified: CME Rep. 02, I-22; Modified: Res. 320, A-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(A-25)

Introduced by: New York

Subject: Disclosure of Individual Physician Volunteers Participation in Committee Decision-making to other Organizations, Stakeholders and Joint Providers

Referred to: Reference Committee C

Whereas, Accredited Continuing Education is recognized as essential for the continuing professional and personal development for physicians to improve the health and wellbeing of patients as well as the communities in which we live and work; and

Whereas, Accreditation Council for Continuing Medical Education (ACCME) updated Standards for Integrity and Independence in accredited Continuing Education policies and guidelines require an accredited provider of Continuing Education (CE) to comply in order to maintain its accreditation status; and

Whereas, the Standard 3 for Integrity and Independence in accredited Continuing Education requires the identification, mitigation and disclosure of relevant financial relationships of all individuals in control of the educational activity to its learners; and

Whereas, the CME committee members are planners of the activity; and

Whereas, the CME committee members, who have fulfilled the stringent requirements of these Standards, are volunteering their time and expertise in the approval process/decision-making of the education activity; and

Whereas, many of the educational activities are with joint providers (of which many are non-physician led CE provider entities) who are engaged in providing accredited CE to physicians; and

Whereas, there are instances when the subject matter and/or the content of the educational activity is considered controversial; and

Whereas, there are instances when the decisions made by the committee are not aligned with the joint provider applicant’s expectations or unfavorable to the joint provider; and

Whereas, despite the existence of an independent appeals process, there have been reported threats of legal action against the committee and its members; and

Whereas, disclosure of individual names of committee members’ attendance, manner of voting or participation in the decision-making of the individual educational activity can have an adverse impact on the volunteers and the committee’s work; and

Whereas, the decisions are made by the committee reflecting its work and not of any individual member, thus making the disclosure of an individual’s personal participation information unnecessary; therefore be it

RESOLVED, that our American Medical Association adopt a policy that individual names of committee members' attendance, manner of voting or participation in the decision-making of the committee activity is considered confidential information and not disclosed to outside entities (other organizations, stakeholders and joint providers) (Directive to Take Action); and be it further

RESOLVED, that our AMA petition the ACCME to amend policies which require disclosure of physician participation in the planning and development of accredited continuing education for physicians. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 4/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(A-25)

Introduced by: Ohio

Subject: Streamlining Annual Compliance Training Requirements for Physicians

Referred to: Reference Committee C

Whereas, compliance training is valuable to maintaining high standards of patient care and professional conduct; and

Whereas, physicians are currently required to complete multiple, often redundant, annual compliance trainings across various healthcare facilities, resulting in undue burdens on their time and resources; and

Whereas, annual compliance training often results in physicians spending an many hours annually on repetitive training sessions, time better utilized for patient care; and

Whereas, the lack of a standardized, centralized system for compliance training contributes to inefficiencies and unnecessary duplication of efforts; and

Whereas, the financial and administrative burdens associated with compliance trainings are significant and often uncompensated; therefore be it

RESOLVED, that our American Medical Association advocate for the creation of reciprocity programs that allow physicians to receive credit for compliance training completed at one healthcare entity towards requirements at other facilities, provided the training meets specified standards (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with relevant stakeholders to explore options for fair compensation or continuing medical education (CME) credits for time spent on mandatory compliance training. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(A-25)

Introduced by: Oklahoma

Subject: Increasing Education on Physician-Led Care and Advocacy in Residency Training

Referred to: Reference Committee C

Whereas, the healthcare landscape is evolving, with increasing pressure from non-physician practitioners and corporate entities, including private equity, which may challenge the physician-led model of care and affect the quality of patient care; and

Whereas, physicians are uniquely qualified to lead patient care in diagnostic and interventional procedures, ensuring that decisions are made with a high degree of medical expertise and in the best interest of patients; and

Whereas, physician-led care is central to the highest quality of healthcare delivery, and preserving this model is crucial to maintaining patient safety, appropriate medical decision-making, and ethical standards in medical practice; and

Whereas, advocacy for physician-led care is essential to protecting the medical profession from external pressures that may dilute physician oversight and autonomy, particularly in the context of healthcare policy, regulation, and corporate influence; and

Whereas, residents are the future leaders of the profession, and it is critical that they are equipped with both the knowledge and skills to advocate for physician-led care and engage in effective advocacy at the local, state, and national levels; and

Whereas, other professions include advocacy in their curricular requirements including engaging with the legislature through advocacy days on the hill such as transporting students to the Capitol during class time for course credit [1] [2] [3]; and

Whereas, our American Medical Association has long lead advocacy, such as the National Advocacy Conference, State Advocacy Summit and Medical Student Advocacy Conference, making it uniquely suited to develop educational modules for trainees; and

Whereas, our AMA plays a pivotal role in supporting education, professional development, and advocacy within the medical community; therefore be it

RESOLVED, that our American Medical Association develop and provide educational resources, toolkits, and workshops that residency programs can implement to teach residents about physician-led care, advocacy strategies, and how to effectively engage with healthcare policymakers and organizations (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage residency programs to include opportunities for residents and trainees to engage in real-world advocacy efforts at the local, state, and national levels, in collaboration with state societies and other medical organizations. (New HOD Policy)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/17/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(A-25)

Introduced by: Resident and Fellow Section

Subject: Protections for Trainees Experiencing Retaliation in Medical Education

Referred to: Reference Committee C

Whereas, discrimination is a pervasive, harmful phenomenon that plagues current graduate medical education programs, with studies finding over 45% of residents had exposure to some type of workplace mistreatment (e.g., discrimination, abuse, harassment) and nearly 25% experience discrimination based on their race, ethnicity, or religion, with the highest rates for Black respondents [1,2,3]; and

Whereas, discrimination has been shown to lead to higher rates of burnout and early withdrawal from residency[2]; and

Whereas, the Accreditation Council for Graduate Medical Education (ACGME) sets and monitors professional educational standards essential in preparing physicians to deliver safe, high-quality medical care to all Americans[4]; and

Whereas, while the ACGME stated in a 2021 press release that it has a process to review reports of discrimination, sexual harassment, and mistreatment, it is not mentioned in their Policies and Procedures manual[5,6]; and

Whereas, there was a recent complaint of an attempt to report discrimination, but no clear path to do so and no support from the ACGME[7]; and

Whereas, residents have reported that the appeals processes offered by their programs were unhelpful as the entities employed to handle these claims primarily serve to protect the institution and not individual residents[8,9]; and

Whereas, fear of program or institutional retaliation for disclosing incidents of harassment and discrimination decreases the likelihood that residents and fellows will use institutional processes[10]; and

Whereas, the concerns of trainees are present across the entire national health care system, suggesting the need for a federal response given the importance of fostering the growth and development of the physician workforce[11]; and

Whereas, the ACGME currently only requires institutions to have "fair, reasonable, and readily available written institutional policies and procedures for grievance and due process" but no further details about this process[12]; and

Whereas, over the last several years, trainees have allegedly been dismissed for private social media posts, whistleblower actions, and book publications with claims that these dismissals were unfair or biased in some way[13]; and

Whereas, residents' and fellows' classifications as either employees or students vary across the healthcare system[14]; and

Whereas, consequences that a trainee faces after termination from their program without sufficient due process protections may result in their inability to continue their education, a consequence that attending physicians do not have[16]; and

Whereas, medical students have experienced retaliation from physicians and non-physicians for advocating for issues relating to patient care, facing threats about their career and future[17]; and

Whereas, medical students have reported fear of potential consequences to the trajectory of their careers, fear of reprisal even in settings of anonymity, and lack of empathy as examples of not reporting mistreatment during medical school[18, 19, 20]; and

Whereas, in AMA Policy H-310.912, "Resident and Fellows' Bills of Rights," the AMA supports trainees to have the opportunity to defend themselves against allegations presented against them with due process guidelines established by the AMA, but these guidelines exist only for physicians, not all trainees; and

Whereas, medical students and physicians in ACGME-accredited residency and fellowship programs do not always receive training in remediation when complaints are lodged against them and are inadequately trained to navigate this process, leading to the risk of dismissal[15,17]; therefore be it

RESOLVED, that our American Medical Association supports efforts to protect residents, fellows, and medical students from disciplinary actions taken by workplaces, institutions, and educational programs that discriminate against an individual based on their identity, beliefs or advocacy (New HOD Policy); and be it further

RESOLVED, that our AMA supports that any disciplinary actions against residents, fellows, and medical students, adhere to due process and use a standardized protocol, which barring patient and workplace safety concerns, may include multiple warnings, opportunities to halt actions in question prior to measures being taken, mediation by and appeals to a third party, especially before long-term suspension, dismissal, expulsion, or termination of contracts. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

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RELEVANT AMA POLICY:

Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools H-310.923
Our AMA encourages residency programs, fellowship programs, and medical schools to: (1) allow trainees to take leave and attend religious and cultural holidays and observances, provided that patient care and the rights of other trainees are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious and cultural holidays and observances. [CME Rep. 10, A-06; Reaffirmed: CME Rep. 01, A-16; Modified: Res. 323, A-22]

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign. [BOT Action in response to referred for decision Res. 602, I-15]

Underrepresented Student Access to US Medical Schools H-350.960
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; (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; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; (5) recognizes

the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations; (6) will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine; (7) will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school; (8) will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants; (9) will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine; and (10) will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, (1) (a) encouraging state and local governments to make quality elementary and secondary education available to all. [Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21; Appended: Res. 305, I-22]

Teacher-Learner Relationship In Medical Education H-295.955
The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality. [BOT Rep. ZZ, I-90; Reaffirmed by CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, I-99; Modified: BOT Rep. 11, A-07; Reaffirmed: CME Rep. 9, A-13; Reaffirmed: BOT Rep. 9, I-20]

Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions H-65.951
Our AMA adopted the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:
GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE
Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.
An effective healthcare anti-discrimination policy should:
• Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
• Ensure the policy is prominently displayed and easily accessible.
• Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.
• Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.
• Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
• Create anti-discrimination policies that:
- Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
- Define expected and prohibited behavior.
- Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.
- Ensure privacy and confidentiality to the reporter.
- Provide a confidential method for documenting and reporting incidents.
- Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.
• These policies should include:
- Taking every complaint seriously.
- Acting upon every complaint immediately.

- Developing appropriate resources to resolve complaints.
- Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
- Communicating decisions and actions taken by the organization following a complaint to all affected parties.
- Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:

• Surveying staff, trainees and medical students, anonymously and confidentially to assess:
- Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Ideas about the impact of this behavior on themselves and patients.
• Integrating lessons learned from surveys into programs and policies.
• Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, bias or microaggressions.
• Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions.
• Providing a designated support person to confidentially accompany the person reporting an event through the process. [Res. 003, A-21]

Support of Human Rights and Freedom H-65.965

1. Our American Medical Association continues to support the dignity of the individual, human rights and the sanctity of human life,
2. Our AMA reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age.
3. Our AMA opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies.
4. Our AMA recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

[CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17; Modified: Res. 013, A-22; Reaffirmed: BOT Rep. 5, I-22]

Residents and Fellows' Bill of Rights H-310.912

1. Our American Medical Association continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows:
    a. Adequate financial support for and guaranteed leave to attend professional meetings.
    b. Submission of training verification information to requesting agencies within 30 days of the request.
    c. Adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period.
    d. Health insurance benefits to include dental and vision services.
    e. Paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year.
    f. Stronger due process guidelines.

2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA:
    a. will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds.
    b. encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement).
    c. encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right t

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

    With regard to education, residents and fellows should expect:

    1. A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations;
    2. Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities;
    3. Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value;
    4. 24-hour per day access to information resources to educate themselves further about appropriate patient care; and
    5. Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

    With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
With regard to evaluation and assessment processes, residents and fellows should expect:
    1. Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work;
    2. To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion;
    3. Access to their training file and to be made aware of the contents of their file on an annual basis; and
    4. Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.
With regard to the workplace, residents and fellows should have access to:
    1. A safe workplace that enables them to fulfill their clinical duties and educational obligations;
    2. Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit;
    3. Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.
    1. With regard to contracts, residents and fellows should receive:
        a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance.
        b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
    2. With regard to compensation, residents and fellows should receive:
        a. Compensation for time at orientation.
        b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
    3. With regard to benefits, residents and fellows must be fully informed of and should receive:
        a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program.
        b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues.
        c. Confidential access to mental health and substance abuse services.
        d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks.
        e. Leave in compliance with the Family and Medical Leave Act.
        f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience:

1. A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME.
2. At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations
With regard to reporting violations to the ACGME, residents and fellows should:
1. Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official.
2. Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process.
3. Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.
10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).
11. The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.
12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles, including resident/fellow empowerment and peer-selected representation in institutional leadership.
13. Our AMA encourages development of accreditation standards and institutional policies designed to facilitate and protect residents/fellows who seek to exercise their rights.
14. Our AMA encourages the formation of peer-led resident/fellow organizations that can advocate for trainees' interests, as outlined by the AMA's Residents and Fellows' Bill of Rights, at sponsoring institutions.

[CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21; Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21; Reaffirmation: A-22; Reaffirmed in lieu of: Res. 307, I-22; Modified: CME Rep. 05, I-23; Reaffirmed: CME Rep. 02, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(A-25)

Introduced by: Resident and Fellow Section

Subject: Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter

Referred to: Reference Committee C

Whereas, housestaff in unions are represented predominantly by the Committee of Interns and Residents (CIR),[1] with other organizations including the Union of American Physicians and Dentists (UAPD), the American Federation of State, County & Municipal Employees (AFSCME), and the American Federation of Teachers (AFT); and

Whereas, given limitations of the residency and fellowship Match that limit free market competition for applicants, including ability to negotiate a contract, unionization is the sole mechanism for negotiation via collective bargaining[2,3]; and

Whereas, housestaff are vulnerable health care workers who are unable to negotiate a contract prior to employment, easily transfer jobs, or leave their job without sacrificing their career prospects; and

Whereas, current AMA policy supports the unionization of physicians (Policy H-385.946, H-385.976) and supports the study of alternative options to the current residency and fellowship Match process which would be less restrictive on free market competition for applicants (Policy D-310.977); and

Whereas, the American Medical Association has promoted unionization for housestaff through its media outlets[4]; and

Whereas, there is no existing AMA policy supporting the dissemination of existing unionized hospitals for trainees to make more informed decisions about their workplace environment during the Match process; and

Whereas, FREIDA™ is the AMA's residency/fellowship database which allows members to browse over 13,000 ACGME-accredited programs, with filters for specialty, location, application type, visas accepted, childcare options, salary, and percentage U.S. MD/DO/IMG; and

Whereas, FREIDA™ does not have a filter for program unionization; therefore be it

RESOLVED, that our American Medical Association supports transparency and access to information about medical training program unionization status (New HOD Policy); and be it further

RESOLVED, that our AMA creates and maintains an up-to-date unionization filter on FREIDA™ for trainees to make informed decisions during the Match. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

REFERENCES:

1. Committee of Interns and Residents: The National Voice of Residents. Committee of Interns and Residents/SEIU Healthcare https://www.cirseiu.org/
2. Boston Medical Center Corp., 330 N.L.R.B. 152 (N.L.R.B-BD 1999)
3. Jung v. Association of American Medical Colleges, 339 F. Supp. 2d 26 (D.D.C. 2004)
4. What I Wish I Knew in Residency About Collective Bargaining. The American Medical Association. March 21, 2024. https://www.ama-assn.org/medical-residents/residency-life/what-i-wish-i-knew-residency-about-collective-bargaining

RELEVANT AMA POLICY:

Investigation into Residents, Fellows and Physician Unions D-383.977
Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment. [Res. 606, A-19]

Resident Physicians, Unions and Organized Labor H-383.998
Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients. [CME Rep. 7, A-00; Reaffirmed: CME Rep. 2, A-10; Modified: Speakers Rep. 01, A-17; Reaffirmed: BOT Rep. 13, A-19]

Political Action by Physicians 1.2.10
Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients. However, they have a responsibility to do so in ways that are not disruptive to patient care. Physicians who participate in advocacy activities should: (a) Ensure that the health of patients is not jeopardized and that patient care is not compromised. (b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice. (c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians' primary and overriding commitment to patients. (d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate. [AMA Principles of Medical Ethics: I,III,VI, Issued: 2016]

Physician Collective Bargaining H-385.976
Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians. (2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature. (3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively. (4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients. (5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care. [BOT Rep. P, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-

03; Reaffirmation A-04; Reaffirmed in lieu of Res. 105, A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT Rep. 17, A-09; Reaffirmation I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed: Res. 206, A-19]

Collective Bargaining for Physicians H-385.946
The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation. [Res. 239, A-97; Reaffirmation I-98; Reaffirmation A-01; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-10; Reaffirmed: Res. 206, A-19]

Physicians' Ability to Negotiate and Undergo Practice Consolidation H-383.988
Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare. [Res. 229, A-12; Reaffirmed: Res. 206, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(A-25)

Introduced by: International Medical Graduates Section

Subject: Selection of IMG Residents Based on Merit

Referred to: Reference Committee C

Whereas, our American Medical Association acknowledges the significant contributions of International Medical Students and Graduates and unequivocally supports their participation in the U.S. residency and fellowship programs; and

Whereas, according to the 2023-2024 GME Data Resource Book from ACGME, of the 133,776 total active residents in specialty programs, 21.7% (29,058) are international medical school graduates (IMGs)[(2)]; and

Whereas, according to the AAMC 2024 U.S. Physician Workforce Data Dashboard, of the 1,010,892 active physicians in the country, 24.7% (249,690) were International Medical Graduates[(3);] and

Whereas, our AMA recognizes the vital role of International Medical Graduates (IMGs) in academic and community medicine and supports policies that enhance their integration, career advancement, and access to opportunities in research and leadership; and

Whereas, our AMA emphasizes that international medical graduates (IMGs) are more likely to practice in lower-income and disadvantaged communities; and

Whereas, our AMA recognizes that more than 20 million people in the United States reside in areas where foreign-trained physicians comprise at least half of the physician workforce. Furthermore, in these rural and underserved areas, at-risk U.S. citizens depend on visa-sponsored physicians to provide essential primary care and specialty health services;[(4);] and

Whereas, our AMA advocates and encourages all residency and fellowship programs to select candidates based on merit, including skills, experiences, and overall qualifications, when being considered for their programs. Furthermore, it should also be ensured that the international medical student or graduate status or the use of an ethnic name should not be considered as a negative factor.[(4,5)] ; and

Whereas, our AMA encourages and will collaborate with the Accreditation Council for Graduate Medical Education (ACGME) and the National Residency Matching Program (NRMP) to eliminate questioning and discrimination related to the race, national origin, and religion of the applicant during the residency and fellowship application process[(7)]; and

Whereas, our AMA strongly opposes the use of any discriminatory filters in the Electronic Residency Application Service (ERAS©) that unfairly screens any potential applicant, including International Medical Graduates[(8)]; and

Whereas, our AMA urges all graduate medical education programs to utilize a standardized interview format for all applicants, regardless of International medical student or graduate status, to promote equity, fairness, and transparency[9]; and

Whereas, our AMA will continue to work with relevant authorities to support residency program directors to establish the necessary and effective connection with the State Department and the Department of Homeland Security; and

Whereas, misinformation about immigration requirements, delayed visa processing times, and increased bureaucratic hurdles can disproportionately impact the recruitment and retention of International Medical Graduates (IMGs) in residency programs, exacerbating workforce shortages and limiting access to care in underserved areas; therefore be it

RESOLVED, that our American Medical Association collaborate with appropriate stakeholders to develop and disseminate educational resources for program directors and institutions on immigration policy updates that may impact resident recruitment and training and actively work to combat disinformation surrounding immigration policies. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/22/25

REFERENCES

1. https://policysearch.ama-assn.org/policyfinder/detail/visa?uri=%2FAMADoc%2Fdirectives.xml-D-255.980.xml
2. https://www.acgme.org/about/publications-and-resources/graduate-medical-education-data-resource-book/
3. https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard
4. https://policysearch.ama-assn.org/policyfinder/detail/merit?uri=%2FAMADoc%2FHOD.xml-0-1782.xml
5. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2022-2-14-AMA-Statement-for-the-Record-re-Immigration.pdf
6. https://policysearch.ama-assn.org/policyfinder/detail/%22International%20Medical%20Graduates%22?uri=%2FAMADoc%2FHOD.xml-0-1790.xml
7. https://policysearch.ama-assn.org/policyfinder/detail/residency%20discrimination%20?uri=%2FAMADoc%2FHOD.xml-0-2503.xml
8. https://policysearch.ama-assn.org/policyfinder/detail/%22International%20Medical%20Graduates%22?uri=%2FAMADoc%2FHOD.xml-H-255.963.xml
9. https://policysearch.ama-assn.org/policyfinder/detail/%22Ensuring%20Equity%20in%20Interview%20Processes%20for%20Entry%20to%20Undergraduate%20and%20Graduate%20Medical%20Education%20H-295.844%22?uri=%2FAMADoc%2FHOD.xml-H-295.844.xml
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RELEVANT AMA POLICY

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.

5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

USMLE Scores not Sole Criteria for Residency Selection H-255.980

1. Our AMA (1) urges that the United States Medical Licensing Examination (USMLE) scores not be used as the sole criteria for selecting interns and residents; (2) recommends that residency programs consider all of the candidates' attributes and qualifications during the selection process; and (3) reaffirms policy that residency appointments should be made solely on the basis of the individual applicant's merit and qualifications.

AMA Principles on International Medical Graduates H-255.988

1. Our American Medical Association supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:
    a. completion of medical school and residency training outside the U.S.;
    b. extensive U.S. medical practice; and
    c. evidence of good standing within the local medical community.
13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.

14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. Our AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. Our AMA membership outreach to IMGs to include
    a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
    b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
    c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
    d. expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
24. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
25. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion;
2. will work with the Accreditation Council for Graduate Medical Education, the National ResidencyMatching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process;
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants;
4. encourages the Association of American Medical Colleges (AAMC) and its Electronic ResidencyApplication Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and
5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

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

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

Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education H-295.844

1. Our American Medical Association will encourage interested parties to study the impact of different interview formats on applicants, programs, and institutions.
2. Our AMA will continue to monitor the impact of different interview formats for medical school and graduate medical education programs and their effect upon equity, access, monetary cost, and time burden along with the potential downstream effects upon on applicants, programs, and institutions.
3. Our AMA recommends that individual medical schools use the same interview format for all applicants to the same class at their institution to promote equity and fairness while allowing for accommodations for individuals with disabilities.
4. Our AMA recommends that individual graduate medical education programs use the same interview format for all applicants to the same program to promote equity and fairness while allowing for accommodations for individuals with disabilities.

Visa Complications for IMGs in GME D-255.991

1. Our American Medical Association will
    a. work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice.
    b. promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates.
    c. work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency

applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.

2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Abolish Discrimination in Licensure of IMGs H-255.966

Our American Medical Association supports the following principles related to medical licensure of international medical graduates (IMGs):

a. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.
b. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.
c. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.
d. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.
e. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards (FSMB) and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.

Our AMA will continue to work with the FSMB to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.

Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.

Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.

Our AMA will:

a. encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas.
b. encourage the FSMB and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure--including successes, failures, and barriers to implementation.

Reference Committee D

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02 Addressing Social Determinants of Health Through Closed Loop Referral Systems
03 Protections Against Surgical Smoke Exposure
04 Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals
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404 Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers
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420 Study of Plant-Based & Lab-Grown Meat
421 Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities
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423 Requiring Universal Vaccine reporting to a National Immunization Registry and Access to a National Immunization Information System
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431 Alcohol & Breast Cancer Risk
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433 Clinical Lactation Care
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REPORT OF THE BOARD OF TRUSTEES

B of T Report 20-A-25

Subject: Guardianship and Conservatorship Reform

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee D

At the 2024 Annual Meeting, the House of Delegates referred Resolution 402-A-24 for a report back at the 2025 Annual Meeting. Resolution 402-A-24 states:

> RESOLVED, that our American Medical Association support federal and state efforts to collect anonymized data on guardianships and conservatorships to assess the effects on medical decision making and rates of abuse (New HOD Policy); and be it further
>
> RESOLVED, that our AMA study the impact of less restrictive alternatives to guardianships and conservatorships including supported decision making on medical decision making, health outcomes, and quality of life. (Directive to Take Action)

BACKGROUND

According to the U.S. Department of Justice, "guardianship should be a last resort because it removes the individual's legal rights and restricts the person's independence and self-determination.[i]" Less restrictive alternatives to guardianships include supported decision-making, delegating health care decision-making to a person chosen by the individual in advance (advance directives), delegating financial decision-making to a person named in advance (financial power of attorney; trust), and a court order authorizing a specific action (such as a health care consent), instead of appointing a guardian whose authority continues over time.[ii] Additionally, medical proxies, living wills, and protective arrangements as specified in the Uniform Guardianship, Conservatorship, and Other Protective Arrangements Act (the "Uniform Guardianship Act") are terms for other less restrictive alternatives to guardianships in the health care setting.[iii]

Due in part to high-profile celebrity cases that illustrate the significant barriers to modifying or overturning a guardianship, there is a nationwide push towards guardianship reform and less restrictive alternatives to guardianships which place more decision-making powers in the hands of the individual or the protected person. In 2022, the Fourth National Guardianship Summit adopted the Uniform Guardianship Act and its provisions regarding less restrictive alternatives and training on alternatives for judges, lawyers and other interested parties.[iv]

The Uniform Guardianship Act provides evidence-based procedures and best practices for guardian appointments. However, the Uniform Guardianship Act has not been adopted by all 50 states. A majority of states require courts to consider whether guardianship is necessary, whether the respondent's needs or interests could be protected by less restrictive means, or both.

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Though all 50 states and the District of Columbia have laws regarding guardianship and conservatorship,[v] the legal framework and terminology vary from state to state. Even the scope of a guardianship may vary, with some guardianships focused only on the individual's personal interests and others focused on the individual's property interests (e.g., financial assets). Some address both aspects.

Requirements for proving that a guardianship is absolutely necessary vary among the 50 states, with the highest level of proof being "beyond a reasonable doubt.[vi]" This is the least used standard, with only New Hampshire applying this standard.[vii] Most states apply a "clear and convincing evidence" standard, which is lower than the "beyond a reasonable doubt" standard but higher than the "preponderance of the evidence" standard, the lowest of the three.[viii] To add to the complexity, some states apply a different standard to overturn or rescind a guardianship than the standard that was used to establish the guardianship.[ix]

The decision-making standards for guardians also vary among the states. Most states use the "substitute judgment" standard which requires the guardian to substitute the protected person's values and desires for their own to make decisions about the protected person, and by extension, to discern the protected person's personal values and wishes.[x] The "best interest" standard is similarly used by many states and requires that the guardian make decisions by reference to the guardian's belief about what is the general best interest of the protected person.[xi] Less restrictive approaches attempt to preserve the will, preferences, and rights of the individual, and these include the "maximum self-reliance standard" and the "least restrictive standard."[xii] Finally, it should be noted some states are silent on the applicable decision-making standard for guardians.

There are other relevant factors that could affect the impact of a guardianship on a protected person's medical decision-making, health outcomes, and quality of life, as compared to a person with a less restrictive alternative. For example, states also vary in their qualifications and monitoring requirements for appointed guardians.

Finally, data about guardianships, conservatorships, and less restrictive alternatives are not uniformly collected. This is in part due to the lack of consistency in definitions regarding guardianships and less restrictive alternatives, including what would be considered a less restrictive alternative. There also does not appear to be a well-known mechanism to collect data, anonymized or not, on the outcomes on medical decision-making and quality of life as a result of these arrangements. The highly sensitive nature of the proceedings demands confidentiality, and such restrictions could make data collection and interpretation difficult. There are few if any organized databases that contain statewide data on guardianships, or on less restrictive alternatives to guardianships. This information is not often collected, and when it is collected, it is stored at the county level. These factors are all significant barriers to a well-designed study.

RELEVANT CURRENT AMA POLICY

Current AMA Policy H-140.845, "Encouraging the Use of Advance Directives and Health Care Powers of Attorney," supports the use of a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD). It further supports a national public health priority to "educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD."

DISCUSSION

The AMA is supportive of efforts to standardize laws concerning the establishment, modification, or termination of a guardianship. High-profile celebrity cases have highlighted existing challenges for individuals to overturn or modify guardianships. To the extent possible, guardianships should be limited in scope and duration, with clear pathways to modify or overturn a guardianship. In the meantime, less restrictive alternatives to guardianship should be favored and guardianships should be viewed as the last resort.

There are inconsistent standards for what constitutes a guardianship, when a guardianship should be established, what decision-making standard should be applied, and how guardians are vetted or appointed. These factors make it difficult to study the impact of less restrictive alternatives to guardianships and conservatorships on medical decision making, health outcomes, and quality of life. Additionally, due to the unclear scope of guardianships in general (since some guardianships address financial interests only and some are a mix of both personal and financial interests), data collection and interpretation in this area may be impractical or otherwise overly burdensome. Though a study may not be feasible or recommended, the AMA encourages more extensive data collection efforts at the state level.

The AMA is supportive of actions that promote increased clarity on when guardianships should be instituted, what conditions should prompt modifications to the guardianship, and when a guardianship should be rescinded or terminated. Similarly, in the health care setting, promoting the use of less restrictive alternatives such as advance directives and health care powers of attorneys should continue to be promoted.

Due to an uneven legal landscape of different standards, terminology, and requirements, combined with inadequate data collection practices on the state level, and the inability to procure a reliable dataset from a reputable source, the Board believes it would not be feasible to complete a well-designed study to consider the impact on medical decision-making, health outcomes, and quality of life, when less restrictive alternatives to guardianships in the health care setting are used. It is likely that such a study would confirm what is already well-supported – that guardianships should be considered a last resort.

The Board encourages state and federal efforts to define and promote less restrictive alternatives to guardianships such as those detailed in the Uniform Guardianship Act. Our AMA is better positioned to support efforts to enact legislation like the Uniform Guardianship Act that preserves the will, preferences, and rights of the protected individual, especially as it relates to medical decisions that directly affect the individual's health outcomes and quality of life.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 402-A-24, and the remainder of the report be filed:

1. That our AMA encourages efforts to standardize laws concerning the establishment, modification, or termination of a guardianship, and favors less restrictive alternatives to guardianship, which should be viewed as a last resort. (New HOD Policy)

2. That Policy H-140.845, "Encouraging the Use of Advance Directives and Health Care Powers of Attorney" be reaffirmed.

AMA Policy H-140.845, "Encouraging the Use of Advance Directives and Health Care Powers of Attorney,"

Our AMA will:
(1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies;
(2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility;
(3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD);
(4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD;
(5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems;
(6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas;
(7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license;
(8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives;
(9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and
(11) advocate for the implementation of secure electronic advance health care directives.

Fiscal Note: Less than $500

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[i] https://www.justice.gov/elderjustice/guardianship-less-restrictive-options (Last access February 24, 2025)
[ii] *Id.*
[iii] *Id.*
[iv] https://www.americanbar.org/content/dam/aba/administrative/law_aging/2022-sdm-lst-rstctd-altntvs.pdf (Accessed February 17, 2025)
[v] https://www.americanbar.org/content/dam/aba/administrative/law_aging/2019-adult-guardianship-statutory-table-of-authorities.pdf (Accessed February 10, 2025)
[vi] Kelly, JD, LLM, Annemarie M., Lewis B. Hershey, PhD, MA, Christina N. Marsack-Topolewski, PhD, LMSW, *A 50-State Review of Guardianship Laws: Specific Concerns for Special Needs Planning, Journal of Financial Service Professionals*, Vol. 75, No. 1, pp 59-79, 61, January 2021.
[vii] *Id.*
[viii] *Id.*
[ix] *Id.*
[x] Kelly, JD, LLM, Annemarie M., Lewis B. Hershey, PhD, MA, Christina N. Marsack-Topolewski, PhD, LMSW, *A 50-State Review of Guardianship Laws: Specific Concerns for Special Needs Planning, Journal of Financial Service Professionals*, Vol. 75, No. 1, pp 59-79, 69, January 2021.
[xi] *Id.*
[xii] *Id.*

REPORT 2 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-25)
Addressing Social Determinants of Health Through Closed Loop Referral Systems
(Reference Committee D)

EXECUTIVE SUMMARY

BACKGROUND. American Medical Association (AMA) Policy D-165.932 "Addressing Social Determinants of Health Through Closed Loop Referral Systems," as adopted by the House of Delegates (HOD), asked that our AMA study the effectiveness and best practices of closed loop referral systems in addressing social determinants of health.

METHODS. English language articles were selected and reviewed from searches of PubMed and Google Scholar using the search terms "closed loop referral system", "United States Core Data for Interoperability," "closed loop referral system AND social determinants of health (SDOH)" and "United States Core Data for Interoperability AND SDOH". Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies; applicable organizations were also reviewed for relevant information.

DISCUSSION. There is compelling evidence that links social risks—such as food, housing, transportation, or economic insecurity—to health care outcomes, which encourages health care practices to consider how to improve patients' social conditions. As a result, health care practices report screening patients for at least one health-related social need (HRSN). For many health care practices, the next step is providing patients with a referral to community-based organizations (CBOs) to address social needs. A closed loop referral platform can allow for efficient communication and coordination between health care professionals and CBOs. It helps ensure patient data and information are communicated to the right individuals at the right time, allowing for review, action, acknowledgment, and documentation. The platform facilitates referrals from health care professionals to CBOs and enables them to report back on whether the patient's HRSNs were addressed.

CONCLUSION. Studies have shown that barriers to implementing closed loop referral systems include technology (electronic referral, response and feedback), processes (effectiveness, efficiency), organizational (management, policy and planning, rules and regulations), and patient-centered individual characteristics (social capital, transportation, awareness, attitude, satisfaction, and social influence). The recommendations of the report are based on best practices to implement closed loop referral systems such as: (1) establishment of collaborative governance for shared decision-making processes, fostering trust, alignment, and transparency among organizations; (2) development of technology linkages between existing platforms to facilitate seamless referrals between organizations and ensure visibility of referral outcomes; (3) integration of regional resource directories into technology infrastructure to ensure resource accessibility/quality; and (4) evaluation of the system's impact on health equity, efficiency, and cost reduction.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-A-25

Subject: Addressing Social Determinants of Health Through Closed Loop Referral Systems

Presented by: John T. Carlo, MD, MS, Chair

Referred to: Reference Committee D

INTRODUCTION

American Medical Association (AMA) Policy D-165.932 "Addressing Social Determinants of Health Through Closed Loop Referral Systems," as adopted by the House of Delegates (HOD), asked that our AMA study the effectiveness and best practices of closed loop referral systems in addressing social determinants of health.

BACKGROUND

Understanding Social Determinants of Health and Health-Related Social Needs

The way communities and individuals experience health and health care is not just based on access to medical services. It is also impacted by other factors that may support or create barriers to health and well-being. At a community level, these factors are referred to as social determinants of health (SDOH) and may also be referred to as "social drivers of health" (See APPENDIX 1 - Key Terms).[1] Examples of SDOH include economic stability, access to quality education and health care, the neighborhood, and built environment.[1] The specific factors that impact individuals directly are called health related social needs (HRSN).[2] Examples of HRSN include lack of stable or affordable housing and utilities, financial strain, lack of access to healthy food, personal safety, and lack of access to transportation.[1] While SDOH and HRSNs often coincide and overlap, the relationship between them can be complex. For example, a household with income below the federal poverty line (which could constitute an individual-level HRSN) that is living in an area with poor economic conditions (a community-level SDOH) is more likely to be exposed to housing that exacerbates health problems like asthma.[1] That household may be unable to afford living in areas with safer housing and may therefore benefit from various forms of housing assistance.[1] In this example, both the HRSN of having low income and the SDOH of living in an area with poor housing quality need to be addressed to holistically improve the household's situation and health outcomes.[1] Addressing SDOH and HRSNs requires implementing sets of policies and interventions involving community partners. Addressing both SDOH and HRSN is an important component of efforts to overcome disparities and achieve health equity for individuals and communities.[2]

A Closer Look at SDOH and HRSN in the U.S.

Systematic and structural inequities such as limited employment and educational opportunities, lack of affordable and safe housing, low availability of nutritious foods, high rates of exposure to environmental health hazards, and inadequate access to health care services, can jeopardize health

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and well-being.[3] Disparities resulting from these structural inequities often disproportionately impact historically underserved individuals such as Blacks, Latinx, members of Tribal Nations, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; persons who live in communities with environmental justice concerns; older persons; women and girls; and persons otherwise experiencing persistent poverty.[3] These disparities exist for many health outcomes, including infant and maternal mortality, heart disease, diabetes, hypertension, chronic illness, disability, cancer, mental illness, substance use, and overall life expectancy.[4–6] For instance, the life expectancy for Black Americans is four years shorter than White Americans.[6] People of color have higher rates of diabetes, hypertension, obesity, asthma, and premature death compared to non-Hispanic Whites, due in part to social and economic factors.[6,7] People living in rural areas are more likely than their urban counterparts to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke.[6,8] Many of these disparities stem from differences in social and economic circumstances between these demographics.

An important contributor to health disparities is the inequitable distribution of social resources in localities across the country.[6,8] For example, a history of racialized practices and policies—housing discrimination, unequal educational opportunities, disproportionate incarceration rates, inequitable employment practices—has created inequities for many communities.[9] Inadequate access to social and health care services in many areas of the country has led to widening gaps in outcomes.[10] Notably, the cumulative impacts of environmental and climate factors have significant influence on health outcomes. Inequitable access to clean water, clean air, and natural green spaces with tree cover led to disproportionate environmental burdens for many communities.[11] These environmental injustices create new and exacerbate longstanding disparities in health outcomes. People who live in communities with environmental concerns may suffer from poorer health and have shorter life expectancies than those in other communities.[6,11] It is estimated that, on average, clinical care impacts only 20 percent of county-level variation in health outcomes, while SDOH affects as much as 50 percent of health outcomes.[6,8]

METHODS

English language articles will be selected from searches of PubMed and Google Scholar using the search terms “closed loop referral system”, “United States Core Data for Interoperability (USCDI),” “closed loop referral system AND social determinants of health (SDOH)” and “United States Core Data for Interoperability AND SDOH”. Additional articles will be identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies; applicable organizations will also be reviewed for relevant information.

DISCUSSION

What Is a Closed Loop Referral System?

Closed loop referral systems provide a means for health care professionals to send patient information to a CBO to help address a patient’s needs that are typically better served outside of clinical workflows.[12] A CBO can provide an array of support programs within the community, including services that address a patient's social needs or address underlying causes of poor health outcomes with the goal of positively impacting the patient’s overall health outcome(s).[12] The CBO can then provide feedback on the outcome of that referral to the referring individual/entity.[12] Closed loop referrals depend on an often-overlooked capability for the referral process to originate in a health care setting and progress to a CBO, and then for the CBO to further refer the patient to

another CBO which may be better positioned to help that patient, with the whole care team then being able to follow the referral through that process and any other redirects that may occur.[13] At the core, a closed loop referral process represents a significant shift in the way systems, institutions, clinicians, communities, and families communicate.[13]

Lessons Learned from Early Adopters of Closed Loop Referral Systems

There is a growing body of evidence on the success of closed loop referral systems to improve health.[14] In a recent study examining 16 years of data from different communities, death due to cardiovascular disease, diabetes and influenza declined significantly among communities that expanded multisector networks supporting population health activities.[14,15] The first randomized control trial (RCT) to evaluate health outcomes of a clinic-based pediatric navigation program, demonstrated a significant decrease in reported HRSN and improved children's overall health status, as reported by caregivers.[14,16] An Eastern Massachusetts project of six pediatric practices engaged parents to create and use an online, interactive community resources map, results showed 76 percent of participants were physically active at new places, 57 percent shopped at new locations for groceries; and 71 percent reported they were very satisfied with the information they received.[14,17]

Studies have also looked at the role of the technology in screening and referrals.[14,16,18,19] A 2014 RCT comparing patient disclosure rates for unmet needs between electronic and face-to-face methods found significantly higher disclosure rates when employing electronic formats for sensitive issues (i.e., household violence, substance use) and marginally higher rates when used for less sensitive issues (i.e., financial insecurity, neighborhood and school safety), suggesting that technology has a role to play in solving challenges related to accurately identifying needs.[19] A separate study of youth found the majority willing to participate in a technology-based system for SDOH screening and that nearly half successfully addressed their priority concern.[18]

Care teams and health care organizations (HCOs) involved in implementing HRSN screening and referral programs have reported multiple challenges.[20] HCO staff reported that they were unfamiliar with the social services organizations in their communities or that the compiled lists of community resources were neither complete nor up to date.[20–23] Staff also reported having difficulty sending referrals to non–HCOs.[20,21,24] Many electronic health record (EHR) systems have historically lacked the capacity to document and track the delivery of care coordination services related to HRSN, as well as the outcomes of social services referrals.[20,25] Over the past decade a cluster of technology companies have developed software products to overcome these barriers to medical and social services coordination.[25]

The impetus to invest in closed loop referral technology systems was the result of a desire to be able to address patients' social needs more efficiently.[20,25] This included wanting to have centralized staff lists of community resources, send electronic referrals, and to receive updates on referral outcomes from community partners to improve their capacity to track patients' access to services across settings.[20] Some groups were motivated by external programs or value-based payment reforms that incentivized or required better care coordination with social services.[20] Examples included the Accountable Health Communities Model of the Centers for Medicare and Medicaid Services (CMS) Innovation Center, the CMS State Innovation Models initiative, and New York's Delivery System Reform Incentive Payment program.[20,26–28]

Implementors of closed loop referral systems described three funding sources used to cover platform licenses and implementation costs: grants and other short-term pilot funds, operational funds, and value-based health care transformation dollars.[20] Pilot funds typically originated from

either foundations or demonstration projects sponsored by federal or state governments, such as the federal Accountable Health Communities Model, and State Innovation Model grants.[20,26,28]To facilitate community partners' use of the closed loop referral systems, HCOs either covered the cost of community partner organizations' software licenses or chose platforms that provided the product free of charge to affiliated CBOs.[20]

The most common challenge was recruiting CBOs to use the platforms, which was necessary for HCOs to be notified of referral outcomes.[20,29] HCOs generally attributed recruitment barriers to community partners' lack of resources and incentives.[20,29] Though community partners were almost universally provided with access to the closed loop referral system at no direct cost, implementation required indirect resources—for example, to train staff on using the closed loop referral system or to develop and maintain effective workflows for monitoring and responding to incoming referrals.[29] CBOs did not always have clear incentives for using the closed loop referral system, and the resources required for implementation prevented many organizations, especially very small ones, from adopting closed loop referral system.[20,29] As a result, many of the groups had not been able to track referral outcomes. Introducing a closed loop referral system could prove burdensome if CBOs were asked by different HCOs to use different platforms for different clients.[20,29] One solution was to use a common platform, as is the case in North Carolina.[20,30]

Among HCOs that reported success in recruiting community partners to use the closed loop referral system, three engagement strategies were cited. First, engaging CBOs in the platform selection process helped establish those partners' buy-in.[20,31] For example, one county health department established a coalition of thirty health care and community-based social services organizations.[20,31] The coalition undertook a joint assessment of platform referral functionalities, defined priority functionalities, and invited vendors to demonstrate their platforms. Once a shared platform was selected, subgroups within the larger coalition were assigned tasks such as designing the resource directory, referral system, and coalition wide release of information form.[20,31] Six months into distribution, the organizations started to exchange referrals through the platform, which was faster than most other organizations were able to implement this function.[20,31]

Second, CBOs were more accepting when HCOs clearly explored and articulated the potential benefits of the closed loop referral system during recruitment of CBOs.[20,32] Some HCOs reported that community partners became especially enthusiastic about the closed loop referral system when they learned that it could help them refer their clients to other organizations or health care professionals, in addition to increasing traffic and coordination for incoming referrals from health care systems.[20,32] Another powerful motivator for some CBOs was the potential to formally contract with and be reimbursed by health systems or payers for services rendered to referred patients, which could be more easily documented in the platform.[32]

Third, HCOs that successfully recruited CBOs as partners also described hiring staff to visit the organizations and stay in close contact to build rapport, support ongoing communication and coordination about the technology, and manage problems.[32] In one instance, a HCO had a network coordinator who published a biweekly electronic newsletter that was sent to all referral partners to answer common questions and provide updates about what kinds of programs partner organizations offered and what new organizations had joined the network.[20,32]

Within HCOs, groups described the need to convey the rationale, vision, and goals for better integrating social care and medical care to internal health care end users; to develop workflows that matched the needs and demands of those users; and to monitor and manage staff expectations.[20,31] One health system hosted an internal planning session with designated end users and then developed a project workflow and selected a set of social risk screening questions for

medical assistants to use.[20,31] Once staff started using the platform and were able to see positive effects on patients' lives, they became more enthusiastic about the technology.[20,31] It was also important to name staff champions, who tended to have experience with social interventions, to improve the internal process.[20,31,32] Staff champions could generate momentum when they endorsed the rationale for closed loop referral system adoption: having these champions helped convince other staff to stay involved as the organization worked to fold social risk screening and referral into workflows.[20,31,32]

A third set of challenges was clustered around the legal and privacy barriers to sharing data with external, non–HCOs.[20] This included the lack of clarity about what patient information could be shared, with whom, and how.[20] Overcoming these privacy concerns took longer when data were shared with multiple sectors, because each sector had different requirements for handling confidential data.[20,31–33] For example, substance use treatment programs cannot disclose any patient identities without consent.[20,31–33] One HCO used its platform only internally because the organization's legal department did not authorize sharing any data with external partners.[33] Patient consent protocols also took time to establish. In some cases, organizations have found ways to record consent over the phone or online to streamline the process.[20,32,33] Despite these important challenges, most groups reported overall satisfaction with the platform they had chosen, although implementation was slower than anticipated.[20,32,33]

Even if implementation challenges were overcome, HCOs and their community partners face the challenge of financially sustaining their platforms.[20] Promising models have emerged in places such as New York, where the Delivery System Reform Incentive Payment program financially incentivizes HCOs to establish partnerships with CBOs.[20,26,30] In California and Oregon, organizations that served Medicaid patients used health insurance benefits, bundled payment, and shared savings programs to support social services and build infrastructure to bridge the gap between medical and social care.[20,34] Continued expansion of state Medicaid social risk interventions could be a major driver of increased adoption of these technologies.[20,35] Health information exchanges, funded through a combination of public and private investment, are coming online and hold promise as infrastructure for closed loop referral systems.[14,36] In California, Oregon, New York, Washington, North Carolina and elsewhere, states are building upon previous Medicaid waivers and layering federal opportunities to establish more ambitious partnerships and programs addressing SDOH.[37–42] However, Medicaid waivers are a time-limited sources of innovation to test and pilot approaches for adoption by states, therefore sustainability of these efforts is uncertain.[26,34,39,41,42]

IMPLEMENTATION CONSIDERATIONS FOR CLOSED LOOP REFERRAL SYSTEMS

Localized Needs and Resource Availability

Historically, the U.S. has relied on CBOs to address social needs. With deep roots in the community and constrained geographical focus, CBOs are well-positioned to provide hyperlocal services that are uniquely tailored to a community's needs, yet this also means that addressing HRSN effectively requires an intimate understanding of local community resources and needs.[14,20,32] Each community is unique, with specific social challenges and available support services, which makes standardization difficult. For example, urban areas might have numerous CBOs, whereas resources in rural areas may be limited.[14,32] Service availability can also fluctuate based on state-level funding and policies, particularly under Medicaid.[26,28,39–41] CBOs may overlap in the types of services they provide or differ in which clients they serve or how they accept clients, and their capacity for new clients may also vary greatly.[14,32] The variability in local resources and needs means that a one-size-fits-all approach is impractical. Effective closed loop referrals must be

tailored to the specific context of each community, which requires robust, localized directories and a deep understanding of community assets.[14]

Technological Disparities Among Organizations

The landscape of CBOs addressing HRSN is highly varied, with significant differences in technological capabilities. While some CBOs operate advanced technology platforms capable of seamless data exchange, others rely on paper-based systems.[20,32] The variation in CBO funding means that some organizations can easily support 24/7 connectivity while others may not even be able to answer the phone consistently.[20,32] This disparity poses a fundamental challenge: the assumption that all organizations can conform to a unified standard is unrealistic. Effective patient referrals must navigate these technological gaps, which can vary dramatically across different local contexts.[20,32] For instance, a food pantry might operate on a basic, manual system, making integration with EHRs difficult.[20,32] Conversely, a large CBO might have the infrastructure to handle sophisticated digital referrals but is unable to communicate with less technologically advanced partners.[20,32] This fragmentation requires flexible expectations that can adapt to various levels of technological readiness.

Complexity and Variety of Referrals

Closed loop referrals to address HRSN are inherently complex and diverse.[20,32] Unlike medical referrals, which typically involve a single instance of care, HRSN referrals can range from short-term assistance, such as food vouchers, to long-term programs, such as job training.[20,32] The nature of these referrals varies significantly based on the needs of the individual. For example, a referral for emergency housing might involve multiple touchpoints and require ongoing support, whereas a referral for a one-time utility payment may be resolved quickly.[20,32] The ability to track and manage varied referrals necessitates a sophisticated data language that can represent different types of needs, interventions, durations, and outcomes.

Challenges of Feedback Mechanisms

Closed loop referrals rely on feedback mechanisms that inform referring clinicians about the status of the referral.[12,43] However, this feedback is not always necessary or feasible. Clinicians often express that receiving status updates on every referral can be overwhelming and counterproductive.[43] An emergency medicine clinician who refers the patient to a CBO is unlikely to have a long-term relationship with that patient that would benefit from regular updates, but if that emergency room is part of an accountable care organization, pooling data about referrals and outcomes is highly important.[43] Multiple approaches might be needed to accommodate varied use cases. For example, some use cases might benefit from a system where a clinician can check in on the fulfillment of the referral without being inundated with unnecessary information.[43] This balance requires thoughtful design of feedback systems to ensure they are informative without being burdensome.

Readiness for Standardization

Communicating the identified need, requested resources, and the status of the request requires shared standards. While USCDI v4 introduces many of the communications standards for SDOH, its implementation will take considerable time as EHRs are currently moving toward the required adoption of USCDI v3 (January 2026).[44,45] While essential, the push towards standardization – exemplified by the USCDI v4 – is insufficient on its own. While EHRs are making strides towards adopting these standards, many health systems are not yet ready to fully integrate the social care

components required for addressing HRSN.[43] The health care delivery system is still evolving in its ability to formally represent and manage social needs.[43] A hybrid approach employing both traditional and innovative methods is necessary to bridge the gap between current capabilities and future requirements.[14,43] This includes supporting standards for closed loop referrals and accommodating the existing variability in readiness and infrastructure among CBOs.[14,43]

Grant and Funding Opportunities

Medicaid funding, including utilization of Medicaid 1115 waivers that offer opportunities for SDOH reimbursement, varies significantly across states.[35,40] This leads to a lack of uniformity in funding and support for HRSN initiatives, creates challenges for standardization, and complicates efforts to develop a consistent approach to closed loop referrals.[14,35] Incentivizing the development of closed loop referral systems through grants and funding is crucial. Similar to the Certified Community Behavioral Health Clinic (CCBHC) grants in the behavioral health sector, specific grants for developing HRSN referral capabilities could accelerate progress.[46] These funds would enable CBOs to invest in the necessary technology, infrastructure, and people skills to participate in closed loop referral systems.[14,46]

History of Collaboration and Backbone Organization Support

It can take several years of systematic effort to develop trust, shared vision, leadership structure, measures of success and cross-sector knowledge for successful collaboration.[14,32,43] Lack of funding support for a backbone organization to plan, convene, facilitate shared goals and track success is cited as a barrier to the more rapid development of closed loop referral systems.[14,43] A further complication is that the funding gap for community-wide collaborations can result in individual health care entities developing or purchasing point to point technology systems between one health plan or health system and CBOs.[14,43] Without a community approach, CBOs are concerned about the potential need to connect to multiple technology systems, complicating their ability to partner.[14,43] Finally, there are many competing priorities in the health care arena and investing effort in community collaborations is a more recent trend that may compete with other initiatives.[43]

Privacy, Security and Data Governance

Consent, access to information, data use agreements and data governance are all challenging hurdles to coordinated systems of care and closed loop technology implementation.[47] Capturing signed consent as far upstream as possible facilitates the greatest benefit for closed loop referral systems to exchange all relevant information; however, this requires dedicated attention and resources to implement and maintain.[47,48] Security is a separate and important consideration for closed loop systems to ensure information is protected from any breach.[47–49] Behavioral health information significantly increases the difficulty of sharing information given its specific privacy rules, and when children are the clients, issues of consent are even more challenging.[47–49] Legal questions, systems to obtain consent and other privacy considerations often prove a long and costly barrier and can delay development and implementation.[47–49] Templates for data security and governance could reduce the time and cost to implement health information exchange (HIE).[47–49]

RELATED FEDERAL INITIATIVES

While the following federal initiatives were current as of the time this report was drafted, their continuation under the current Administration is uncertain.

U.S Playbook to Address SDOH

On November 16, 2023, the White House released the "U.S. Playbook to Address Social Determinants of Health," which outlines an initial set of actions that federal agencies are undertaking to support health by improving the social circumstances of individual and communities.[50] These actions were developed to serve as guideposts for other agencies and organizations to engage in efforts to address SDOH and HRSN. This playbook focuses on the following three pillars:

1. Expand Data Gathering and Sharing: Advance data collection and interoperability among health care, public health, social care services, and other data systems to better address SDOH with federal, state, local, tribal, and territorial support.[50]
2. Support Flexible Funding to Address Social Needs: Identify how flexible use of funds could align investments across sectors to finance community infrastructure, offer grants to empower communities to address HRSN, and encourage coordinated use of resources to improve health outcomes.[50]
3. Support Backbone Organizations: Support the development of community backbone organizations and other infrastructure to link health care systems to CBOs. Backbone organizations manage community-based partnerships formed across sectors such as health care, housing, social services care, nutrition assistance, employment training, and economic development to care for populations holistically.[50]

Centers for Medicare & Medicaid Services (CMS)

Though Medicaid rules limit spending on non-medical services, nearly all states have implemented at least some policies or initiatives to address HRSN through their Medicaid programs for various populations.[37] In January 2021, CMS issued a State Health Official letter identifying opportunities for states to better address SDOH under Medicaid and CHIP and to support states with improving outcomes and lowering costs by addressing SDOH.[51] Using a variety of mechanisms, including using section 1905(a) State Plan Authority, Home and Community Based Services (HCBS), section 1115 demonstrations, section 1945 Health, and managed care contract requirements, among others, states are addressing HRSN, including housing-related services and supports, non-medical transportation, home delivered meals, educational services, employment, community integration and social support, and case management (See APPENDIX 2).[51]

Center for Medicare and Medicaid Innovation (CMMI) established the Accountable Health Communities (AHC) Model in 28 locations to promote clinical-community collaboration to address HRSN of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services.[28] The model, which focuses on five core HRSN of housing instability, food insecurity, transportation problems, utility difficulties, and interpersonal violence, found that 15 percent of the nearly 483,000 beneficiaries screened were eligible for navigation services, and more than half of these navigation-eligible beneficiaries reported more than one core HRSN.[52] CMMI is working to incorporate learnings from the AHC model into future models. As part of their Strategy Refresh, CMMI will require all new models to collect and report on data on HRSN and SDOH, as appropriate.[52] In addition, CMS will consider models that aim to address upstream, community-level SDOH.[52]

CMS has also worked to address HRSN and SDOH in the Medicare program. As of 2019, CMS expanded the definition of supplemental benefits in Medicare Advantage (MA) plans to better address SDOH.[53] As of 2019, MA plans can offer a broader array of benefits that are primarily health-related, such as transportation, meal delivery, and adult day care, and as of 2020, plans can offer non-primarily health-related benefits to the chronically ill, such as pest control.[53] In addition,

Medicare ACOs provide high-quality care to Medicare beneficiaries to ensure that patients get the right care at the right time through care coordination.[53] In FY22, CMS also included a request for information in the final Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) rule that sought ideas to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable.[53] Inclusion of such measures in future payment rules would also build on the work of the CMMI AHC model.[54]

Administration for Community Living (ACL)

ACL funds a nationwide network of aging and disability organizations that provide access to a variety of local community-based services that address social needs.[55] Through this network, ACL provides 150 million home-delivered meals to over 883,000 individuals and 73.6 million congregate meals to more than 1.5 million seniors, funded through the OAA Nutrition Program.[55] In addition to meals, the program provides nutrition screening, assessment, education, and counseling, and provides connections to other in-home and community supports.[55] ACL also provides transportation services through their network, providing more than 20.4 million rides to doctor's offices, grocery stores, pharmacies, senior centers, meal sites, and other critical daily activities.[56]

In addition, ACL's Social Care Referrals Challenge is working to support health care systems and CBOs through health IT solutions.[57] The challenge seeks to cultivate care coordination, including the sharing of standardized data on SDOH, by developing or optimizing interoperable, scalable technology solutions that foster connections between community-based organizations and health care systems.[57] ACL is also supporting the infrastructure of 12 Network Lead Entities, or community hubs, that coordinate the activities of a broader network to efficiently contract health plans and providers to address social needs.[58] Increasingly, CBOs are organizing to form networks, allowing them to deliver a broad scope of services, expand populations served and geographic coverage, build stronger administrative functions, and offer a single point of contracting for payers.[58] As part of their support for their disability network, ACL also offers several grants to enhance the cultural and linguistic competency of the disability network to ensure that all people with disabilities can access ACL-funded programs and services.[58]

The Office of the National Coordinator for Health Information Technology (ONC)

ONC seeks to improve the health and well-being of individuals and communities using technology and health information, including SDOH information, that is accessible when and where it matters most.[59] Advancing the use and interoperability of SDOH data is important to improve the health and well-being of all individuals and communities.[59] ONC is focused on ensuring that both patients and providers understand what capabilities are possible and required by the 21st Century Cures.[59] Standardization of the way in which the data is obtained and exchanged will help providers more easily address non-clinical factors, such as food, housing, and transportation insecurities, which can have a profound impact on a person's overall health.[60] For example, as of March 2022, almost all hospitals and roughly 75 percent of physicians use EHRs certified through the ONC Health IT Certification Program, helping to enable widespread capabilities for the capture, reporting, exchange, and use of granular race and ethnicity data.[60] This functionality will extend to the widespread use of interoperable SDOH data that can be electronically captured, used, and exchanged.[60] ONC works collaboratively with federal partners and the community to advance the electronic exchange and use of SDOH data to help improve individual and population health by guiding the development, dissemination, and adoption of health IT standards; informing the development of policies to overcome SDOH data interoperability challenges and data use; supporting states and local governments as they build the infrastructures for SDOH data; and

driving innovation in care delivery by using health IT tools and standards to integrate SDOH data into workflows.[60]

STATE INITIATIVES IN IMPLEMENTING CLOSED LOOP REFERRAL SYSTEMS

North Carolina. NCCARE 360 is a statewide backbone organization that electronically connects North Carolinians who have unmet social needs to community resources.[61] It allows for feedback and follow-up through a shared technology network provided by Unite Us so that those seeking help are served.[61] The program includes a team of dedicated navigators to support referrals, as well as a community engagement team that works with community-based organizations, social service agencies, health systems, independent providers, and community members to create a statewide, coordinated care network.[61] NCCARE360 is available in all 100 counties across North Carolina and has multiple functionalities including:

- A team of dedicated Navigators with the expertise to support complex NCCARE360 referrals. Navigators support CBOs that are not able to stay with the client through the referral process, as well as self-referrals submitted by individuals through our website.[61]
- A robust statewide resource directory supported by a dedicated resource team at NC 211 who regularly verifies and updates programs and services in the NCCARE360 platform.[61]
- A shared technology platform powered by Unite Us that enables providers to assess for and identify unmet social needs, send and receive secure electronic referrals, and track outcomes.[61]
- Onboarding, training, and technical support provided by Unite Us. The NCCARE360 technology is robust and transformative so all network partners are trained and empowered to use it to better serve their patients and clients.[61]

New York. In 2024, the New York State Department of Health selected organizations to lead the Social Care Network (SCN) in their region.[62] SCN leads are accountable for maintaining a comprehensive network of CBOs that will be responsible for delivering and tracking services addressing HRSN to eligible Medicaid members.[62] Selections included five Unite Us partner organizations that serve nine regions, including Care Compass Collaborative, Health and Welfare Council of Long Island, Healthy Alliance Foundation Inc., Hudson Valley Care Coalition Inc., and Public Health Solutions.[62] Unite Us will serve as the infrastructure for collaboration in each region's network of CBOs, health care professionals, and managed care organizations, which together represent 72 percent of Medicaid members across the state.[62]

Washington. The Seattle Indian Health Board connects thousands of Seattle-area residents to health and social services across the region.[63] Funding from several foundations as well as from government is braided and blended to support the Board's programs.[63] One such program is the Gender-Based Violence programming that provides confidential services to individuals fleeing from or who are survivors of gender-based violence.[63]

New Jersey. In 2020, New Jersey established the Regional Health Hubs program to coordinate provision of person-centered health care.[64] This innovative model establishes a regional network of non-profit organizations that partner with Medicaid and State agencies to reduce health disparities and improve health outcomes by combining robust connections to social services and community resources at both the patient and organizational levels.[64] The state began with establishing four Regional Health Hubs and plans to expand.[64]

California. The California Advancing and Innovating Medi-Cal (CalAIM) Initiative to Support Children and Families Initiative is a series of initiatives and reforms, in which California's Department of Healthcare Services (DHCS) is advancing and innovating Medi-Cal to create a more

coordinated, person-centered, and equitable health system that works for all Californians.[65] The CalAIM Initiative is set to introduce a transformative requirement in 2025 around a "Closed Loop Referral" policy.[65,66] This new referral policy is important to improve care for children under Medi-Cal for Kids & Teens, reduce disparities in children's and maternity care and improve depression screening and mental health follow-up rates.[65,67] Furthermore, this new policy shows promise as a critical tool in overcoming health access challenges that children and youth in foster care disproportionately face.[65,67] There are already several opportunities underway to build out the infrastructure that will be needed to support closed loop referrals.[65] For example, specifically for the rollout of the CalAIM Enhanced Care Management (ECM) and Community Supports benefits, Medi-Cal Managed Care Plans (MCPs) can use Incentive Payment Program (IPP) payments to build out networks of providers, including community health workers, who can support opening and closing referral loops.[65,68]

For primary care providers (PCPs), the recently announced Equity and Practice Transformation (EPT) Payments present opportunities "to advance health equity and reduce COVID-19-driven care disparities by investing in up-stream care models and partnerships to address health and wellness and funding practice transformation.[69]" PCPs can use the EPT payments to build the infrastructure and staffing in their practice for closed loop referrals.[69] Further, MCPs and other interested parties can operationalize closed loop referral policies through memorandums of understanding (MOU) requirements.[70] Specifically, starting in January 2024, MCPs are required to enter MOUs with Third Parties (i.e., various programs and agencies) to facilitate care coordination and information exchange, including WIC agencies, county child welfare departments, and regional centers.[70]

BEST PRACTICES FOR IMPLEMENTATING CLOSED LOOP REFERRAL SYSTEMS

Require Clear Definitions and Standards

The term "closed loop referral" is not consistently understood or used in the same way across sectors, to the extent it is used at all.[71,72] Definitions and standards will be important for closed loop referral policies so that it is clear to all parties involved the role/responsibility of each entity/person, the information and actions that constitute a referral, and the key steps, sequences, and methodologies, that constitute the closing of a referral loop.[71,72] It is also important to identify which types of referrals are the highest priority for tracking and monitoring. These definitional standards need to be consistent statewide and will need to be incorporated into electronic interfaces, workflows, and staffing models across provider types.[71,72] HCOs and CBOs involved in referral loops will need clear directions for how to make referrals and a basic understanding of who is eligible for services that could be available to them.[71,72] Further, these definitions should consistently be codified in formal contracts and agreements, like MOUs, when developing standards and timelines, including processes for expediting closed loop referrals for urgent needs.[71,72]

Leverage Data and Integrate Technology

Data sharing is necessary for closed loop referrals, but data sharing is limited and varied. Experience suggests that "the future of resource database design should center on technology and solutions that strengthen pathways for coordination and communication between health care, community resources and community members."[71,73] Yet, there are many concerns and challenges around data literacy and how referral and service information will be shared in a timely way across systems and referral management platforms and vendors to close referral loops.[73] The field uses many platforms and resource directories for referrals that are not standardized, cohesively linked, up-to-date, or connected, especially with EHR systems or health plan data systems.[20,71,73] As a

result, health care professionals navigate multiple referral systems depending on the patient's needs and what community support services and community partners are available to the patient.[20,71,73] Further, some platforms may not be able to fully capture and/or communicate all stages of a closed loop referral, much less share patient care plans or be used for ongoing quality improvement.[20,71] Patient/family access to their own referral information varies across systems designed towards connecting agencies or institutions, but thoughtful communication modalities and technologies like apps and text-messaging can help close the information gap in some instances.[20,71]

The variation in referral systems creates an unreasonable burden on the health care professionals who are responsible for opening and closing referral loops and may have preferred EHR systems or other data systems they use for their patient/client/member care.[20,71,73] Participants in some studies reported finding referral solutions, such as communicating with external partners through their Microsoft Teams communications platform or using the clinic's EHR system to fax referrals to community mental health providers.[20,71] Interoperable data systems and workflows will require training of health care professionals and staff and providers in community-based organizations on how to use them and ensure appropriate user permissions, and ideally these systems could track all stages of the closed loop referral in as real- time as possible.[20,71] There are also significant concerns about sharing personal identifiable and protected health information with other providers or agencies.[20,71] It should be noted there are initiatives to improve data interoperability such as through Regional Health Information Organizations (RHIO). The goal of RHIO is to oversee the means of information exchange within a geographical area among various provider settings, payers and government agencies.[74] This initiative may be a potential pathway to consider in addressing data interoperability in a closed loop referral system.[74]

Rely On Trusted Partnerships and Referral Pathways

While technology and electronic data-sharing is important for referrals, it does not replace interpersonal work, relationships, and interorganizational networks that are foundational to referrals.[75] Closed loop referrals are most effective in promoting equitable health outcomes when individuals are engaged in a timely manner (i.e., no scheduling delays or geographic barriers to care) and in a meaningful way (i.e., the individual's preferred language, information provided is easy to understand, etc.).[75] Common barriers to closing the referral loop include the lack of collective and consistent use of referral platforms by the entities involved in referrals, as well as challenges finding available and qualified providers and resources (i.e., housing, food, culturally congruent providers, etc.) to refer individuals to.[75]

Health system partnerships with libraries, places of worship, laundromats, barber shops, fire departments, dollar stores, shopping malls, and other local sites offer the chance to connect with families who most need referral and navigation support in places within the community they already trust enough to meet their other basic needs.[76] Health care professionals will need to authentically engage clinics, local CBOs, county agencies, and other partners to support the establishment of effective workflows, data exchanges, legal agreements, and communication channels.[76] Work will need to be done to understand and address the needs and constraints of both the referring clinician and the receiving provider and provide ongoing training, technical assistance, monitoring, and financial resources or incentives to promote closed loop referrals.[76]

Further, it is important to remember that due to the past and ongoing impact of racism in health care, inclusive of systematic segregation, differential medical treatment based on race and ethnicity, and limited resources allocated to people and communities of color, there is wide variability in the availability of and access to local resources in communities.[75] In addition, many areas may lack reliable internet and broadband access needed for electronic referrals and data

sharing.[75] Gaps in service area resources will need to be identified early to make the best use of available providers and map the places where service expansion will be needed.[75]

Training and Ongoing Support

It is critical to establish an efficient and compassionate referral network that meets the needs of individuals.[20,75,77] Best practices for this include assessing the need for initial and ongoing training for health care professionals and providers in CBOs on how to operationalize a closed loop referral system and coaching to foster a patient-centered approach to making referrals.[20,71,77] Operational training equips health care professionals and providers in CBOs with the skills to effectively navigate and utilize referrals in a digital landscape. Understanding the operational intricacies of a digital system, documentation requirements, referral initiation procedures, and tracking mechanisms is vital for ensuring that the referral process is seamless, efficient, and protective of sensitive information.[71,75,77] This training ensures health care professionals and providers in CBOs can use the system proficiently, thereby improving the accuracy, timeliness, and success of referrals they make, ultimately enhancing the quality of care.[71,75,77] Successful referrals are patient-centered, which often require cultural humility, empathetic communication, and a trauma-informed approach.[77] These skills should be integrated into closed loop referral coaching and support for all health care professionals and providers in CBOs.

To ensure referral-making is trauma-informed, health care professionals and providers in CBOs should be coached on how to prioritize creating a safe and supportive environment and respect the patient's autonomy and choices.[71,75,77]Health care professionals and providers in CBOs should understand how to consider the potential triggers and sensitivities related to the referral process, aiming to minimize retraumatization.[71,75,77] A patient-centered approach to referrals also considers the background and circumstances of the patient. Historically, patients of color and varying gender and sexual identities have been discriminated against and disrespected in health care settings.[71,75,77] It is critical that health care providers and staff and providers in community-based organizations understand the disparities that affect these communities and are culturally conscious in how they communicate during the referral process. Furthermore, the closed loop referral process should emphasize and acknowledge that health care professionals and providers in CBOs who are embedded in the community are best situated to make referrals.[71,75,77]

It is also important to note that studies have identified higher physician engagement in addressing HRSN were associated with a greater likelihood of burnout.[78] Specifically, high engagement in addressing HRSN was observed among physicians identifying as women or transgender women, those reporting Black or African American or other race and ethnicity, and those who frequently used non-English languages in patient communication.[78] This could be due to intrinsic factors, with physicians from certain racial and ethnic groups potentially feeling a stronger commitment to addressing HRSN.[78] Importantly, these findings add an additional layer to diversity, equity, and inclusion efforts in medicine by critically considering the "minority tax"—the extra responsibilities that historically marginalized physicians often experience.[78,79] Recognizing patients' ongoing, unmet HRSN without being able to fully address them could potentially lead to a sense of helplessness, contributing to burnout.[78,80] Addressing HRSN necessitates interdisciplinary teamwork, such as HRSN screening often being led by nonphysician staff (i.e., nurses, social workers, and community health workers); therefore, training and education can be incorporated to help physicians effectively collaborate with interprofessional team members to address HRSN for patient populations.[78,81]

Resource and Monitor Referrals

The infrastructure to make closed loop referrals possible will need to be fully resourced and sustained. This goes beyond the high start-up costs of technological platforms or data integration but also applies to the ongoing needs to maintain a workforce (hiring, training, etc.) to manage referrals and ensure there are qualified providers available to receive referrals and deliver referred services.[20,32,71] This will require intentional and ongoing efforts and formalized relationships (i.e., contracts, MOUs, etc.) between health care professionals and community providers, as well as ongoing, cross-sector community reinvestment at state, local, and health system levels that are refined over time to fill in gaps and meet the changing needs of the patient population.[20,32,70,71] Furthermore, data captured on both successful and unsuccessful implementation of closed loop referrals should be used to fund and build local infrastructure to meet the needs of patients.[20,32,71]

EXISTING AMA POLICY

AMA policy H-165.822 "Health Plan Initiatives Addressing Social Determinants of Health," recognizes that social determinants of health encompass more than health care and encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health. This policy also states that the AMA supports: continued efforts by public and private health plans to address SDOH in health insurance benefit designs; mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians; and research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs. Further, it encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

The AMA has also involved in efforts aimed at improving patients' health by addressing SDOH. This includes but is not limited to being a founding member of the Gravity Project, a Robert Wood Johnson-funded initiative with more than 2,500 participants from organizations and entities representing health care, social services, payers, technology vendors, and government agencies working to develop consensus-driven data standards to support the collection, use and exchange of SDOH data.

CONCLUSION

Responding to compelling evidence that links social risks—such as food, housing, transportation, or economic insecurity—to health care outcomes, health care practices are considering how to improve patients' social conditions.[43,87] Several forces have spurred the momentum to act on evidence linking social risks and health care outcomes including the ongoing shift towards value-based care in the Affordable Care Act and beyond, campaigns advanced by clinician organizations such as the American Academy of Family Physicians, and influential reports by the National Academies of Sciences, Engineering, and Medicine and others.[43,88,89] As a result, health care practices report screening patients for at least one HRSN.[34,43,88] Information on patients' HRSN can be used by health care professionals to gain a deeper understanding of their patients' lives, to adjust patient's care plan (i.e., changes to medications or follow-up schedule), and to improve social conditions.[43,88] For many health care practices, the next step is providing patients with a referral to CBOs to address their social needs.[43,88] Closed loop referral platforms can be used to address this next step by allowing for efficient communication and coordination between health care

professionals and CBOs.[12,13] It ensures that patient data and information are communicated to the right individuals at the right time, allowing for review, action, acknowledgment, and documentation.[12,13] The platform facilitates referrals from health care professionals to CBOs and enables reporting back on whether the patient's HRSN were addressed.[12,13]

There are many factors impacting the success of a closed loop referral system, including: technology (electronic referral, response and feedback), processes (effectiveness, efficiency), organizational (management, policy and planning, rules and regulations), and patient-centered individual characteristics (social capital, transportation, awareness, attitude, satisfaction, and social influence).[14,32,65,71,88] However, efforts have been underway to address these barriers to improve the effectiveness of the closed loop referral systems in improving social and health outcomes. Successful efforts thus far have incorporated four main best practices: (1) establishment of collaborative governance for shared decision-making processes, fostering trust, alignment, and transparency among organizations; (2) development of technology linkages between existing platforms to facilitate seamless referrals between organizations and ensure visibility of referral outcomes; (3) integration of regional resource directories into technology infrastructure to ensure resource accessibility/quality; and (4) evaluation of the system's impact on health equity, efficiency, and cost reduction.[12,14,32,65,71,75] It should be noted that more states are exploring the integration of closed loop referral systems to address SDOH which will continue to shape the best practices needed for successful implementation.[34,62,66,82]

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1. Our AMA acknowledges closed loop referral systems are a mechanism to address social determinants of health (SDOH) through a community-level, system approach that connects clinicians and the patients they serve to health care services and social support services.
2. Our AMA supports the continued evaluation of closed loop referral systems in addressing SDOH and health-related social needs to identify best practices and improve health outcomes.
3. Our AMA supports continued research to streamline the workflow processes and ensure two-way communication for closed loop referrals between health care systems and community-based organizations to address SDOH and health-related social needs.
4. Our AMA supports: (a) using data to foster hospitals, health insurance, private sector, philanthropic organizations, and community- and faith-based organizations investment in addressing SDOH, (b) reducing barriers to using grants to address SDOH, and (c) promoting federal- and state- initiatives to expand funding for SDOH health-related social needs interventions. (New HOD Policy)

Fiscal Note: less than $1,000

APPENDIX I – Key Terms

There are a few key terms that will be used throughout this report that are important to define because they are often used interchangeably when they have different definitions. These key terms are as follows:

- **Social determinants of health** (SDOH): The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH refers to community-level factors.[90] They are sometimes called "social drivers of health."[90]
- **Health-related social needs** (HRSN): Social and economic needs that individuals experience that affect their ability to maintain their health and well-being.[2] They put individuals at risk for worse health outcomes and increased health care use. HRSN refers to individual-level factors such as financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care, and lack of access to transportation.[2]
- **Health disparities**: Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health, health quality, or health outcomes experienced by disadvantaged populations.[91]
- **Health equity**: The attainment of the highest level of health achievable for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.[92]
- **Community-Based Organization** (CBO): A non-profit organization whose members represent a local community and focus on addressing the community's sociocultural conditions and lived experiences.[93] This can include improving the community members' social and health risks.[93]
- **Care Coordination Services**: A model of care approach aimed at connecting individuals to a full range of community health promotion services.[94]

APPENDIX II – CMS Waivers and Demonstration Programs for HRSN

- **Section 1905(a) State Plan Authority**: States have used Section 1905(a) to establish peer support and case management services, which are then used to link beneficiaries to HRSN supports. As of 2018, 19 states indicated that case management is a covered benefit in their program, and 36 indicated that targeted case management is a covered benefit (though this benefit may be provided under section 1915(g)*).[95,96]
- **Home and Community Based Services (HCBS)**: Several states have utilized HCBS to implement housing-related services, including 46 states with section 1915(c) waivers; † four states with section 1915(i) benefits; and eight states with section 1915(k) benefits as of 2021.[97] For example, Minnesota is using section1915(i) state plan authority to provide housing stabilization services to certain individuals that are experiencing homelessness or are at risk of becoming homeless.[98] In their first year, the state reported that they served 7,203 individuals.[97,98]
- **Section 1115 Demonstrations**: As of 2021, 25 states have utilized the flexibility provided by section 1115 demonstrations to address HRSN, such as housing-related services,

nutrition, transportation, and interpersonal violence.[97,98] For example, CMS recently approved an 1115 waiver for California's Medicaid program (Medi-Cal) to launch California Advancing and Innovating Medi-Cal (CalAIM), which seeks to integrate the Medi-Cal program with other social services through a "no wrong door" approach that couples clinical care with Medicaid reimbursable nonmedical services, including housing supports, medical respite, personal care, medically tailored meals, and peer supports.[66] However, as of February 2022, four states have also used section 1115 demonstrations to waive NEMT, a benefit that is typically required.[99]

- **Section 1945 Health Homes**: As of April 2021, there are 37 Health Home models across 21 states and the District of Columbia, all of which must include comprehensive case management, individual and family support, and referrals to community and social services, among other required services.[100]
- **Managed Care Programs**: As of 2018, 37 states have implemented requirements in their managed care contracts related to HRSN and SDOH.[101]

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REPORT 3 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-25)
Protections Against Surgical Smoke Exposure
(Resolution 404-A-24)

EXECUTIVE SUMMARY

BACKGROUND. Resolution 404-A-24, "Protections Against Surgical Smoke Exposure," was referred. This resolution called for AMA to support efforts to limit surgical smoke in operation rooms. This report provides a summary of the available evidence on the potential health impacts of surgical smoke, currently available preventive strategies, the landscape of legislative activity to limit surgical smoke, and a summary of potential concerns or barriers to effective prevention.

METHODS. English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: "surgical smoke" AND "health" as well as "surgical smoke" AND "prevention." Additional searches were performed on both effectiveness and cost concerns of current preventive measures. Legal websites were searched to identify which states have passed legislation on this topic. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies and advocacy organizations were also reviewed for relevant information.

DISCUSSION. Surgical smoke results from the use of energy-generating devices during surgery, including electric knives, ultrasonic scalpels, and lasers, which causes the temperature of tissue to rise to the point of tissue vaporization, released as surgical smoke. Surgical smoke has been estimated to be about 95 percent water vapor and five percent organic byproducts, the latter being responsible for potential adverse exposure risks. Surgical smoke is a health concern as it may contain a number of known health hazards, including benzene, toluene, hydrogen cyanide, formaldehyde, viruses, and bacteria. The potential negative impacts from surgical smoke are severalfold. First, surgical smoke may limit visibility within the operative field, affecting the safety of the surgical operation to some extent if it is not actively cleared. Second, surgical smoke can cause short-term discomfort and potential illness to surgical staff. Depending on the size and types of particles released, surgical smoke can cause acute irritation of the eyes and throat while smaller particles in smoke can settle further in the lungs. Inhalation of particulate matter smaller than 2.5 micrometers (PM2.5) has been associated with increased incidence of asthma, chronic obstructive pulmonary disease, lung cancer, and cardiovascular disease. Lastly, surgical smoke may increase the risk of disease transmission through the presence of viral and bacterial pathogens in the smoke. Despite potential health hazards, there is heterogeneity of findings in the available research, which is partially explained by challenges in understanding the true exposure risk, as it differs by the type of surgery, specialty, profession, and what role an individual has in the operating room. However, there are several preventive measures recommended by multiple organizations that can be employed to reduce risk to personnel, which include the use of smoke evacuation equipment, having appropriate ventilation, and wearing appropriate PPE, which may include surgical masks or N95 respirators.

CONCLUSION. While more research is needed to better understand the potential health impacts associated with surgical smoke, there is currently no known safe level. In taking a public health precautionary principal approach, it is reasonable to take preventive measures even if health hazards are uncertain. Recommended preventative approaches are well known and consistent across multiple organizations. Additionally, increased education on the potential health risks of surgical smoke among health care personnel is needed, as many have not received any sort of training or education on the subject.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-A-25

Subject: Protections Against Surgical Smoke Exposure

Presented by: John T. Carlo, MD, MS, Chair

Referred to: Reference Committee D

INTRODUCTION

Resolution 404-A-24, "Protections Against Surgical Smoke Exposure," was referred. This resolution called for AMA to support efforts to limit surgical smoke in operation rooms. Testimony noted conflicting evidence as well as ergonomic and cost considerations of smoke evacuation technologies. This report provides a summary of the available evidence on the potential health impacts of surgical smoke, currently available preventive strategies, the landscape of legislative activity to limit surgical smoke, and a summary of potential concerns or barriers to effective prevention. While surgical smoke can also be of concern to patients, this report focuses on the issue from an occupational health and safety perspective for health care personnel.

BACKGROUND

Surgical smoke results from the use of energy-generating devices during surgery, including electric knives, ultrasonic scalpels, and lasers, which causes the temperature of tissue to rise to the point of tissue vaporization, released as surgical smoke. Surgical smoke has been estimated to be about 95 percent water vapor and five percent organic byproducts, the latter being responsible for potential adverse exposure risks.[1] Surgical smoke is a health concern as it may contain a number of known health hazards, including benzene, toluene, hydrogen cyanide, formaldehyde, viruses, and bacteria.[2] The potential negative impacts from surgical smoke are severalfold. First, surgical smoke may limit visibility within the operative field, affecting the safety of the surgical operation to some extent if it is not actively cleared. Second, surgical smoke can cause short-term discomfort and potential illness to surgical staff.[3,4] Depending on the size and types of particles released, surgical smoke can cause acute irritation of the eyes and throat while smaller particles in smoke can settle further in the lungs. Inhalation of particulate matter smaller than 2.5 micrometers ($PM_{2.5}$) has been associated with increased incidence of asthma, chronic obstructive pulmonary disease, lung cancer, and cardiovascular disease.[5] Lastly, surgical smoke may increase the risk of disease transmission through the presence of viral and bacterial pathogens in the smoke.[6]

METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: "surgical smoke" AND "health" as well as "surgical smoke" AND "prevention." Additional searches were performed on both effectiveness and cost concerns of current preventive measures. Legal websites were searched to identify which states have passed legislation on this topic. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies and applicable professional and advocacy organizations were also reviewed for relevant information.

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DISCUSSION

Health hazards of surgical smoke

There are several different types of energy-generating devices utilized during surgery to cut and cauterize tissue, including electric knives, ultrasonic scalpels, and lasers. The composition of surgical smoke, particle size, and the amount produced is dependent on the device used and the type of tissue where it is employed. For example, the cauterization of solid organs or fat tissue versus muscle tissue has been found to create higher emissions.[7] In one study, much higher levels of ultrafine particulate matter were measured while operating on the liver compared to surgeries involving muscle, adipose tissue, and blood vessels.[3] Additionally, surgical smoke particles with the smallest size, generally less than 0.1 micrometers (μm), are produced by electrocautery, followed by laser tissue ablation (~0.3 μm) and ultrasonic scalpel usage (0.35–6.5 μm).[8] Particle sizes of less than five μm are of more concern as they are respirable, with smaller particles of sizes less than two μm being of the greatest concern as they can penetrate and be deposited deeper in the lungs.[8] Surgical smoke is a health risk for a range of health care staff. The Occupational Safety and Health Administration (OSHA) estimates that around half a million workers, including surgeons, nurses, anesthesiologists, gynecologists, perioperative practitioners, dermatologists, and surgical technologists, are exposed annually to surgical smoke.[9]

Concern over surgical smoke is driven by its composition as it may contain several known health hazards, including chemicals such as hydrogen cyanide, polycyclic aromatic hydrocarbons (PAHs), volatile organic compounds (VOCs – such as benzene, toluene, formaldehyde, etc.), pathogens (viruses and bacteria), and particulate matter.[1] However, the exposure to any of these health hazards may differ by specialty and profession, in terms of the type of surgeries they perform, as well as what role an individual has in the operating room. Additionally, exposure levels differ among staff members depending on where they stand during surgical procedures and the length of working hours. Coupled with the heterogeneity in the study methods used to assess risk and different types of surgery, it remains a challenge to obtain an accurate picture of exposure to surgical smoke to operating staff during procedures. While there have been a predominance of nonhuman studies assessing negative impacts of surgical smoke, human studies have yet to show a direct causal link between surgical smoke exposure and poor health outcomes besides acute irritative symptoms such as headache, eye irritation and watering, and throat irritation and cough.[3,4]

Studies assessing operating staff exposure to various chemicals in surgical smoke illustrate these multiple challenges. For example, there are concerns that surgical smoke contains VOCs such as benzene and formaldehyde, but studies conducted by the National Institute of Occupational Safety and Health (NIOSH) where they sampled surgical theaters found few VOCs. Even when detected, they were at levels below OSHA and NIOSH recommended exposure limit levels.[10] Another study has noted that VOCs were found to be higher during open surgery versus laparoscopic surgery.[3]

Nonetheless, due to the varied components in surgical smoke, there are several different biological mechanisms and pathways impacting health. Potential health impacts from surgical plumes are categorized into four main groups and are summarized below.

Respiratory impacts

There is a potential for ultrafine particles (particles 0.1μm in size) in surgical smoke plumes that can penetrate and be deposited deep in the lungs.[10] Known health impacts of particulate matter (PM) exposure include cardiovascular effects, including heart attacks, heart failure, and strokes, as well as respiratory effects, including asthma attacks and increased respiratory symptoms such as

coughing, wheezing, and shortness of breath.[5] Data from the U.S. Nurses' Health Study, an ongoing prospective cohort that started in 1976 with biennial surveys, have shown that operating room (OR) nurses have a higher risk of chronic obstructive pulmonary disease compared to nurses in administrative positions, but they were equivalent to those working in the emergency department or within in-patient hospital units.[11] From this same study, OR nurses were also found to have lower incidence of asthma compared to those working in administrative positions.[12] On the other hand, other studies have noted OR staff have an increased risk of respiratory diseases, such as sinus problems, allergies, asthma, and bronchitis, compared to the general population.[13]

For PM, direct measurement of smoke in 100 laparoscopic surgeries found unhealthy concentrations of PM 2.5 but the measurement duration was not reported, which restricts comparisons with established standards that are used for other occupational settings or the U.S. Clean Air Act.[3] Multiple studies have found widely variable concentrations of PM levels, some over known Environmental Protection Agency (EPA) limits, others comparable to daily office exposure or lower than outdoor urban or rural environments, and still others found very brief but extremely high peaks in concentrations.[3,14] Another limitation that could explain wide variations in findings on PM levels is that studies examining surgical plumes for ultrafine particles have used devices that are unable to discern between water vapor and PM, a significant design flaw as living tissue has a high-water content.[10] As a whole, these data make it difficult to conclude whether surgical smoke contains levels of PM of concern for OR personnel.

Cancer risk

Several of the compounds found in surgical smoke are known carcinogens, notably benzene, 1,2-dichloroethane, and polycyclic aromatic hydrocarbons (PAHs).[15] In one study, the concentration of PAHs from 10 mastectomies were investigated to estimate cancer risk to surgical staff. Looking at the PAH concentrations within the breathing zones of surgical staff, the study authors found the concentrations to be 20 to 30 times higher than those in regular outdoor environments and thus their cancer risk was significantly higher than the benchmark set by EPA.[16] To note, even though measured PAH concentrations were higher by the surgeon, the anesthetic technologists had a higher cancer risk due to their longer working hours in operation rooms.[16] While the increased cancer risk may be greater than the general population, assessed exposure levels have varied from study to study, with some noting higher concentrations while others have noted they are within acceptable limits.[3] Due to the PM and carcinogenic compounds within surgical smoke, an increased risk of lung cancer is a concern among surgical personnel in the literature. Several studies have aimed to compare the carcinogenic risk of surgical smoke to smoking cigarettes, with comparisons ranging from exposure similar to smoking six cigarettes to inhaling the secondhand smoke of 27 to 30 unfiltered cigarettes a day.[17,18]

The first study on this was published in 1981. Utilizing electrosurgery tools on a canine tongue, smoke condensates was collected in a closed box system to assess the mutagenicity of the smoke using the Ames test (a well-established assay to evaluate the mutagenicity of agents) and found that the smoke from one gram of tissue was equivalent to those from three to six cigarettes in terms of total mutagenicity.[17] More recently, a study by plastic surgeons assessed ablated human and porcine tissue to determine how much tissue was destroyed over five minutes and then reviewed the total electrosurgery time in their operating room over a 44 day period to determine a daily average level of exposure. Using the one gram of tissue equivalency to six cigarettes assumption from the 1981 study, it was concluded that daily electrosurgery produced the equivalent of secondhand smoke of 27-30 unfiltered cigarettes.[18] Although these figures are often cited in the literature to demonstrate the hazards of surgical smoke, several researchers have called these findings into question. They argue that the methods used in the original 1981 study were limited in

that the mutagenicity test was based on smoke produced in a close-system smoke chamber, which is not reflective of the surgical theater environment and exposure, and thus the concluded equivalency is faulty and misleading.[3,10,19]

Importantly, there is no evidence demonstrating that exposure to surgical smoke increases the risk of lung cancer. On the contrary, the Nurse's Health Study cohort, which focused on 87,000 nurses with and without operating room experience in 1984, showed no increase in lung cancer incidence at follow-up nearly 15 years later. In fact, the nurses with the longest operating room experience had significantly less incidence of lung cancer on follow-up, even after controlling for cigarette smoking history.[3]

Infectious diseases

Another concern with surgical smoke is the presence of viral fragments within the plume with some evidence demonstrating RNA or DNA fragments of SARS-CoV-2, human papillomavirus (HPV), hepatitis B, and human immunodeficiency virus (HIV) in surgical smoke.[20] Concern over HPV exposure in surgical smoke has been raised more frequently due to the common use of energy-generating devices in LEEP and anal wart ablative surgeries. While HPV particles have been detected in surgical smoke and inhalation of these particles into the upper airways has been detected, the evidence for transmission is more controversial.[21] The evidence of HPV-related disease in operation room staff following exposure to HPV is largely based on retrospective and survey data, which did not verify findings through confirmatory testing, and a small number of case studies (n = 4).[6] Increased prevalence of HPV infection or HPV-related disease in operating room staff following occupational exposure to surgical smoke has not been convincingly demonstrated.[6]

For example, HPV DNA was detected in nasal epithelial cells of surgeons performing ablative surgery on HPV+ patients much more frequently than surgeons who do not conduct these types of operations. However, with a notable loss of follow-up, all became negative at two years.[21] The highest level of evidence and most cited studies have been case reports of laser surgeons diagnosed with HPV+ laryngeal papillomatosis (n = 1) and tonsillar cancer (n = 2), as well as an operating room nurse with papillomatosis who was frequently exposed to ablative excision of anogenital warts.[3] Another more recent study assessed HPV prevalence among operating room staff using post-surgery nasal swabs to detect whether HPV was present and in greater than 98 percent of samples, no HPV was present. The operating team had used a smoke evacuator system, and an overwhelming majority wore surgical masks, versus N95 masks. In the less than two percent of staff where HPV DNA was detected in nasal swabs, no HPV related disease was detected after 3-6 months of follow-up.[6] Researchers have noted that despite the limited evidence for HPV-related disease risk from surgical smoke, for cases where HPV lesions are to be cauterized, the use of smoke evacuators and/or N95 masks are reasonable precautionary measures.[10]

During the COVID-19 pandemic, concern over the transmissibility of human coronavirus during surgical procedures was also raised. A 2021 study evaluating the existence and infectivity of human coronavirus RNA in surgical smoke found that while viral RNA was present in the smoke, it was not demonstrated to be infectious and the study authors found that surgical masks were able to effectively reduce the amount of viral RNA by at least 99.8 percent.[20] Lastly, there have been no case reports of suspected transmission of HIV or viral hepatitis via surgical smoke.[10] Evidence for concern is solely based on existence of DNA fragments in surgical smoke.

Reproductive outcomes

Female surgeons have been shown to have higher rate of adverse pregnancy outcomes and infertility compared to the general population, but there have been no studies evaluating the direct effects of exposure of surgical smoke on reproductive outcomes.[7] However, other studies have demonstrated negative reproductive health outcomes from various components found in surgical smoke. For example, PM exposure has been linked to low birth weight and preterm labor. Toluene has been associated with cognitive impairment, congenital defects and infertility while benzene has been linked to an increased risk of childhood leukemia. Lastly, 1,2-Dichlorethane is associated with an increased risk of spontaneous abortion and infertility (but in animal studies only).[7] These are just a few of the 45 different chemicals that have been identified in surgical smoke. More research is needed to better understand whether OR exposure to surgical smoke could be related to negative reproductive health outcomes.

Known prevention strategies, evidence of effectiveness, and barriers to implementation

The issue of clinician exposure to surgical smoke was brought to the attention of the OSHA, the primary federal agency responsible for developing protective standards related to health care occupations, nearly 35 years ago but regulations were never formulated on the topic.[22,23] Despite the lack of a federal regulatory standard, OSHA, NIOSH, the American National Standards Institute, ECRI, and the Association of periOperative Registered Nurses (AORN) have developed recommendations on minimizing exposure to surgical smoke in the operating environment.[24–27] AORN has a Go Clear program, a comprehensive surgical smoke-free recognition program for facilities who want to ensure a smoke-free environment.[25] Across guidance documents, the most recommended preventive measure to limit exposure to surgical smoke in the operating rooms is utilizing smoke evacuation equipment to remove smoke near the surgical site where smoke is generated.[28] An operating room smoke evacuation system is designed to capture surgical smoke and includes a capture device (either free standing or fitted over an electrosurgical tool), a vacuum system, and some type of filtration unit capable of capturing contaminants.[1,29] Illustrative examples are provided at the end of this report.

Wearing personal protective equipment (PPE), including standard surgical masks or even N95 respirators and masks containing activated carbon have also been recommended. PPE can provide some level of protection but is not protective against all possible particles contained in surgical smoke, particularly particles less than 0.3 μm (the functional limit of N95 masks).[24] Additionally, having appropriate ventilation in the operation room to avoid any lingering presence of smoke in the operating environment is also recommended.[9] However, NIOSH determined that the Centers for Disease Control and Prevention's (CDC) recommended air exchanges per hour is insufficient on its own for adequate surgical smoke evacuation.[7] Furthermore, in outpatient surgical settings there may be little to no ventilation in comparison to operating rooms, which are required to adhere to specific ventilation requirements.[24] From outside the U.S., the British Association of Dermatologists has called for smoke extractors to be made available in all settings where dermatology surgery takes places and further occupational health research on potential health risks from surgical plumes be conducted.[30]

Due to concerns of increased risk HPV infection and resulting oropharyngeal cancer in health care personnel, HPV vaccination of health care staff exposed to HPV through surgical smoke has been raised as a potential preventative strategy.[31] In the U.S., the American Society for Colposcopy and Cervical Pathology (ACSSP) has recommended the HPV vaccine for individuals working in gynecology routinely exposed to HPV.[32] However, the American College of Obstetricians and Gynecologists and CDC's Advisory Committee on Immunization Practices do not currently have

similar recommendations for health care personnel to receive the HPV vaccine.[33,34] The AMA has sent a letter to the CDC asking them to review the available evidence for recommending the HPV vaccine for health care professionals to prevent health care related infection of HPV.

While implementing smoke evacuation systems is understood to be the most effective strategy for reducing surgical smoke exposure, their use is limited and inconsistent, with one study finding that only about 10 percent of surgeons consistently use them.[35] A number of barriers to implement effective preventive strategies, both at the individual and organizational level, have been identified.[36] At the individual level, barriers to usage include surgeon resistance, impaired surgical view, excessive noise, and lack of education.[7] To illustrate the lack of education among surgical staff, in a 2016 survey of dermatologist residents, nearly 72 percent had not received any education on the potential hazards of electrosurgery smoke during their medical training.[37] In terms of excessive noise, a 2021 study assessed the noise associated with 11 identified surgical smoke evacuators used during dermatologic surgery and found none of them had sound levels greater than the permissible upper limit as recommended by OSHA, and therefore would not be considered an occupational hazard based on a 8-hour exposure.[38]

Even if smoke evacuator noises do not exceed OSHA standards, operating team members may subjectively still find the noise excessive, a distraction, or an annoyance. Perceived excessive noise in the operation room can increase risk for error, by making it difficult to hear critical information or communicate effectively, and thus presents an unsafe environment the patient.[39] However, as the smoke evacuator would only need to be operational during the period in which smoke is being produced by electrosurgery tools, it could be assumed the noise would not be a constant and therefore minimally distracting.

At the organizational or hospital level, barriers include a lack of resources, associated costs with purchases smoke evacuation systems, and insufficient or nonexistent internal policies on the matter.[40] Improving awareness among health care staff around the potential harms of surgical smoke and the protective measures designed to minimize personal harm among health care workers could help improve personal and organizational uptake of appropriate preventive measures.

Legislation

As there is no federal standard or regulation around surgical smoke, some states have passed policy to require surgical smoke evacuation systems. Rhode Island was the first state to pass such a policy in 2018.[24] Based on a review of state laws in the summer of 2024, 18 states have passed surgical smoke legislation. In terms of countries that have passed legislation on this topic, Denmark was the first and remains one of the only countries in the world to pass national legislation requiring employers to install evacuation systems that remove smoke and other harmful substances as close as possible to the source in surgical theaters.[41] To date, there are no evaluation or implementation studies that have assessed the effectiveness or impacts of these state laws on reducing surgical smoke exposure.

AMA POLICY

Existing AMA policy does not address surgical smoke directly but supports the development of regulations to protect workers from occupational carcinogens using the best available scientific data and the protection of medical trainees from potential hazardous exposures.[42]

CONCLUSIONS

While more research is needed to better understand the potential health impacts associated with surgical smoke, there is currently no known safe level. In taking a public health precautionary principal approach, it is reasonable to take preventive measures even if health hazards are uncertain. There are several preventive measures that are recommended by multiple organizations and can be employed to reduce risk to personnel, which include the use of smoke evacuation equipment, having appropriate ventilation, and wearing appropriate PPE, which may include surgical masks or even N95 respirators. Additionally, increased education on the potential health risks of surgical smoke among health care personnel is needed, as many have not received any sort of training or education on the subject.

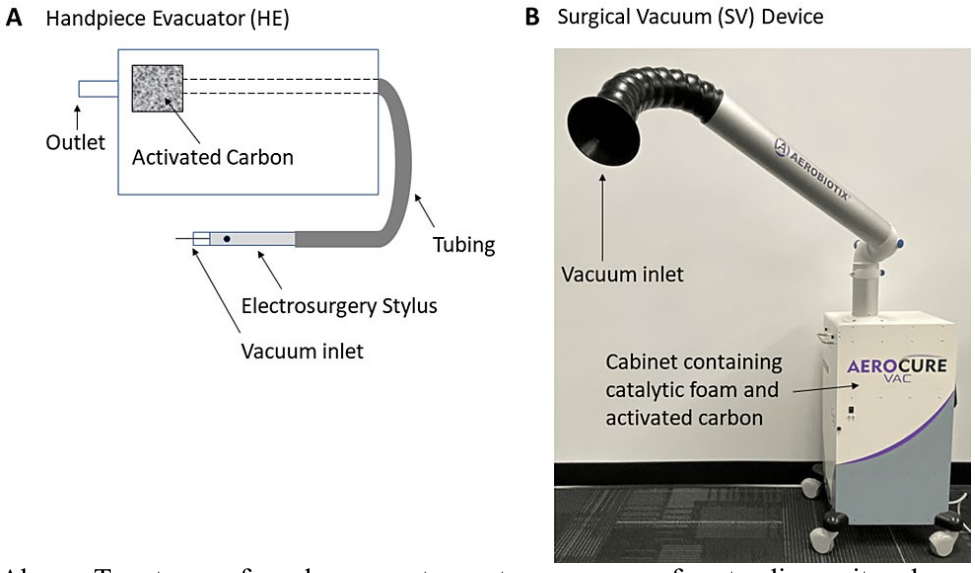
RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

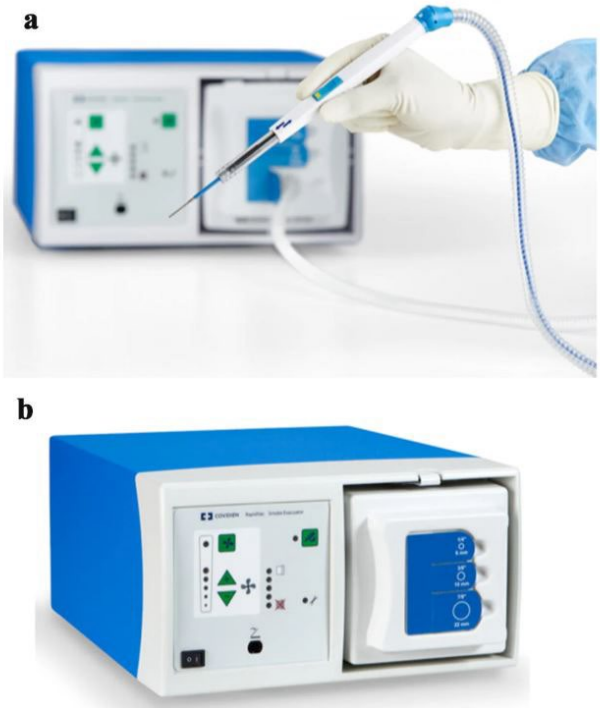
That our American Medical Association:
(1) supports efforts to limit surgical smoke exposure in operating rooms, including where exposure to infectious diseases such as human papillomavirus may occur, using various methods such as smoke evacuators, appropriate ventilation, and/or appropriate personal protective equipment;
(2) recommends education on surgical smoke among medical students and health care professionals that work and/or train in operating rooms to improve awareness of the potential dangers of surgical smoke and preventive measures that can be taken; and
(3) encourages ongoing monitoring, data collection, and longitudinal research into the health impacts of surgical smoke to better inform understanding of potential health risks and evidence-based interventions to reduce risk. (New HOD Policy)

Fiscal Note: less than $1,000

APPENDIX: Examples of Smoke Evacuation Systems. TO NOTE: The AMA does not endorse any specific smoke evacuation device or manufacturer. These are only included as illustrative of different types of systems.



Above: Two types of smoke evacuator systems, one as a freestanding unit and one with the vacuum inlet over the electrosurgery tool.[43]



Smoke evacuation device showing (a) electrosurgical pencil containing capture system surrounding protruding electrode connected to (b) vacuum-driven smoke evacuator with replaceable ULPA filtration unit. ©2020 Medtronic. All rights reserved. Used with permission of Medtronic

Above: Example of a smoke evacuation device with an electrosurgical pencil containing capture system.[1]

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REPORT 4 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-25)
Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals
(Reference Committee D)

EXECUTIVE SUMMARY

INTRODUCTION. Resolution 427-A-24, referred by the House of Delegates, asked that our American Medical Association: condemn the practice of universally shackling every patient who is involved with the justice system while they receive care in hospitals and outpatient health care settings; and advocate for the universal assessment of every individual who is involved with the justice system who presents for care, by medical and security staff in collaboration with correctional officers, to determine whether shackles are necessary or may be harmful, and, if restraint is deemed necessary, that the least restrictive alternative to shackling with metal cuffs is used when appropriate; and advocate nationally for the end of universal shackling, to protect human and patient rights, improve patient health outcomes, and reduce moral injury among physicians.

METHODS. English language articles were reviewed from searches of PubMed and Google Scholar using the search terms “shackling in health care settings”, “shackling AND harm to health care professional” and “shackling AND harm”. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies such as the Department of Justice; applicable organizations were also reviewed for relevant information such as the National Commission on Correctional Health Care.

DISCUSSION. The United States has the highest incarceration rate in the world. Compared to the general population, individuals with a history of incarceration are in worse mental and physical health. Individuals who are incarcerated typically have high rates of psychiatric conditions, communicable diseases, substance use disorders, and chronic diseases. When medical care required by a person who is incarcerated exceeds the capabilities of the correctional facility’s health system, that individual is transferred to a contracted hospital or, in emergent cases, to the nearest health care institution. Clinicians practicing outside of correctional settings face unique medical, legal, and ethical issues surrounding the care of patients who are incarcerated. One of those challenges is the routine shackling of patients who are incarcerated and seeking care. Shackling policies for patients who are incarcerated are different from hospital restraint policies for patients who are agitated or combative. The latter is governed by Center for Medicare & Medicaid Services guidelines mandating the least restrictive form of restraint and for the shortest duration of time needed to ensure patient and staff safety. In contrast, case reports describe patients who are incarcerated being shackled with metal cuffs indefinitely, even while intubated, paralyzed, disabled, or in labor.

CONCLUSION. This report evaluates the current protocol for shackling of patients who are incarcerated when they are seeking health care, the arguments in support of shackling, and current reforms to ban or limit universal shackling of incarcerated patients. Future reports should examine special considerations for certain incarcerated populations such as older individuals, individuals who are disabled, and individuals in the juvenile justice system. The recommendations encourage health care facilities to develop and implement policies that eliminate or reduce universal shackling of patients who are incarcerated while receiving health care. Recommendations also support allowing health care professionals to communicate to correctional officers about what is medically necessary to provide the standard of care.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 4-A-25

Subject: Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals

Presented by: John T. Carlo, MD, MS, Chair

Referred to: Reference Committee D

INTRODUCTION

Resolution 427-A-24, referred by the House of Delegates (HOD), asked that our American Medical Association (AMA):

> condemn the practice of universally shackling every patient who is involved with the justice system while they receive care in hospitals and outpatient health care settings; and
>
> advocate for the universal assessment of every individual who is involved with the justice system who presents for care, by medical and security staff in collaboration with correctional officers, to determine whether shackles are necessary or may be harmful, and, if restraint is deemed necessary, that the least restrictive alternative to shackling with metal cuffs is used when appropriate; and
>
> advocate nationally for the end of universal shackling, to protect human and patient rights, improve patient health outcomes, and reduce moral injury among physicians.

BACKGROUND

People who are justice system-involved have a higher prevalence of acute and chronic health conditions than the general U.S. population.[1] Federal law mandates the provision of health care for people who are incarcerated.[2,3] When an incarcerated patient requires medical care that exceeds the capacity of the correctional facility in which they are housed, they are transferred to a community hospital.[2] Health care professionals practicing outside of correctional facilities receive little dedicated training in the care of justice-system involved patients, may be unaware of guidelines for the treatment of justice-system involved patients, and practice in health care systems with varying policies toward these patients.[2,4–6] Hospitalized incarcerated patients are commonly shackled throughout their duration of treatment in community hospitals to prevent escape or harm to others.[7,8] While federal and state laws regulate shackling of pregnant people, no similar protections guide shackling of non-pregnant, incarcerated patients in the acute care setting.[7,9,10] As a result, health care professionals rarely unshackle incarcerated patients during routine hospital care.[9,9,10] Further it should be noted that shackling incarcerated patients in medical settings has been limited internationally. For example, in the Netherlands, shackles are never used on incarcerated patients in the medical setting and handcuffs are used only in exceptional circumstances.[11]

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METHODS

English language articles were reviewed from searches of PubMed and Google Scholar using the search terms “shackling in health care settings”, “shackling AND harm to health care professional” and “shackling AND harm”. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies such as the Department of Justice; applicable organizations were also reviewed for relevant information such as the National Commission on Correctional Health Care (NCCHC).

DEFINITIONS

The terms “restraint” and “shackling” are important to define because they are often used interchangeably despite having different definitions. These key terms may also have slightly different definitions depending on the source.

Restraint. (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or (B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. (C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).[12]

Shackling: the use of any physical restraint or mechanical device to control the movement of a prisoner’s body or limbs, including handcuffs, leg irons, and belly chains.[2] The use of all devices which encircle the ankle or wrist of an incarcerated individual and restrict movement.[13]

DISCUSSION

Hospital Restraint Policies

It is important to differentiate shackling policies for patients who are incarcerated from hospital restraint policies for patients who are agitated or combative. The latter is governed by Centers for Medicare & Medicaid Services (CMS) guidelines requiring the least restrictive form of restraint that protects the physical safety of the patient, staff, or others.[2,14] Health care professionals are required to document the reason for restraint, form of restraint, reevaluations of continued restraint need, and any consequences for patient health.[2,14] However, no such policy exists for shackling in the hospital setting.[2] Shackles are not medically necessary and are often used “as a means of coercion, discipline, convenience, or retaliation.”[15,16] It is up to the treating health care professional to determine whether appropriate care can be delivered with shackles in place.[2,15] Custody officials are then responsible for determining an alternative manner to safely secure, or not secure, a patient that allows for standards of medical care to be met.[2,15]

Applying Restraints to People Who Are Incarcerated

Federal regulations for the use of physical restraints on people who are incarcerated provide that staff are authorized to apply physical restraints necessary to “gain control” of an incarcerated individual “who appears to be dangerous” because the individual: assaults another individual; destroys government property; attempts suicide; inflicts injury upon self; or becomes violent or

displays signs of imminent violence.[17] This regulation does not restrict the use of restraints in situations requiring precautionary restraints, particularly in the movement or transfer of incarcerated people (e.g., the use of handcuffs in moving incarcerated individuals to and from a cell in detention, escorting an incarcerated person to a Special Housing Unit pending investigation).[18] The restraint equipment or devices (e.g., handcuffs) may not be used in any of the following ways: as a method of punishment, through placement around an incarcerated individual's neck or face, or in any manner which restricts blood circulation or obstructs the incarcerated individual's airways, in a manner that causes unnecessary physical pain or extreme discomfort, to secure an incarcerated individual to a fixed object, such as a cell door or cell grill, except under certaincircumstances.[19] Further, all incidents involving the use of force and the application of restraints must be carefully documented.[20]

Summary of Types of Medical Restraints

It is important for health care professionals to have a solid working knowledge of their own health care facility's "least restrictive to most restrictive" spectrum of available physical restraints and restraint alternatives.[14] When restraint use is warranted, the least restrictive potentially effective measure should be considered first.[14,21] Examples of physical restraints are outlined in Appendix I. It is important to note that de-escalation techniques and diversionary devices should be tried before the decision is made to use any type of restraint.[14,22] Diversionary devices such as activity aprons and fidget sensory aids, for example, are designed to provide stimulating activities and textures for patients with decreased cognitive function and/or requiring tactile stimulation.[22]

Human Rights and Shackling

It has been argued that routine shackling of patients who are incarcerated violates foundational international human rights principles, including those contained in the Universal Declaration of Human Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, and the International Covenant on Civil and Political Rights.[23–25] These principles were designed to protect human dignity and protect people from discrimination and cruel, inhuman, and degrading treatment.[23–25] It has been argued that shackling patients who are incarcerated who are critically ill or at the end of life are an affront to their human dignity and increase pain and suffering in this vulnerable time.[23–26] Routine shackling violates the United Nations Standard Minimum Rules for the Treatment of Prisoners (The Nelson Mandela Rules)—the internationally accepted standard for the treatment of people who are incarcerated.[27] These standards note that restraints are to be imposed only when no lesser form of control would be effective to address the risks posed by unrestricted movement; the method of restraint shall be the least intrusive method that is necessary and reasonably available to control the person's movement, based on the level and nature of the risks posed; and restraint shall be imposed only for the time required, and they are to be removed as soon as possible after the risks posed by unrestricted movement are no longer present.[27] Further, in accordance with the Mandela Rules and the Charter of Fundamental Rights of the European Union, the head of the British prison service has stated that the "shackling of patients in hospital[s] should not occur," emphasizing that "security is important, but it should never blind us to the overriding need for compassion and humanity."[28] In the Netherlands, shackles are never used and handcuffs are used only in exceptional circumstances.[11]

Legal Challenges to Shackling

The use of shackles during hospital visits has been challenged in U.S. courts and routinely upheld.[29] In one case, a patient who was incarcerated with renal failure received injuries after his leg edema was so severe that "at one point the shackles themselves were barely visible."[29,30]

Though he was injured, the shackles were determined to have served a penological purpose outside of punishment, such as preventing escape, and the injuries were the result of the patient's guards not following protocol.[29,30] In the U.S. peripartum shackling of pregnant people who are incarcerated has been condemned. Though courts have had a mixed record on challenges, the practice has been banned in 23 states, though in most states significant exemptions exist.[31] Through the First Step Act of 2018, the federal government banned peripartum shackling for those in federal correctional facilities, but as most incarcerations are under state or local control, a considerable number of pregnant people who are justice system-involved can legally be shackled during their labor and deliveries.[32]

RATIONALE FOR SHACKLING PATIENTS WHO ARE INCARCERATED

Protecting Health Care Staff from Violence

The most frequently cited argument for shackling is that "not shackling people increases the risk of violence against health care staff," which is a legitimate concern.[15,33] Preliminary survey data suggest that violence against health care staff, such as nurses, escalated during the increased tension due to the COVID-19 pandemic.[15,34] However, there is currently no evidence suggesting that people who are incarcerated are contributors to these trends.[15,34] In fact, studies investigating the contributing factors to violence against health care staff reveal that hospital overcrowding, long waiting hours, staff shortages, and lack of staff training are key predictors of increased violence and that these factors point to a variety of strategies for addressing the issue.[15,35]

There is also a misconception that patients who are justice system-involved and have been convicted of a "violent" crime were convicted due to violent physical harm.[15] However, robbery (without assault) and drug-related offenses (such as stealing drugs and manufacturing methamphetamines) are considered violent crimes in many states.[15,36] Shackling to prevent violence in health care settings may result in unnecessary suffering of patients who may pose no risk of violence.[15] For instance, there have been reports of patients who are incarcerated being shackled while sedated and paralyzed.[37] There is also documentation of elderly patients who are incarcerated being shackled while dying, affecting dignity at the end of life.[38]

Protection Against Flight Risk

Data on the incidence of escape of patients who are incarcerated while hospitalized in community medical facilities is limited. A single study from 2011 using online media tracking identified 99 discrete incidents of patients who were incarcerated escaping medical facilities or medical transport over the course of a year.[7,39] This represents a minority of all individuals who are incarcerated and a small fraction of those seen within health care settings.[7,39] Articles in the press describe hospitalization and medical transport as times of vulnerability for law enforcement.[40] Press reports detail scenarios where shackles were removed prior to escape as well as instances in which shackles were in place during escape.[41] However, these reports do not demonstrate a relationship between indefinite shackling in health care settings and prevention of escape or harm to others.[39,41] Furthermore, the data show that escapes are few and far between in general but that if they are going to occur, it is most likely at the end of transportation back to the carceral facility after medical care has been received.[42] Systemic data identifying patient, incident, and facility-level contributing variables would allow better assessment of the use of shackles in the health care setting.[43]

Further, the risk of fleeing does not account for the fact that patients who are critically ill or under anesthesia are unable to flee. In several legal challenges against perinatal shackling instances, the

court concluded that prepartum, peripartum, and postpartum patients were not in a medical state to flee.[15] For example, in the 1993 class action suit *Women Prisoners of District of Columbia Department of Corrections v. District of Columbia*, the court concluded that "the physical limitations of a woman in the third trimester of pregnancy…make complete shackling redundant and unacceptable in light of the risk of injury to a woman and baby.… While a woman is in labor and shortly thereafter, however, the Court holds that shackling is inhumane."[44] This case outlines the inhumanity in shackling patients whose medical status bars them from posing a flight risk.[44] In 2004, the court in *Nelson v. Correctional Medical Services* stated that "an incarcerated individual in the final stages of labor cannot be shackled absent clear evidence that she is a security or flight risk."[45] Yet again, this case references how patients' medical state dictates their inability to physically pose flight risk.[45] These same principles can be extended to nonpregnant patients who are incarcerated. Patients who are critically ill or sedated are physically unable to pose a security risk; thus, shackling is deemed not only inhumane but also wholly unnecessary.[46] Despite this limited evidence, many health care organizations have policies that call for shackling of patients who are incarcerated by default or lack protection against shackling by correctional staff.[46]

Shackling Facilitates the Work of Health Care Professionals by Ensuring Cooperation

Shackling patients who are incarcerated during procedures presents an increased risk for harm relative to performing the same procedures without shackles.[7] Shackling is a physical and psychological barrier to health care professionals providing the highest-quality medical care.[7] For those admitted with terminal diagnoses, shackles limit palliative providers' ability to provide dignity-driven end of life care.[38] Further, there is evidence of patients who are incarcerated being shackled while undergoing physical examinations, outpatient office procedures, inpatient bedside procedures involving local or regional anesthesia and/or minimal to moderate sedation, and surgeries involving moderate to deep sedation or general anesthesia.[47]

Shackles manifest as a barrier for health care professionals in two ways. First, physical examinations and procedures are most effective and efficient with as few externally imposed movement restrictions as possible.[15] Shackles impede exam maneuvers, preventing full range-of-motion and other assessments that require the patient to move or turn over, and complicate positioning for procedures in clinics, hospital rooms, and operating rooms.[15,48] For example, a physician noted a time when they cared for a terminally ill 70-year-old female patient who was shackled to the bed.[15] The patient remained shackled during medical examinations and treatment despite being too weak to lift their leg against gravity.[15] The shackles made it more difficult for health care professionals to conduct comprehensive neurological exams and to roll the patient to prevent bed ulcers.[15] Second, shackling increases risk of medical complications.[7,15] Shackling sedated or anesthetized patients, for example, predisposes them to perioperative falls, tissue injury, and venous thromboembolism (VTE).[7,15] Patients who are sedated or anesthetized cannot maintain balance or request removal of shackles that compress their tissue.[7,15] As individuals recover from sedation or anesthesia, their immobility is already a risk factor for VTE, and being shackled exacerbates this risk.[7,15]

HARMS OF UNIVERSAL SHACKLING OF INCARCERATED PATIENTS

Shackles can cause proactive injury to patients who are incarcerated. Over-tightening of cuffs, potentially compounded by forced limb movement, has been shown to damage underlying structures leading to skin breakdown, compressive neuropathies, and fractures of the small bones of the hand.[7,49,50] When blanket shackling policies do not account for individual medical risk assessment, patients who are incarcerated with disabilities are disproportionately impacted.[7] For example, a shackled patient with hemiplegia may lose the ability to perform independent activities

if their functional deficits are not accounted for in limb placement.[7] An inability to comply with continuous cuffed restraint can precipitate delirium in those with impaired cognition.[7]

Shackling also increases risk of emotional harm as it erodes trust between patients who are justice system-involved and clinicians.[15,51] Evidence shows that shackles can reinforce existing negative biases toward patients who are justice system-involved, setting the stage for inappropriate use of force by health care staff and security personnel.[2,15,52,53] Patients who experience discrimination and perceive stigma due to their criminal legal status are more likely to have poor health outcomes.[15,54] The harms of discrimination are further intertwined with issues of race, as people of color—who are overrepresented in the population who is justice system-involved—are less likely to trust their health care professionals.[15,54] Further, Black patients routinely report greater mistrust than White patients in the outcomes of care and the motivations of physicians, in large part due to past and current discrimination and the medical community's history of experimentation.[7,15] Incarcerated patients may therefore view their clinician and/or hospital as complicit with shackling, and health care professionals may act on internalized biases when treating shackled patients who are incarcerated.[15]

BEST PRACTICES TO PROVIDE COMPASSIONATE CARE

Allowing hospitalized patients who are incarcerated to remain indefinitely shackled during medical treatment can lead to harmful outcomes.[7] Despite the desire for compassionate care from health care professionals, patients remain in shackles as a default practice.[7,9] Health care professionals are taught to employ a risk–benefit analysis to any interventions affecting patient health.[7,9] However, by deferring the management of shackles in the acute care setting, health care settings are passively accepting a structure that perpetuates inequities in care for people who are justice system-involved - a population already at risk for poor health outcomes.[7,9] Health care professionals should work collaboratively with carceral facilities and hospital security to identify the least restrictive means available to secure a patient and correctional representatives should be tasked with proactively demonstrating a correctional necessity that requires a patient to be shackled.[7,9] In this way, health care professionals and institutions can deliver legally grounded care that prevents unnecessary physical harm, reduces prejudice towards patients who are incarcerated, and relinquishes an overreliance on shackles in favor of security measures tailored to the needs of patients, providers, and custody officers.[7,9] Health care professionals should also regularly examine restraint sites for injuries and assess inpatients for conditions particularly impacted by restraint.[9]

Further, health care professionals should familiarize themselves with state and facility policies, including contractual relationships.[7,9] If health care professionals encounter barriers to unshackling patients who are incarcerated during treatment or apprehension addressing custody officers, one starting point is to contact the patient's health care professional at the referring correctional institution, who can offer context and patient advocacy.[7,9] Health care systems should standardize routes of communication between health care professionals and custody officers to facilitate collaborative relationships that ensure medical, and security needs are met.[7,55]

For health care systems, aligning policy on the shackling of patients who are incarcerated with policy guiding restraint of patients in general, creates parity and promotes the least restrictive form of restraint needed to secure a patient.[7] This change involves working from the assumption that all hospitalized patients should remain unshackled until a proven need for such restriction arises.[7] Such structural transformation mitigates the risks of active and passive harm to patients, lessens the prejudice shackles precipitate, and reflects shackling practices outside of health care settings.[7] Health care systems should also acknowledge the safety concerns of staff, real or perceived, as a barrier to care.[7] Examples of targeted interventions that address such concerns without reliance on

shackles include individualized security risk assessments on admission, strategic room allocation, protocols for supervised patient-clinician interactions, and use of soft restraints when necessary.[7,9]

Boston Medical Group: A Successful Case Study

Recently, medical students spearheaded revision of the policy and clinical practice for the shackling of patients incarcerated patients at Boston Medical Center (BMC), the largest safety net hospital in New England.[26] The modified policy allows for individualized assessments and allows incarcerated patients to be unshackled if they meet defined criteria.[26] Changes pioneered at BMC led the Mass General Brigham health system to follow suit. Most importantly, a BMC patient who was incarcerated, sedated, and intubated was unshackled by correctional officers for the purpose of preserving human dignity.[26] This protocol identifies incarcerated patients who may be safely unshackled and provides a framework for restraint removal while ensuring safety.[26] It can be integrated into existing policy systems, electronic health record (EHR) flowsheets, and health care workflows, while also providing individualized care for incarcerated patients.[26] The next steps include continuation of staff training about the modified policy and EHR documentation.[26]

This process solicited input from key interested parties including nursing and medical staff, public safety, and general counsel, and collaborated with the local correctional facility to guide implementation.[26] The policy outlined a schematic for communication and decision-making among correctional facilities, hospital security, and the patient's healthcare team (Figure 1).[26] The protocol parallels existing clinical assessments of any patient who is restrained in the hospital for medical or behavioral reasons and is incorporated into theEHR.[26] The EHR identifies incarcerated patients and prompts a member of the healthcare team to perform a "Recurring Shackle Assessment." This functions to determine if a shackled, patient who is justice system-involved meets any "Special Circumstances" for shackle removal.[26] These include but are not limited to the following: sedation, significant weakness due to age or clinical condition, dependence on life-support, end-of-life care, or paralysis for any reason.[26] If the patient meets any "Special Circumstance," the EHR protocol prompts the health care team to determine whether shackle removal is appropriate. If appropriate, care team members first notify hospital public safety.[26] The attending physician directly calls the medical team at the correctional facility, requests the accompanying correctional officers to contact their commanding officer, or utilizes a contact at each local correctional facility to communicate with the commanding officer at the facility. The supervisor can then direct the accompanying correctional officers to remove shackles.[26] If there is a disagreement between the care team and the correctional facility about shackle removal, the care team follows an appeal process, escalating the request to hospital public safety leadership.[26]

Although this reform was successful, obstacles were noted and are important to understand for future implementation. The most common obstacles in adopting this policy change include parsing patient and physician rights, determining who can request the modification or removal of shackles, determining who wields the practical authority to approve or deny such requests, and identifying and engaging all appropriate interested parties.[26] Success was attributed to identifying written policies wherever possible, collaborating with colleagues from across clinical specialties and with hospital administration, and working directly with correctional facility leadership.[26]

New York City

New York City recently provided clear guidelines for the Department of Corrections, the Health Authority, and the Health and Hospitals Corporation regarding shackling of patients who are incarcerated seeking health care outside of secure medical wards of community hospitals.[15,56] The guideline discourages routine shackling of patients who are incarcerated, details medical

circumstances in which patients should never be shackled, and outlines data reporting recommendations.[15,56] The guideline also recommends that patients be shackled only at the direction of the chief correctional officer once he or she has reviewed evidence of custodial and safety risks posed by the patient and concedes that patients who behave violently and/or attempt escape may be shackled regardless of their medical condition.[15,56] However, the guideline attempts to dissuade correctional staff from shackling patients out of convenience by suggesting that the decision to shackle a patient be routinely reevaluated by the chief correctional officer.[15,56] The guideline promotes patient advocacy among health care staff by recommending evaluating whether the shackles threaten the patient's life, in which case they can advocate for immediate shackle removal.[15,56] The guideline further recommends that health care staff routinely assess and communicate whether shackling is medically contraindicated and should be removed. The guideline also promotes increased data collection by recommending that health care organizations keep written records summarizing the reason for shackling, details of the shackling, and patient information.[15,56]

CURRENT AMA POLICY

AMA Code of Medical Ethics 1.2.7 "Use of Restraints" states that all individuals have a fundamental right to be free from unreasonable bodily restraint. It is noted that if health conditions may result in behavior that puts patients at risk of harming themselves, it may be ethically justifiable for physicians to order the use of chemical or physical restraint to protect the patient. The code also states that patients should never be restrained punitively, for convenience, or as an alternative to reasonable staffing and physicians who order chemical or physical restraints should: (a) Use best professional judgment to determine whether restraint is clinically indicated for the individual patient; (b) Obtain the patient's informed consent to the use of restraint, or the consent of the patient's surrogate when the patient lacks decision-making capacity; and (c) Regularly review the need for restraint and document the review and resulting decision in the patient's medical record. Finally, the code notes that in certain limited situations, when a patient poses a significant danger to self or others, it may be appropriate to restrain the patient involuntarily and that the least restrictive restraint reasonably should be implemented, and the restraint should be removed promptly when no longer needed.

AMA policy D-430.997 "Support for Health Care Services to Incarcerated Persons" supports NCCHC standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities. AMA policy D-430.993, "Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections," supports the development of clearly defined and consistently implemented processes between health care professionals and law enforcement that:
can best protect patient confidentiality, privacy, and dignity while meeting the needs of patients, health professionals, and law enforcement and ensures security measures do not interfere with the capacity to provide medical, mental health, pregnancy, end of life care, palliative care, and substance use care, especially in emergency situations. AMA policy H-420.957, "Shackling of Pregnant Patients in Labor," prohibits the use of shackles on pregnant people unless flight or safety concerns exist. The AMA advocacy resource center has also developed model legislation prohibiting shackling of pregnant people who are incarcerated.

American Public Health Association (APHA) and NCCHC Policies

APHA's policy 20233 "A Call to Stop Shackling Incarcerated Patients Seeking Health Care" called on state and federal legislatures to pass laws requiring health care organizations and correction agencies to implement policies that ban shackling of patients receiving health care and requests that

the CMS and general assemblies enforce those regulations.[15] In the absence of shackling bans APHA outlines steps to end the practice of shackling during health care through: (1) legislative action, (2) national research efforts, (3) clinical guidance, and (4) clinical practice.[15]

The NCCHC remains the only national organization dedicated solely to improving correctional health care quality.[57] NCCHC's standards have provided uniquely valuable guidance to help correctional health professionals and administrators improve the health of their populations (and the communities to which they return), increase efficiency of health services delivery, strengthen organizational effectiveness, and reduce the risk of adverse legal judgments.[57] NCCHC's guidelines for "Use of Restraints for Nonmedical Purposes" notes that correctional health personnel should not participate in either the decision to restrain someone or in the placement of such restraints for nonmedical reasons. NCCHC standards explicitly prohibit health care staff from participating in this activity but recommend they monitor the health status of individuals placed in security restraints.[58] If they observe conditions or practices that threaten a patient's health, their concerns should be communicated to the prison or jail administrator as soon as possible.[58] It is acknowledged that this may be a situation in which the underlying ethical principle is one of "doing the least harm," and that NCCHC's position is an approach that is likely to result in less harm to the incarcerated individual.[58]

CONCLUSION

The U.S. has the highest incarceration rate in the world.[2,59] Compared to the general population, individuals with a history of incarceration are in worse mental and physical health.[2,60] Incarcerated individuals typically have high rates of psychiatric conditions, communicable diseases, substance use disorders, and chronic diseases.[2] Correctional facilities offer a range of health care services from primary care to hospital-level care, but few states have stand-alone hospitals for patients who are incarcerated.[2,60,61] When medical care required by a person who is incarcerated exceeds the capabilities of the correctional facility's health system (for specialty care, diagnostics, or acuity of illness), that individual is transferred to a contracted hospital or, in emergent cases, to the nearest health care institution.[2,15] Clinicians practicing outside of correctional settings face unique medical, legal, and ethical issues surrounding the care of patients who are incarcerated.[2,15] One of those challenges is the harmful and discriminatory routine shackling of patients who are incarcerated and seeking care.

Shackling policies for patients who are incarcerated are different from hospital restraint policies for patients who are agitated or combative. The latter is governed by CMS guidelines mandating the least restrictive form of restraint and for the shortest duration of time needed to ensure patient and staff safety.[2,14] In contrast, case reports describe patients who are incarcerated are shackled with metal cuffs indefinitely, even while intubated, paralyzed, disabled, or in labor.[26] Most health care professionals are aware of the negative consequences of restricting patient movement during hospitalization, including delirium and venous thromboembolism, and although most hospital policies allow health professionals to request removal of shackles for medical necessity, such requests are rarely made.[2,6] Incarcerated patients often remain shackled for the duration of their hospitalization, independent of any individual risk assessment.[2,6]

One potential starting place for shackling reform is for hospital policy on shackling of patients who are incarcerated to align with internal policy on the restraint of persons who are nonincarcerated.[15,26] Hospital policy should delineate for clinicians when and how to communicate to security what is medically necessary to provide the standard of care.[15,26] Special circumstances should be defined in which shackles are prohibited, and procedures should be developed for

compassionate removal.[15,26] Further, special considerations should be made for certain incarcerated populations such as older individuals, individuals who are disabled, individuals with serious mental illness, and individuals in the juvenile justice system. While this report does not directly address these specific populations, this is an area that warrants further study. It should be noted that AMA policy supports NCCHC standards and AMA's Code of Medical Ethics supports the use of the least restrictive restraint if it is appropriate to restrain a patient that the restraint should be removed promptly when no longer needed. However, this framework is currently not applied to patients who are incarcerated.[58,62]

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

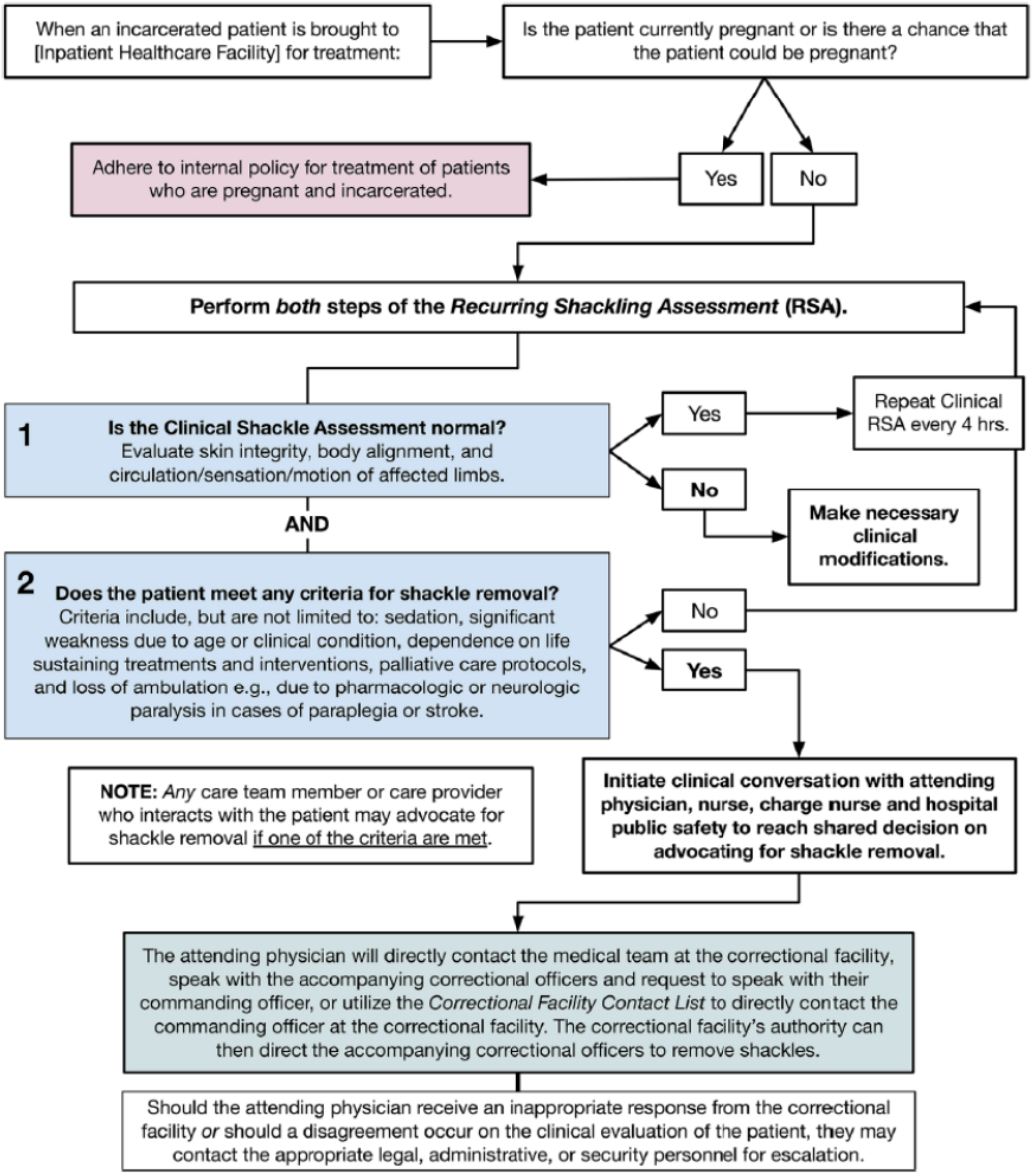
1. Our AMA opposes the universal shackling of patients in medical settings who are incarcerated as a means of punishment, control, and oppression and believes shackling should only be used when there is an immediate and serious threat of self-harm, harm to others, or risk of elopement, that cannot be reasonably mitigated by other least restrictive means necessary. (New HOD Policy)

2. Our AMA encourages health care facilities in collaboration with carceral facilities and hospital security, to develop and implement policies that eliminate or reduce universally shackling of patients who are incarcerated while receiving health care. Such policies should include:
   (a) individualized assessments that allow patients who are incarcerated to be unshackled when appropriate, particularly when incapacitating medical conditions are present such as weakness due to age or clinical condition, sedation, paralysis, dependence on life support, or while receiving end of life care;
   (b) clearly delineated procedures for shackle removal and/or replacement of shackles with the least restrictive means necessary; and
   (c) expeditious procedures for health care professionals to communicate to and collaborate with carceral facilities and hospital security when shackle removal is medically necessary to provide the standard of care. (New HOD Policy)

3. That our AMA reaffirm Policy H-420.957 "Shackling of Pregnant Women in Labor." (Reaffirm HOD Policy)

Fiscal Note – less than $1000

Figure 1: Generalizable protocol to supplement existing hospital policies for the care of patients who are incarcerated.[26]



APPENDIX I – Types of Restraints

Vest restraints	Designed to help prevent unassisted wheelchair, bed, and stretcher exits. These are considered one of the more physically restrictive types of patient restraints available for use.[22]
Limb restraints (limb holders)	Designed to limit the movement of wrists and/or ankles in patients assessed to be at risk of disrupting life-saving treatment, pulling lines/tubes, exacerbating skin conditions, compromising wound site integrity, or self-injury.[22] Sometimes these devices are referred to as being either soft restraints or hard restraints, depending on specific features such as cuff and strap materials and whether or not they can be locked.[22]
Belts	Designed for use with patients who need a reminder to call for assistance before exiting a hospital bed or wheelchair, for limiting unassisted exit and unwanted movement, or for patients who require a positioning device for added safety or to assist medical treatment.[22] Belts can be made from a variety of materials, can offer locking capabilities, and can be designed specifically to allow patients to self-release.[22] A belt's specific features help determine if it is considered a less restrictive or more restrictive device.[22] In some states and facilities, belts are not considered restraints.[22]
Hand mitts	Designed to help protect patients who are prone to disrupting medical treatment or to self-harm.[22] Mitts hinder picking and tube pulling and their construction and padding varies, as does the level of hand visibility afforded and the degree of finger movement permitted.[22] Mitts are generally considered to be less physically restrictive devices, and in some states and facilities they are not considered restraints.[22]
Multipurpose arm sleeves	Designed to limit or minimize patient arm movements without the use of rigid splints.[22] Multipurpose sleeves are in the least restrictive device category, and in some states and facilities they are not considered restraints.[22]
Enclosure beds	Designed to provide a safe, controlled environment for patients at risk of injury from an unassisted bed exit.[22] Although it's considered a restraint because it limits the patient's ability to get out of bed, an enclosure bed is less restrictive than other types of restraints.[63] Use of enclosure beds can help eliminate the need for more restrictive devices like limb holders or vest restraints.[22]

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REPORT6 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-25)
Fragrance Regulation (Resolution 501-A-24)
(Reference Committee D)

EXECUTIVE SUMMARY

OBJECTIVE: Resolution 501-I-24, "Fragrance Regulations" was referred by the House of Delegates. This report examines the evidence on the prevalence and severity of fragrance sensitivity (e.g., multiple chemical sensitivity (MCS), chemical sensitivity (CS), chemical intolerance (CI), toxicant-induced loss of tolerance (TILT), idiopathic environmental intolerance (IEI), and environmental illness (IE)) to understand the etiology and impacts, as well as the potential methods to reduce exposure (e.g., state and federal legislation, industry regulation, accommodations under the Americans with Disabilities Act, or implementation of fragrance-free policies).

METHODS: English language reports were selected from searches of PubMed and Google Scholar databases using the search terms: "fragrance sensitivity," "fragrance-free policies" AND "fragrance regulations." Additional articles were identified by manual review of the reference lists of pertinent publications. There was also a review of state and federal fragrance regulations as well as case law on fragrance sensitivity, MCS, and disability. Web sites managed by federal agencies and applicable professional and advocacy organizations were also reviewed for relevant information.

RESULTS: Fragrance sensitivity is a controversial, unexplained, and complex disorder. There is extensive self-reported evidence suggesting that fragrance sensitivity is a serious problem for a significant portion of the population. Yet, the heterogeneity of symptoms and exposures coupled with the sheer volume of ingredients in fragranced products (and consumer products more broadly) makes understanding the causal mechanism extremely difficult. Consequently, most of the evidence, which varies wildly in quality, falls into three categories: (1) self-report of exposure to fragrance followed by a constellation of symptoms; (2) toxicological and epidemiological associations between chemicals found in fragranced products and potential risk of harm; and (3) analysis of potential mechanisms in individuals with a diagnosis of fragrance sensitivity. It is possible to connect the evidence to form a compelling narrative of how exposure to harmful chemicals from personal care and household cleaning products causes serious adverse health effects through several plausible mechanisms. However, the throughline between these categories of research is often attenuated, weak, or based on limited data.

CONCLUSION: The sheer volume of self-reported evidence suggests that fragrance sensitivity could result in adverse health effects; however, the evidence also illustrates the need for more research and better consensus regarding differences between MCS, CS, CI, TILT, IEI, and IE. At the same time, inaction on this topic means that many patients will continue to be misdiagnosed, offered health care solutions with limited or no effect, or be met with mistrust and doubt. Therefore, it is worth pursuing efforts to reduce exposure through other means including: (1) improving product labeling transparency, and (2) implementation of flexible, voluntary, fragrance-free policies.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 6-A-25

Subject: Fragrance Regulation (Resolution 501-A-24)

Presented by: John T. Carlo, MD, MS, Chair

Referred to: Reference Committee D

INTRODUCTION

Resolution 501-I-24, "Fragrance Regulations" was referred by the House of Delegates. This resolution asked that our AMA: (1) recognize fragrance sensitivity as a disability; (2) encourage fragrance-free policies in hospitals, outpatient clinics, urgent cares, and other patient care areas inclusive of medical schools; (3) advocate for governmental regulatory bodies to recommend fragrance-free policies; (4) work with relevant parties to support the appropriate labeling of fragrance-containing personal care products, cosmetics, and drugs; and (5) support increased identification of hazardous chemicals in fragrance compounds, as well as research focused on fragrance sensitivity.

METHODS

English language reports were selected from searches of PubMed and Google Scholar databases using the search terms: "fragrance sensitivity," "fragrance-free policies" AND "fragrance regulations." Additional articles were identified by manual review of the reference lists of pertinent publications. There was also a review of state and federal regulations on fragrance regulations as well as case law on fragrance sensitivity, multiple chemical sensitivity, and disability. Web sites managed by federal agencies and applicable professional and advocacy organizations were also reviewed for relevant information.

BACKGROUND

Humans are exposed to thousands of chemicals in complex and dynamic mixtures everyday through fragrance materials that are pervasive in personal care and household cleaning consumer products.[1–6] Although fragrance materials must be generally regarded as safe for the intended use and dose, the ubiquity of exposure coupled with the limited transparency about the chemical constituents and reports of adverse health impacts after exposure raises the concerns about: 1) the harmful effects of fragrance chemicals on the skin including allergic contact dermatitis, phototoxicity, and photoallergy; (2) toxic effects (e.g., cancer, endocrine disruption, respiratory, immune, cardiovascular, neurological, reproductive, and developmental harm, etc.) that might arise through transdermal absorption, inhalation, or ingestion of fragrance chemicals; and (3) environmental consequences of fragrance chemicals on waste water and air quality.[4,7]

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DISCUSSION

What is fragrance sensitivity?

Multiple names have been used to describe sensitivity to fragrances, chemicals, and the environment more broadly including: multiple chemical sensitivity (MCS), idiopathic environmental intolerance (IEI), environmental illness (IE), chemical intolerance (CI), chemical sensitivity (CS), toxicant-induced loss of tolerance (TILT), and fragrance sensitivity (FS).[8–16] The specifics of each condition vary, but they share two key elements: (1) environmental exposure at relatively low doses (e.g., below thresholds of harm for the average person) and (2) consequent recurrent symptoms that affect multiple and variable organ systems.

Conceptually, FS is the most narrowly defined, with a focus on fragranced chemicals.[16] MCS, CS, CI, and TILT are more expansive as they focus on chemicals which may or may not to be expressly fragranced. Finally, IEI and IE are the broadest definitions acknowledging any potential environmental exposure (e.g. fragrances, chemicals, electromagnetic forces, and radio signals). Additionally, while some researchers maintain that MCS, CS, and CI are really the same disorder, others suggest MCS is a more severe form of CI, and still others suggest that TILT is a two-stage disease mechanism (e.g., initiation and trigger), which can be used to explain and unite MCS, CS, CI, IEI, and IE.[14,17,18] There is still no consensus regarding naming; however, some researchers suggest that CI and TILT are being used with greater frequency now and that MCS, EI, and IEI are descriptive phases of the constellation of allergy-like symptoms, rather than distinct diseases.[14] Arguably, this naming inconsistency is indicative of the lack of consensus in the field, which ironically facilitates further uncertainty. For the purposes of this report, fragrance sensitivity is used as an umbrella term; however, when citing specific studies, deference is given to the language of the authors.

Diagnostic Criteria

One of the most important problems when diagnosing fragrance sensitivity is the variability of symptoms, the lack of symptomatic patterns in relation to frequency, sex or age of onset, and the breadth of distinct, but very similar conditions with similar and overlapping diagnostic criteria.[19] Despite over 50 years of research on the topic, including advances in understanding potential underlying mechanisms, there is also no single biomarker or test that can be used to definitively diagnose fragrance sensitivity.[15,20–23] The most frequently referenced diagnostic method for this disease is the QEESI (Quick Environmental Exposure and Sensitivity Inventory).[19,24–29] The instrument has four scales: Symptom Severity, Chemical Intolerances, Other Intolerances, and Life Impact. Each scale contains 10 items which are scored from 0 = “not a problem” to 10 = “severe or disabling problem.”[30]

Prevalence of Fragrance Sensitivity

Extensive self-reported data suggests exposure to fragrances and chemicals is associated with a variety of adverse health impacts including respiratory, eye, and skin irritation, mucosal symptoms, headaches and migraine, asthma exacerbation, and respiratory, cardiovascular, neurological, gastrointestinal, musculoskeletal, immune, and endocrine issues.[16,19,31–42] However, estimates of fragrance sensitivity prevalence vary. This is likely a product of: (1) the lack of consensus on what condition is being assessed (e.g., MCS, IEI, TILT, CI, CS, and FS); (2) variable study methods (e.g., reliance on self-report symptoms vs evidence of formal diagnosis); (3) environmental exposure variations based on socioeconomic, cultural, and societal differences; and (4) potential prevalence changes over time.

One international study comprised of nationally representative self-report surveys conducted between 2016 and 2017 in the U.S., Australia, the UK, and Sweden found that 34.7 percent, 33.0 percent, 28.7 percent, and 33.1 percent of the population, respectively, reported at least one adverse health effects from exposure to fragranced products.[32,37,39] The same survey found that across these four countries 19.9 percent of the population report chemical sensitivity, 7.4 percent report medically diagnosed MCS, 21.2 percent report chemical sensitivity and/or medically diagnosed MCS, and 32.2 percent report fragrance sensitivity.[37,39] These findings are emblematic of the overall variability of prevalence data due to uncertainty around disease definition (e.g. MCS, CS, CI, TILT, IEI, IE, and FS) and use of different methods (self-report of symptoms vs. diagnosis). For example, other self-report studies published between 1998 and 2015 in the U.S., Canada, Germany, Sweden, Finland, Australia, Korea and Japan found chemical intolerance prevalence estimates of 9–16 percent with lower rates of 0.5–3.9 percent reported for doctor-diagnosed MCS.[1,43–52] Additionally, it is possible some of the variability is a result of increases over time. Nationally representative U.S. population surveys conducted between 2002-2003, 2005-2006, and 2016-2017, by the same researchers who performed the study of international prevalence, found that self-reported chemical sensitivity and medically diagnosed MCS may have increased by more than 200 percent and 300 percent respectively, with chemical sensitivity prevalence increasing from (11.1-11.6 percent) to 26 percent and medically diagnosed MCS increasing from (2.5-3.9 percent) to 13 percent.[1,14,16,37,39,40]

There are also several demographic differences. Women are more likely to report fragrance sensitivity and chemical intolerance as are middle-aged individuals, and those who renovated their home in the past seven years.[13,19,27,42,53–57] There also appear to be high rates of self-reported CI and FS among individuals with asthma/asthma-like conditions and autism/autism spectrum disorder.[33,37,39,58] Finally, the evidence regarding socioeconomic status is mixed. A cross-sectional study of Danish adults showed increased risk of MCS among individuals with lower socioeconomic and subjective social status.[53] Other studies appear to suggest that on average individuals with MCS tend to be well-educated, of higher socioeconomic status, and middle aged.[42]

Sources of Fragrance Exposure

Fragrances are complex mixtures of organic chemicals – solvents, fixatives, essential oils, stabilizers, and preservatives – nearly all of which are either aromatic volatile organic compounds (VOCs) (e.g., ester, aldehydes, and alcohols) like limonene, alpha-pinene, beta-pinene, ethanol, acetone, and acetaldehyde that produce aromas, or semi-volatile organic compounds (SVOCs) like phthalates and parabens.[41,59,60] The complex and variable nature of fragrance means that the fragrance industry uses more than 3,000 chemical substances, both synthetic and naturally occurring, in personal care and other consumer products - a single perfume or fragrance may contain up to 300 different molecules.[4,31,41]

Most people are exposed to fragrance ingredients daily from personal care (e.g., perfumes, lotions, shampoos, bar soaps), air care (e.g., candles, environment fresheners), fabric care (e.g., detergents, fabric softeners), and home care products (kitchen, bathroom, and other household cleaners).[61,62] Scented products represent 89 percent of laundry, 79 percent of surface cleaning, and 99 percent of dish washing product sales in the U.S. and mouthwashes, toothpastes, soaps, and shampoos are the most frequently used scented products.[61,63,64] Fragrance exposures occur via direct contact, skin absorption, inhalation, and ingestion and once inside the body, the materials can impact any organ or system.[41,65]

Hazardous chemicals in consumer goods

There are more than 80,000 chemicals in thousands of regularly used consumer products and hazardous chemicals are commonly found in consumer products in the U.S.[36,66,67] One study used quantitative high throughput exposure assessment to evaluate the chemical content in common household products and found substantial risks associated with paints, paint strippers, pesticides, leave-on personal care products, and cleaning products.[67] Additionally, many of the ingredients commonly found in consumer goods are associated with asthma exacerbation, endocrine disruption, reproductive and developmental harm, cancer, immune system issues, nervous system damage, and headaches.[36,59]

Hazardous chemicals in fragranced consumer goods

Multiple studies have found evidence of endocrine disrupting chemicals (e.g., parabens and phthalates, bisphenol A), triclosan, and VOCs (e.g., ethanolamines, alkylphenols, fragrances, glycol ethers, cyclosiloxanes) in fragranced cleaners, synthetic detergents, fabric softeners, air fresheners, sunscreen, and deodorants for preservative properties.[34,68–80] Studies also suggest fragrance products have a higher concentration of these chemicals compared to non-fragranced products and that these chemicals are the most important contaminants in perfumes and colognes.[34,59] Furthermore, more frequent use of personal care products was associated with higher urinary concentrations of parabens.[68,72–74,77–80] Finally, exposures happen despite existing regulations and many detected chemicals were not listed on product labels.[34]

Social, cultural, and socioeconomic impacts on exposure

As noted earlier, social, cultural, and socioeconomic differences facilitate wildly disparate exposures and consequently risk from these exposures are not equally distributed.[36] Multiple studies have demonstrated that women have higher exposure to scented products than men, which may be driven by sociocultural forces that influence women to use more cosmetic, personal care, and cleaning products than men.[31,36,64,81,82] There is also some evidence of age differences, with individuals aged 40 years and older showing a significant lower exposure to scented products.[64] Additionally, individuals in The Netherlands and Germany had higher levels of exposure to scented products than individuals in Sweden.[64] Finally, there is evidence that products with more toxic ingredients are often marketed to marginalized communities, including racial minorities and low-income populations.[35,4036,83]

Workplace environments also impact exposure. Custodial professionals may use general-purpose cleaners, degreasers, detergents, and other household products more frequently than others.[36,41] Similarly, individuals working in the cosmetics industry including beauticians, nail and hair salon professionals, and aromatherapists are likely exposed to VOCs emitted from shampoos, styling products, lotions, nail products, cosmetics, and sanitizers.[36,41] The same is true for home and automobile maintenance and repair professionals who experience cumulative exposure to heavy-duty cleaners, degreasers, adhesives, lubricants, sealants, caulks, and paint strippers.[36] The highest intensity of VOC exposures in the workplace is expected during the use of floor strippers and general-purpose cleaners because they contain the highest concentrations of VOCs in the bulk.[84] Finally, there is some evidence of increased risk of fragrance allergy among individuals in professions with high workplace VOC exposure.[41,85,86]

A historical perspective on fragrance exposure

A brief look at history provides helpful context regarding the increased prevalence of exposures over time. MCS was first described in the 1950s, around the same time as the post-WWII expansion of the petrochemical industry including widespread production of organophosphate pesticides, solvents, dyes, and fragrances.[8,14] Sick building syndrome was first described in the 1970s, with MCS, IEI, and EI entering the popular press shortly thereafter to describe the myriad of symptoms reported internationally from exposures like: (1) employment in the U.S. Environmental Protection Agency (EPA) headquarters during renovation in 1987; (2) participation in the Gulf War in the 1990s; and (3) the World Trade Center tragedy.[14] By 1994, U.S. synthetic organics production reached over 460 billion pounds per year.[14] Moreover, as VOCs were becoming increasingly prevalent, people transitioned to spending more time indoors and building envelopes of homes and workplaces became better sealed to improve energy efficiency resulting in less fresh air circulation.[1,87,88] Consequently, indoor air quality is often worse than outdoor air quality with VOC concentrations approximately four times higher inside compared to outside.[88] Notably, mixed VOCs and SVOCs, followed by pesticides and combustion products were most prevalent across CI, MCS, and TILT initiation events.[1,14]

HEALTH, ENVIRONMENTAL, AND SOCIOECONOMIC IMPACTS

Self-report evidence suggests exposure to fragrances and chemicals are associated with a variety of adverse health impacts including skin irritation, mucosal symptoms, headaches and migraines, asthma exacerbation, and respiratory, cardiovascular, neurological, gastrointestinal, musculoskeletal, immune, cognitive and neurological issues (see Table 1).[16,16,19,31–40,42,89–96] Yet, understanding the potential health, environmental, and socioeconomic impacts of exposure to fragrances is extremely difficult because of the complexity of exposures, methodological limitations, and significant comorbidities and overlapping conditions. Currently, the strength of the evidence varies depending on the symptoms and organ system impacted.

Skin irritation and contact allergies

There is strong evidence that exposure to fragrances can cause skin irritation, contact dermatitis, contact urticaria, photosensitivity, phototoxicity, and photoallergy.[4,31,41,61,65,97–101] The prevalence of fragrance allergy appears to range between 1 and 9 percent depending on the population and the allergen test used.[41,97,98,102] In one meta-analysis, an estimated 4.5 percent of the general adult population was estimated to be allergic to fragrance materials (e.g., fragrance mix 1), and 1.9 percent has clinically relevant fragrance contact allergies.[41,103] Another systematic review found that the overall prevalence of sensitization to fragrance mix I (FM I) was 6.81 percent and FM II was 3.64 percent and among pediatric dermatitis patients, sensitization prevalence for FM I and FM II was 4.09 percent and 2.17 percent.[98]

The strong, consistent evidence of contact allergy associated with fragrances is not surprising considering more than 150 fragrance ingredients used in personal care and household cleaning products are known to cause contact allergies.[41,97,104] Nevertheless, neither the U.S. nor the European Union requires disclosure for all 150 known allergens. In the U.S., the Food and Drug Administration (FDA) has identified fragrance allergies, but has not yet published the list of allergens that must be included on labels, despite the original proposed June 2024 release date.[105–108] In contrast, the European Union recently updated the list of fragrance allergies required on labels from 26 products to 82.[102] There is also evidence that endocrine disrupting chemicals, many of which are found in fragranced products, may cause skin sensitization and allergic responses.[75,76]

Comorbid conditions, overlapping symptoms, and shared triggers

An important factor that complicates the ability to understand the health impacts of fragrance exposure is that there are numerous comorbid conditions (e.g., fibromyalgia, Sjogren's, autism, chronic fatigue, asthma, and migraine) with overlapping symptoms (e.g., fatigue, nausea, headache, etc.), and shared triggers.[1,1,8,13,31,42,59,109–115]
For instance, there are conditions like migraine that have osmophobia, sensitivity to odor, as a symptom, as well as exposure to fragrance as a trigger.[31,35,60,60,91,114,115] Specifically, there is evidence from retrospective comparison and cross-sectional studies of migraine patients that fragrances trigger migraine at high rates (70 percent and 90.2 percent), with perfume being the most common trigger (95.1 percent), followed by cleaning products (81.3 percent), cigarette smoke (71.5 percent), and motor vehicle exhaust (70.5 percent).[113–115]

Similarly, fragrance and fragranced consumer products have been linked to asthma, asthma exacerbation, and respiratory reactions in the respiratory tract that range from acute temporary upper airway irritation to obstructive lung disease.[16,31,34,39,54,61,65,97,116] As noted earlier, patients with asthma report that fragrances, in particular perfumes (56 percent), air fresheners (32 percent), and scented detergent (28 percent), can worsen their asthma symptoms.[31,117]

There is also some evidence that MCS patients often have comorbid autoimmune diseases (e.g., Hashimoto's thyroiditis, systemic lupus erythematosus (SLE), Sjogren's syndrome).[8,118] Similarly, autoimmunity may be linked to postural tachycardia syndrome (POTS) and myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS), which are associated with IEI and SBS.[119] One study found close correspondence between symptom patterns for mast cell activation syndrome (MCAS) and TILT such that as the likelihood of patients having CI increases, so did the likelihood of having MCAS.[120] This suggests that mast cell sensitization could be an underlying cause for both TILT and MCAS.[121,122]

Finally, there are extensive studies showing an association between mental illness and MCS, CI, CS, and FS.[9,13,15,42,123–131] Some research suggests that roughly half of MCS subjects meet the criteria for at least one mental health condition in their lifetime as well as significantly higher rates of depression and anxiety.[13,17] Additionally, one study found that 68 percent of the chemically intolerant women surveyed reported a past diagnosis of depression, anxiety, or panic disorder, which was significantly higher than those without chemical intolerance.[13,17,132] Likewise, a cross-sectional study of the association between MCS and mental illness among Canadian adults also found that individuals with MCS were more likely to have major depressive disorder, generalized anxiety disorder, major depressive disorder and generalized anxiety disorder, severe distress, and languishing/moderate mental wellbeing.[13]

Although the evidence on comorbidities, overlapping symptoms, and shared triggers does not provide much additional clarity on fragrance sensitivity, it does shed light on potential mechanism (e.g., inflammatory sensitization, immune dysfunction), illustrate some of the challenges in studying and understanding complex conditions like fragrance sensitivity, and highlight the value of efforts to reduce exposure to fragrances – as it may improve the health and well-being of individuals with shared triggers and comorbid conditions.

Epidemiological evidence of health impacts

Fragranced products often contain endocrine disruptors, carcinogens, and other toxic materials; however, the evidence connecting exposure to these materials in consumer and personal products to health impacts is limited and often weak or attenuated. There is limited evidence suggesting the ingredients in fragranced household products are associated with increased cancer risk as sixty percent of the chemical combinations in household products have hazard quotients exceeding 1, and 9 percent have lifetime cancer risks exceeding 10.[4,67] Similarly, there are epidemiological associations between MCS and tachycardia, arrhythmia, a mitral valve prolapses and electrocardiogram abnormalities.[8,133–135] Finally, there is some epidemiological evidence that MCS is associated with endocrinological disorders (i.e., hyposurrenalism, dysthyroidism and hyperprolactinemia).[8,136–139] Similarly, endocrine disrupting chemicals (EDCs), which are often found in fragranced products, may have synergistic endocrine disruption.[75,76] However, aside from the evidence that synthetic musks have been shown to have estrogenic effects, the evidence connecting EDCs in fragranced personal care and household cleaning products to endocrine disorders and disruption is weak.[34,140–142] However, in each of these examples the evidence is weak and attenuated.

Environmental Impacts

In addition to the multiple direct and immediate health risks associated with exposure to fragrances, there are also environmental impacts. One study found that fragrance substances are continuously discharged in large amounts into the environment, especially via wastewater.[143] Furthermore, fragrances and in particular musks are ubiquitous, persistent, bioaccumulative pollutants that can be highly toxic.[35,143] Yet, evaluating the overall impact is difficult because data on persistence, bioconcentration, and aquatic toxicity is only available for ~0.2 percent, one percent, and 11 percent respectively of chemicals registered in the European Union.[144–148] There is also concern that because many fragrance compounds are identical to those which are signal substances of environmental organisms at very low concentrations it is potentially impacting the ecosystem balance.[143,145,146] Additionally, fragrance VOCs and SVOCs contribute to air pollution and decrease air quality.[35,65]

Social and economic impacts

There is strong self-reported evidence that people with fragrance sensitivities report avoiding certain places because of potential exposure.[32,33,91,111,149]Specifically, individuals who experienced chemicals triggering adverse physical symptoms avoided social and occupational settings because of widespread use of chemicals.[149] Similarly, there is self-reported evidence suggesting that exposure to fragrances results in stigma, missed work, loss of income, and occasionally loss of employment.[111,149] One study found that those with fragrance sensitivity reported missing 7.4 workdays on average due to illness from fragranced product exposure in the workplace.[32] Moreover, one study found that of the individuals surveyed with a hypersensitivity to fragrance, 13.5 percent (1.8 percent of the entire sample) reported losing their jobs because of their hypersensitivity.[111]

PATHOPHYSIOLOGICAL THEORIES OF FRAGRANCE SENSITIVITY

Fragrance sensitivity is a complex condition and despite decades of research there is no consensus around a unified theory of fragrance sensitivity pathophysiology. However, there are multiple rationally grounded hypotheses about the underlying mechanisms of fragrance sensitivity (e.g., neural sensitization/hyperresponsivity/central sensitization, limbic system dysfunction, neurogenic inflammation, immune system dysregulation, and psychological theories) as well as cross-cutting themes and common ground for many of these theories (e.g., the importance of genetic and immune factors, altered metabolic capacity, and oxidative stress). [1,8,12,14,15,17,42,109,110,112,121,150,151]

Neurogenic Inflammation

Neurogenic inflammation is a type of inflammation that is triggered by the activation of sensory neurons. Under the neurogenic inflammation hypothesis, fragrances trigger the responses of unmyelinated c-fiber neurons in the respiratory mucosa, leading to central nervous system (CNS) inflammation, and eventually symptoms like headache or tachycardia.[42,152–158]

Limbic system dysregulation and neural sensitization

Limbic system dysregulation and neural sensitization are parallel processes that involve acquired hyper-responsiveness manifested in several body systems. Limbic system dysfunction hypothesis focuses on hyper-responsiveness in the limbic system. Specifically, recurrent low-level intermittent exposure to chemicals, could produce something similar to kindling, where an increased electrical response in the brain following repeated low-level electrical stimulations of limbic structures can permanently lower the seizure threshold.[42,150,159–164] Neural sensitization, sometimes referred to as hyperresponsivity or central sensitization, also involves increased responsiveness of neurons, but with a focus on non-limbic areas in the CNS. For instance, with neural sensitization increased EEG activity and changes in skin conductance occurred after repeated intermittent exposures to chemicals in chemically sensitive women compared to normal controls.[42,137,165,166] There is some evidence of both sensitization events and clear cellular-level impacts from fragrance and chemical exposure in the central and peripheral nervous and immune systems.[1,14,167] This is grounded in the notion that the olfactory nerve acts as a vector for neurotoxic agents to be transported into the central nervous system bypassing the blood brain barrier.[150,159] Neuroimaging studies support the idea that the development of MCS may be attributed to neural sensitization.[1,153,168–173] [150,173]

Immune dysregulation

Allergic response and immune system dysregulation is another proposed etiological mechanism to explain fragrance sensitivity.[8,112,119,121,150,174] Some researchers theorize that mast cell degranulation and mediator release, caused by indoor air contaminants (e.g., volatile organic chemicals outgassing from new construction and remodeling materials, pesticides, mold, disinfectants, and cleaning agents) at extremely high levels, could provide an explanation for the myriad illnesses and symptoms associated with MCS, TILT, and IEI as well as the comorbid and often overlapping conditions (e.g., fibromyalgia, chronic fatigue, depression, asthma, eczema, and neurodivergence).[120–122,175–177] One study demonstrated that individuals with MCS displayed a distinct systemic immune mediator profile suggestive of low-grade systemic inflammation, as plasma levels of interleukin-1β, -2, -4, and -6 were significantly increased in the MCS group compared with controls.[112]

Psychogenic theory

The psychogenic theory of MCS hypothesizes that MCS patients, who often have high levels of depression, anxiety, and mental distress, have a greater sensitization towards environmental stimuli, which they then focus their attention on to explain their psychological symptoms.[9,13,15,26,42,95,123–129,131,178–180] This is further complicated by the fact that some psychiatric disorders (e.g., panic disorder, and PTSD) share many of the same symptoms or features of MCS.

Other common factors to consider

Although not expressly tied to a given pathophysiological theory, there is also consistent evidence of the importance of genetic and immune factors, altered metabolic capacity, and oxidative stress. For instance, the clinical manifestations of MCS may be associated with a variety of genetic polymorphism many of which result in alterations in metabolic capacity.[19,181 8,18,23,109,150,182–186] There is also some evidence suggesting these polymorphisms could increase oxidative stress.[8,15,17,18,183,186–188] Therefore, it is possible that gene expression is epigenetically modulated by exposure, leading to potential hypersensitivity and MCS.[8,182–186]

LEGISLATIVE AND REGULATORY LANDSCAPE

Federal Legislation and Administrative Oversight

Historically there have been few regulations regarding fragrances and a patchwork of federal agencies that have authority over different products with fragrances. The FDA has the authority to regulate the safety of food, drugs, medical devices, and cosmetics. Additionally, The Fair Packaging and Labeling Act (FPLA or Act) directs the Federal Trade Commission (FTC) and the FDA to issue regulations requiring that all "consumer commodities" be labeled to disclose net contents, identity of commodity, and name and place of business of the product's manufacturer, packer, or distributor.[189] In the U.S., most cleaning products are regulated by the Consumer Product Safety Commission, which does not require full fragrance ingredients or even the presence of fragrances on either the product label or the material safety data sheet (MSDS).[65] Personal care products are regulated by the FDA, which requires ingredients on the product label, but not on the MSDS. Notably, the FDA does not require companies to disclose “trade secrets,” of which fragrance formulas are likely to be. Consequently, fragrance ingredients were simply listed as “fragrance,” rather than disclosed on an individual basis.[7,190,191] In short, the FDA required finished cosmetic products to be safe when used by customers in accordance with product labeling or customary usage and to not be misbranded or adulterated while the FPLA required cosmetics marketed on a retail basis to consumers in interstate commerce to be honestly and informatively labeled.[65,190] Together the FDCA and FPLA were the primary pieces of federal legislation governing fragrance chemicals in personal care products, cosmetics, and consumer goods until the Modernization of Cosmetics Regulation Act of 2022 (MoCRA) was passed.

The goal of MoCRA was to expand the FDA’s authority to regulate cosmetics. Specifically, the new powers provided to the FDA under MoCRA include: (1) expanded adverse event reporting and transparency; (2) recall authority; (3) requiring manufacturers and processors to register with the FDA; (4) good manufacturing processes (GMP); (5) expanded labeling requirements (e.g., contact for adverse event reporting and disclosure of fragrance allergens); (6) maintenance records supporting safety substantiation; (7) screening Talc-containing products for asbestos; and (8) assessment of per- and polyfluoroalkyl substances (PFAS) safety in personal care products (e.g., summary report in collaboration with National Center for Toxicological Research) issued within

three years.[190,192,193] Many of the new requirements became effective on December 29, 2023, but FDA delayed enforcement until July 1, 2024.[194,195]

Despite the improvements brought by MoCRA, there are still clear gaps and areas of improvement. First, although the new label requirements include the disclosure of fragrance allergens, which is a step in the right direction, as of the writing of this report, the FDA has not published a list of fragrance allergens. Additionally, fragrance ingredients that are not on the list of allergens may still be identified only as, "fragrance" to protect company trade secrets. Second, there are some exemptions under MoCRA. Specifically, certain small businesses (e.g., companies whose average gross annual sales of cosmetic products in the U.S. for the past three years is less than $1 million) are exempt from compliance with GMP, registration requirements, and adverse event record retention. However, the exemption does not apply to facilities that manufacture or process products that: (1) regularly come into contact with the mucus membrane of the eye; (2) are injected; (3) are intended for internal use; or (4) are intended to alter appearance for more than 24 hours.[194] MoCRA does preserve the authority of states to ban or regulate chemicals of concern in personal care products. Thus, the hard work of regulating specific ingredients now falls to the states.[193]

State Legislation

Currently, twenty states have passed laws limiting certain substances in cosmetics, including California, Colorado, Florida, Hawaii, Illinois, Iowa, Maryland, Minnesota, Montana, Mississippi, Nevada, New Jersey, New Mexico, New York, Ohio, Oregon, Vermont, Virginia, Washington and Wisconsin.[193] These states have stricter limits on some chemicals (e.g. 1,4-dioxane, cadmium, color additives, formaldehyde, mercury, parabens, PFAS, phthalates, methyl alcohol and methyl methacrylate) due to concerns about their potential health effects.[193]

California is a leader in consumer safeguards, specifically, regarding protection against harmful substances in personal care products, and therefore the best example of successful fragrance regulation at the state level. In 1986, the state passed Proposition 65, the Safe Cosmetics Act, which required manufacturers to reveal the presence of Proposition 65 chemicals. The Prop 65 list currently includes 624 carcinogens and 323 reproductive/developmental toxicants; however, it does not include other hazard endpoints, such as neurotoxicity, asthmagenicity, or endocrine disruption.[36,66] Then California passed the Professional Cosmetics Labeling Requirements Act, which mandated ingredient labels on professional salon products. Next, in 2020 the Toxic-Free Cosmetics Act banned 24 toxic chemicals sold in California and the Cosmetic Fragrance and Flavor Ingredient Right to Know Act was passed, requiring disclosure of fragrance mixture ingredients in personal care products. Finally, in 2022, California banned intentionally added PFAS chemicals from personal care products, effective on January 1, 2025.

Industry Self-Regulation

The final regulatory mechanism is industry self-regulation. The Research Institute for Fragrance Materials (RIFM) and the International Fragrance Association (IFRA) make up the international self-regulation system for the fragrance industry.[4] RIFM was formed as a member-supported nonprofit organization in 1966 and in 1967 RIFM established their Expert Panel for Fragrance Safety as an independent team of researchers and academics (e.g., dermatologists, pathologists, toxicologists, and environmental scientists) that review and approve all RIFM work. This includes the RIFM database which provides information (e.g., chemical features, safety assessment, genotoxicity, repeated dose and reproductive toxicity, skin sensitization, photoirritation and photoallergenicity, local respiratory toxicity, mutagenicity, carcinogenicity, metabolism and toxicokinetics, and environmental consequences) on 7,000 raw fragrance materials. However,

RIFM does not evaluate final fragrance formations and the database is only available to members.[4,65] IFRA was founded in 1973 and acts as the official representative body of the international fragrance industry. As such they represent the collective interests of the industry. The primary activity of IFRA is the publication of the list of usage standards for fragrance materials, based on the findings of RIFM. The most recent publication (the 51st Amendment) was implemented in January 2024 and updates are scheduled to occur every three years.[196] Ultimately, industry self-regulation is helpful, but labeling transparency and disclosure of all fragrance ingredients in consumer products may not be in their best interest.

Although the enactment of MoCRA and state legislation to either prohibit or provide notice of certain harmful ingredients in personal care and household cleaning consumer goods are actions that will likely help reduce exposure to potentially harmful chemicals and fragrances, other mechanisms may yield better results.

LEGAL LANDSCAPE AROUND FRAGRANCE SENSITIVITY AND DISABILITY

In the absence of more stringent state and federal legislation around fragrance regulation, the most likely tool to reduce exposure to fragrances for those who experience fragrance sensitivity is either: (1) exercising rights under the Americans with Disabilities Act (ADA) or (2) relying on organizations to pursue self-regulation and implementation of fragrance-free policies.[197]

ADA and third-party accommodations

Under the ADA, a disability means: (1) a physical or mental impairment that substantially limits one or more major life activities of such individual; (2) a record of such an impairment; or (3) being regarded as having such an impairment.[198]

The ADA uses the concept of reasonable accommodation to establish a form of positive rights. Specifically, the ADA affirmatively requires public and private entities to make reasonable modifications to physical environments, rules, and policies to make spaces accessible.[197] Generally, interpretation of what constitutes reasonable accommodation focuses on two parties, the individual seeking the accommodation to achieve equitable access and the employer or public/private actor who is being asked to engage in or refrain from certain behaviors. However, fragrance-free policies would require third-party accommodations, because other individuals using the shared space would also need to accommodate.[197] Third-party accommodation can be both passive behaviors (such as prohibiting peanuts in schools) as well as active behaviors (such as washing hands or wearing a mask).[197] In the case of fragrance-free policies, the accommodation would require multiple third parties to refrain from using certain fragranced products.

Often the criticism of third-party accommodations (and disability accommodations in general), is that they may be viewed as special rights that infringe on the rights of third parties. However, there are examples of successful third-party accommodation, starting with smoke-free policies that paved the way as both a disability accommodation as well as a general public health practice.[197,199] This provides hope for the potential success of other third-party accommodations.

Smoke-free policies as accommodations

Historically, courts have been sympathetic to claims of secondhand smoke-related disabilities and acknowledged employers should have granted reasonable accommodation such as prohibition of smoking on the job or inside the building.[197,200] Importantly, the standard courts have taken to evaluate the reasonableness of third-party accommodations, is whether the accommodation creates undue burden for others. For instance, smoke-free workplace policies and laws have been considered reasonable because they are inexpensive to implement and do not harm or burden businesses that have implemented them.[197,201]

Food allergy bans and mask requirements as accommodations

As with smoke-free policies, there has been evolution over the years with respect to accommodating food allergies and mask requirements – particularly in education, air travel, and the workplace. Section 504 is the primary statutory framework used to accommodate students with disabilities in schools and it has been used to accommodate students with food allergies and immune conditions.[197,202] Regarding food allergies, reasonable accommodations include allergen-free lunch tables, handwashing requirements, an allergen-free classroom, and self-carry epinephrine (EpiPen).[197,203] Although, there has been occasional resistance from parents of non-allergic kids, generally food bans as accommodations are well accepted and practiced with many schools banning nuts schoolwide.[197,199] In contrast, mask requirements in schools as a reasonable disability accommodation have had mixed results with circuit courts split.[197] One researcher theorizes that some courts are resistance to blanket mask requirement policies because they lack flexibility, applying mask requirements to everyone regardless of whether they come into contact with the student in need of accommodation. In contrast, a third-party accommodation argument and more importantly policy, which can be tailored to the specific needs of the individual being accommodated as well as the other parties, may be more successful in these circuits.[197]

Food allergies and self-regulation to avoid tort liability

The airline industry has shown similar successes regarding making planes safer for individuals with food allergies (specifically peanuts); however, it has taken the form of self-regulation. In the absence of federal or industry regulation banning peanuts, many airlines (but not all) decided to stop serving them to prevent potential tort liability.[197,204] Consequently, the current landscape theoretically gives consumers enough room to choose the safest airline for them. However, this sort of informal self-regulation, which is driven by the desire to avoid potential tort liability, has not been perfect – with reports of families being removed from planes when they raise questions regarding exposure or situations when the airline determines the severity of an allergy made it unsafe for them to fly.[197,205,206] In this way, the airline industry provides a cautionary example for informal self-regulation as opposed to formal regulation.

Third-party accommodations and fragrance sensitivity?

Smoke-free policies, mask requirements, and bans on food allergens provide a potential roadmap for fragrance sensitivity. Moreover, in many ways the current situation with fragrance sensitivity mirrors what was going on with food allergies 70 years ago. People with fragrance sensitivity experience symptoms when exposed to fragrances, but there is not a proven biological mechanism

or clear clinical biomarker. Likewise, prior to the discovery of immunoglobulin E (IgE) as an indicator allergy in the mid-1960s, food allergy was considered a controversial condition.[197,207] This is particularly interesting as successful ADA and Section 504 challenges for food allergy accommodations helped normalize narrowly applied third-party accommodations such that more widespread nut bans in schools are now more well accepted. At the same time, to avoid liability, the airline industry has relied on self-regulation to give consumers choice. It is not yet clear whether fragrance-free policies will have a similar divide.

ADA cases involving fragrance sensitivity

Initial efforts of individuals with MCS to exercise their rights under the ADA were largely unsuccessful. A study of 17 early ADA cases involving MCS (between 1995 and 2003) found that motions for summary judgment by the defendant were granted or affirmed in 14 cases.[197,208] Similarly, a review of cases involving MCS prior to the 2008 Americans with Disabilities Act Amendments Act (ADAAA), which broadened the definition of disability, demonstrate that courts regularly questioned whether the plaintiffs were truthful about the presence or severity of their condition.[197,209] Moreover, in 2022, with the ADAAA in place for some time, the Eastern District Court of Virginia still excluded from evidence a medical diagnosis of the condition because it "lacked reliability and the medical community has not accepted MCS as a diagnosis."[197,210,211] This suggests courts are reticent to acknowledge MCS as a condition meriting accommodation.

Moreover, even in cases where courts acknowledge fragrance sensitivity as a disability meriting accommodation, there remains the question of whether fragrance-free policies are considered a reasonable accommodation that does not unduly burden third parties. For instance, the Minnesota District Court decided that fragrance-free policies "impose an undue financial and administrative burden on employers, because they are very difficult to enforce."[197,212] Similarly, when evaluating the reasonableness of a fragrance-free policy in a public school, the court determined that, "a public school could never be free from any objectionable smell or any deodorant, perfume, cologne, hand lotion, or cleaning products."[197,211] At the same time there have been some successful ADA cases involving MCS.[213–216] In short, while there is a pathway under the ADA to ensure accommodations for individuals with fragrance sensitivity, evidence suggests the court system may not be the best tool to achieve equity.

Self-regulation and implementation of fragrance-free policies

Fragrance-free policies, which often apply to both individuals and spaces, aim to make spaces more accessible for individuals with MCS, as well as those with other conditions with symptoms that may be triggered by fragrance.[217] For instance, efforts are taken to promote the use of fragrance-free cleaning products, and people coming into those spaces asked to avoid or limit wearing perfume, using fragranced laundry detergent/dryer sheets, applying personal care products that contain fragrances, or refrain from using fragranced products when in fragrance-free spaces.[217]

As illustrated above, some blanket fragrance-free policies have been struck down by courts. Consequently, it is important to consider what sorts of fragrance-free policies might be the most successful.

Where are fragrance-free policies being implemented?

Fragrance-free polices are gaining traction in workplaces and schools. Since 2009, the Centers for Disease Control (CDC) has encouraged employees to be as fragrance-free as possible.[218] The rational for the policy was to establish guidance and procedures to protect and maintain safe indoor environmental quality for all CDC employees at all CDC work areas. Importantly, the policy does not expressly prohibit individuals from using fragranced products, but it does prohibit carrying or using such products inside the CDC.[218] Therefore, it is a good example of a flexible policy. There have also been efforts to implement and advocate for fragrance free spaces and product options elsewhere by the CDC, the American Lung Association, the Job Accommodation Network (JAN), and the U.S. EPA.[218–221] Additionally, University of Illinois Chicago (UIC) and University of California Los Angelas both advocate and provide resources for implementing fragrance-free policies on their campuses and Portland was the first city to ban fragrance.[141,217,222,223] Importantly, Portland's ban, like CDC's policy, is flexible. It applies only to City of Portland employees who are asked, "to refrain from the use of personal scented products in the workplace where the sole purpose is to produce a scent, such as perfume, after shave, and cologne and to avoid the use of strongly scented personal hygiene products such as laundry soap, dryer sheets hand lotion, powder, hair spray, and deodorant."[223]

It is not clear if increased implementation of fragrance-free spaces is based predominantly on the strength of the scientific evidence, the precautionary principle, or the legal landscape regarding MCS as a disability. However, currently fragrance-free policies appear to be the most effective method for reducing exposure to fragrances, particularly when the policies are flexible, creative, and voluntary rather than focusing on strict bans.[224]

CURRENT AMA POLICY

Our AMA does not currently have any policy related to fragrance regulations or fragrance-free policies. However, policy H-440.855, "National Cosmetics Registry and Regulation," does support the creation of a publicly available registry of all cosmetics and their ingredients. Additionally, although it is not a formal policy the AMA does discuss the complex medical and legal nature of disability. For instance, HOD policy supports the designation of alcohol use disorder as a disability and opposes the classification of obesity as a disability.

CONCLUSION

Fragrance sensitivity is a controversial, unexplained, and complex disorder. There is extensive self-report evidence suggesting that fragrance sensitivity is a serious problem for a significant portion of the population. Yet, the heterogeneity of symptoms and exposures coupled with the sheer volume of ingredients in fragranced products (and consumer products more broadly) makes understanding the relationship between fragrance exposure and health impacts extremely difficult. Most of the evidence, which varies wildly in quality, falls into three categories: (1) self-report of exposure to fragrance followed by a constellation of symptoms; (2) toxicological and epidemiological associations between chemicals found in fragranced products and potential risk of harm; and (3) analysis of potential mechanisms in individuals with a diagnosis of fragrance sensitivity. It is possible to connect the evidence to form a compelling narrative of how exposure to harmful chemicals from personal care and household cleaning products causes serious adverse health effects through several plausible mechanisms. However, the throughline between these categories of research is often attenuated, weak, or based on limited data.

This clearly illustrates the need for more research on fragrance sensitivity (e.g., diagnostic tools, mechanisms, health impacts, impacts of fragrance on other diseases, and fragrance-free interventions). Although more research is needed, inaction means that those with fragrance sensitivity will continue to be misdiagnosed, offered health care solutions with limited or no effect, or be met with mistrust and doubt. Furthermore, efforts to reduce exposure to fragrances and other chemicals will likely benefit individuals with fragrance sensitivity, as well as those with comorbidities and shared triggers that are also negatively impacted by exposure to fragrances. Therefore, it is worth pursuing efforts to reduce exposure.

It is unlikely that either federal regulation or industry self-regulation will bring significant changes or improvements regarding labeling transparency or ingredient bans, but some states have been making promising progress in these areas suggesting this may be an area worth more focus. Likewise, there is a viable mechanism for accommodation under the ADA, though decisions are mixed. Instead, the most effective approach has been self-regulation in the form of implementation of fragrance-free policies. Notably the most successful fragrance-free policies and third-party accommodations appear to be those that afford flexibility and creativity rather than blanket bans.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

Our American Medical Association:

(1) recognizes that some environmental exposures may have the potential to substantially limit major life activities of an individual with fragrance sensitivity and related disorders.

(2) encourages health care facilities, government agencies, and nonprofit organizations to adopt and promote fragrance-free policies that recommend individuals avoid or limit use of fragrances and support the use of fragrance-free products when feasible.

(3) encourages research on fragrance sensitivity to (a) improve diagnostic tools; (b) understand the impact of fragrances on other diseases; (c) evaluate the impact of fragrances on health; and (d) evaluate the impact of fragrance-free intervention.

(4) supports the identification of fragrance allergens and disclosure of fragrance ingredients as part of labeling of personal care products, cosmetics, and drugs. (New HOD Policy)

Fiscal Note: less than $1,000

Table 1. Variations is self-report symptom prevalence (%) across different populations and subgroups

	Steinemann*					Steinemann*	Steinemann*	Caress*	Fares-Medina*		Andresson**	Caress**	Hausteiner**	Borchein***	Klascha****		
	US	AU	UK	SE	AVG	US	US	US	ES-w	ES-m	nr	US	DE	nr	DE-FS	DE-Autists	DE-Asthmatics
Migraine headaches	15.7	10	8.4	16.1	12.6	8.4	15.7	7.2	19		66	88	58	33	25.1	22.4	12
Asthma attacks	8	7.6	6.8	5.5	7	6.8	8	4.7		29	59				16.9	20.4	13.8
Neurological problems (e.g., dizziness, seizures, head pain, fainting, loss of coordination)	7.2	4.5	3.7	5	5.1		7.2	3.2	10		22	7.2-46	22	19	27.4	30.6	11.1
Respiratory problems (e.g., difficulty breathing, coughing, shortness of breath)	18.6	16.7	11.6	20	16.7	11.6	18.6	9.5		47-60					55.3	30.6	24.4
Skin problems (e.g., rashes, hives, red skin, tingling skin, dermatitis)	10.6	9.5	9.8	6.5	9.1	9.8	10.6	5.7	15	1	30		19		32	34.7	16
Cognitive problems (e.g., difficulties thinking, concentrating, or remembering)	5.8	4.1	2.8	4.5	4.3	2.8	5.8		2-9		21-51	32	17-46	13-27	18.7	28.6	12.4
Mucosal symptoms (e.g., watery or red eyes, nasal congestion, sneezing)	16.2	14	9.2	13.5	13.2	9.2	16.2	7.6	42	2	22-65	59-77	11	12	35.6	28.6	14.2
Immune system problems (e.g., swollen lymph glands, fever, fatigue)	4	3.3	1.9	1.5	2.7	1.9	3.8					17.4			13.2	38.8	9.3
Gastrointestinal problems (e.g., nausea, bloating, cramping, diarrhea)	5.5	3.3	3	3.5	3.8	3	5.5		20	2	25-26		30	15	21.9	24.5	10.2
Cardiovascular problems (e.g., fast or irregular heartbeat, jitteriness, chest discomfort)	4.4	3	3.2	2.1	3.2	3.2	4.4		3		21-30	46-55	14-27	19-Dec	14.6	24.5	8
Musculoskeletal problems (e.g., muscle or joint pain, cramps, weakness)	3.8	2.6	2	1.5	2.5	2	1.7		17	2		30.4		19-21	9.6	24.5	6.7
Other	1.7	1.9	2.1	2.2	2		1.7					50.7			3.2		1.3

nr = not reported, AVG = average

**General popluation/nationally representative sample*

***Individuals with self reported chemical intolerance*

****Individuals with a diagnosis of MCS*

*****German subpopulations (FS = fragrance sensitive individuals, autists, and asthmatics)*

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REPORT 7 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-25)
Addressing the Health Issues Unique to Minority Communities in Rural Areas
(Reference Committee D)

EXECUTIVE SUMMARY

BACKGROUND. Resolution 433-A-24 asked that our American Medical Association study health issues unique to minority communities in rural areas, such as access to care difficulties. Rural minority populations are not a homogeneous group of individuals and ethnic and racial diversity within rural America has increased significantly within the past twenty years. Despite limitations in available data and health studies, it has been well established that racial and ethnic minority populations in rural areas often experience disparities in health status, health insurance coverage, rates of chronic disease, life expectancy, and rates of unintentional injury compared to their White rural counterparts. This report provides a summary of the available evidence on health disparities within minority rural populations, with a focus on Black/African American, Hispanic/Latinx, American Indian/Alaskan Native (AI/AN), as well as the LGBTQ+ community. Additionally, the report explores the historical and current contributors to ongoing health disparities, such as the social determinants of health and structural racism.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms “rural” AND “minority”; “rural” and “health disparities”, and “rural” and “health inequities.” Additional articles were identified by manual review of the reference lists of pertinent publications and as new areas of exploration were revealed through identified articles. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

DISCUSSION. Many studies demonstrate that rural minority populations have poor health outcomes across multiple measures compared to their White rural counterparts. For example, as of 2017, close to 30 percent of AI/ANs, non-Hispanic blacks, and Hispanics self-reported poor or fair health compared to only about 18 percent of non-Hispanic Whites. While many rural racial minority populations suffer worse health outcomes and have poorer health care access compared to their White rural counterparts, each group experiences a unique set of challenges which are influenced by intersecting social determinants of health. Rural minorities are functionally impacted by two overlapping disparity processes - disparities associated with their rural geography and disparities associated with being a member of a particular minority group. Among the various social determinants of health, a lack of education, economic stagnation, and lack of investment within rural communities are notable as they have led to disproportionate rates of poverty in rural areas, leading to lower tax bases that limit the ability for educational and health systems to thrive. As a result, upstream social and economic determinants are negatively impacted, including housing, food security, access to places to be physically active, and health care access. Many of these social determinants are deeply rooted in centuries of discrimination, racism, violence, as well as disinvestment and injustice.

CONCLUSION. Rural minority populations suffer a disproportionate burden of adverse health outcomes compared to rural White populations or urban minority populations. Rural minority residents experience dual disparities and poor health outcomes are a result of intersecting structural and social determinants of health. Longstanding disparities in health care access within rural areas are compounded by additional and unique barriers experienced by rural minority populations.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 7-A-25

Subject: Addressing the Health Issues Unique to Minority Communities in Rural Areas

Presented by: John T. Carlo, MD, MS, Chair

Referred to: Reference Committee D

INTRODUCTION

Resolution 433 was adopted at the 2024 Annual Meeting resulting in policy H-350.937, "Improving Healthcare of Minority Communities in Rural Areas." Item five of this policy asks that "our American Medical Association (AMA) will research and study health issues unique to minority communities in rural areas, such as access to care difficulties."

BACKGROUND

As of 2020, around 46 million Americans, or 14 percent of the U.S. population, lived in rural areas.[1] Rural Americans face numerous health disparities compared with their urban counterparts. Rural Americans are more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke than their urban counterparts.[2] Unintentional injury deaths are approximately 50 percent higher in rural areas than in urban areas, partly due to greater risk of death from motor vehicle crashes and opioid overdoses.[3,4] In general, residents of rural areas in the U.S. tend to be older and sicker than their urban counterparts.[2,5]

While rural America is still overwhelmingly White (constituting about 76 percent of the rural population), it has become more ethnically and racially diverse over the last twenty years.[1] Despite limitations in available data and health studies, it has been well established that racial and ethnic minority populations in rural areas often experience disparities in health status, rates of chronic disease, life expectancy, and rates of unintentional injury compared to their White rural counterparts.[6–8] As an example, in a recent study, rural counties with a majority non-Hispanic Black or American Indian/Alaska Native (AI/AN) residents were found to have a higher premature death rate compared to rural counties with a majority of non-Hispanic White residents.[9] In places where race and ethnicity overlay with rural geography, residents often experience dual disparities and face some of the worst outcomes in the nation. Poor health outcomes for rural minority populations are a result of intersecting social determinants of health factors, which are further elucidated in this report.

In 2022, the AMA's Council on Science and Public Health (CSAPH) authored a report on improving rural public health infrastructure, which found that rural local health departments are often limited by budgets, staffing, and capacity constraints in providing public health services, limiting their ability to respond to national public health and health care policy initiatives and emergencies. With less funding and fewer staff, rural local health departments are often not able to meet the needs of a sicker population over a larger geographical area, contributing to the lack of essential public health services offered in rural areas. Building from the previous CSAPH report, this report provides a summary of the available evidence on health disparities within minority rural populations, with a focus on Black/African American, Hispanic/Latinx, AI/AN, as well as gender

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and sexual minority populations. Additionally, the report explores the historical and current contributors to ongoing health disparities, such as the social determinants of health and structural racism.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms "rural" AND "minority"; "rural" and "health disparities", and "rural" and "health inequities." Additional articles were identified by manual review of the reference lists of pertinent publications and as new areas of exploration were revealed through identified articles. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

DISCUSSION

Rural minority populations are not a homogeneous group of individuals and ethnic and racial diversity within rural America has increased significantly within the past twenty years.[1] For the purposes of this report, rural minority populations are grouped into four general categories: African American/Black, Hispanic/Latinx, AI/AN, and the LGBTQ+ community. To note, the non-Hispanic multiracial population has also increased in rural areas as of the 2020 Census, now representing 3.9 percent of the rural population.[1] However, due to the recency of this population increase and little information in the literature on the health issues of this population, this report focuses primarily on the four above noted categories.

Data from the Behavioral Risk Factor Surveillance System (BRFSS), an annual state-based, random-digit–dialed telephone survey of the noninstitutionalized U.S. population aged 18 years or older, demonstrates that rural minority populations have poor health outcomes across multiple measures compared to their White rural counterparts.[6] For example, as of 2017, close to 30 percent of AI/ANs, non-Hispanic blacks, and Hispanics self-reported poor or fair health compared to only about 18 percent of non-Hispanic Whites.[6] While many rural racial minority populations suffer worse health outcomes and have poorer health care access compared to their White rural counterparts, each group experiences a unique set of challenges.[6] The following sections summarize health challenges unique to each of the four minority groups.

Non-Hispanic African American/Black. As of the 2020 Census, rural African Americans account for about 7.7 percent of nonmetropolitan inhabitants, with a concentrated population in the rural south.[1] This geographic concentration is an artifact of our countries' history of chattel slavery, as many black families stayed in the south following emancipation and the Civil War despite the large migration to other regions of the country in the early 20th century. The history of slavery in the U.S. is an important social determinant influencing the health disparities experienced by rural African Americans today (discussed further below). Rural African Americans have significantly lower rates of health care coverage (73.2 percent) compared to White populations (83.9 percent) and almost one in four (24.5 percent) have not seen a doctor in the past 12 months due to cost.[6] Based on BRFSS data, rural African Americans are significantly more likely to have two or more chronic health conditions (40.3 percent prevalence), are more likely to be severely obese (12.1 percent have a BMI greater than or equal to 40 kg/m2), and are more likely to get no leisure-time physical activity (38.2 percent prevalence) compared to non-Hispanic White populations (36.0 percent prevalence of two or more chronic conditions, 5.0 percent prevalence of severe obesity, and 27.7 percent prevalence of no leisure time physical activity).[6] As a result, rural African American communities are particularly impacted by cardiovascular disease, hypertension, stroke, and diabetes.[7] Rural African Americans are 20 percent more likely to be diagnosed with diabetes

compared to urban residents and also tend to have poorer diabetes disease control, leading to increased rates of complications that arise from diabetes.[7]

Poor control of hypertension among rural African American communities is also high, which may be linked to the high rates of stroke found in this population. The high rate of stroke is so stark that southern states where many rural African Americans reside have been nicknamed "The Stroke Belt."[7] Lastly, due to barriers faced in accessing preventive services in rural areas, cancer disparities are more acutely felt among rural African Americans.[7,10] For example, African American women in rural areas have the highest breast cancer mortality rate compared to other racial and ethnic populations in the U.S.[7] The high prevalence of poorly managed chronic disease, lack of access to preventive services and care, ultimately lead to higher mortality rates among rural African Americans. Based on one study, the age-adjusted mortality rates estimated across a five year period (2013-2017) were highest among rural African Americans compared to all other minority groups, in both rural and urban settings (981.3 deaths per 100,000).[8]

Hispanic/Latinx. As of the 2020 census, Hispanics represent the largest share of the rural minority population, with a population of about 4.1 million or 9.0 percent.[1] Since 1980, Hispanics have been the fastest growing population in rural America, often relocating for employment opportunities in the agriculture, construction, and manufacturing sectors.[7] A result of the intersection of largely being immigrants (26.7 percent of rural Hispanics were born outside of the U.S.) and working in lower skilled jobs, rural Hispanics have the lowest prevalence of health care coverage among rural minority populations (61.1 percent) and nearly a quarter have not seen a doctor in the past 12 months due to cost (23.1 percent).[6] In terms of health conditions, rural Hispanics are impacted by a high prevalence of diabetes compared to rural White populations and urban Hispanic populations, as well as a higher burden of hypertension, heart disease, and stroke.[7] Rural Hispanics with diagnosed diabetes and/or hypertension are significantly less likely to be managing their conditions.[7] Significant barriers to accessing care unique to the rural Hispanic community are lack of bilingual staff or qualified medical interpreters within health care settings.[7] Despite higher prevalence and burden of some health conditions, rural Hispanics have a lower age-adjusted mortality rate compared to their African American, AI/AN, and White rural counterparts (580.7 per 100,000) but it is significantly higher than urban Hispanic populations (522.7 per 100,000).[8]

American Indian/Alaskan Native. AI/AN populations are largely rural in composition, with approximately 54 percent living in rural areas of small towns, and 68 percent living on or near their tribal homelands.[11] AI/AN communities have a significantly higher prevalence of depressive disorder (23.2 percent), obesity (38.5 percent), and are more likely to be current smokers (36.7 percent) compared to non-Hispanic Whites (20.3 percent prevalence of depressive disorders, 32.0 percent obese, and 24.7 percent are current smokers).[6] Rural AI/AN communities also have the highest rate of death by unintentional injury compared to all other racial/ethnic groups, both urban and rural (101.9 deaths per 100,000).[8] Notable health conditions of concern in AI/AN community include high rates of diabetes and hypertension, substance use, suicide, as well as respiratory health conditions such as tuberculosis, asthma, pneumonia, and more recently, COVID-19.[7,12] As a result of the numerous health disparities experienced by the AI/AN community, they have a lower life expectancy compared to all other racial groups in the U.S. population (65.2 years in 2021 compared to 76.4 for White populations).[12] While life expectancy declines from the COVID-19 pandemic were experienced among the entire population, AI/AN groups experienced the largest decline which is reflective of the disproportionate burden of excess deaths from COVID-19 experienced in this community.[12]

LGBTQ+ community. While exact numbers of the LGBTQ+ population in rural areas are difficult to assess compared to racial and ethnic minorities as there is no standardized method for collecting

this information, (such as the Census) and ongoing stigma targeted at the LGBTQ+ community makes self-reporting unreliable, it is estimated that there are approximately three to four million LGBTQ+ individuals living in rural areas.[7,13] Data is limited in terms of unique health conditions experienced in this community. However, it has been documented that self-reported health among rural LGBTQ+ populations is more likely to be poor or fair and they are more likely to report having three or more chronic conditions compared to urban LGBTQ+ populations.[14] Sexual minority populations are at an elevated risk for substance use and substance use disorders compared to heterosexual populations, which has been associated with chronic stress and use of substances as a coping mechanism.[15] Rural LGBTQ+ populations may experience more stress due to continued stigmatization and prejudice, with reduced access to supportive communities, leading to higher levels of anxiety and depression.[13,14] It has also been estimated that rural sexual minorities have lower access to substance use disorder treatment, but few studies have evaluated this issue.[15]

Causes of Rural Minority Health Disparities: Intersecting Social Determinants of Health

Rural minorities are functionally impacted by two overlapping disparity processes - disparities associated with their rural geography and disparities associated with being a member of a particular minority group, which can be exponential, not just additive.[7] In other words, existing rural health disparities are a product of a complex intersection and interplay of many social and structural determinants of health. Among the various social determinants of health, a lack of education, economic stagnation, and lack of investment within rural communities are notable as they have led to disproportionate rates of poverty in rural areas, leading to lower tax bases that limit the ability for educational and health systems to thrive.[7] As a result, upstream social and economic determinants are negatively impacted, including housing, food security, access to places to be physically active, and health care access.[16,17]

While many consider housing shortages and affordability an urban issue, many rural areas are also facing similar challenges caused by an overall lack of housing development over many decades as well as the growth in seasonal and recreational use of available housing.[18,19] These issues were exacerbated by the COVID-19 pandemic, when urban dwellers and remote workers moved to rural areas.[20] Housing shortages and affordability not only impact low-income minority populations but also makes recruitment and retention of rural health care professionals even more challenging.[18,19] Multi-modal transportation infrastructure, such as public transportation, sidewalks, and biking-walking trails, is also lacking in rural areas compared to most urban and suburban municipalities.[21,22] Combined with long distances between destinations, this reduces the availability of daily opportunities for physical activity and creates a reliance on personal automobiles to access daily needs and services.

To understand how the current social determinants of health were created, it is useful to look from a structural and historical perspective. The relationship between rural minority groups and current poor health outcomes is rooted in centuries of discrimination, racism, violence, as well as disinvestment and injustice.[23] Structural racism in the U.S. is defined as "the totality of ways in which societies foster racial discrimination through mutually reinforcing systems…These patterns and practices in turn reinforce discriminatory beliefs, values and distribution of resources."[24] Structural racism plays a critical role in the existing health disparities experienced by minority rural populations as it has influenced housing and lending discrimination, cultural stigma, forced migration, occupational inequalities, and xenophobic immigration policies.[25] For Black Americans in the rural South and AI/AN populations, the historical legacy of land dispossession is a critical structural determinant in understanding the current context of high poverty levels and poor health.

In the rural South, particularly the Mississippi Delta area (an area defined as the northwest section of the U.S. that lies between the Mississippi and Yazoo rivers), 98 percent of black agricultural landowners have lost ownership of their land, equating to a loss of 12 million acres over the last century.[26] Following the civil war and during the Reconstruction era, Black ownership of land increased and even outnumbered White landowners in some southern counties. At the beginning of the 20th century, it was estimated that African Americans owned as much as 14 million acres of farmland.[27] That changed starting during the Great Depression and through the 1960s when federal agencies and policy directives, implemented in a structurally discriminatory manner, transformed the nature of farm ownership and increased racial disparities in farm owner acreage. As an example, Black farmland in Mississippi totaled 2.2 million acres in 1910. Fifty years later, according to the Census of Agriculture, black farmers lost almost 800,000 acres of land over a fourteen-year period. This was largely a result of discriminatory loan servicing and loan denial practices by the USDA and other federal and financial institutions (as found by major audits and investigations).[26] Coupled with the onset of Jim Crow laws in the late nineteenth and early twentieth century, rural African American communities have struggled economically, with the long-term effects on health clear today.

Among indigenous communities in the U.S., the overall level of land dispossession is even more staggering. The colonization and imperial expansion by Western European countries of North America led to the displacement and forced migration of indigenous communities across the U.S., the erosion of their languages and culture, and dismantling of their social structures.[28,29] It is estimated that there has been an aggregate reduction in historical indigenous lands of about 98.9 percent.[29] The eviction of indigenous people from their ancestral lands has had long-term intergenerational impacts on indigenous families and community. For both the African American and AI/AN communities, the dispossession of their lands has led to an overwhelming loss of actual and potential net wealth that could have been passed on between generations. For African Americans, it has been estimated that as of 2013 the median net wealth of their households is $11,200, while it is thirteen times greater for White households.[30] For ancestral AI/AN lands, one study estimated that the total worth of the transfer of land resources was equivalent to approximately half a billion dollars.[30] Overall, loss of land has been found to have stemmed from "discrimination in federal and state programs, swindles by lawyers and speculators, unlawful denials of private loans, and even outright acts of violence or intimidation."[26] Considering the extreme level of poverty experienced by these rural minority communities today, the importance of this historical loss of wealth cannot be overstated. Additionally, current lands where indigenous populations have been relocated to are more exposed to climate change risks and hazards, including more extreme heat and less precipitation.[29]

Occupational Hazards

In the Hispanic/LatinX rural population, occupational health hazards represent an important and unique social determinant of health which intersects with low pay for the work they do, few regulatory protections, limited services, as well as discrimination and harassment.[16] Hispanic migrants make up an overwhelming majority of hired crop workers in the U.S. One estimate is that they account for around 83 percent of hired U.S. farm workers. Rural Hispanics are also overly represented in the workforce of large scale agricultural processing facilities (e.g., poultry processing).[31] Working in the agricultural sector, rural Hispanics face numerous environmental and physical threats, including chemical hazards from pesticides and air pollutants, physical hazards such as those from occupational injuries and the effects of extreme heat, as well as biological hazards from inadequate access to drinking water and basic sanitation.[32,33]

Pesticides are not only a source of injury and acute illness among farm workers, but long-term exposure is also linked to several chronic health effects. Acute, short-term health impacts of pesticide exposure depend on the type of chemicals used but can include eye and skin irritation, nausea, dizziness, and diarrhea.[34] Chronic health effects from pesticide exposure can include cancer, birth defects and reproductive harm, neurological and developmental impacts, and disruptions to the endocrine system.[34] Farm workers are also exposed to numerous air pollutants, including black carbon, particulate matter, carbon monoxide, nitrogen dioxide, sulfur dioxide, and diesel-related emissions from farm activities, such as tractor driving, maintenance and repair of machinery and equipment, and agricultural crop residue burning.[32] An emerging threat to farm worker health is exposure to smoke, dust, and poor air quality from wildfires, which are expected to increase in frequency and intensity in the coming years because of climate change.[35]

Machine related injuries are another top occupational risk for farm workers as well as musculoskeletal injuries from physical exertion and repetitive motions.[16,32,36] Bacterial and viral threats from working in agriculture are also unique to farm workers and there are several recent examples of this. During the COVID-19 pandemic, farm workers were considered essential and had to keep working, thus increasing their risk of COVID exposure.[32] Most recently with the spread of highly pathogenic avian influenza A (H5N1) in dairy cows, the small number of cases that have occurred in farm workers has affected primarily Latino migrants.[37] Despite working on farms and harvesting food, the combination of low wages and living in highly rural areas with a low density of available supermarkets means that food insecurity is especially high among migrant workers in the rural/agricultural sector.[5] Additionally, there is a lack of quality housing for migrant workers and available low-cost housing is limited. Reports have consistently found high rates of overcrowded and substandard housing among migrant workers.[32]

Environmental Conditions

Increased risk of exposure to hazardous environmental exposures and conditions are not limited to the rural Hispanic community. Rural Black and AI/IN populations also experience similar but unique environmental justice issues. For example, intensive livestock operations, such as large hog farms, are disproportionately located near rural, low-income African American communities, which results in wide range of adverse health impacts including eye irritations, respiratory ailments, cardiovascular issues, mental health issues, and noxious odors.[38] Additionally, low-income, African American communities are disproportionately exposed to toxic air pollution from the fossil fuel industry, with more than 1 million African Americans living within a half-mile of oil and natural gas wells, processing, transmission and storage facilities.[39] Abandoned hard rock mining operations in the Western U.S. are disproportionately located on American Indian lands, creating an increased likelihood that American Indians living near these mines are exposed to high levels of toxic metals, which are associated with increased risk of kidney disease, hypertension, and other chronic diseases.[40]

Concerns over water quality and waste management in rural African American and AI/AN communities are also prevalent, as many of these communities are not connected to larger municipal water and sewage treatment systems but rather rely on wells and septic systems.[41] One report estimates that 48 percent of households on American Indian reservations lack clean water or adequate sanitation.[42] Another study found that American Indians, Black, and Hispanic households are much more likely to live in a household without indoor plumbing and running water and "plumbing poverty" is geographically clustered in Alaska, the U.S. Southwest, the Upper Midwest, the Northeast (especially northern Maine and New Hampshire), and the Allegheny and Appalachian regions of Pennsylvania and West Virginia.[43] Moreover, for those with access, particularly well water, they are still at risk of contamination. The Hopi Tribe estimates 75 percent

of its community members are drinking contaminated water.[44] Similarly, multiple studies documented home well contamination with the Navajo nation exposed to uranium and arsenic in their well water and 39 percent of Tribal families' wells on the Crow Reservation showing unsafe levels of metals and/or nitrate.[45]

Fear of Deportation

Lastly, for migrant and immigrant Hispanic communities, the fear of and experience of deportation is an ongoing concern with both mental and physical health consequences, to the individuals themselves, their families, and their communities. If arrested and targeted for deportation, a person is held within an immigration detention center. In recent years, U.S. immigration detention centers have seen increasing reports of civil and human rights abuses as well as preventable in-custody deaths.[46] One study of detained immigrants in California found that greater exposure to confinement conditions within detention facilities increased the likelihood of one or more negative health conditions, but researchers also found a cumulative negative effect on their overall health.[47] Not only are the conditions of detention centers inhumane, but immigrants may fear what sort of conditions and punishment they will face upon return to their home country.[48]

Deportation efforts also separate individuals from their families and social support networks, often breaking up families that may have mixed immigration status. Large scale deportation efforts can be economically devastating for families, potentially plunging millions of families into poverty, increasing housing instability and food insecurity.[49] Mass deportation efforts also negatively impact communities. After deportation raids, communities are often more fearful and less trusting of public institutions, are less likely to participate in social and cultural activities, are less likely to seek health care, and are more reluctant to report crime to the police.[48]

Health Care Access

There are longstanding disparities in health care access within rural areas, which suffer from a shortage of health care professionals, the need to travel long distances to health care facilities and a lack of public transportation options for those who do not own cars, lower rates of health insurance coverage, as well as an increase in rural hospital closures.[5,50–55] Intersecting with these longstanding challenges, racial and ethnic segregation also impact access to health care in rural areas. While rural areas have lower proportions of racial and ethnic minorities compared to urban areas, estimates of residential segregation patterns are similar.[56] Segregation can perpetuate existing disparities by restricting various health promoting opportunities, such as education, employment, concentrating poverty, as well as access to health care resources. More than half of rural counties are estimated to be either whole or partially within a health primary shortage area, and those in this designation are more likely to be in counties that are majority Hispanic and/or African American.[56] In a study assessing residential segregation and health care access, both African American and Hispanic segregation were negatively associated with having a usual source of care but higher levels of segregation were also positively associated with health care needs being reported as met.[56] This second finding, as the study authors note, "underscores the need to identify assets and sources of resilience on which racial/ ethnic minority communities rely," in order to meet health care needs.[56]

Southern states, which have the highest populations of rural Black populations, were less likely to accept Medicaid expansion following the Affordable Care Act (ACA), therefore limiting the ability for lower-income minority rural patients to have access to health insurance coverage.[10] Medicaid plays an important role in rural areas for those who are low-income and unemployed (or underemployed). Medicaid coverage rates tend to be higher in rural areas versus urban areas and

the expansion of Medicaid under the ACA has been instrumental in expanding insurance coverage in rural America. It has also been demonstrated that Medicaid expansion decisions have been racialized as there are large differences in support for Medicaid expansion across different races. For example, state adoption decisions have been positively related to White opinion and do not respond to non-White support levels. Additionally, evidence indicates that when the size of the Black population increases and White support levels are low, states were significantly less likely to expand Medicaid.[57]

Outside of hospital settings, community health centers play an important role in providing primary care in rural areas that have a shortage of health care professionals. There are two federal programs which help to meet this gap – the Rural Health Clinics program and the Federally Qualified Health Centers program.[58] In terms of distance to health care facilities, one study found that rural zip code tabulation areas with a high proportion of Black or Hispanic residents tended to have better geographic access, defined as shorter distances, to both Rural Health Centers and Federally Qualified Health Centers compared to White populations, but those distances were still longer than urban minority populations.[55] However, in this study AI/AN populations had the poorest geographic access to Rural Health Centers and Federally Qualified Health Centers, with the longest distances, and areas with higher minority populations have been found to be more likely to have experienced a decline in Rural Health Centers compared to low-minority communities.[55,58]

The growing use of telemedicine has been hailed as a potential solution to help improve health care access and utilization, but evidence of a rural/urban and ethnic/racial digital divide has made equitable access to telemedicine challenging.[59] One study looking at the utilization of telemedicine amid the COVID-19 pandemic found that both adults living in rural areas and minority race/ethnicity groups were less likely to use telemedicine.[60] This may be due to the fact that ethnic minorities, particularly rural African Americans, report less access to a computer or laptop with high-speed internet, smartphone with a data plan, or any digital access compared to non-Hispanic Whites based on 2019 American Community Survey data.[61,62] According to one estimate, there are approximately 3 million people living in rural areas without adequate broadband access or healthcare, and these populations are geographically concentrated in the rural South, Appalachia, and the remote West.[63] In addition to the challenges of internet access in rural areas, telemedicine has limits in terms of the types of medical issues that can be addressed, such as physical exams or medical testing. Thus, if accessing health care in-person is too far or expensive for rural minority communities, then telemedicine can only do so much to meet the existing health care needs.

Other barriers to accessing health care include stigma and cultural practices inherent to the current health care system.[59] Among LGBTQ+ populations in rural areas, stigma around seeking mental health care was a concern.[59] In particular, transgender and gender-diverse individuals living in rural areas face numerous barriers to accessing health care, including systemic transphobia and lack of health care professionals with sufficient training in gender-affirming care.[64] Another instance where stigma around gender and sexual identity intersects with health care access is the current epidemic of HIV in the South which has shifted towards rural areas.[65,66] Rurality has been associated with lower availability of HIV testing, prevention education, and Pre-Exposure Prophylaxis, which leads to later HIV diagnosis, later adoption of antiretroviral therapy, and increased HIV-related mortality.[66,67] To give an example, in one national study, HIV testing rates were 66 percent for nonurban participants versus 88 percent for urban participants.[66] Additionally, on top of all the other challenges in health care access, there is also a lack of access to clinicians with HIV expertise.[66] Based on the most recent data from the Centers for Disease Control and Prevention (CDC), nearly half of all new HIV infections were in the Southern region of the U.S., and the most affected subpopulations were Hispanic/LatinX men and African American men who had male-to-male sexual contact.[65] Thus, individuals who have multiple minority identities coupled

with HIV diagnoses may experience even more significant stigma and discrimination in their interactions with the health care system, which may negatively impact their willingness to seek treatment or manage their health conditions.

Reproductive Health Care Access

The impacts of the reversal of *Roe v. Wade*, in terms of limiting access to reproductive health care, may be especially acute for minority women in rural areas. Pregnant and postpartum women in rural areas already experience worse health outcomes, with one study finding that rural women had a 9 percent greater probability of severe maternal morbidity and mortality compared to urban residents.[53] State abortion bans exacerbate existing workforce shortages based on location and specialty, with OB/GYN, trauma and emergency medicine, and primary care in rural areas being most adversely impacted.[68] Consequently, an increasing number of rural women travel long distances to see health care professionals and have more nonindicated induction and C-sections.[69] Moreover, areas with more abortion restrictions also have fewer social safety net and maternal and child health resources.[70,71] Minority women are thus seriously impacted by intersecting barriers to care including long travel distances and maternity care deserts, waiting periods, parental consent, and financial burden.[69,72,73]

Strategies to Improve Rural Minority Health

The challenges facing rural minority populations are immense, multigenerational and multifactorial, and as such require targeted investment and resources across multiple sectors. Reversing the health care professional shortages and trends in hospital closures in high minority rural areas would be an initial step but bolstering public health and preventive services would need to occur simultaneously. However, due to the historical and entrenched poverty in many rural minority communities, changes in available economic and housing opportunities, investment in education, improved environmental regulation and clean-up, as well as stronger occupational regulations would also be needed to reverse the historical and ongoing trauma of disinvestment and injustice.

There have been federal agency initiatives aimed at improving rural minority health disparities. In 2023, the National Institute on Minority Health and Health Disparities in the National Institutes of Health started an initiative to address gaps in scientific knowledge and support research that addresses multilevel and multiple domains influences related to health disparities experienced by people who live in rural communities.[74] In 2022, the Centers for Medicare & Medicaid Services published their Framework for Advancing Health Care in Rural, Tribal and Geographically Isolated Communities, which has six priority areas that aim to support, strengthen, and improve data collection efforts, health care professionals, health care coverage, as well as medical and communication technology in these communities.[75] Additionally, in 2023 the CDC established the Office of Rural Health and in 2024 published its Rural Public Health Strategic Plan, FY 2024-2029. The Strategic Plan has four key priorities: (1) advance results-based engagement with partners and communities to address rural public health challenges, (2) strengthen rural public health infrastructure and workforce, (3) advance rural public health science, and (4) improve rural public health preparedness and response capacity.[76] With all that being said, changes to federal priorities with the election of a new administration in 2024 may impact the existence or scope of these initiatives moving forward.

CURRENT AMA POLICY

There are over 20 existing AMA policies pertinent to rural health and health care. The most relevant, AMA Policy H-350.937, "Improving Healthcare of Minority Communities in Rural Areas," was adopted in parallel with this request for study. In addition to a study, the policy (1) encourages health promotion, access to care, and disease prevention through educational efforts and publications specifically tailored to minority communities in rural areas; (2) encourages enhanced understanding by federal, state and local governments of the unique health and health-related needs, including mental health, of minority communities in rural areas to improve their quality of life; (3) encourages the collection of vital statistics and other relevant demographic data of minority communities in rural areas; (4) states AMA will advise organizations of the importance of minority health in rural areas; (5) states AMA will channel existing policy for telehealth to support minority communities in rural areas, and lastly (6) encourages AMA's Center for Health Equity to support minority health in rural areas through programming, equity initiatives, and other representation efforts. AMA also recently adopted policy in 2024 (D-135.963) supporting access to water and adequate sanitation, water treatment, and environmental support and health services in AI/AN communities.[77]

CONCLUSION

Despite more limited data compared to urban minority populations, it is clear rural minority populations experience a disproportionate burden of adverse health outcomes compared to rural White populations or urban minority populations. Rural minority residents experience dual disparities and poor health outcomes as a result of intersecting structural and social determinants of health. There are also longstanding disparities in health care access within rural areas in general, which are compounded by additional barriers experienced by rural minority populations, including racial and ethnic segregation, limited transportation options, lower rates of health insurance coverage, poor internet and broadband coverage which limits the ability for expanded telemedicine, as well as stigma and discrimination.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1. That Policy H-350.937, "Improving Healthcare of Minority Communities in Rural Areas" be amended by addition and deletion to read as follows:

    1. Our American Medical Association encourages health promotion, access to care, and disease prevention through educational efforts and publications specifically tailored to minority communities in rural areas.
    2. Our AMA encourages enhanced understanding by federal, state and local governments of the unique health and health-related needs, including mental health, of minority communities in rural areas in an effort to improve their quality of life.
    3. Our AMA encourages the collection of vital statistics and other relevant demographic data of minority communities in rural areas.
    4. Our AMA will advise organizations of the importance of minority health in rural areas.
    ~~5. Our AMA will research and study health issues unique to minority communities in rural areas, such as access to care difficulties.~~

~~6.~~ 5. Our AMA will channel existing policy for telehealth to support improved broadband internet access in minority communities in rural areas to increase the availability of telemedicine where clinically appropriate.

~~7.~~ 6. Our AMA ~~encourages our Center for Health Equity to~~ supports minority health in rural areas through programming, equity initiatives, and other representation efforts.

7. Our AMA encourages the development of strategies and mechanisms for communities to share resources and best practices to serve their rural minority populations. (Modify Current HOD Policy)

2. That Policy H-135.905, "Furthering Environmental Justice and Equity H-135.905" be amended by addition and deletion to read as follows:

1. Our American Medical Association supports prioritizing greenspace access and tree canopy coverage for communities that received a "D" rating from the Home Owners' Loan Corporation, otherwise known as being "redlined," or those that have been impacted by other discriminatory development, loan servicing, and building practices with full participation by the community residents in these decisions.
2. Our AMA supports measures to protect frontline communities from the health harms of proximity to historical and current harmful industrial and mining operations, including fossil fuel extraction, refining and combustion, and large-scale agriculture, such as using the best available technology to reduce local pollution exposure ~~from oil refineries~~, or health safety buffers from ~~oil extraction~~ industrial operations.

Fiscal Note: less than $1,000

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(A-25)

Introduced by: American Academy of Ophthalmology

Subject: Reducing Pickleball-Related Ocular Injuries

Referred to: Reference Committee D

Whereas, the estimated number of annual pickleball-related injuries presenting to U.S. emergency departments increased by 91% from 2020 to 2022 (8,894 to 16,997 injuries), and pickleball-related hospital admissions increased by 257% in the same period (992 to 3,541 hospital admissions); and

Whereas, older adults (65-80 years) accounted for 61.1% of pickleball-related injuries with a mean injury ago of 64 years in the period 2013 to 2022; and

Whereas, there are a growing number of reports of pickleball-related ocular injuries including corneal abrasions, iritis, traumatic lens subluxation, vitreous hemorrhage, symptomatic retinal tear, retinal detachment, and angle recession and commotio retinae; and

Whereas, a pickleball traveling at speeds of 25 mph or more can fit within the orbital socket, posing a significant risk of blunt-force ocular trauma; and

Whereas, the ASTM F3164-24 standard specification for eye protectors for racket sports (i.e, racquetball, squash, tennis, and pickleball) is designed to prevent serious eye injuries; and

Whereas, protective eyewear is not currently mandated to play pickleball at any level; and

Whereas, existing AMA policy (H-10.970) supports protective eyewear for high-risk sports, but does not address the emerging risks of pickleball injuries or advocate for broader injury prevention strategies; therefore be it

RESOLVED, that our American Medical Association advocate for international, national, and local pickleball organizations, leagues, and recreational facilities to adopt eye injury prevention strategies—such as mandating protective eyewear—particularly for older adults and individuals with pre-existing ocular conditions. (Directive to Take Action); and be it further

RESOLVED, that our AMA support targeted educational initiatives on pickleball-related eye injury prevention, with specific outreach to older adults, high-risk individuals, and healthcare professionals, to promote safe play and increase awareness of ocular injury risks (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage continued research and injury surveillance efforts to evaluate the long-term impact of pickleball-related eye injuries on healthcare costs, rehabilitation outcomes, and the effectiveness of preventive strategies (Directive to Take Action); and be it further

RESOLVED, that our AMA recognize the growing popularity of pickleball among aging populations and encourage physicians to incorporate counseling on sports-related eye injury prevention as part of routine patient care. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

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RELEVANT AMA POLICY

H-10.970 Use of Protective Eyewear by Athletes
Our American Medical Association supports the use of protective eyewear for sports participants who have had intraocular surgery or eye trauma, or are functionally one-eyed individuals, and for all other sports participants engaged in high-risk eye injury sports, as advocated by the American Academy of Pediatrics and the American Academy of Ophthalmology. [Res. 404, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH REP. 01, A-18]

H-10.998 Impact-Resistant Lens
Our AMA recommends that physicians providing eye care which involves spectacles of any kind, including sunglasses, should continue to prescribe impact-resistant lenses whenever this is medically feasible. [BOT Rep. Y, A-72, Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20B]

H-470.967 Safety in Youth Baseball and Softball
The AMA urges youth baseball and softball organizations to adopt policies for the use of protective equipment and encourages sponsors of organized youth sports activities to adopt written emergency and first responder plans. [Res.408, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 3, A-15; Modified: CSAPH Rep. 1, A-15]

H-470.960 Soccer Injuries
Our AMA recognizes the problem of injuries in soccer and encourages additional studies into the

incidence of soccer-related injuries and methods to reduce those injuries. [Res. 408, I-95; Reaffirmed: CSA Rep. 8 A-05; Reaffirmed: CSAPH Rep. 3, A-15; Modified: CSAPH Rep. 1, A-15]

H-470.955 Support of Protective Headgear (Helmets) in the Sport of Girls'/Women's Lacrosse
Our American Medical Association supports requiring approved protective headgear for all athletes participating in the sport of girls'/women's lacrosse. [Res. 423, A-15]

H-470.985 Goalie Face Masks in Hockey
Our American Medical Association endorses the mandatory use of an adequate cage-type face mask for goalies in all amateur, high school and college hockey programs in the nation. [Res. 4, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

H-470.986 Helmets for Hockey Referees
Our American Medical Association endorses the use of hockey helmets for all referees in amateur, high school and college hockey programs in the US. [Res. 123, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

H-470.954 Reduction of Sports-Related Injury and Concussion
1. Our American Medical Association:
    a. will work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan.
    b. will promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.
2. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations.
3. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries.
4. Our AMA urges appropriate agencies and organizations to support research to:
    a. assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of concussions and repetitive head impacts over the life span; identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval between head impacts and concussions;
    b. develop and evaluate effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and
    c. develop objective biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients.
5. Our AMA supports research into the detection, causes, and prevention of injuries along the continuum from subconcussive head impacts to conditions such as chronic traumatic encephalopathy (CTE).
6. Our AMA encourages evidence-based studies regarding post-injury management protocols and return-to-play criteria that can help guide physicians who are caring for injured athletes. [CSAPH Rep. 3, A-15; Appended: Res.905, I-16; Appended: Res. 904, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(A-25)

Introduced by: American Association of Public Health Physicians, Medical Student Section

Subject: Protecting In-Person Prison Visitations to Reduce Recidivism

Referred to: Reference Committee D

Whereas, reducing recidivism enhances public safety, lowers taxpayer costs, and supports reintegration, with close family relationships shown to reduce recidivism, enhance job prospects post-prison, and ease harms and improve mental health outcomes for family members who are separated from their loved ones[1-8]; and

Whereas, an estimated 684,500 U.S. state and federal prisoners are parents of at least one minor child, and reducing recidivism among incarcerated mothers benefits their children, as maternal incarceration is linked to higher rates and earlier onset of arrests among children[9,10]; and

Whereas, in-person prison visits include either non-contact “through-the-glass” visits or contact visits[11-14]; and

Whereas, frequent in-person visits between children and their incarcerated parents are positively associated with stronger parent-child relationships, promoting healthier psychological outcomes later in life[8]; and

Whereas, in-person visitation has been shown to reduce recidivism by up to 26%, felony reconviction by 13%, prison misconduct by up to 25%, and technical violations by 25%[3-6]; and

Whereas, in-person visitations have shown to improve mental health outcomes for visitors, increase the likelihood of long-term family reunions, and foster prosocial connections among incarcerated individuals, although challenges such as security risks and contraband introduction remain[1-6,15-18]; and

Whereas, barriers limiting the frequency of in-person visitations, such as prison location, transportation accessibility, caregiver willingness to take children to visit their parents, restricted visiting hours, and varying policies across correctional facilities, result in fewer than 50% of inmates receiving visitations[19-21]; and

Whereas, private telecommunications companies promote video visitation systems as a cheap and easy alternative to in-person visitations, as well as a profitable means of generating revenues[22]; and

Whereas, at least 600 jails and prisons in America have instituted video visitation programs and 74% of these correctional facilities have either reduced or eliminated in-person visits[23,24]; and

Whereas, video visits may alleviate certain barriers but fail to replicate the psychological benefits of in-person visitation, are not preferred by the majority of incarcerated individuals or

their visitors, and have significant drawbacks, including poor reliability, low quality, and higher costs[5,6,17,18,25-27]; and

Whereas, in March 2024, two lawsuits were filed against Michigan counties alleging that the video-only policy violated the civil rights of families, arguing that abolition of a child's "right to hug" their parent through contact visits "akin to torture"[26]; and

Whereas, the Bureau of Justice Assistance, the National Institute of Corrections, and the U.S Department of Health and Human Services partnered in 2016 to support a $1 million effort to develop family-strengthening policies that could be implemented in correctional facilities to reduce the traumatic impact of parental incarceration on children, including family-friendly visiting policies and procedures[7]; and

Whereas, the average number of in-person monthly visits increased when both in-person visitation and video calling were available, and numerous states have approved or are pending legislation that protects in-person visits for incarcerated people[6,28,29]; therefore be it

RESOLVED, that our American Medical Association support local, state, and federal efforts that protect and improve accessibility to in-person visitations at correctional facilities to reduce recidivism while encouraging and supporting all custodial efforts to reduce (or eliminate) the introduction of illegal substances and contraband during such in-person visitations. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/6/25

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RELEVANT AMA POLICY

Improving Care to Lower the Rate of Recidivism H-430.978
Our AMA will advocate and encourage federal, state, and local legislators and officials to increase access to community mental health facilities, community drug rehabilitation facilities, appropriate clinical care, and social support services (e.g., housing, transportation, employment, etc.) to meet the needs of indigent, homeless, and released previously incarcerated persons.

Our AMA will advocate and encourage federal, state, and local legislators and officials to advocate prompt reinstatement in governmental medical programs and insurance for those being released from incarceration facilities. [Res. 244, A-23; Reaffirmed: CSAPH Rep. 07, A-24]

Reducing the Burden of Incarceration on Public Health D-430.992
Our AMA will support efforts to reduce the negative health impacts of incarceration, such as: (1) Implementation and incentivization of adequate funding and resources towards indigent defense systems. (2) Implementation of practices that promote access to stable employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records. (3) Housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings.

Our AMA will partner with public health organizations and other interested stakeholders to urge Congress, the Department of Justice, the Department of Health and Human Services, and state officials and agencies to minimize the negative health effects of incarceration by supporting programs that facilitate employment at a living wage, and safe, affordable housing opportunities for formerly incarcerated individuals, as well as research into alternatives to incarceration. [Res. 902, I-22]

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism. [Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12; Modified: CSAPH Rep. 1, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(A-25)

Introduced by: American Association of Public Health Physicians

Subject: Promoting Evidence-Based Responses to Measles and Misuse of Vitamin A

Referred to: Reference Committee D

Whereas, there is a measles outbreak of unprecedented scale in the United States[1] in 2025, with nearly 600 confirmed cases in Texas and outbreaks in other states the vast majority of cases occurring in unvaccinated individuals[2] and three reported deaths among unvaccinated individuals, including two children and one adult[3]; and

Whereas, the measles, mumps and rubella (MMR) vaccine is highly effective, providing approximately 93% protection against measles with a single dose and 97% protection with two doses, making it by far the most effective method of preventing measles[4]; and

Whereas, extensive scientific research has found no evidence linking the MMR vaccine to autism[5]; and

Whereas, vitamin A supplementation at the proper dosage can reduce the risk of morbidity in children with measles, especially among those with severe measles disease or vitamin A deficiency, but does not cure or prevent the disease[6]; and

Whereas, there is also evidence that vitamin A supplementation in the treatment of measles in higher-income countries, such as the United States, may not show great benefit[7]; and

Whereas, there is an immense amount of misinformation regarding the prevention, treatment, and cure of measles being spread by both members of the public and some physicians[8,9]; and

Whereas, recent cases of severe liver injury from vitamin A toxicity have been reported, potentially resulting from misinformation about measles treatments[10,11]; therefore be it

RESOLVED, that our American Medical Association will make and widely distribute a public statement to actively counter misinformation regarding vitamin A as more than an adjunct for treatment, particularly claims that suggest it can replace vaccination, cure the disease, or be safely used as a self-treatment practice (Directive to Take Action); and be it further

RESOLVED, that our AMA will educate the public and healthcare professionals about the proper role of vitamin A in measles management—specifically, that while it may reduce the risk of measles-related complications, including but not limited to blindness, it neither prevents nor cures measles (Directive to Take Action); and be it further

RESOLVED, that our AMA will advocate for the use of vitamin A in the context of measles only under the supervision of a competent healthcare professional (Directive to Take Action); and be it further

RESOLVED, that our AMA will continue to support the use of FDA-licensed measles vaccines, currently measles-mumps-rubella (MMR) and measles-mumps-rubella varicella (MMRV) as the most effective method of preventing measles and will promote efforts to improve public confidence in immunization through transparent, science-based communication. (New HOD Policy)

Fiscal Note: (Assigned by HOD)

Received: 4/21/25

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RELEVANT AMA POLICY

Complete and Prompt Reporting of Measles (Rubeola) H-440.995
Our AMA: (1) encourages and requests all physicians and others charged with the responsibility for reporting cases of measles to report them promptly to the local and state public health officials; and (2) encourages both public health officials and those in the private practice of medicine to intensify and expand their efforts at immunization of persons susceptible to measles whenever second or successive generation cases of measles are detected in a locality.
Citation: Res. 108, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Measles Vaccine H-440.956
It is the policy of the AMA (1) to encourage state medical societies through their state journals and other publications to campaign for measures that improve the delivery and storage of measles vaccine to inner city and other vulnerable populations; (2) to promote the development of guidelines for the proper vaccine storage and shipment to lower the incidence of measles vaccine failure; and (3) to use its publications to inform residents and house staff training programs and medical schools about appropriate measures to ensure that house staff and medical students have adequate immunity to measles.
Citation: Sub. Res. 192, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Routine Immunization Against Measles in Children H-440.952
Our American Medical Association endorses recommendations of both the American Academy of Pediatrics and the Centers for Disease Control for a second dose of measles vaccine (in the form of MMR) for children.
Citation: Res. 85, I-90; Modified: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Immunization Programs for Children H-440.991
...organizations to promote appropriate immunization programs for children throughout the world, especially in such critical and cost-effective areas as the prevention of poliomyelitis and measles; and (3) expresses the need for private and public research institutions to help develop more technically advanced products, such as new heat stable…
Policy for Physician Entrepreneur Activity H-140.926
Members of the AMA shall not: (1) coerce their patients to purchase medications, vitamins, nutritional supplements or medical devices from the physician's practice; and (2) recruit their patients to participate in marketing programs in which the...Res. 7 , A-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmed: CEJA Rep. 03, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(A-25)

Introduced by: American College of Cardiology, Society of Cardiovascular Computed Tomography

Subject: Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers

Referred to: Reference Committee D

Whereas, lung cancer and atherosclerotic heart disease, leading causes of death and disability in America, share many demographics and predispositions, and

Whereas, both lung cancer and atherosclerotic heart disease are increasing in incidence and effective treatments are impaired by late diagnosis of advanced disease, and

Whereas, the American Cancer Society updated lung cancer screening guidelines with a non-contrast Chest CT to include adults aged 50-80 years with a 20+ pack year smoking history in November 2023[1], and lung cancer screening among chronic smokers has been shown to save lives in both large-scale randomized trials and real-world settings[2-4], and

Whereas, among smokers, the prevalence of lung cancer related mortality and cardiovascular mortality was similar in the NLST trial (22.9% vs. 26.1%)[2] and in the NELSON trial (18.4% vs. 21.8%)[3] respectively; smoking increased the risk of coronary heart disease by 2 to 4 times[5-6] and causes one of every fourth death from cardiovascular disease[7], and

Whereas, coronary artery disease on low dose lung cancer screening CT scans can be detected by the presence and burden of coronary artery calcification (CAC). The prevalence of CAC on low-dose lung cancer screening CT is 53%, with 15% of patients having severe CAC on visual estimation[8]. Of those who qualified for statin primary prevention, 56.8% did not report a history of statin use[9]. Compared with chronic smokers with CAC score of zero, patients with CAC score of >300 are two to five times more likely to have incident ASCVD events[10]. Detection of CAC on low-dose CT can result in change in management of 20% of patients[11], and

Whereas, CAC is a marker of coronary atherosclerosis and represents its burden. Its role in cardiac risk stratification has been established in multiple large population studies[12-16]. Studies have shown that patients undergoing CAC assessment are more likely to have improved compliance with preventive medications (3-fold greater likelihood of aspirin and statin usage)[13] and superior coronary artery disease risk factors control[14]. CAC can be easily detected on non-contrast chest CT scans performed for various reasons; and

Whereas, the improvement in machine learning has improved detection of CAC on non-contrast chest CT[17-18], thereby improving chances of detection and early intervention in such high-risk patients[19]. Detection of CAC on non-contrast non-gated chest CT scans performed for non-cardiac reasons can provide an opportunity for an aggressive and early preventive measure in such high-risk patients, and

Whereas, lung cancer screening remains underutilized with only 4.5% of the eligible population in the US received lung cancer screening in 2022[20] and there is a critical need to increase public awareness regarding the value of undergoing a non-contrast chest CT to detect lung cancer and coronary artery disease. Although the current focus of lung cancer screening is for early detection of lung cancer, the same scans can be used to detect CAC, a marker of coronary atherosclerosis and as such, can provide an opportunity for an aggressive and early preventive cardiovascular measure in such high-risk patients. Such an approach may help to improve lung cancer and cardiovascular outcomes in such patients through early detection and intervention; therefore be it

RESOLVED, that our American Medical Association will partner with other professional and public health organizations as well as key stakeholders in cardiology, pulmonology, oncology, and imaging specialties to increase awareness amongst chronic smokers (who would benefit from appropriate lung cancer screening) regarding their risk for both lung cancer and coronary artery disease and encourage their participation in screening programs through a joint public campaign effort (Directive to Take Action); and be it further

RESOLVED, that our AMA promote physician education and awareness regarding the value of chest CT in detecting both lung cancer and calcified atherosclerotic plaque and encourage reporting the extent of coronary artery calcification in non-contrast chest CT studies performed as a part of lung cancer screening program. (Directive to Take Action)

Fiscal Note: $43,166

Received: 4/22/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(A-25)

Introduced by: American College of Preventive Medicine

Subject: Health Warning Labels on Alcoholic Beverage Containers

Referred to: Reference Committee D

Whereas, alcohol use is a leading risk factor for premature death and disability[1]; and

Whereas, 1 in 8 deaths among U.S. adults aged 20-64 are attributable to alcohol use[1]; and

Whereas, the International Agency for Research on Cancer (IARC) has classified alcoholic beverages as a group 1 carcinogen since 1988[2]; and

Whereas, alcohol is the third leading modifiable risk factor for cancer, behind only tobacco and excess weight[3]; and

Whereas, even low levels of alcohol consumption can increase cancer risk, with no safe level of consumption[4,5]; and

Whereas, only 1 in 3 Americans are aware that alcohol use increases the risk of cancer[6,7]; and

Whereas, in 2017-18, a real-world alcohol warning label experiment in Canada found that the warning labels, which included a cancer warning, were associated with a 6.6% decrease in alcohol sales, increased recall of national drinking guidelines, and increased recall of the alcohol-cancer association[8-10]; and

Whereas, American Medical Association policy already supports health warning labels on containers of tobacco, a known carcinogen[11]; and

Whereas, a recent review published in 2022 found that there is good public support for alcohol warning labels[12]; and

Whereas, the World Health Organization published a 2021 policy brief recommending health warning labels on alcoholic beverages[13]; and

Whereas, the US Surgeon General has recommended updating health warning labels on alcohol containers to include a cancer risk warning and to be more visible, prominent, and effective in improving knowledge about the relationship between alcohol and cancer[14]; and

Whereas, labels displaying the number of standard drinks in the container and national dietary guidelines for alcohol use effectively increase consumer awareness of these components[10,15-21]; and

Whereas, a recent review on alcohol warning label effectiveness concluded there was evidence to support the use of large label size, contrasting colors, large text size and prominent position of the label on the product[22]; and

Whereas, the Pan American Health Organization recommends that alcohol warning labels be accompanied by graphics[23]; and

Whereas, the FDA sets requirements for nutritional labelling including requirements for sufficient lettering contrast, prominent font size and legible text[24]; therefore be it

RESOLVED, that our American Medical Association support regulations that mandate alcoholic beverage containers to display the number of standard drinks in the container, paired with national dietary guidelines for alcohol use (New HOD Policy); and be it further

RESOLVED, that our AMA support regulations that ensure alcohol containers have labels which are large in size, use contrasting colors, use large text, have accompanying graphics, and display in the label in a prominent position. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

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RELEVANT AMA POLICY

Alcohol Consumption and Health H-30.934
Our AMA recognizes that alcohol consumption at any level, not just heavy alcohol use or addictive alcohol use, is a modifiable risk factor for cancer. [Res. 516, A-19].

AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages H-30.940
Our AMA (1.) (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act.... [CSA Rep. 1, A-04 Reaffirmation A-08 Reaffirmed: CSAPH Rep. 01, A-18 Modified: Res. 427, A-22 Modified: Res. 918, I-22].

Setting Domestic and International Public Health Prevention Targets for Per Capita Alcohol Consumption as a Means of Reducing the Burden on Non-Communicable Diseases on Health Status H-30.937
Our AMA will: (1) continue to address the role of alcohol use on health status and the impact of behaviorally-associated chronic illnesses (including obesity, diabetes, heart disease, chronic respiratory diseases, and many cancers) on the overall burden of disease and the costs of health care services in America; (2) encourage federal health services planning agencies and public health authorities to address the role of alcohol and tobacco consumption on health and to promote environmental interventions including evidence based tobacco control and alcohol control policies to improve the health status of Americans; and (3) encourage the World Health Organization to continue its work on the impact of Non Communicable Diseases (NCDs) on health status and to include targets for reduced per capita alcohol consumption among its major proposed interventions in developed and developing nations to reduce the incidence of, prevalence of, and rates of disability and premature deaths attributable to chronic non-communicable diseases. [Res. 413, A-12 Reaffirmation: A-18].

Fetal Alcohol Syndrome Warning Legislation H-420.981
The AMA supports appropriate mechanisms, including legislation, intended to increase public awareness of Fetal Alcohol Syndrome. [Sub. Res. 76, I-87 Reaffirmed: Sunset Report, I-97 Reaffirmed: CSAPH Rep. 3, A-07 Reaffirmed: CSAPH Rep. 01, A-17].

Tobacco Product Labeling H-495.989
Our AMA: (1) supports requiring more explicit and effective health warnings, such as graphic warning labels, regarding the use of tobacco (and alcohol) products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco, and ingredients of tobacco products sold in the United States); (2) encourages the Food and Drug Administration, as required under Federal law, to revise its rules to require color graphic warning labels on all cigarette packages depicting the negative health consequences of smoking; (3) supports legislation or regulations that require (a) tobacco companies to accurately label their products, including electronic nicotine delivery systems (ENDS), indicating nicotine content in easily understandable and meaningful terms that have plausible biological significance; (b) picture-based warning labels on tobacco products produced in, sold in, or exported from the United States; (c) an increase in the size of warning labels to include the statement that smoking is ADDICTIVE and may result in DEATH; and (d) all advertisements for cigarettes and each pack

of cigarettes to carry a legible, boxed warning such as: "Warning: Cigarette Smoking causes CANCER OF THE MOUTH, LARYNX, AND LUNG, is a major cause of HEART DISEASE AND EMPHYSEMA, is ADDICTIVE, and may result in DEATH. Infants and children living with smokers have an increased risk of respiratory infections and cancer;" (4) urges the Congress to require that: (a) warning labels on cigarette packs should appear on the front and the back and occupy twenty-five percent of the total surface area on each side and be set out in black-and-white block; (b) in the case of cigarette advertisements, warning labels of cigarette packs should be moved to the top of the ad and should be enlarged to twenty-five percent of total ad space; and (c) warning labels following these specifications should be included on cigarette packs of U.S. companies being distributed for sale in foreign markets; and (5) supports requiring warning labels on all ENDS products, starting with the warning that nicotine is addictive [CSA Rep. 3, A-04 Modified: Res. 402, A-13 Modified: Res. 925, I-16 Modified: Res. 428, A-19].

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(A-25)

Introduced by: Academic Physicians Section

Subject: Call for Study: Should Petroleum-Powered Emergency Medical Services (EMS) Vehicles in Urban Service Areas be Replaced by Renewably-Powered Electric Vehicles?

Referred to: Reference Committee D

Whereas, a 2022 report from the Commonwealth Fund noted that the health care industry worldwide produces as much as 4.6% of all of global "greenhouse gas" (GHG) emissions (chiefly carbon dioxide, methane and ozone), while in the United States, the health care industry contributes about 8.5% of the nation's GHG emissions[1]; and

Whereas, GHG emissions since the onset of the "Industrial Revolution" are widely understood to have contributed to a progressively increased carbon dioxide (CO2) fraction of the air, and to a progressively increased average temperature of the surface of the Earth (long-term, non-human-induced cyclical fluctuations of Earth temperatures not due to human-induced GHG emissions, such as volcanic activity and other influences notwithstanding); and

Whereas, these elevated temperatures have contributed measurably to increased morbidity and mortality of human inhabitants of the Earth, not limited to residents of warmer climates and occupational groups such as outdoor laborers; and

Whereas, these elevated temperatures are also adversely impacting the natural environment upon which all life depends in ways too numerous to list in this proposed Resolution; and

Whereas, these elevated temperatures are also clearly associated with increased numbers of extreme weather events; and

Whereas, American Medical Association policy D-135.966, most recently modified in 2022, has declared climate change to be a public health crisis[2], such that the goal of 50% reduction in greenhouse gas emissions by 2030 and "carbon neutrality" by 2050 are goals endorsed by this policy; and

Whereas, ambulances contribute significantly to health care's GHG burden, because they are large, petroleum-powered vehicles; and

Whereas, delivery vehicles powered by renewable energy (electricity) are currently being deployed in urban areas by the delivery services UPS[2] and FedEx,[3] suggesting an opportunity exists for the health care sector to replace petroleum-powered ambulances with renewable energy-powered electric ambulances of a similar size to these delivery vehicles, at least in urban areas of the United States, as older petroleum-powered ambulances are retired from service; and

Whereas, UPS is committed to “carbon neutrality” by 2050,[2] with FedEx pursuing “carbon neutrality” by 2040,[3] inclusive of their large ambulance-sized delivery vehicles, which they are already deploying for home package delivery; and

Whereas, the wide availability of petroleum-powered electrical generators at hospitals and government buildings should make concerns moot that electric-powered urban ambulances would become non-operational during widespread electrical outages such as can transiently occur with hurricanes, tornadoes, derechos and other large weather events; and

Whereas, the 15-20 minutes that an ambulance is out of service when parked at a hospital’s ambulance garage during the delivery of a patient to a hospital represents an opportunity for electric-powered ambulances to recharge their batteries, once ambulance bays became equipped with rapid recharging stations; and

Whereas, the National Health Service of Great Britain has moved beyond study of the matter, and has begun to purchase or lease only “Low Emission” and “Ultra Low Emission” vehicles as of 2021, with the goal that 90% of the NHS fleet will be low-emission or ultra-low emissions vehicles by 2028, with this specifically including electric-powered ambulances[4]; therefore be it

RESOLVED, that our American Medical Association study the potential feasibility that our nation’s urban ambulance fleet be replaced with renewably-powered electric vehicles when current petroleum-powered EMS ambulances become retired from service, with a report back at the next meeting of the AMA House of Delegates (Directive to Take Action); and be it further

RESOLVED, that our AMA will forward the results of this study to health care journalists, hospital regulators, hospital executives, EMS system leaders, and other relevant parties, toward the eventual implementation of the findings and recommendations that are anticipated to be reached. (Directive to Take Action)

Fiscal Note: Modest – Between $4,000 - $5,000

Received: 2/28/2025

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RELEVANT AMA POLICY

D-135.966 Declaring Climate Change a Public Health Crisis

1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.
2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and

incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.

3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions.
4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050.
5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(A-25)

Introduced by: American Thoracic Society, American College of Chest Physicians (CHEST)

Subject: Sleep Deprivation as a Public Health Crisis

Referred to: Reference Committee D

Whereas, over one-third (36.8%) of US adults are sleeping less than 7 hours per night, which is the minimum recommended amount of sleep for adults;[1] and

Whereas, the problem of sleep deprivation is growing; the percent of US adults with a short sleep duration is believed to have increased over the last 40-70 years[2]; data show that since 2013, the percent of females with sleep deprivation has increased from 32.6% (CI: 32.1%-33.1%) to 36% (35.6 - 36.5) and the percent of males with sleep deprivation has increased from 33.9% (33.3 - 34.4) to 37.5% (37.0 - 37.9)[1]; and

Whereas, epidemiologic survey data show that rates of sleep deprivation are highest across Southeastern, Appalachian and Mississippi Delta/Ozarks regions, as well as in several island states/territories, and higher in Black/African American Adults (CI: 45.4%-47.4%) than the overall population (35.8-36.4);[1] and

Whereas, evidence and expert consensus now strongly support a causal relationship from sleep deprivation and poor sleep towards chronic physical and mental health conditions;[3] and

Whereas, sleep is a determinant of physical health, contributing to cardiovascular and metabolic health, with sleep deprivation (under 5-6 hours per day) increasing the risk of hypertension, type 2 diabetes, other cardiovascular disease;[4] and with inappropriate sleep duration increasing the risk of coronary artery disease;[5] and with short sleep duration increasing the risk of obesity in children and adults;[6,7] and

Whereas, sleep impacts the neuroendocrine system and neuroplasticity and is a major determinant of neurocognitive health, with sleep deficiency leading to impacts on executive function, attention, and memory loss;[4] and pathophysiologic models linking poor sleep quality to the pathology of Alzheimer's Disease;[3] and

Whereas, sleep and mental illnesses are tightly associated, particularly depression and anxiety, with mounting evidence that mental health is a consequence of poor sleep and not just a symptom;[3,4] and

Whereas, inadequate sleep is associated with errors in executive function, attention, and task performance, leading to inadequate sleep being a leading cause of all types of vehicular accidents,[8] for which the AMA has instituted policy on drowsy driving as a major public health issue; and

Whereas, social determinants of poor sleep include psychosocial stressors and environmental factors, leading to racial/ethnic and socioeconomic disparities in sleep health;[3,4] and

Whereas, the rising intake of caffeine is considered a reason for increases in sleep deprivation over the last several decades;[9] however, more recently high caffeine beverages like sports drinks, energy drinks, and wellness beverages are correlated with reduced sleep duration and quality;[10] they are being heavily marketed for energy, focus, concentration, and productivity but with little known about the long-term impacts on public health; and

Whereas, sleep disruption has also been tied to diet and physical activity, as well as to sugar, nicotine, cannabis, and alcohol consumption;[10] the impact of emerging nicotine products and legalized cannabis on the epidemiology of sleep problems is unknown; and

Whereas, the emergence in the last decades of increased screen time through digital tools and social media are an increasing disruptor of sleep onset, quality, and duration;[3,11] and

Whereas, the American Heart Association expanded its "Simple 7" rules for heart health to "Essential 8" in 2022 to include sufficient sleep for children and adults to promote heart health and improve brain function and published the change in an AHA Presidential Advisory;[5,12] and

Whereas, increasing the proportion of adults, high school students, and children who get enough sleep are Healthy People 2030 objectives, with a goal of improving health, productivity, well-being, quality of life, and safety;[13] therefore be it

RESOLVED, that our American Medical Association recognizes the role of sleep health for all people, the contributions of sleep duration and quality on chronic health outcomes, mental health, and trauma, and the systemic drivers of modern living contributing towards poorer sleep (New HOD Policy); and be it further

RESOLVED, that our AMA declare sleep deprivation a public health crisis in the United States and to declare sleep health a public health priority (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts to increase research into the socioeconomic, psychosocial, environmental, technologic, and commercial drivers of sleep deprivation, poor sleep quality, and shortened sleep duration (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for public health interventions and policies to improve sleep health. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/22/25

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RELEVANT AMA POLICY

Interrupted Patient Sleep H-373.991

1. Our American Medical Association encourages physicians, trainees, patient care teams, and hospital administration to reduce the number of patient sleep interruptions as much as possible, including considering the impact of circadian and environmental factors on sleep, to only those interruptions which are necessary and cannot be performed at another time.
2. Our AMA supports efforts to improve quality, duration, and timing of patient sleep. Res. 704, A-23

Insufficient Sleep in Adolescents H-60.930

1. Our AMA identifies adolescent insufficient sleep and sleepiness as a public health issue and supports education about sleep health as a standard component of care for adolescent patients.
2. Our AMA: (a) encourages school districts to aim for the start of middle schools and high schools to be no earlier than 8:30 a.m., in order to allow adolescents time for adequate sleep; (b) encourages physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times to accommodate the biologic sleep needs of adolescents; and (c) encourages continued research on the impact of sleep on adolescent health and academic performance.

Fatigue, Sleep Disorders, and Motor Vehicle Crashes H-15.958

1. Our American Medical Association recognizes sleepiness behind the wheel as a major public health issue and continues to encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups.
2. Our AMA recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions.
3. Our AMA recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep.
4. Our AMA encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness- testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment.
5. Our AMA urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology.
6. Our AMA recommends that physicians:

a. become knowledgeable about the diagnosis and management of sleep-related disorders.
b. investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories.
c. inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries.
d. advise patients about possible medication-related effects that may impair their ability to safely operate a moto vehicle or other machinery.
e. inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries.
f. become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice.

7. Our AMA encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state.
8. Our AMA recommends that states adopt regulations for the licensing of commercial and private drivers with sleep-related and other medical disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries.
9. Our AMA reiterates its support for physicians' use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries.
CSA Rep. 1, A-96Appended: Res. 418, I-99Reaffirmed: CSAPH Rep. 1, A-09Modified: CSAPH Rep. 01, A-19Reaffirmation: A-22

Medical Education on Sleep and Sleep Disorders H-295.894
Our AMA supports diagnosis and management of sleep and sleep disorders as an essential and integral component of medical education. Res. 310 , I-98Reaffirmed: CME Rep. 2, A-08Reaffirmed: CME Rep. 01, A-18

Harmful Effects of Screen Time in Children H-60.911
Our AMA encourages: (1) primary and secondary schools to incorporate into health class curricula the topic of balancing screen time with physical activity and sleep; and (2) primary care physicians to assess pediatric patients and educate parents about amount of screen time, physical activity and sleep habits. Alt. Res. 901, I-17Reaffirmation: A-18

Light Pollution: Adverse Health Effects of Nighttime Lighting H-135.932
1. Our American Medical Association supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency.
2. Our AMA recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment.
3. Our AMA supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night.
4. Our AMA supports work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place. CSAPH Rep. 4, A-12Reaffirmation: A-22Reaffirmed: CSAPH Rep. 1, A-22Reaffirmed: BOT Rep. 30, A-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(A-25)

Introduced by: California

Subject: Removing Artificial Turf in Schools, Parks, and Public Places

Referred to: Reference Committee D

Whereas, in the past artificial (synthetic) turf was considered to be the best alternative to natural turfgrass because of overall reduced costs, including decreased water usage, and lower maintenance but newer information regarding the adverse direct and indirect environmental, health and economic impacts of synthetic grass and increased costs compared to natural turfgrass have been reported; and

Whereas, artificial turf creates significantly higher temperatures in local heat islands from the lack of evaporative cooling, posing a risk of burns, heat exhaustion, and heat stroke in athletes, including children, and this will be an increasing problem with climate change; and

Whereas, an increased incidence of sports injuries and infections is reported to occur on synthetic turf sports fields; and

Whereas, artificial turf contains hazardous chemicals, plasticizers, crumb rubber and heavy metals to which athletes and children come into close contact, resulting in their inhalation and/or ingestion, as well as their being brought into homes on clothing and shoes. In addition, these chemicals can leach into soil, therein posing risks to human health and the environment; and

Whereas, one artificial turf field weighs a total of 280,000 to 760,000 pounds, and is typically discarded in a landfill after 8 to 10 years of use, and, moreover, is not recyclable as artificial turf contains a mixture of plastics with continued leaching of chemicals in the landfill; and

Whereas, considering a full life cycle analysis, the cost of installing and maintaining a natural turfgrass field is much less than that of a synthetic field; and

Whereas, natural green spaces encourage physical activity, reduce stress and improve physical and mental wellbeing; and

Whereas, cities, such as Boston, are banning artificial turf because of health and environmental concerns; and

Whereas, California is proposing to ban the forever chemical PFAS in all artificial turf products, and also mandate that schools replace heat trapping surfaces, such as synthetic turf, with cooler and natural systems that mitigate heat and pollution as part of a School Extreme Heat Action Plan; therefore be it

RESOLVED, that our American Medical Association recommend replacing artificial turf with natural, drought-tolerant and hardiness zone appropriate turfgrass in parks, sports fields and lawns when it is to be replaced (New HOD Policy); and be it further

RESOLVED, that our AMA support natural, drought-tolerant and hardiness zone appropriate turfgrass as the preferred choice on sports fields or lawns, in all public and private schools and colleges, as well as in city parks. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(A-24)

Introduced by: California

Subject: Guidelines for Restricting Cell Phones in K-12 Schools

Referred to: Reference Committee D

Whereas, smartphones have become an incredibly prevalent part of the lives of today's youth, with 75% of American children owning a cell phone by age 12.6, a figure that increases to almost all children owning a smartphone by age 15 (1); and

Whereas, cell phones are a major source of distraction that interferes with students' ability to focus on school-related activities, with the average student checking their phone over 11 times per school day and spending 20.9% of classroom time using their devices for non-academic activities (2), while the mere presence of a cell phone, even when on silent, is distracting and detrimental to an individual's ability to focus on cognitive tasks or acquire information, even when the individual is not checking or interacting with the device, with this distraction being reversible with the removal of the device from their presence (3); and

Whereas, while most schools enforce some restrictions on cellphone use (4), many still allow cell phones to be used during break periods, such as lunch and recess, which has been shown to limit students' engagement in social and physical activities compared to their peers who do not have cell phone access during these times (5); and

Whereas, schools that enforce a phone ban during school hours show a 6.41% increase in test scores on average, with the greatest benefit seen in students scoring in the lowest quintile (6) indicating banning phones is both effective and beneficial for students' ability to do well in school, with the greatest benefit to those students who need the most help in class; and

Whereas, the presence of media devices in adolescents' sleep area and the use of such devices around bedtime, as well as increased use of devices (>2hrs) during the day (7), has a deleterious effect on the sleep of adolescents, resulting in increased sleep deprivation, fewer hours of sleep per night, poor sleep quality, and increased daytime sleepiness (8), all of which contributes to poor health outcomes; and

Whereas, smartphones negatively impact adolescent mental health, with as many as 23% of children and adolescents report problematic smartphone usage, which has been associated with increased risk of depression, higher perceived stress, and anxiety (9), which is particularly problematic given that many adolescents use their smartphones to access social media, which has been shown to increase feelings of jealousy, negative body image, and eating disorders (10); therefore be it

RESOLVED, that our American Medical Association support the establishment of uniform guidelines for cell phone and smart device access in schools and best practices for use outside school including recommendations for nighttime device access for children (New HOD Policy); and be it further

RESOLVED, that our AMA support schools implementing limitations on smartphone usage during school hours (New HOD Policy); and be it further

RESOLVED, that our AMA encourage parents and children to limit children's nighttime phone usage before bedtime. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/22/25

RELEVANT AMA POLICY

Addressing Social Media and Social Networking Usage and its Impacts on Mental Health D-478.965

1. Our American Medical Association will collaborate with relevant professional organizations to:

    a. support the development of continuing education programs to enhance physicians' knowledge of the health impacts of social media and social networking usage; and

    b. support the development of effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing health sequelae of social media and social networking usage.

2. Our AMA advocates for schools to provide safe and effective, evidence-based educational programs so that:

    a. all students can learn to identify and mitigate the onset of mental health sequelae of social media and social networking usage; and

    b. all students develop skills in digital literacy to serve as an individual protective foundation for interaction with various types of digital media (including social media).

3. Our AMA affirms that use of social media and social networking has the potential to positively or negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions.

4. Our AMA advocates for and support media and social networking services addressing and developing safeguards tailored to youth users, including ensuring robust protections for youth online privacy, providing effective tools to manage screentime content and access, considering special circumstances for certain youth populations (such as LGBTQ+ youth and youth with disabilities), and promoting the development and dissemination of age-appropriate digital literacy training.

5. Our AMA advocates for the study of the positive and negative biological, psychological, and social effects of social media and social networking services use.
Res. 905, I-17Modified: Res. 420, A-21Reaffirmation: A-23Modified: CSAPH Rep. 05, I-24

Teens and Social Media H-478.976
Our American Medical Association urges physicians to:

a. educate themselves about social media;

b. be prepared to counsel patients and/or their guardians about the potential risks and harms of social media; and

c. consider expanding clinical interviews to inquire about social media use.

2. Our AMA encourages further clinical, epidemiological, and interdisciplinary research on the impact of social media on health.

3. Our AMA supports education of clinicians, educators, and the public on digital media literacy and the health effects of social media.

4. Our AMA recognizes that the relative risks and benefits of social media may depend on individual differences (e.g., social media engagement, pre-existing traits, and environment).

5. Our AMA supports legislative, regulatory, and associated initiatives that, at a minimum, provide youth with strong data privacy protections, require platforms to be designed to align with child development, and provide transparency into the potential harms posed by platforms to young people and any steps taken to mitigate those harms.

6. Our AMA will collaborate with professional societies, industry, and other stakeholders to improve social media platform privacy protections, transparency (e.g., algorithmic, data, and process), data sharing processes, and systems for accountability and redress in response to online harassment.
(Res. 430, A-23Appended: CSAPH Rep. 05, I-24)

Medical and Public Health Misinformation Online D-440.915

1. Our American Medical Association encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information.

2. Our AMA encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms.

3. Our AMA will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts.

4. Our AMA will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information.
Res. 421, A-21Reaffirmed: BOT Rep. 15, A-22Reaffirmation: A-23Modified: Res. 509, A-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(A-24)

Introduced by: California

Subject: Hate Speech is a Public Health Concern

Referred to: Reference Committee D

Whereas, the United Nations Strategy and Plan of Action on Hate Speech defines hate speech as “any kind of communication in speech, writing or behavior that attacks or uses pejorative or discriminatory language with reference to a person or a group on the basis of who they are, in other words, based on their religion, ethnicity, nationality, race, color, descent, gender or other identity factor;” and

Whereas, hate speech is in general protected by law under the First Amendment unless it rises to the level of incitement; and

Whereas, hate speech has been recently amplified by internet social media platforms; and

Whereas, hate spreads like a communicable disease and hate speech is the vector for spread; and

Whereas, the progression from racist or prejudicial thoughts to words and violent actions can be slowed by discouraging and countering hate speech; and

Whereas, hatred is a public health threat and hate crimes have been recognized as a public health issue; and

Whereas, hate speech is a public health concern because it causes emotional, mental, social, and physical harm to our patients; therefore be it

RESOLVED, that our American Medical Association declare hate speech a public health concern (New HOD Policy); and be it further

RESOLVED, that our AMA support public and professional campaigns to educate against hate speech and its detrimental effects on the mental and physical well-being of the public (New HOD Policy); and be it further

RESOLVED, that our AMA encourage internet social media and search engines to establish and enforce meaningful content moderation to protect against the spread of hate speech on their platforms. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/22/25

RELEVANT AMA POLICY

Opposing Violence, Terrorism, Discrimination, and Hate Speech D-65.975
Our American Medical Association calls for continued collaboration and partnership with organizations representing diverse communities.
(Res 018, A-24)

Opposing Violence, Terrorism, Discrimination, and Hate Speech H-65.937
1. Our American Medical Association strongly condemns all acts of violence, terrorism, discrimination, and hate speech against any group or individual, regardless of race, ethnicity, religious affiliation, cultural affiliation, gender, sexual orientation, disability, or other factor.
2. Our AMA affirms its commitment to promoting dialogue, empathy, and mutual respect among diverse communities, recognizing the importance of fostering understanding and reconciliation.

3. Our AMA recognizes the importance of commemorating and honoring the victims of tragedies throughout human history, in a manner that respects the dignity and sensitivities of all affected communities.

4. Our AMA encourages initiatives that promote education, awareness, and solidarity to prevent future acts of violence and promote social cohesion.

5. Our AMA acknowledges the diverse perspectives and experiences within its membership and commits to facilitating constructive dialogue and engagement on sensitive and polarizing issues.
(Res 018, A-24)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(A-25)

Introduced by: Colorado

Subject: Protecting Access to mRNA Vaccines

Referred to: Reference Committee D

Whereas, 13 Billion doses of mRNA vaccine have been given world-wide as of August 2024; and

Whereas, estimates of lives saved in the first year alone are as high as 19.8 Million; and

Whereas, there are fewer than 1 case of severe allergic reactions or myocarditis/pericarditis (with most cases fully recovered) per 200,000 doses; and

Whereas, a CDC convened advisory committee in 2024 reported “no unusual patterns of death were detected that might suggest a potential safety concern”; and

Whereas, The FDA reviewed COVID-19 vaccine safety surveillance and reported in January 2025 that “FDA strongly believes that the known and potential benefits of COVID vaccination greatly outweigh their known and potential risks”; and

Whereas, mRNA vaccines hold great promise for Avian flu[1], HIV, Zika and cancers like melanoma[2] and renal cancer[3]; and

Whereas, misinformation and disinformation regarding mRNA vaccines have been and are extensively spread through multiple media sources; and

Whereas, according to a Kaiser Family Foundation poll[4] published in January 2025, 13% of Republicans think it is definitely true and 27% that it is “probably true” that “more people have died from COVID-19 vaccines than have died from the COVID-19 virus”; and

Whereas, seven states or more are debating bills to ban mRNA vaccines, sometimes with criminal penalties against physicians that administer them as well as revocation of their licenses; and

Whereas the current Secretary of Health and Human Services (which oversees the CDC and FDA) previously petitioned the FDA to rescind approval for COVID-19 vaccines and has called them the “deadliest vaccine ever made”; and

Whereas, in February, Rep Thomas Massey (R-KY) said on social media that the “FDA should immediately revoke approval of these shots” and Sen Ron Johnson (R-WI) is leading an investigation into the safety of the vaccines; therefore be it

RESOLVED, that our American Medical Association actively lobby for protections for use, research and development of mRNA vaccines for infectious diseases and cancer treatment (Directive to Take Action); and be it further

RESOLVED, that our AMA develop state level model legislation to promote state level protections for use, research and development of mRNA vaccines with report back at I-25. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/15/25

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2 https://nyulangone.org/news/perlmutter-cancer-center-clinical-trial-tests-personalized-mrna-vaccine-treating-metastatic-melanoma

3 https://medicine.yale.edu/news-article/personalized-therapeutic-vaccine-steers-the-immune-system-to-fight-kidney-cancer/

4 https://www.kff.org/health-information-and-trust/poll-finding/kff-tracking-poll-on-health-information-and-trust-january-2025/

RELEVANT AMA POLICY

Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875

1. It is our American Medical Policy that all persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as soon as possible following publication of these recommendations in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR).
2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.
3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.
4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ACIP-recommended vaccines, and the timely distribution of ACIP-recommended vaccines to providers).
5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ACIP-recommended vaccines.
6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.
7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.
8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.

9. Until compliance of our AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients.
10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines.

BOT Action in response to referred for decision Res. 524, A-06Reaffirmation A-07, Appended: Res. 531, A-07Reaffirmation A-09Reaffirmed: Res. 501, A-09Reaffirmation I-10Reaffirmation A-11Reaffirmed in lieu of Res. 422, A-11Reaffirmation: I-12Appended: Res. 824, I-14Reaffirmed: Res. 411, A-17Reaffirmed: CMS Rep. 3, I-20Reaffirmed: Res.228, A-21

Secure National Vaccine Policy H-440.882
Our American Medical Association advocates for and supports programs that ensure the production, quality assurance and timely distribution of sufficient quantities of those vaccines recommended by the Centers for Disease Control and Prevention to the US population at risk.
Res. 709, I-04Reaffirmation A-05Reaffirmed in lieu of Res. 422, A-11: BOT action in response to referred for decision Res. 422, A-11Reaffirmed: CSAPH Rep. 1, A-21

Pandemic Preparedness H-440.847
In order to prepare for a pandemic, our American Medical Association:

1. urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, supplies, vaccine, drug, and data management capacity to prepare for and respond to a pandemic or other serious public health emergency.
2. urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary **vaccines**, anti- microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people, without overreliance on unreliable international sources of production; and (b) to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to a pandemic or other serious public health emergency.
3. encourages states to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency.
4. urges the federal government to meet treaty and trust obligations by adequately sourcing medical and personal protective equipment directly to tribal communities and the Indian Health Service for effective preparedness and to respond to a pandemic or other major public emergency.
5. urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of health care personnel in direct patient care settings;
6. supports the position that:
    a. relevant national and state agencies (such as the CDC, NIH, and the state departments of health) continue to plan and test distribution activities in advance of a public health emergency, to assure that physicians, nurses, other health care personnel, and first responders having direct patient contact, receive any

appropriate vaccination or medical countermeasure in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic.

b. such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care provider.

7. will monitor progress in developing a contingency plan that addresses future vaccine production or distribution problems and in developing a plan to respond to a pandemic in the United States.
8. will encourage state and federal efforts to locate the manufacturing of goods used in healthcare and healthcare facilities in the United States.
9. will support federal efforts to encourage the purchase of domestically produced personal protective equipment.

CASPH Rep. 5, I-12Reaffirmation A-15Modified: Res. 415, A-21Reaffirmed: CASPH Rep. 1, I-22Appended: Res. 924, I-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(A-25)

Introduced by: LGBTQ+ Section

Subject: Supporting inclusive long-term care facilities

Referred to: Reference Committee D

Whereas, the American Medical Association has argued that LGBTQ+ seniors often experience greater social isolation than their heterosexual peers due to estranged family relationships or the loss of a partner or close friends. Many may not have children or a support network, which is critical as they age[1]; and

Whereas, survey studies have shown that many LGBTQ+ seniors fear discrimination in mainstream long-term care facilities[2,3]. Staff or other residents may harbor biases, leading to mistreatment, neglect, or isolation. Some seniors may feel compelled to hide their sexual orientation or gender identity, reversing the openness they had embraced in earlier life stages[4]; and

Whereas, a significant proportion of LGBTQ+ seniors face financial hardship due to lifelong employment discrimination, lack of legal recognition for their relationships (prior to marriage equality), or barriers in accessing retirement benefits[5,6]; and

Whereas, Section 1557 of the ACA explicitly prohibits discrimination on the basis of sex, which includes gender identity and sexual orientation, meaning that long-term care facilities receiving federal funding (like Medicare or Medicaid) cannot discriminate against LGBTQ+ individuals[10]; and

Whereas, several states provide funding for senior housing, healthcare, and anti-discrimination initiatives that can be leveraged for LGBTQ+ care[11]; and

Whereas, AMA policy seeks to support LGBTQ+ older adults (D-65.979) and prevent discrimination of sexual and gender minorities (D-65.996), which should extend to LGBTQ+ people in long-term care facilities; therefore be it

RESOLVED, that our American Medical Association supports federal and state policies for making long-term care facilities LGBTQ+ inclusive. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

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RELEVANT AMA POLICY

Senior Care H-25.993

Our AMA supports accelerating its ongoing efforts to work responsibly with Congress, senior citizen groups, and other interested parties to address the health care needs of seniors. These efforts should address but not be limited to: (1) multiple hospital admissions in a single calendar year; (2) long-term care; (3) hospice and home health care; and (4) pharmaceutical costs. [Sub Res. 181, I-89 Reaffirmed: Sunset Report, A-00 Reaffirmed: CSAPH Rep. 1, A-10 Reaffirmed: CSAPH Rep. 01, A-20]

LGBTQ+ Older Adults D-65.979

1. Our American Medical Association will disseminate educational content to increase awareness and understanding of LGBTQ+ health aging issues among the general public, healthcare professionals, and policy makers.
2. Our AMA will promote cultural competency training for clinicians in caring for LGBTQ+ older adults.
3. Our AMA will promote policies and practices for implementation within all healthcare settings that are inclusive and affirming for LGBTQ+ older adults.
4. Our AMA will advocate for increased funding and resources for research into health issues of LGBTQ+ older adults. [Res. 424, A-24]

Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations D-65.996

Our AMA will encourage and work with state medical societies to provide a sample printed nondiscrimination policy suitable for framing, and encourage individual physicians to display for patient and staff awareness-as one example: "This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or gender identity." [Res. 414, A-04 Modified: BOT Rep. 11, A-07 Modified: Res. 08, A-16Res. 16, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(A-25)

Introduced by: LGBTQ+ Section

Subject: Preservation of Public Funding for Physicians and Hospitals Providing LGBTQ+ Care

Referred to: Reference Committee D

Whereas, care tailored to the LGBTQIA+ population has been consistently recognized as medically necessary, evidenced-based healthcare supported by major medical organizations including the American Association of Pediatrics (AAP), the American College of Obstetrics and Gynecology (ACOG), the Endocrine Society, and the American Medical Association[1]; and

Whereas, physicians rely on stable public funding through sources such as Medicare, Medicaid, and federal grants to provide patient care, train student doctors, and conduct medical research, and restrictions on this funding jeopardize both LGBTQ+ healthcare and the broader medical system[2]; and

Whereas, existing AMA policies H-185.950 and H-185.905 affirm support for public and private insurance coverage of gender-affirming care, but do not recognize the growing threats to federal funding, medical education, and physician autonomy posed by restrictions on care; and

Whereas, existing AMA policy H-290.963 opposes caps on federal Medicaid funding and advocates for AMA input in Medicaid funding decisions, but does not account for limitations on federal Medicaid funding related to provision of certain categories of healthcare; and

Whereas, current federal and state governmental actions and propositions such as Executive Order 14187[3], Georgia's SB 39[4], Kansas' SB 63[5], and Kentucky's HB 154[6] all intend to limit or prohibit federal funding based on provision of evidence-based and life-saving care for transgender and gender diverse people, which sets a dangerous precedent for government control of healthcare and loss of physician autonomy; therefore be it

RESOLVED, that our American Medical Association supports preservation and maintenance of federal and state public funding for physicians and institutions engaged in clinical care, research, and medical education regarding LGBTQ+ populations. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

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RELEVANT AMA POLICY

The Physician's Right to Exercise Independent Judgement in All Organized Medical Staff Affairs H-225.952
Our American Medical Association supports the unfettered right of a physician to exercise personal and professional judgment in voting, speaking and advocating on any matter regarding:

1. patient care interests;
2. the profession;
3. health care in the community;
4. medical staff matters;
5. the independent exercise of medical judgment as appropriate interests to be incorporated into physician employment and independent contractor agreements; the right
6. not to be deemed in breach of their employment or independent contractor agreement for asserting the foregoing enumerated rights; and
7. not to be retaliated against by his/her employer in any way, including, but not limited to, termination of employment or independent contractor agreement, commencement of any disciplinary action, or any other adverse action against them based on the exercise of the foregoing rights.

Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations H-65.976
Our American Medical Association encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.

Removing Financial Barriers to Care for Transgender Patients H-185.950
Our American Medical Association supports public and private health insurance coverage for evidence-based treatment of gender-affirming care gender dysphoria as recommended by the patient's physician.

Health Care Disparities in Same-Sex Partner Households H-65.973
Our American Medical Association recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families.

1. Our AMA recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households.
2. Our AMA will work to reduce health care disparities among members of same-sex households including minor children.
3. Our AMA will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(A-25)

Introduced by: LGBTQ+ Section

Subject: Expanding Sexually Transmitted Infection Care for Persons with Unstable or No Housing

Referred to: Reference Committee D

Whereas, the number of people with unstable or no housing in the United States reached an all-time high in 2023, with over 771,000 individuals recorded in a single night[1]; and

Whereas, one in three individuals with unstable or no housing in the United States in 2023 experienced chronic homelessness[1]; and

Whereas, Whereas, in 2023 in the United States there was a 33% increase in children with unstable or no housing and a 10% rise in unaccompanied youth[1]; and

Whereas, structural inequities continue to disproportionately affect marginalized communities—Black, African American, and African individuals remain overrepresented among the population with unstable or no housing[1]; and

Whereas, 17% of LGBTQ+ adults report having unstable or no housing, and up to 40% of youth with unstable or no housing identify as LGBTQ+[2]; and

Whereas, in 2023 over 2.4 million cases of syphilis, gonorrhea, and chlamydia were diagnosed in the United States[3]; and

Whereas, congenital syphilis rates in the United States reached all time high since 1992 with a 235% increase since 2016[3]; and

Whereas, the CDC has estimated that 1 in 5 people had an STI on any given day in 2018[3]; and

Whereas, adolescent and young adult populations (15-24yo) accounted for 53% of new STI diagnoses in 2020[4]; and

Whereas, only 51% of sexually active adolescents reported using condoms[4,5]; and

Whereas, men who have sex with men were disproportionately impacted by STIs such as gonorrhea, syphilis, and HIV co-infection in 2023[6]; and

Whereas, although non-Hispanic Black and African American persons represented 12.6% of the United States population in 2023, they accounted for 32.4% of all cases of chlamydia, gonorrhea, and syphilis[6]; and

Whereas, rates of primary, secondary, and congenital syphilis were highest among American Indian and Alaska Native persons in 2023[6]; and

Whereas, people with unstable or no housing have a higher prevalence of acute and chronic physical and mental health conditions and higher mortality rates[7]; and

Whereas, people with unstable or no housing have higher rates of emergency room utilization[8], longer hospital stay[9], and higher hospital readmission rates[10] compared to the housed population; and

Whereas, a higher rate of sexually transmitted infections and HIV among people with unstable or no housing indicates suboptimal STI testing and underutilization of prevention services, despite a higher percentage of healthcare visits compared to the housed population[11]; and

Whereas, transactional sex survival behavior among women with low socioeconomic status correlates with diverse racial identities, lesbian or bisexual identities, childhood trauma, experiencing unstable or no housing, substance use, and condomless sex. Moreover, women engaging in transactional sex have higher rates of bacterial STIs and hepatitis and lower rates of HIV screening and prophylaxis[12]; and

Whereas, untreated STIs increase long-term risks of infertility, ectopic pregnancy, heart failure, seizures, nerve damage, blurry vision, blindness, hearing loss, and balance dysfunctions[13,14]; and

Whereas, the average annual unadjusted total Medicaid spending for people who experienced episodes of homelessness was 2.5 times greater than that of the comparison population[15]; and

Whereas, unstably housed people who are living with HIV have challenges with daily oral antiretroviral therapy (ART) adherence and experience significantly higher rates of viremia and onward HIV transmission than housed people living with HIV[16]; and

Whereas, existing AMA STI prevention policies do not sufficiently address the needs of LGBTQ+ individuals with unstable or no housing manifesting in significant disparities in health outcomes and access to care for this population; therefore be it

RESOLVED, that our American Medical Association support federal and state efforts to expand access to comprehensive sexually transmitted infection (STI) screening, treatment, and prevention services for persons with unstable or no housing. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

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RELEVANT AMA POLICY

Sexually Transmitted Infections Control H-440.996
Our AMA (1) supports continued action to assert appropriate leadership in a concerted program to control sexuallytransmitted infection; (2) urges physicians to take all appropriate measures to reverse the rise in sexually transmitted infection and bring it under control; (3) encourages constituent and component societies to support and initiate efforts to gain public support for increased appropriations for public health departments to fund research in development of practical methods for prevention and detection of sexually transmitted infection, with particular emphasis on control of gonorrhea; and (4) in those states where state consent laws have not been modified, encourages the constituent associations to support enactment of statutes that permit physicians and their co-workers to treat and search for sexually transmitted infection in minors legally without the necessity of obtaining parental consent. Sub. Res. 6, I-72 Reaffirmed: CLRPD Rep. C, A-89 Reaffirmed: Sunset Report, A-00 Modified: CSAPH Rep. 1, A-10 Modified: CSAPH Rep. 01, A-20

Update on Sexually Transmitted Infections H-440.983
The AMA (1) urges medical students, primary care residents, and physicians in all specialties to familiarize themselves with sexually transmitted infections (STI), so that they will be better able to diagnose and treat them; (2) encourages physicians to always include a sexual history as part of their routine history and physical exam; (3) encourages STI instruction, both didactic and clinical, in all medical school and primary residency programs; (4) encourages the establishment of STI fellowships by primary care specialties in order to develop a pool of clinical and research expertise in the area; (5) encourages state and local medical societies to promote STI public service TV and radio announcements in their communities; and (6) supports continued communication of updated STI information regularly through AMA publications. CSA Rep. E, A-83 Reaffirmed: CLRPD Rep. 1, I-93 Reaffirmation A-99 Modified and Reaffirmed: CSAPH Rep. 1, A-09 Reaffirmed: CSAPH Rep. 01, A-19

Contraception and Sexually Transmitted Infections H-75.994
Our American Medical Association, in cooperation with state, county, and specialty medical societies, encourages physicians to educate their patients about sexually transmitted infections, including HIV disease, and condom use. While such counseling may not be appropriate for all contraception patients, physicians should be encouraged to provide this information to any contraception patient who may benefit from being more aware of the risks of sexuallytransmitted infections. BOT Rep. E, A-89 Reaffirmation A-99 Reaffirmed and Title Change: CSA Rep. 4, A-03 Reaffirmed: CSAPH Rep. 1, A-13 Modified: CSAPH Rep. 8, A-23

Control of Sexually Transmitted Infections H-440.979
The AMA urges increased efforts at all levels of organized medicine to bring sexually transmitted infections under control, through professional and public education, and support of the efforts of state Departments of Health, the Centers for Disease Control and Prevention, the National Institutes of Health, and other appropriate organizations. Res. 84, A-84 Reaffirmed by CLRPD Rep. 3 - I-94 Reaffirmation A-99 Modified and Reaffirmed: CSAPH Rep. 1, A-09Reaffirmation A-10 Reaffirmed: CSAPH Rep. 01, A-20

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
1. [...] 2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors. 3. [...] 4. [...] CSA Rep. C, I-81 Reaffirmed: CLRPD Rep. F, I-91 CSA Rep. 8 - I-94 Appended: Res. 506, A-00 Modified and Reaffirmed: Res. 501, A-07 Modified: CSAPH Rep. 9, A-08 Reaffirmation A-12 Modified: Res. 08, A-16 Modified: Res. 903, I-17 Modified: Res. 904, I-17 Res. 16, A-18 Reaffirmed: CSAPH Rep. 01, I-18 Reaffirmed: CSAPH Rep. 08, A-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(A-25)

Introduced by: Minority Affairs Section

Subject: Promoting Child Welfare and Communication Rights in Immigration Detention

Referred to: Reference Committee D

Whereas, detention centers have been shown to increase the risk of depression, anxiety, Post-Traumatic Stress Disorder, injury and abuse, Adverse Childhood Experiences, and chronic conditions exacerbated by lack of access to care amongst detainees[1-4]; and

Whereas, maternal deprivation and family separation through institutionalization increase stress responses in children, hindering brain development and emotional resilience, while comforting touch, such as hugging, has been shown to reduce stress, balance cortisol levels, and support healthy brain development, with daily affective touch proving particularly effective in mitigating attachment disorders and fostering resilience in institutionalized children[5-14]; and

Whereas, despite no formal policies prohibiting detained youth and siblings from hugging, reports reveal detention agents mistakenly enforcing no-touch rules, preventing youth from offering comfort, while such blanket policies ignore the critical need for physical affection to help mitigate the severe trauma of family separation[15-18]; and

Whereas, the American Academy of Pediatrics has stated that the conditions in immigration detention centers are not appropriate for children and can lead to significant psychological and emotional distress[19]; and

Whereas, due to current overcrowding in detention facilities and limited transparency in the immigration court process, many detained individuals in detention centers suffer from cramped living quarters and are unaware of their status in the court proceedings[20,21]; and

Whereas, Office of Refugee Resettlement (ORR) policy mandates placing unaccompanied minors in “the least restrictive setting that is in the best interests of the child” with consideration for special needs, but children with disabilities are disproportionately housed in ORR’s most restrictive placement settings[22]; and

Whereas, immigration detention centers previously allowed free phone calls for detained individuals; however, recent ICE policy changes have caused detainees to pay for phone access despite the nearly nonexistent income of many detained individuals, thus effectively losing access to external communication with social support networks and legal services, a barrier that may impede the detained individual’s right to a fair trial[23-25]; and

Whereas, regular contact with familial and social support networks have been shown to mitigate the many adverse mental health outcomes of detained individuals in detention facilities, such as depression, anxiety, and post-traumatic stress disorder[26]; and

Whereas, The National Institutes of Corrections suggests that people in correctional facilities should have free, unfettered access to telephone and mail communication to their family members, support system, and legal counsel[27]; and

Whereas, current AMA policy prioritizes health disparities faced by immigrant communities (H-350.957); and

Whereas, the limited communication access offered to detainees based on payment of monetary fees exacerbates the unique health conditions in immigrants, especially those in detention facilities[28]; therefore be it

RESOLVED, that our American Medical Association advocate for the implementation of evidence-based, child-centered, and trauma-informed policies across all detention centers, ensuring detained minors have access to developmentally appropriate socioemotional care, including physical contact, and for all detained people, free, unfettered communication access including regular in-person communication, phone calls, and letters (Directive to Take Action); and be it further

RESOLVED, that our AMA support efforts to address and mitigate concerns and accusations of child abuse and neglect in detention centers. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Date Received: 4/21/25

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RELEVANT AMA POLICY

H-350.955 Care of Women and Children in Family Immigration Detention

1. Our American Medical Association recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.

5. Our AMA will advocate for the preferential use of alternatives to detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies. [Res. 002, A-17; Appended: Res. 218, A-21; Reaffirmed: Res. 234, A-22]

H-350.957 Addressing Immigrant Health Disparities

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA calls for asylum seekers to receive medically-appropriate care, including vaccinations, in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
4. Our AMA supports efforts to train physicians to conduct medical and psychiatric forensic evaluations for asylum seekers.
5. Our AMA supports medical education that addresses the challenges of life-altering events experienced by asylum seekers.
6. Our AMA urges physicians to provide medically-appropriate care for asylum seekers.
7. Our AMA encourages physicians to seek out organizations or agencies in need of physicians to provide these services.
8. Our AMA encourages provision of resources to assist people seeking asylum, including social and legal services. [Res. 804, I-09; Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19; Modified: BOT Rep. 08, I-24]

D-160.921 Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare

Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities. [Res. 232, I-17]

H-315.966 Patient and Physician Rights Regarding Immigration Status

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. [Res. 018, A-17]

D-350.983 Improving Medical Care in Immigrant Detention Centers

Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention. [Res. 017, A-17]

H-65.958 Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court

Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations focus solely on the health and well-being of the children; and (2) condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent. [Res. 013, A-19]

D-350.975 Immigration Status is a Public Health Issue

1. Our American Medical Association declares that immigration status is a public health issue that requires a comprehensive public health response and solution.
2. Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.
3. Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.
4. Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities. [Res. 904, I-22Reaffirmed: Res. 210, A-23]

D-60.968 Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth

Our American Medical Association will work with medical societies and all clinicians to (i) work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services that support their health and well-being, and (ii) secure federal, state, and other funding sources to support those services. [Res. 8, I-14BOT Rep. 09, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
A-25

Introduced by: Minority Affairs Section

Subject: Culturally and Religiously Inclusive Food Options

Referred to: Reference Committee D

Whereas, access to culturally and religiously appropriate food is a fundamental aspect of dignified, patient-centered care, encompassing Halal, Kosher, and other foods that honor the heritage, beliefs, and dietary practices of diverse populations; and

Whereas, nearly one in four individuals in the United States identifies as part of an ethnic minority group, and by 2044, minority groups are estimated to make up 50% of the US population, highlighting the need for more inclusive healthcare practices for patients[1-2]; and

Whereas, studies have demonstrated that offering culturally appropriate foods in healthcare settings enhances nutritional intake, leading to better overall health outcomes[3]; and

Whereas, having culturally and religiously appropriate food options improves patient trust and satisfaction, directly improving well-being[4]; and

Whereas, providing meals that align with patients' cultural and religious beliefs is not only essential for fostering equitable, inclusive, and patient-centered healthcare services but is also shown to have a direct positive correlation to their health[5-6]; and

Whereas, a study in Malaysia found that Muslim patient satisfaction significantly increased when halal food options were made available, demonstrating the importance of culturally aligned dietary accommodations[7]; and

Whereas, healthcare provider knowledge on halal food and dietary restrictions are simplistic and more policies are needed to educate staff to accommodate Muslim patients[8]; and

Whereas, institutions and hospitals report some of the greatest perceived barriers to implementing diverse cuisines are due to the time it takes to learn and cook additional foods, as well as the willingness of administrators and staff to implement culturally inclusive foods[9]; and

Whereas, one study noted that individuals who handle food at the hospital have varying knowledge about what a gluten-free meal is which could affect the safety of patients with celiac disease[10]; and

Whereas, adopting halal food options expands our reach to a global patient population, as seen in South Korea, which attracts many medical tourists from the Middle East[11]; and

Whereas, New York City Health + Hospitals implemented an innovative menu featuring plant-based culturally sensitive foods that yielded a 95% acceptance from patients in addition to a $0.59 cost reduction per meal[12]; and

Whereas, renowned American hospital systems such as the Johns Hopkins Health System have implemented significant accommodations for Jewish patients by providing a fully stocked Kosher Food Pantry for both patients and their families in collaboration with the Bikur Cholim of Baltimore, a local Jewish volunteer group[13-14]; and

Whereas, the American Medical Association has written a letter to the U.S. Food and Drug Administration advocating for clearer labeling of foods by their culture or religion, for example, as Kosher or Halal[15]; and

Whereas, the AMA is committed to embedding racial justice and advancing health equity, as outlined in its 2024–2025 Organizational Strategic Plan to Advance Health Equity, which emphasizes the need for equitable healthcare practices that respect and accommodate the diverse cultural and religious backgrounds of patients[16]; and

Whereas**,** AMA policy H-150.949 states the AMA already encourages healthy and nutritious food options in health care facility cafeteria and inpatient meal menus, but does not include support for culturally and religiously sensitive food options[17]; therefore be it

RESOLVED, that our American Medical Association amend Policy H-150.949 “Healthful Food Options in Health Care Facilities” by addition to read as follows:

Healthful <u>Culturally and Religiously Inclusive</u> Food Options in Health Care Facilities H-150.949

1. Our American Medical Association encourages healthful<u>, culturally and religiously inclusive</u> food options be available, at reasonable prices and easily accessible, on the premises of health care facilities.
2. Our AMA hereby calls on all health care facilities to improve the health of patients, staff, and visitors by:
    a. Providing a variety of healthy food, including plant-based meals, and meals that are low in saturated and trans fat, sodium, and added sugars.
    b. Eliminating processed meats from menus.
    c. Providing and promoting healthy beverages.
    d. <u>Improving access to culturally and religiously inclusive food options.</u>
3. Our AMA hereby calls for health care facility cafeterias and inpatient meal menus to publish nutrition information.
4. Our AMA will work with relevant stakeholders to define “access to food” for medical trainees to include overnight access to fresh<u>, culturally and religiously inclusive</u> food and healthy meal options within all training hospitals.

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

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RELEVANT AMA POLICY

H-150.949 Healthful Food Options in Health Care Facilities

1. Our American Medical Association encourages healthful food options be available, at reasonable prices and easily accessible, on the premises of health care facilities.
2. Our AMA hereby calls on all health care facilities to improve the health of patients, staff, and visitors by:
    a. Providing a variety of healthy food, including plant-based meals, and meals that are low in saturated and trans fat, sodium, and added sugars.
    b. Eliminating processed meats from menus.
    c. Providing and promoting healthy beverages.
3. Our AMA hereby calls for health care facility cafeterias and inpatient meal menus to publish nutrition information.
4. Our AMA will work with relevant stakeholders to define "access to food" for medical trainees to include overnight access to fresh food and healthy meal options within all training hospitals. [Res. 410, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Appended: Res. 406, A-17; Modified: Res. 425, A-18; Modified: Res. 904, I-19; Appended: Res. 304, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 417
(A-25)

Introduced by: Minority Affairs Section, National Medical Association, American Academy of Addiction Psychiatry, American Academy of Family Physicians, American Association of Public Health Physicians, American College of Obstetricians and Gynecologists, American Psychiatric Association, American Society of Addiction Medicine

Subject: Updating Alcohol Health Warning Labels to Reflect Evidence-Based Health Risks and Supporting National Labeling and Signage Policy Reform

Referred to: Reference Committee D

Whereas, alcohol is classified by both the World Health Organization and the U.S. National Cancer Institute as a Group 1 carcinogen, causally linked to at least seven types of cancer, including breast, liver, and colorectal cancers[1-2]; and

Whereas, public awareness of alcohol's carcinogenicity remains low, and the federally mandated warning under the Alcoholic Beverage Labeling Act (ABLA) of 1988 has not been updated in over 35 years, currently limited to warnings about pregnancy and impaired driving[3]; and

Whereas, research demonstrates that alcohol health warning labels, particularly those focused on cancer risk, can increase consumer awareness, reduce misperceptions, improve knowledge, influence behavioral intentions, and reduce alcohol consumption, including findings from a quasi-experimental study in Yukon, Canada, which showed statistically significant improvements in awareness and purchasing behavior in response to warning labels[4-9]; and

Whereas, systematic reviews, international policy analyses, and experimental studies in the U.S. and globally suggest that health warnings using direct language and clear visual design, particularly when paired with point-of-sale signage, have a stronger impact on risk perception, can disrupt the social normalization of alcohol use, and serve as a cost-effective, population-wide public health intervention[7-8, 10]; and

Whereas, jurisdictions including California (Prop 65), Alaska (SB15/HB37), and countries such as Ireland (Public Health Alcohol Act, 2018) and South Korea (National Health Promotion Act, 2016) have implemented or proposed container labels and/or point-of-sale signage highlighting alcohol's link to cancer and other health harms[11-15]; and

Whereas, public support for clearer, science-based health warnings on alcohol products and signage is consistently high, especially when messages are prominently displayed and focus on known harms such as cancer, liver disease, and fetal injury[9,16,17]; and

Whereas, the American Medical Association has longstanding policies supporting health and nutritional labeling in other domains - most notably tobacco, nicotine, and food products - and existing AMA Policy H-30.940 supports nutritional labeling of alcohol products, but does not yet explicitly address alcohol's health harms such as cancer; and

Whereas, the AMA publicly supported the January 2025 U.S. Surgeon General's Advisory on alcohol's cancer-causing risk, reinforcing the importance of accurate public health communication[18,19]; and

Whereas, the AMA's February 6, 2025 public comment letter on the 2025–2030 Dietary Guidelines for Americans urged stronger federal recommendations on alcohol use, highlighting that the risk of harm increases with greater alcohol consumption[20]; therefore be it

RESOLVED, that our American Medical Association support the modernization of alcohol health warning labels to reflect the best available science, including explicit acknowledgment of alcohol's causal link to cancer and the evidence that the risk of harm increases with greater alcohol consumption (New HOD Policy); and be it further

RESOLVED, that our AMA support federal and state policy measures requiring clear, evidence-based point-of-sale warning signage in physical and digital retail environments where alcohol is sold (New HOD Policy); and be it further

RESOLVED, that our AMA support research and evaluation initiatives to study the impact of alcohol warning labels and signage on consumer knowledge and behavior, health outcomes, and alcohol sales patterns, with ongoing assessment to ensure future labeling interventions are evidence-informed and population-appropriate. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

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RELEVANT AMA POLICY

H-30.940 AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages

1. Our American Medical Association:
    a. supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol.
    b. supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors.
    c. urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels.
    d. urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act.
2. Our AMA:
    a. expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underaged use of alcohol.
    b. recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant people, as well as the dangers of irresponsible use to all sectors of the populace).
    c. recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof).
3. Our AMA actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA:
    a. supports federal and/or state oversight for all forms of alcohol advertising.
    b. supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse.
    c. opposes any form of advertising which links alcoholic products to agents of socialization in order to promote drinking.
    d. will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems.
    e. urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications.
    f. urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications.
4. Our AMA:
    a. urges producers and distributors of alcoholic beverages to discontinue all advertising directed toward youth, including promotions on high school and college campuses.

b. urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance).
c. supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking.
d. commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol. [CSA Rep. 1, A-04; Reaffirmation A-08; Reaffirmed: CSAPH Rep. 01, A-18; Modified: Res. 427, A-22; Modified: Res. 918, I-22; Modified: Speakers Rep. 02, I-24]

H-420.977 Posting of Warnings Against Use of Alcohol During Pregnancy
The AMA supports seeking appropriate federal or state legislation to require that warning signs stating that drinking alcoholic beverages during pregnancy can cause birth defects be posted in a prominently visible location in all places where alcoholic beverages are sold. [Sub. Res. 123, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18]

H-30.934 Alcohol Consumption and Health
Our AMA recognizes that alcohol consumption at any level, not just heavy alcohol use or addictive alcohol use, is a modifiable risk factor for cancer. [Res. 516, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 418
(A-25)

Introduced by: Medical Student Section, Oregon, Washington

Subject: AMA Study on Plastic Pollution Reduction

Referred to: Reference Committee D

Whereas, plastic products comprise up to 13% of the planet's total carbon budget, prompting global concerns about climate change, marine life, and human health[1]; and

Whereas, exposure to toxic chemicals that are found in plastic products during manufacturing, usage, and disposal have been associated with adverse human health outcomes such as cancers, birth defects, and endocrine and reproductive disruptions[2]; and

Whereas, studies have shown a significant relationship between urine levels of bisphenol A, a plastic metabolite, and cardiovascular disease, type II diabetes, and liver enzyme abnormalities[2, 3]; and

Whereas, implementation of plastic product consumption accountability measures such as taxes and fees is shown to be one of the most successful initiatives to reduce plastic products consumption, and to promote alternatives to plastic products[4-10]; and

Whereas, the $1.3 billion revenue generated by leveraging taxes against single-use plastics in Spain, Italy, and the United Kingdoms provided funds for renewables advocacy campaigns, plastic alternatives research, and offsetting the costs associated with transitioning to clean energy[11]; and

Whereas, the United States loses $255 million in revenue annually due to marine plastic pollution and paid an estimate of $24.5 billion of taxpayer money in 2019 for waste management and cleaning[12, 13]; and

Whereas, avoiding a plastic tax on single-use consumer goods such as cups, straws, bottles, and caps by switching to reusable products can save the US single consumer $5,279 and businesses up to $10 billion annually[13,14]; and

Whereas, this issue could benefit from American Medical Association study and involvement given its significant implications on patient health, and opportunities for state and federal regulations; therefore be it

RESOLVED, that our American Medical Association will study and report back with policy recommendations on ways to reduce plastic pollution and its impact on climate change and health, including but not limited to federal, state, and local taxes and limitations on the use of single-use plastic consumer products and other types of plastic, interventions to reduce microplastics, and alternatives to plastic. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Date Received: 4/10/25

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RELEVANT AMA POLICY

Toxic Disposable Consumer Products H-135.940
Our AMA supports federal legislation to create standardized and easily recognizable sites for safe disposal and/or recycling of toxic substances and electronic waste materials in easily accessible locations. [Res. 416, A-08; Reaffirmed: CSAPH Rep. 01, A-18]

Policy to Reduce Waste from Pharmaceutical Sample Packaging H-115.979
Our AMA: (1) supports reducing waste from pharmaceutical sample packaging by making sample containers as small as possible and by using biodegradable and recycled materials whenever possible; and (2) supports the modification of any federal rules or regulations that may be in conflict with this policy. [Res. 508, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

Conservation, Recycling and Other "Green" Initiatives G-630.100
AMA policy on conservation and recycling include the following: (1) Our AMA directs its offices to implement conservation-minded practices whenever feasible and to continue to participate in "green" initiatives. (2) It is the policy of our AMA to use recycled paper whenever reasonable for its in-house printed matter and publications, including JAMA, and materials used by the House of Delegates, and that AMA printed material using recycled paper should be labeled as such. (3) During meetings of the American Medical Association House of Delegates, our AMA Sections, and all other AMA meetings, recycling bins, where and when feasible, for white (and where possible colored) paper will be made

prominently available to participants. [CCB/CLRPD Rep. 3, A-12; Modified: Speakers Rep., A-15; Reaffirmed: CCB/CLRPD Rep. 1, A-22]

Declaring Climate Change a Public Health Crisis D-135.966

1. Our American Medical Association declares climate change a public health crisis that threatens the health and well-being of all individuals.
2. Our AMA will protect patients by advocating for policies that:
    a. Limit global warming to no more than 1.5 degrees Celsius.
    b. Reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050.
    c. Support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.
3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions.
4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050.
5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.
6. Our AMA supports the use of international, federal, regional, and state carbon pricing systems as an important tool to reduce global greenhouse gas emissions and achieve net-zero targets. Our AMA recommends that carbon dividends or energy subsidies for low-income households be a key component of any established carbon pricing system, to reduce the potential economic burden on households with lower incomes. [Res. 420, A-22; Appended: CSAPH Rep. 02, I-22; Appended: BOT Rep. 11, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 419
(A-25)

Introduced by: Medical Student Section

Subject: Advocating for Universal Summer Electronic Benefit Transfer Program for Children (SEBTC)

Referred to: Reference Committee D

Whereas, in 2022, 8.8% of all food-insecure U.S. households included children, and overall food insecurity increased from 10.2% in 2021 to 12.8% in 2022, affecting an additional 4.1 million children, along with bringing forward developmental concerns by parents via screening tests[1-,6]; and

Whereas, food insecurity disproportionately affects children with disabilities, Black, Native American/Alaska Native, other children of color, and children with low socioeconomic status while also being a toxic stressor and is recognized as an Adverse Childhood Experience[7-10]; and

Whereas, access to healthy food early in life improves educational outcomes, promotes good nutrition, and provides significant health benefits to children across all developmental stages by reducing the risk of psychiatric illness, cognitive deficits, asthma, and anemia[9,11-14,17-19]; and

Whereas, infants and children in families participating in Supplemental Nutrition Assistance Program (SNAP) are more likely to regularly see a primary care physician for checkups and have improved long-term health as adults[14]; and

Whereas, evidence shows that universal free school meal programs improve school attendance and academic performance[14-19]; and

Whereas, school-aged children experience higher rates of food insecurity during the summer months when school is not in session, and USDA-funded Summer Feeding programs have been shown to improve food security, diet quality, and nutrition in low-income children[4,20,21]; and

Whereas, the Summer Electronic Benefits Transfer for Children (SEBTC) program reduced food insecurity by one-third and can benefit over 29 million children across the U.S., however only 37 states have implemented SEBTC with the remaining states having high childhood food insecurity rates[22-24,26]; and

Whereas, the American Academy of Pediatrics advocates for SEBTC and policies to combat food insecurity, urging collaboration with governments to ensure equitable access to healthy food for all children[25]; therefore be it

RESOLVED, that our American Medical Association support federal and state efforts to reduce childhood food insecurity, including expansion of the Summer Electronic Benefits Transfer for Children Program. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Date Received: 4/17/25

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RELEVANT AMA POLICY

H-150.937 Improvements to Supplemental Nutrition Programs
Our American Medical Association supports:

a. improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity;
b. efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and
c. the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.

Our AMA will request that the federal government support SNAP initiatives to:

a. incentivize healthful foods and disincentivize or eliminate unhealthful foods; and
b. harmonize SNAP food offerings with those of WIC.

Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives. [Res. 414, A-10; Reaffirmation A-12; Reaffirmation A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18; Reaffirmed: Res. 259, A-23]

D-150.978 Sustainable Food
Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) supports sustained funding for evidence-based policies and programs to eliminate disparities in healthy food access, particularly for populations vulnerable to food insecurity, through measures such as tax incentive programs, community-level initiatives and federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems. [CSAPH Rep. 8, A-09; Reaffirmed in lieu of Res. 411, A-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 205, A-12; Modified: Res. 204, A-13; Reaffirmation A-15; Modified: CSAPH Rep. 2, I-22]

H-150.925 Food Environments and Challenges Accessing Healthy Food
Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; (2) recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; (3) supports policy promoting community-based initiatives

that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food; and (4) will advocate for CMS and other relevant agencies to develop, test, and then implement evidence-based innovative models to address food insecurity, such as food delivery and transportation services to supermarkets, food banks and pantries, and local farmers markets for healthy food options. [Res. 921, I-18; Modified: Res. 417, A-21; Appended: Res. 117, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 420
(A-25)

Introduced by: Medical Student Section

Subject: Study of Plant-Based & Lab-Grown Meat

Referred to: Reference Committee D

Whereas, alternatives to animal meat are a growing industry, prompting the global food sector undertake efforts to ensure the safety of foods in this category[1-7]; and

Whereas, meat alternatives are either plant-based (structured plant-derived products designed to resemble animal meat) and lab-grown meat (animal cells cultured in vitro)[8-9]; and

Whereas, plant-based meat presents economic, and environmental benefits without the ethical conflicts, antibiotic resistance, and climate impact of animal meat production[6-7,10]; and

Whereas, emerging studies suggest health benefits of both plant-based meat and lab-grown meat, including reduced risk of bacterial contamination, effects on the gut microbiome, absence of antibiotics and growth hormones, lower saturated fats and cholesterol, and reduced incidence of heart disease, obesity, and some cancers[3,7,11,13-21]; and

Whereas, production of both plant-based and lab-grown meats has potential economic and environmental benefits with decreased greenhouse gas emissions, land and water use, risk for antibiotic resistance, and ethical considerations for animal safety[6,7,10,22,23]; and

Whereas, plant-based meat is primarily regulated by the FDA, and lab-grown meat is dually regulated by both the FDA (cell collection and differentiation) and USDA (cell harvesting), but states also regulate labeling of both plant-based and lab-grown meats[24,25]; therefore be it

RESOLVED, that our American Medical Association study and report back with policy recommendations on the health- and climate-related effects of consuming plant-based and lab-grown meat. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/17/25

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RELEVANT AMA POLICY

H-150.922 Reduction in Consumption of Processed Meats

Our AMA supports: (1) reduction of processed meat consumption, especially for patients diagnosed or at risk for cardiovascular disease, type 2 diabetes, and cancer; (2) initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition; (3) public awareness of the risks of processed meat consumption; and (4) educational programs for health care professionals on the risks of processed meat consumption and the benefits of healthy alternatives. [Res. 406, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 421
(A-25)

Introduced by: New York

Subject: Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities

Referred to: Reference Committee D

Whereas, studies have shown that minority populations, including African Americans, Latinx, and low-income communities, are disproportionately exposed to aircraft noise and its associated health risks; and

Whereas, exposure to persistent noise pollution can lead to numerous health issues, including hearing impairment, sleep disturbances, cardiovascular problems, and increased stress levels; and;

Whereas, air pollution from aviation contributes to respiratory diseases, cardiovascular diseases, and other serious health effects, with minority communities often facing higher exposure levels; therefore be it

RESOLVED, that our American Medical Association seek a study and report back providing recommendations at the federal level to reduce the adverse impact of air and noise pollution in disproportionately impacted and vulnerable communities from aviation, including the following areas:

1. Promotion of Sustainable Aviation Fuels: Advocate for the adoption of sustainable alternative jet fuels, which have been shown to decrease premature death rates in communities near airports and downwind.

2. Implementation of Noise Abatement Procedures: Encourage the use of flight paths and operational procedures that minimize noise impact on residential areas, particularly those inhabited by minority populations disproportionately impacted communities.

3. Investment in Noise Mitigation Infrastructure: Support the installation of soundproofing materials in homes, schools, and healthcare facilities located in high-noise areas to reduce the adverse health effects of noise pollution as well as non-combustion engines (i.e. solar or electric).

4. Community Engagement and Education: Foster partnerships with affected communities to raise awareness about the health impacts of air and noise pollution and involve them in decision-making processes regarding aviation operations.

5. Research and Monitoring: Advocate for ongoing research to monitor air and noise pollution levels in minority populations disproportionately impacted communities and study the effectiveness of implemented interventions. (Directive to Take Action)

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 422
(A-25)

Introduced by: New York

Subject: Protecting the Integrity of the U.S. Healthcare System from Misinformation and Policy

Referred to: Reference Committee D

Whereas, the healthcare system in the United States is built upon scientific integrity, evidence-based medicine, and public trust; and

Whereas, the dissemination of medical misinformation poses a significant risk to public health, leading to decreased vaccine confidence, increased preventable disease burden, and mistrust in medical institutions; and

Whereas, Robert F. Kennedy Jr. the new Secretary of Health and Human Services has consistently promoted scientifically unsubstantiated and widely debunked views on vaccines, public health policies, and medical science; and

Whereas, the influence of misinformation-driven policies could undermine critical public health initiatives, including vaccine programs, pandemic preparedness, and environmental health protections; and

Whereas, it is the responsibility of the medical community to uphold ethical standards, promote fact-based healthcare policy, and advocate for the well-being of patients and communities; therefore be it

RESOLVED, that our American Medical Association will work to educate both medical professionals and the public on the importance of scientific literacy and medical accuracy, the risks associated with healthcare misinformation, and the importance of continued advancement of evidence-based healthcare. (Directive to Take Action)

Fiscal Note: $102,954

Received: 4/22/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 423
(A-25)

Introduced by: New York

Subject: Requiring Universal Vaccine reporting to a National Immunization Registry and Access to a National Immunization Information System

Referred to: Reference Committee D

Whereas, access to comprehensive, up-to-date immunization records for individuals is critical in preventing gaps in vaccination coverage, and supporting public health initiatives; and

Whereas, the New York State Immunization Information System (NYSIIS) and the Citywide Immunization Registry (CIR) serve as vital public health tools to track and monitor immunization records, ensure vaccine coverage, reduce the risk of vaccine-preventable diseases, and improve the overall health of the population; and

Whereas, we live in a fluid society where many people move throughout the state and most parents believe that all medical records are accessible to all medical practices throughout the state; and

Whereas, physicians and medical practices are only permitted access to NYSIIS if the practice is located within New York State and are outside of New York City, and are only permitted access to CIR if the practice is within the five boroughs of NYC; and

Whereas, the New York State Immunization Information System (NYSIIS) and the Citywide Immunization Registry (CIR) serve as vital public health tool to track and monitor immunization records, ensure vaccine coverage, reduce the risk of vaccine-preventable diseases, and improve the overall health of the population; and

Whereas, all childhood vaccines are required to be reported to the New York State Immunization Information System (NYSIIS) or the Citywide Immunization Registry (CIR) but for adults it is an opt-in reporting and not required; and

Whereas, New York State law requires all vaccinations administered to children be submitted to the respective registry and requires that all vaccines ever given to the child if a vaccine record is provided be inputted into the respective registry; and

Whereas, some practices are not in compliance with this law, causing the unnecessary re-administration often by schools and turmoil for parents due to the lack of oversight and consequences in the law; and

Whereas, pharmacies across New York State are increasingly becoming an important point of access for vaccinations, particularly for routine vaccines, flu shots, and other immunization services; and

Whereas, hospitals across New York State administer vaccines (influenza and COVID) to hospital employees including nurses and practitioners to protect patients, as well as to inpatients; and

Whereas, accurate and timely reporting of vaccination data to the NYSIIS and CIR is critical to maintaining comprehensive, up-to-date immunization records for individuals, preventing gaps in vaccination coverage, and supporting public health initiatives; and

Whereas, currently, not all pharmacies, providers and hospitals may consistently report immunization data to the NYSIIS and CIR, which can lead to incomplete vaccination records, potential duplication of vaccinations, and missed opportunities to identify under-immunized individuals; and

Whereas, many adult patients receive their vaccinations outside of their primary care providers' offices and do not always recall which vaccines they received, nor do they carry a record of the vaccine administered. This practice often leads to duplicate administration, which results in denied insurance claims; and

Whereas, a comprehensive, real-time record of vaccinations will enhance patient care, facilitate better public health responses, and improve the accuracy of immunization data for state and federal health agencies; and

Whereas, the reporting of vaccinations by pharmacies, hospitals and all providers to NYSIIS and CIR is a necessary step in the modernization and improvement of New York State's immunization infrastructure; therefore be it

RESOLVED, that our American Medical Association seek legislation for a national immunization registry as well as universal mandatory vaccine reporting for all vaccines administered in the United States and its territories to improve the public health of our society. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 424
(A-25)

Introduced by: Ohio

Subject: Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records

Referred to: Reference Committee D

Whereas, blood pressure variability (BPV) refers to the dynamic and continuous fluctuations in blood pressure that occur over different time frames, ranging from seconds to years, influenced by factors such as environmental conditions, physical activities, emotional states, and the body's cardiovascular regulatory systems, which ensure proper blood flow to organs[1]; and

Whereas, despite growing recognition of BPV as an important cardiovascular risk factor by major medical journals and healthcare entities including the American Heart Association and The Lancet, the lack of established thresholds to differentiate normal from pathological BPV and limited clinical data have delayed its inclusion in standardized management guidelines as a therapeutic target[2-3]; and

Whereas, a study conducted on a cohort of 221,803 adults found that one-third of hypertensive and one-sixth of normotensive patients had high BPV[4]; and

Whereas, blood pressure variability has a prognostic value comparable to cholesterol levels in predicting cardiovascular disease, with hazard ratios for BPV similar to those observed for cholesterol measures[5]; and

Whereas, long-term blood pressure variability is associated with an 18% increased risk of cardiovascular mortality, an increased risk of macrovascular and microvascular events, and a 15% higher risk of all-cause mortality, independent of mean blood pressure levels[5-6]; and

Whereas, among patients with an average systolic blood pressure under 140 mmHg, patients with higher BPV had a 16% increased risk of heart attack, stroke, and other cardiovascular events compared to those with lower BPV[7]; and

Whereas, studies suggest that BPV is similarly predictive of adverse outcomes across varying patient populations, including those with hypertension, hypotension, and those taking antihypertensive medications[8]; and

Whereas, higher blood pressure variability is associated with increased risk of recurrent ischemic stroke, major cardiovascular events, and all -cause death, and increased systolic BPV after hemorrhagic stroke is associated with worse functional outcomes[9]; and

Whereas, diastolic blood pressure variability (DBPV) independently predicts worse clinical outcomes related to death from cardiovascular causes, acute coronary syndrome (ACS), acute decompensated heart failure, coronary revascularization, atrial fibrillation, and stroke[10]; and

Whereas, DBPV is associated with increased risk for readmission and wound infection and should, therefore, be factored into presurgical risk assessment[11]; and

Whereas, although an effective medical treatment for BPV has not yet been established, patients can reduce their risk of BPV-related complications through lifestyle modifications, including adopting a healthy diet to reduce obesity, smoking cessation, engaging in aerobic and resistance training, and getting adequate quality sleep[12-14]; and

Whereas, BPV can be manually estimated by calculating the greatest change between two consecutive blood pressure measurements, making it a reasonable and immediate tool for incorporation into clinical practice until automated solutions become available[11]; and

Whereas, other studies have demonstrated that BPV can feasibly be determined through automated calculations within electronic medical records (EMR), and these visit-to-visit variations are associated with mortality in diverse populations at high risk of coronary artery disease[15]; therefore be it

RESOLVED, that our American Medical Association support the integration of blood pressure variability data into electronic medical records, emphasizing automated calculation capabilities similar to those established for body mass index (New HOD Policy); and be it further

RESOLVED, that our AMA support research efforts to establish pathological BPV thresholds to guide dietary and exercise recommendations, sleep evaluation, risk stratification, and other evidence-based interventions by healthcare providers. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/22/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 425
(A-25)

Introduced by: Oklahoma

Subject: Alcohol Consumption and Health

Referred to: Reference Committee D

Whereas, the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Agriculture (USDA) update The Dietary Guidelines every five years, as required by law; Each update provides advice about healthy eating patterns to promote health and prevent disease[1]; and

Whereas, guidance on the consumption of alcoholic beverages has been included in the Dietary Guidelines since the first edition in 1980[1]; and

Whereas, the current guidelines recommend no more than one drink per day for women and two per day for men, based on an overall assessment of the health risks associated with alcohol[2]; and

Whereas, the number of deaths caused by alcohol-associated diseases more than doubled during the years 1999-2020[3]; and

Whereas, in an advisory in January 2025, Surgeon General Dr. Vivek Murthy notes that alcohol consumption is the third leading preventable cause of cancer in the United States; contributes to almost 100,000 cancer cases and nearly 20,000 deaths every year[4]; and

Whereas, the Surgeon General writes, drinking alcohol increases the risk for at least seven types of cancers, most notably breast, colon and rectum, esophagus, larynx, liver, and throat cancers; fewer than half of Americans are aware of the relationship and he recommends updating the health warning label on alcoholic beverages[4]; and

Whereas, on Feb. 6, 2025, the AMA submitted comments on the draft report for the 2026-2030 Dietary Guidelines for Americans during the public comment period; The AMA commended the Dietary Guideline Advisory Committee's (DGAC) focus on the link between diet and chronic disease and the AMA strongly urges the DGAC to update its 2025-2030 guidance to explicitly warn about the risks of alcohol consumption and its relationship to certain cancers and other diseases and affirm that there is no safe threshold for alcohol consumption[5]; and

Whereas, regarding alcohol, the AMA appreciates that the DGAC recognizes that alcohol contains sugars, is not essential to a nutritious diet, and recommends limiting alcohol[5]; and

Whereas, AMA understands that the DGAC scientific committee is largely relying on two reports to determine updates to its 2025-2030 recommendations regarding alcohol consumption[5 6 7]; and

Whereas, there are additional materials that the AMA believe are important for the DGAC to consider; The recent Surgeon General's advisory describes in detail scientific evidence for the

causal link between alcohol consumption and increased risk for at least seven different types of cancer[5]; and

Whereas, the draft Dietary Guidelines report states: “Two separate scientific reviews on adult alcohol consumption and health are being conducted as of the time of this report’s preparation, one by an interagency committee led by HHS, the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD), and the other by the National Academies of Sciences, Engineering, and Medicine (NASEM);These reviews are independent of each other yet are working on complementary tracks. Both projects include external scientific peer review and opportunities for public participation; Each will result in a report with scientific findings—not recommendations—on alcohol consumption; These findings will be considered by HHS and USDA as the Departments develop the Dietary Guidelines for Americans, 2025-2030” [8 9 10]; therefore be it

RESOLVED, that our American Medical Association encourage the US Department of Health and Human Services and the U.S. Department of Agriculture to reassess alcohol limit guidelines based on an overall assessment of the health risks associated with alcohol consumption as stated in the Surgeon General’s 2025 advisory report and make recommendations for the next edition of the Dietary Guidelines that is scheduled to be released in 2025 (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage the US Department of Treasury to reassess the health warning label required to appear on distilled spirit labels as per the Alcoholic Beverage Labeling Act (ABLA) of 1988 with the recent data on cancer risk included in the Surgeon General’s 2025 advisory report and subsequently send an updated warning label to congress that includes cancer risk. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 4/17/25

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RELEVANT AMA POLICY

Alcohol Consumption and Health H-30.934
Our AMA recognizes that alcohol consumption at any level, not just heavy alcohol use or addictive alcohol use, is a modifiable risk factor for cancer

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 426
(A-25)

Introduced by: Organized Medical Staff Section

Subject: Addressing Patient Safety and Environmental Stewardship of Single-Use and Reusable Medical Devices

Referred to: Reference Committee D

Whereas, the Council on Science & Public Health *Report Improving Research Standards, Approval processes Post-Market and Surveillance Standards for Medical Devices* published in 2023 opened the door for the American Medical Association to develop further policy that specifically addresses concerns about the design, use, and maintenance of reusable medical devices in the context of antibiotic-resistant microbes; and

Whereas, the same report also opened the door for the AMA to consider policy that addresses single-use/disposable medical devices with regard to adverse environmental consequences and the balance of fiscal expense versus patient safety; and

Whereas, the presence of antibiotic-resistant microbes leading to the shutdown of surgical suites is well documented as is the relationship between these events and the use of inadequately reprocessed reusable devices[1,2]; and

Whereas, there is not currently a universal standard or rubric for evaluating the costs and benefits of single-use and reprocessed reusable medical devices relative to the risk and cost to patients, though some public bodies have attempted to craft such a standard[3]; and

Whereas, without an industry standard approach that has been evaluated and carefully considered by physicians, the creation of such a standard is falling to private industries which are free to develop the standards without physician input[4]; and

Whereas, medical device spending increased at an average rate of 5.8 percent in 2021 and inflationary pressure is expected to continue to push spending higher in the coming years[5,6]; and

Whereas, the development of a gold standard “cradle-to-grave” lifecycle assessment tool that can evaluate single-use and reusable medical equipment, developed between physicians and other key stakeholders, holds the best promise for a fruitful and meaningful method of containing costs, maintaining a minimal environmental impact, and protecting patient safety[7,8]; therefore be it

RESOLVED, that our American Medical Association work with interested stakeholders to develop and/or confirm a comprehensive cradle-to-grave life-cycle assessment for single-use versus reusable medical devices factoring safety relative to cost effectiveness and environmental impact (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for federal regulation on medical devices that addresses patient safety as it intersects with fiscal and environmental considerations and promotes the use

of a “gold standard” life-cycle assessment for single-use and reusable medical devices (Directive to Take Action).

Fiscal Note: Modest – between $1,000 - $5,000

Received: 2/28/2025

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RELEVANT AMA POLICY

Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices H-480.934

Our AMA believes that to support innovation while protecting patient safety, approval pathways for medical devices should incorporate the following principles:

a. Evidence-based, measurable performance benchmarks, such as those used in the Safety and Performance Based Pathway, should be used wherever possible for classes of known, well-studied medical devices;

b. For a subset of higher risk devices receiving approval but have not completed clinical trials, time-limited approvals may be appropriate, after which the manufacturer may be required to provide post-market data to support full device approval;

c. Medical devices with known safety concerns should not be usable as predicate devices for the purposes of proving substantial equivalence. In the event safety concerns of predicate devices arise after approval has been granted, additional due diligence should be initiated as appropriate; and

d. Approval for medical devices should include criteria for adequate performance in racialized, minoritized, or otherwise historically excluded groups when feasible.

Citation: CSAPH Rep. 02, A-23

Reprocessing of Single-Use Medical Devices H-480.959
1. Our AMA: (a) supports the Food and Drug Administration (FDA) guidance titled "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals" that was issued on August 2, 2000; (b) supports the development of device-specific standards for the reuse and reprocessing of single-use medical devices involving all appropriate medical and professional organizations and the medical device industry; (c) encourages increased research by the appropriate organizations and federal agencies into the safety and efficacy of reprocessed single-use medical devices; and (d) supports the proper reporting of all medical device failures to the FDA so that surveillance of adverse events can be improved.
2. Our AMA strongly opposes any rules or regulations regarding the repair or refurbishment of medical tools, equipment, and instruments that are not based on objective scientific data.
Citation: CSA Rep. 3, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Appended: Res. 217, I-17; Reaffirmed: Res. 936, I-22

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues;
(15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.
Citation: CSA Rep G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10, Reaffirmed: I-16

Environmental Preservation H-135.972

It is the policy of the AMA to support state society environmental activities by:
(1) identifying areas of concern and encouraging productive research designed to provide authoritative data regarding health risks of environmental pollutants;
(2) encouraging continued efforts by the CSAPH to prepare focused environmental studies, where these studies can be decisive in the public consideration of such problems;
(3) maintaining a global perspective on environmental problems;
(4) considering preparation of public service announcements or other materials appropriate for public/patient education; and
(5) encouraging state and component societies that have not already done so to create environmental committees.
Citation: Res. 52, A-90; Reaffirmed: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
Citation: Res. 924, I-16; Reaffirmed: I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 427
(A-25)

Introduced by: Obesity Medicine Association, American Society for Metabolic and Bariatric Surgery, Endocrine Society, American Association of Clinical Endocrinology

Subject: Elevate Obesity as a Strategic Objective

Referred to: Reference Committee D

Whereas, obesity has been recognized by our American Medical Association as a disease[1]; and

Whereas, the primary drivers of obesity are genetics and environment, and the current American environment is causing obesity rates to spiral out of control; and

Whereas, public perception of obesity is still that it is the fault of the individual. This is akin to blaming a person for developing cancer or heart disease. Just like those diseases, people with obesity deserve evidence-based treatment by a properly trained physician; and

Whereas, without substantial environmental change, obesity threatens to reverse the increases in lifespan we have experienced, and cause extreme financial strain on the healthcare system; and

Whereas, a top strategic objective of our AMA is to improve health outcomes with regards to pre-diabetes and hypertension;[2] and

Whereas, obesity rates continue to skyrocket, and obesity currently affects 42% of Americans, and overweight/pre-obesity (BMI 25 - 29.9) affects 32% of Americans[3], with a prevalence of over 50% projected by 2030[4]; and

Whereas, pediatric obesity is estimated to affect approximately 20% of US youth[5]; and

Whereas, obesity is currently estimated to kill 320,000 Americans and cost 1.72 trillion dollars (9.3% of GDP) per year[6]; and

Whereas, obesity is estimated to decrease lifespan in those aged 20-39 with a BMI of 35 or more by 6.4 to 8 years[7]; and

Whereas, obesity disproportionately affects women and minorities[8,9,10]; and

Whereas, “The prevalence of adult obesity and severe obesity will continue to increase nationwide, with large disparities across states and demographic subgroups;”[11] and

Whereas, obesity rates in children ages 2-19 continue to increase and obesity is currently estimated to affect 19% of children[12]; and

Whereas, in a nationally representative sample of US adults, the prevalence of diabetes increases with increasing weight classes. Nearly one fourth of adults with diabetes have poor glycemic control and nearly half of adults with diabetes have obesity suggesting that weight loss is an important intervention in an effort to reduce the impact of diabetes on the health care system[13]; and

Whereas, the Framingham Heart Study, a famous study for 44 years, estimated that excess body weight (including overweight and obesity), accounted for approximately 26 percent of cases of hypertension in men and 28 percent in women, and for approximately 23 percent of cases of coronary heart disease in men and 15 percent in women[14]; and

Whereas, driven by the increasing obesity rates, the prevalence of diabetes will increase by 54% to more than 54.9 million Americans between 2015 and 2030; annual deaths attributed to diabetes will climb by 38% to 385,800; and total annual medical and societal costs related to diabetes will increase 53% to more than $622 billion by 2030[15]; and

Whereas, treating pre-diabetes and diabetes but without a focus on obesity prevention and treatment will not alter this trajectory; and

Whereas, consistent with the AMA's improving health outcomes strategic plan initiative, "The best solution for turning around the diabetes epidemic is preventing prediabetes and its progression to diabetes in the first place. Achieving such an outcome calls for addressing underlying societal risk factors that can contribute to unhealthy lifestyles, and would require a "population-wide" approach that addresses health promotion, obesity prevention, and creates a physical, cultural, and psychological environment that supports healthy living naturally. This outcome could not be achieved by individual health providers and patients alone, but requires integrated systems of care incentivized for desired health outcomes. It also would require a political will for effective policies and commitment of the public at all levels"[16]; and

Whereas, "Low levels of emotional rapport in primary care visits with patients with overweight and obesity may weaken the patient-physician relationship, diminish patients' adherence to recommendations, and decrease the effectiveness of behavior change counseling," leading to increases in physician burnout[17]; and

Whereas, our AMA is in a position to influence public policies around obesity ranging from public awareness and physician education to public policy around nutrition and insurance coverage of evidence-based obesity prevention and treatment services; and

Whereas, in spite of the numerous policies our AMA has adopted regarding obesity, education remains sparse[18], coverage for evidence-based services remains inconsistent, and current efforts at prevention and treatment remain largely ineffective; and

Whereas, surgical treatment of obesity has been shown to: decrease the risk of cancer death by 52%, decrease cancer risk by 68%, decrease all-cause mortality by 56%, decrease stroke risk by 59%, decrease cardiovascular events by 53%, and decrease heart failure risk by 60%[19]; and

Whereas, medical treatment of obesity has been shown to reduce the risk of recurrent major adverse cardiovascular events by 20%, improve renal function, decrease the risk of metabolic dysfunction associated steatohepatitis, and decrease knee osteoarthritis symptoms[20]; and

Whereas, medical treatment of obesity has advanced significantly in the past 4 years with the introduction of highly effective GLP-1 medications, but exorbitant pricing is creating extraordinary stress for physicians due to skyrocketing patient demand, sparse insurance coverage, arduous prior authorization, drug shortages, an explosion of unregulated compounded versions of the medications, usage of these compounds by non-prescribers at med-spas and online-only operations with virtually no patient support or monitoring resulting in significant patient harm including at least 7 deaths[21]; and

Whereas, an Obesity Caucus, formed in 2015, has been growing and attracting multiple state and specialty societies; and

Whereas, our AMA has a history of success in combating other complicated threats to the health of Americans, including nicotine and opioids; and

Whereas, our AMA Board of Trustees is responsible for setting the strategic direction of the AMA; therefore be it

RESOLVED, that our American Medical Association adopt addressing the public health issue of obesity including prevention and treatment as a strategic objective. (New HOD Policy)

Fiscal Note: $293,127

Received: 3/14/25

REFERENCES

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Relevant AMA Policy:

H-440.842: Recognition of Obesity as a Disease: Our American Medical Association recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 428
(A-25)

Introduced by: Resident and Fellow Section, American College of Physicians, American Academy of Family Physicians, American Association of Public Health Physicians, LGBTQ+ Section, Minority Affairs Section

Subject: Public Health Implications of US Food Subsidies

Referred to: Reference Committee D

Whereas, our American Medical Association is committed to promoting the betterment of public health and has long supported policies that aim to improve dietary and nutritional standards in the United States; and

Whereas, the United States government, through various subsidies, supports the production of certain agricultural commodities, which plays a role in shaping agricultural policy and food systems[1-3]; and

Whereas, US agricultural subsidies have historically favored the production of crops, including corn, soybeans, wheat, and rice, which are often processed into ingredients like high-fructose corn syrup, refined grains, and vegetable oils, commonly used in the production of processed food;[1-3] and

Whereas, overconsumption of processed foods, which are high in added sugar, unhealthy fats and refined carbohydrates, is associated with an increased risk for diabetes, obesity, and other chronic diseases;[1-5] and

Whereas, US agricultural subsidies can affect the relative prices of different foods, making some food less expensive and more accessible, while potentially making others relatively more expensive, which can influence consumer choices, potentially contributing to the consumption of less healthy foods and beverages;[2-5] and

Whereas, the availability and affordability of subsidized foods may influence dietary choices and nutritional intake, particularly among low-income populations, which may contribute to poor dietary quality and negative health outcomes;[2,4,5] and

Whereas, intensive monoculture farming is an agricultural practice supported by subsidies, which has negative environmental consequences including soil degradation, water pollution, and greenhouse gas emissions;[6] and

Whereas, environmental degradation can indirectly impact public health by compromising food and water security, contributing to climate change-related health risks[6]; and

Whereas, while agricultural subsidies are intended to support agricultural production and stabilize food prices, there are unintended consequences on public health, especially when they disproportionately benefit certain crops or food groups, and disproportionately harm low-income populations[6]; and

Whereas, there is a need for a comprehensive review of food subsidies to evaluate their impact on dietary patterns, health disparities, and overall public health, aiming for alignment with nutritional guidelines that promote wellness and disease prevention[6]; therefore be it

RESOLVED, that our American Medical Association study the public health implications of United States Food Subsidies, focusing on: (1) how these subsidies influence the affordability, availability, and consumption of various food types across different demographics; (2) potential for restructuring food subsidies to support the production and consumption of more healthful foods, thereby contributing to better health outcomes and reduced healthcare costs related to diet-related diseases; and (3) avenues to advocate for policies that align food subsidies with the nutritional needs and health of the American public, ensuring that all segments of the population benefit from equitable access to healthful, affordable food. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/25

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RELEVANT AMA POLICY:

The Health Effects of High Fructose Syrup H-150.919
Our AMA: (1) recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS; (2) encourages independent research (including epidemiological studies) on the health effects of HFCS and other added sugars, and evaluation of the mechanism of action and relationship between fructose dose and response; and (3) in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added sugars in their diet. [CSAPH Rep. 8, A-23]

Strategies to Reduce the Consumption of Food and Beverages with Added Sweeteners H-150.927
Our AMA: (1) acknowledges the adverse health impacts of sugar- sweetened beverage (SSB) consumption and food products with added sugars, and support evidence-based strategies to reduce the consumption of SSBs and food products with added sugars, including but not limited to, excise taxes on SSBs and food products with added sugars, removing options to purchase SSBs and food products with added sugars in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption and food products with added sugars, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption and food products with added sugars, such as controlling portion sizes; limiting options to purchase or access SSBs and food products with added sugars in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs and food products with added sugars to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with

healthier beverage and food choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage and food choices for students; (5) recommends that taxes on food and beverage products with added sugars be enacted in such a way that the economic burden is borne by companies and not by individuals and families with limited access to food alternatives; (6) supports that any excise taxes are reinvested in community programs promoting health and (7) will advocate for the end of tax subsidies for advertisements that promote among children the consumption of food and drink of poor nutritional quality, as defined by appropriate nutritional guiding principles. [CSAPH Rep. 03, A-17; Modified: Res. 429, A-22]

Reform the US Farm Bill to Improve US Public Health and Food Sustainability H-150.932
Our AMA supports the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders. [Res. 215, A-13; Reaffirmed: BOT Rep. 09, A-23]

Combating Obesity and Health Disparities H-150.944
Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol. [Res. 413, A-07; Reaffirmation A-12; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 429
(A-25)

Introduced by: Senior Physicians Section

Subject: Addressing the Health Consequences of Microplastics in Humans

Referred to: Reference Committee D

Whereas, microplastics are small plastic particles (less than 5 mm in size) that result from the breakdown of larger plastics and are ubiquitous in the environment, including in water, air, soil, and our food systems[1]; and

Whereas, microplastics have been found in numerous human tissues indicating widespread exposure through ingestion, inhalation, and dermal absorption; and

Whereas, preliminary studies suggest microplastics may have adverse effects on human health, including inflammation, oxidative stress, endocrine disruption, reproductive toxicity and potential carcinogenicity; and

Whereas, vulnerable populations, including children, pregnant individuals, older adults and those with preexisting health conditions, may be disproportionately impacted by microplastic exposure; and

Whereas, current scientific research on the long-term health consequences of microplastics remains limited[2,3]; therefore be it

RESOLVED, that our American Medical Association recognize the potential health risks associated with microplastics exposure and encourage increased research to better understand the human health effects of microplastics (Directive to Take Action); and be it further

RESOLVED, that our AMA support the respective specialty medical societies with subject matter expertise and federal and state public health agencies, including the Centers for Disease Control and Prevention (CDC) and the Environmental Protection Agency (EPA), to develop evidence-based guidelines for monitoring and mitigating microplastic exposure in water, food, air, and other consumer products (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with relevant stakeholders to promote public education about microplastics, their sources, potential health risks, and possible strategies for reducing exposure. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/20/25

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RELEVANT AMA POLICY

H-135.929 Banning Plastic Microbeads in Personal Care Products

Our AMA supports local, state, and federal laws banning the sale and manufacture of personal care products containing plastic microbeads.
[Res. 916, I-15]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 430
(A-25)

Introduced by: Senior Physicians Section

Subject: Addressing the Health Impacts of Ultraprocessed Foods

Referred to: Reference Committee D

Whereas, ultraprocessed foods (UPFs) are industrial formulations of chemically modified substances, typically high in added sugars, unhealthy fats, salt, and artificial additives; and

Whereas, a growing body of evidence links UPF consumption to an increased risk of obesity, cardiovascular disease, diabetes, cancer and mental health disorders[1,2,3]; and

Whereas, UPFs often disproportionately affect vulnerable populations, including low-income communities and people experiencing food insecurity; and

Whereas, public awareness of the health risks associated with UPFs remains limited, and there is a lack of clear labeling and regulatory standards to inform consumer choices; and

Whereas, physicians play a critical role in educating patients about nutrition and advocating for health policies that reduce dietary risks; therefore be it

RESOLVED, that our American Medical Association support and promote public awareness and education about the health risks of ultraprocessed foods and the benefits of minimally processed and unprocessed foods (Directive to Take Action); and be it further

RESOLVED, that our AMA support federal, state, and local policies that promote and incentivize the production and distribution of healthier, affordable, minimally-processed and unprocessed foods (New HOD Policy); and be it further

RESOLVED, that our AMA encourage the integration of nutrition education into all levels of medical education to empower clinicians to best counsel patients efficiently and effectively on reducing UPF consumption (New HOD Policy); and be it further

RESOLVED, that our AMA support increased funding to the FDA for research into the health impacts of ultraprocessed foods and strategies to mitigate their risks. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/20/25

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RELEVANT AMA POLICY

H-150.927 Strategies to Reduce the Consumption of Food and Beverages with Added Sweeteners
1. Our American Medical Association acknowledges the adverse health impacts of sugar- sweetened beverage (SSB) consumption and food products with added sugars, and support evidence based strategies to reduce the consumption of SSBs and food products with added sugars, including but not limited to, excise taxes on SSBs and food products with added sugars, removing options to purchase SSBs and food products with added sugars in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption and food products with added sugars, and the use of
plain packaging.
2. Our AMA encourages continued research into strategies that may be effective in limiting SSB consumption and food products with added sugars, such as controlling portion sizes; limiting options to purchase or access SSBs and food products with added sugars in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs and food products with added sugars to children; and changes to the agricultural subsidies system.
3. Our AMA encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price.
4. Our AMA encourages physicians to
    a. counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with healthier beverage and food choices, as recommended by professional society clinical guidelines.
    b. work with local school districts to promote healthy beverage and food choices for students.
5. Our AMA recommends that taxes on food and beverage products with added sugars be enacted in such a way that the economic burden is borne by companies and not by individuals and families with limited access to food alternatives.
6. Our AMA supports that any excise taxes are reinvested in community programs promoting health.
7. Our AMA will advocate for the end of tax subsidies for advertisements that promote among children the consumption of food and drink of poor nutritional quality, as defined by appropriate nutritional guiding principles.
[CSAPH Rep. 03, A-17; Modified: Res. 429, A-22]

H-150.929 Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake
1. Our American Medical Association calls for a step-wise, minimum 50% reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade.
2. Our AMA urges the FDA to publish future editions of their voluntary targets expeditiously to make further progress on sodium reduction.
3. Our AMA supports federal, state, and local efforts to set robust targets for reducing sodium levels in school meals, meals in health care facilities, and other meals provided by daily meal providers.
4. Our AMA will advocate for federal, state, and local efforts to reduce sodium levels in products from food manufacturers and restaurants to the greatest extent possible, without increasing levels of other unhealthy ingredients, such as added sugars or artificial ingredients.
5. Our AMA supports federal, state, and local efforts to require front-of-package warning labels for foods that are high in sodium based on the established recommended daily value.
6. Our AMA will assist in achieving the Healthy People 2030 goal for sodium consumption, by will working with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, Academy of Nutrition and Dietetics, and other interested partners to educate consumers about the benefits of reductions in sodium intake and other dietary approaches to

reduce hypertension.
7. Our AMA supports the continuing education of physicians and other members of the health care team on counseling patients on lifestyle modification strategies to manage blood pressure, advocating for culturally relevant dietary models that reduce sodium intake.
8. Our AMA recommends that the FDA consider all options to promote reductions in the sodium content of processed foods.
9. Our AMA supports further study and evaluation of national salt reduction programs to determine the viability, industry engagement, and health and economic benefits of such programs.
10. Our AMA supports federal, state, and local efforts to regulate advertising of foods and products high in sodium, especially advertising targeted to children.
[CSAPH Rep. 01, A-16; Modified: CSAPH Rep. 04, I-24]

H-150.939 Accurate Reporting of Fats on Nutritional Labels
Our AMA urges the Food and Drug Administration to require the use of more precise processes to measure the fat content in foods, particularly trans fats and saturated fats, and to require that the most accurate fat content information based on these processes be included on food labels.
[Res. 412, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

D-150.974 Support for Nutrition Label Revision and FDA Review of Added Sugars
1. Our AMA will issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period.
2. Our AMA will recommend that the FDA further establish a recommended daily value (%DV) for the new added sugars listing on the revised nutrition labels based on previous recommendations from the WHO and AHA).
3. Our AMA will encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans.
4. Our AMA encourages the FDA to: (a) develop front-of-package warning labels for foods that are high in added sugars based on the established recommended daily value; and (b) limit the amount of added sugars permitted in a food product containing front-of-package health or nutrient content claims.
[Res. 422, A-14; Res. 903, I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 431
(A-25)

Introduced by: Women Physicians Section

Subject: Alcohol & Breast Cancer Risk

Referred to: Reference Committee D

Whereas, the largest burden of alcohol-related cancer as well as cancer-related deaths in the U.S. is breast cancer[1]; and

Whereas, for cancers like breast, mouth, and throat, the risk increases with one or less drinks per day[1]; and

Whereas, women who drink three alcoholic drinks per week are 15% more likely to develop breast cancer than those that do not[2]; and

Whereas, analysis of a CDC survey from 2020 demonstrated that only one in four women were aware that alcohol is a risk factor for breast cancer[2]; and

Whereas, organizations including the American Society of Clinical Oncology released statements detailing the importance of alcohol control strategies to comprehensive cancer treatment plans[3]; and

Whereas, “pinkwashing”, a marketing strategy used by companies to display superficial promotion of a cause despite the organization often contributing to the issue, has been a marketing technique for alcoholic beverages[4]; therefore be it

RESOLVED, that our American Medical Association work with relevant parties to (1) promote public education about the risks between alcohol use and cancer, especially breast cancer; and (2) educate clinicians regarding the influence of alcohol use and breast cancer as well as other cancer risks and treatment complications (Directive to Take Action); and be it further

RESOLVED, that our AMA supports evidence-based efforts to prevent excessive alcohol use, including eliminating the use of “pinkwashing” to market alcohol products and supporting warning labels on the ingredients and products. (New HOD Policy)

Fiscal Note: $70,454

Date Received: 04/21/2025

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RELEVANT AMA POLICY

Alcohol Consumption and Health H-30.934
Our AMA recognizes that alcohol consumption at any level, not just heavy alcohol use or addictive alcohol use, is a modifiable risk factor for cancer.
[Res. 516, A-19]

Setting Domestic and International Public Health Prevention Targets for Per Capita Alcohol Consumption as a Means of Reducing the Burden on Non-Communicable Diseases on Health Status H-30.937
Our AMA will: (1) continue to address the role of alcohol use on health status and the impact of behaviorally-associated chronic illnesses (including obesity, diabetes, heart disease, chronic respiratory diseases, and many cancers) on the overall burden of disease and the costs of health care services in America; (2) encourage federal health services planning agencies and public health authorities to address the role of alcohol and tobacco consumption on health and to promote environmental interventions including evidence based tobacco control and alcohol control policies to improve the health status of Americans; and (3) encourage the World Health Organization to continue its work on the impact of Non Communicable Diseases (NCDs) on health status and to include targets for reduced per capita alcohol consumption among its major proposed interventions in developed and developing nations to reduce the incidence of, prevalence of, and rates of disability and premature deaths attributable to chronic non-communicable diseases.
[Res. 413, A-12 Reaffirmation: A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 432
(A-25)

Introduced by: Women Physicians Section

Subject: Support for Long-Term Sequelae of Pregnancy

Referred to: Reference Committee D

Whereas, ACOG defines the postpartum period as the 6 weeks immediately following childbirth when the body is recovering from pregnancy and delivery[1]; and

Whereas, the American Rescue Plan Act of 2021 introduced the option for states to expand coverage of postpartum care reimbursable by Medicaid and Children's Health Insurance Program (CHIP) up to 12 months[2]; and

Whereas, previous society recommendations for a postpartum visit within 6-weeks has been updated to reflect the need for postpartum care to be an ongoing process[1]; and

Whereas, definitions of the postpartum period neglect that more than one-third of women experience long-term sequelae from pregnancy[3]; and

Whereas, many complications of pregnancy are associated with an increased risk of cardiovascular disease long after delivery[4]; and

Whereas, gestational diabetes, which affects 5-9% of U.S. pregnancies, is associated with a 50% increased risk of diabetes mellitus type 2 later in life[4]; and

Whereas, pregnancy-related pelvic girdle pain can persist long after pregnancy and delivery, causing severe disability[5]; and

Whereas, vaginal delivery is a known risk factor for pelvic floor dysfunction and persistent urinary incontinence[6], with the prevalence of symptomatic pelvic floor dysfunction projected to be 43.8 million by 2025[7,8]; and

Whereas, women suffering from urinary incontinence suffer a high cost-burden for management and treatment, spending upwards of $10,000 in the 2-year post-index period with higher costs associated for women on Medicaid[9,10]; and

Whereas, experiencing a stillbirth is associated with clear long-term psychological impacts including depression, post-traumatic stress disorder, anxiety[11]; and

Whereas, despite the high prevalence of stillbirths, the financial impact of these significant events to individuals and the healthcare system is not well-understood[11]; and

Whereas, supportive bereavement services are a helpful option for families navigating loss from stillbirths[12]; and

Whereas, post-traumatic stress disorder is well-documented in women after childbirth, however it is understudied and lacks adequate longitudinal mental health support[13,14]; and

Whereas, there are gaps in provider knowledge of long-term sequelae of pregnancy including gestational weight gain guidelines[15] and of increased cardiovascular risk following a hypertensive disorder of pregnancy[16]; and

Whereas, there are gaps in patient knowledge of risk and/or management long-term sequelae of pregnancy including cardiovascular risk[16], pelvic floor disorders[17], and type 2 diabetes mellitus[18]; and

Whereas, there is a lack of research on the effectiveness of postpartum education[19]; therefore be it

RESOLVED, that our American Medical Association will work with relevant parties to support research on the long-term sequelae of pregnancy, their development, and possible treatments, including reducing disparities in maternal health outcomes (Directive to Take Action); and be it further

RESOLVED, that our AMA will support further insurance coverage of treatments for conditions related to long-term sequelae of pregnancy (New HOD Policy); and be it further

RESOLVED, that our AMA will support appropriate organizations working to improve awareness and education among patients, families, and clinicians of the risks of long-term sequelae of pregnancy. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 04/21/2025

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RELEVANT AMA POLICY

Improving Mental Health Services During Pregnancy and Postpartum H-420.953

1. Our American Medical Association will support improvements in current mental health services during pregnancy and postpartum periods.
2. Our AMA will support advocacy for inclusive insurance coverage of and sufficient payment for mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum.
3. Our AMA will support appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum.
4. Our AMA will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs.
5. Our AMA will advocate for evidence-based postpartum depression screening and prevention services to be recognized as the standard of care for all federally-funded health care programs for persons who are pregnant or in a postpartum state.

[Res. 102, A-12 Modified: Res. 503, A-17 Modified: 227, A-23 Modified: Speakers Rep. 02, I-24]

Reducing Inequities and Improving Access to Insurance for Maternal Health Care H-185.917

3. Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.

8. Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.

9. Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.

[Joint CMS/CSAPH Rep. 1, I-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 433
(A-25)

Introduced by: Women Physicians Section

Subject: Clinical Lactation Care

Referred to: Reference Committee D

Whereas, research shows breastfeeding is associated with significant risk reduction of short-term and long-term illnesses and diseases compared to infant formula feeding[1]; and

Whereas, the American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for approximately 6 months after birth with continued breastfeeding, along with appropriate complementary foods introduced at about 6 months, as long as mutually desired by mother and child for 2 years or beyond[2]; and

Whereas, nationally 83% of mothers/infant dyads leave the hospital breastfeeding, but only 25% meet the AAP six-month recommendation[3], and the racial disparities are stark[4]; and

Whereas, within the first several weeks after hospital discharge many mother/baby dyads experience breastfeeding difficulty[5]; and

Whereas, mother's own milk is particularly important for premature and other critically ill NICU infants, yet physiologically it can be very difficult for those separated mothers to produce and pump an adequate milk supply[6]; and

Whereas, clinical assessment and determination of lactation and breastfeeding issues can take more than an hour of a clinician's time and encounters often require specialized knowledge for the provision of risk-appropriate and safe clinical care[7]; and

Whereas, currently there is a confusing array of lactation personnel with more than 20 "credentials" that often represent only 2-5 days of abbreviated general breastfeeding education[8]; and

Whereas, without a state license, anyone can call themselves a "lactation consultant" –with or without the requisite education, training, and verified competency; and

Whereas, physicians risk liability for referrals for clinical patient care to anyone who does not have a state license to perform this clinical work[9]; and

Whereas, without licensure of clinical lactation care personnel, there is no state oversight of their work and nationally there have been reports of patient harm[10]; and

Whereas, the Federation of State Medical Boards states:
All discussions about changes in scope of practice should begin with a basic understanding of the definition of the practice of medicine and recognition that the education received by physicians differs in scope and duration from other health care professionals. Non-physician

practitioners may seek authorization to provide services that are included in the definition of the practice of medicine under existing state law[11]; and

Whereas, the American College of Obstetricians and Gynecologists, in their 2021 Committee Opinion, states: "Lactation consultants should be accessible to parents in the hospital and after the parent goes home. Although the Patient Protection and Affordable Care Act (ACA) covers breastfeeding support without cost sharing, this practice has yet to be fully implemented in most communities because of state licensure or insurance issues, or both"[12]; therefore be it

RESOLVED, that our American Medical Association recognizes the importance of clinical lactation care provided by qualified clinicians and clinical professionals. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 04/21/2025

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RELEVANT AMA POLICY

AMA Support for Breastfeeding H-245.982
1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.
2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.
3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.
4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).
5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines.
[CSA Rep. 2, A05 Res. 325, A-05 Reaffirmation A-07 Reaffirmation A-12 Modified in lieu of Res. 409, A-12 and Res. 410, A-12 Appended: Res. 410, A-16 Appended: Res. 906, I-17 Reaffirmation: I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 434
(A-25)

Introduced by: Medical Society of the District of Columbia

Subject: Breast Cancer Risk Reduction

Referred to: Reference Committee D

Whereas, the National Cancer Institute reports that one in eight women born in the U.S. today will develop breast cancer, and, according to the Centers for Disease Control and Prevention, Black women have a disproportionately high breast cancer death rate; and

Whereas, the National Cancer Institute, Centers for Disease Control and Prevention, American Institute for Cancer Research, and other authorities have determined that individuals may reduce their risk of breast cancer incidence and/or mortality by maintenance of a healthy body weight, limiting alcohol intake, and having regular physical activity, among other steps; and

Whereas, the Dietary Guidelines Advisory Committee reported on December 20, 2024, that dietary patterns characterized by higher intakes of vegetables, fruits, legumes and nuts, and whole grains and lower intakes of red and processed meats, refined grains, and sugar-sweetened foods and beverages are associated with lower risk of postmenopausal breast cancer; and

Whereas, a robust body of evidence has shown that consumption of vegetables, fruits, and soy products is associated with reduced risk of post-menopausal breast cancer; and

Whereas, meta-analyses of prospective studies show that increases in dietary fiber intake are associated with a significant reductions in breast cancer risk, and, confirming the results of observational studies, an intervention diet emphasizing plant-based foods, such as vegetables, fruits, legumes, and whole grains, along with olive oil or nuts, was shown in the randomized, controlled PREDIMED study, including 4,282 women, to lead to a 51% reduction in breast cancer incidence (95% CI, 0.24-0.98), compared with an unmodified diet; and

Whereas, cancer organizations have expressed concern about a persistent lack of knowledge among the general public about preventive measures; and

Whereas, a poll of 2,017 US women conducted by Morning Consult between July 25 and 28, 2024, showed that only 28% of respondents were aware of any dietary factors associated with reduced risk of developing breast cancer; and

Whereas, when asked in the Morning Consult poll about soy products specifically, nearly as many women mistakenly believed that soy products were associated with increased breast cancer risk as women who knew that soy products were associated with reduced risk; and

Whereas, our American Medical Association currently has policy statements regarding breast cancer detection and treatment, but not regarding steps that individuals can take to reduce their risk of developing breast cancer; and

Whereas, regarding lung cancer prevention, our AMA currently has highly specific policy statements encouraging doctors to address with patients the risks of smoking (H490.917) and encouraging measures to decrease radon exposures if appropriate, but placing them in proper perspective, because smoking is a substantially more significant cause of lung cancer (H455.984), yet AMA policy provides no guidance regarding breast cancer risk reduction; and

Whereas, nutrition is a key aspect of cancer care, as noted by the American Cancer Society Nutrition and Physical Activity Guideline for Cancer Survivors and guidelines from the National Comprehensive Cancer Network and the American Society for Clinical Oncology, which highlight plant-based dietary patterns; and

Whereas, individuals at risk for breast cancer have a right to decide for themselves which preventive steps they wish to implement, and can do so only if they are aware of possible options; and

Whereas, physicians can play a key role in educating patients and their families about means for cancer risk reduction; therefore be it

RESOLVED, that our American Medical Association supports efforts to educate the public about the benefits of lifestyle changes that may reduce breast cancer risk, including regular physical activity, maintenance of a healthy body weight, a healthy plant-based diet, and limiting alcohol intake (New HOD Policy); and be it further

RESOLVED, that our AMA encourages physicians to regularly discuss with their individual patients the benefits of lifestyle changes that may reduce cancer risk; and be it further. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 3/7/25

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RELEVANT AMA POLICY

Screening and Treatment for Breast and Cervical Cancer Risk Reduction H-55.971
1. Our AMA supports programs to screen all at-risk individuals for breast and cervical cancer and that government funded programs be available for low income indivduals; the development of public information and educational programs with the goal of informing all at-risk individuals about routine cancer screening in order to reduce their risk of dying from cancer; and increased funding for comprehensive programs to screen low income individuals for breast and cervical cancer and to assure access to definitive treatment.
2. Our AMA encourages state and local medical societies to monitor local public health screening programs to ensure that they are linked to treatment resources in the public or private sector.
3. Our AMA encourages the Centers for Medicare and Medicaid Services to evaluate and review their current cervical cancer screening policies to ensure coverage is consistent with current evidence-based guidelines.
4. That our AMA support further research by relevant parties of HPV self-sampling in the United States to determine whether it can decrease health care disparities in cervical cancer screening.

Breast Density Notification H-525.977
1. Our AMA supports the inclusion of breast tissue density information in the mammography report when appropriate and education of patients about the clinical relevance of such information, but opposes state requirements for mandatory notification of breast tissue density to patients.
2. Our AMA encourages research on the benefits and harms of adjunctive screening for breast cancer for women identified to have dense breasts on an otherwise negative screening mammogram, in order to guide appropriate and evidence-based care and insurance coverage of the service.
3. Our AMA supports insurance coverage for and adequate access to supplemental screening recommended for patients with “dense breast” tissue following a discussion between the patient and their physician which integrates secondary risk characteristics.

Mammography Screening for Breast Cancer D-525.998
In order to assure timely access to breast cancer screening for all women, our AMA shall advocate for legislation that ensures adequate funding for mammography services.

Screening Mammography H-525.993
Our AMA:
a. recognizes the mortality reduction benefit of screening mammography and supports its use as a tool to detect breast cancer.
b. recognizes that as with all medical screening procedures there are small, but not inconsequential associated risks including false positive and false negative results and overdiagnosis.
c. favors participation in and support of the efforts of professional, voluntary, and government organizations to educate physicians and the public regarding the value of screening mammography in

reducing breast cancer mortality, as well as its limitations.
d. advocates remaining alert to new epidemiological findings regarding screening mammography and encourages the periodic reconsideration of these recommendations as more epidemiological data become available.
e. believes that beginning at the age of 40 years, all women should be eligible for screening mammography.
f. encourages physicians to regularly discuss with their individual patients the benefits and risks of screening mammography, and whether screening is appropriate for each clinical situation given that the balance of benefits and risks will be viewed differently by each patient.
g. encourages physicians to inquire about and update each patient's family history to detect red flags for hereditary cancer and to consider other risk factors for breast cancer, so that recommendations for screening will be appropriate.
h. supports insurance coverage for screening mammography.
i. supports seeking common recommendations with other organizations, informed and respectful dialogue as guideline-making groups address the similarities and differences among their respective recommendations, and adherence to standards that ensure guidelines are unbiased, valid and trustworthy.
j. reiterates its longstanding position that all medical care decisions should occur only after thoughtful deliberation between patients and physicians.

Male Breast Cancer H-55.977
Our AMA:
1. recognizes that breast cancer is a condition that affects males as well as females;
2. recognizes that men who carry a known BRCA mutation, have a strong family history of cancer (especially male breast cancer), have a personal history of breast cancer, or have an altered estrogen-testosterone ratio are at increased risk of developing male breast cancer;
3. supports the utilization of heightened surveillance methods when indicated, and consideration of genetic testing when appropriate, in men who are at increased risk of developing breast cancer;
4. supports physician and patient education about the risks, signs, and symptoms of male breast cancer, and genetic consultation for males at increased risk and for their family members; and
5. supports Medicare and insurance coverage for male breast cancer surveillance and diagnostic methods, including clinical breast examination, mammography, genetic consultation, and genetic testing, when indicated.

Setting Domestic and International Public Health Prevention Targets for Per Capita Alcohol Consumption as a Means of Reducing the Burden on Non-Communicable Diseases on Health Status H-30.937
Our AMA will: (1) continue to address the role of alcohol use on health status and the impact of behaviorally-associated chronic illnesses (including obesity, diabetes, heart disease, chronic respiratory diseases, and many cancers) on the overall burden of disease and the costs of health care services in America; (2) encourage federal health services planning agencies and public health authorities to address the role of alcohol and tobacco consumption on health and to promote environmental interventions including evidence based tobacco control and alcohol control policies to improve the health status of Americans; and (3) encourage the World Health Organization to continue its work on the impact of Non Communicable Diseases (NCDs) on health status and to include targets for reduced per capita alcohol consumption among its major proposed interventions in developed and developing nations to reduce the incidence of, prevalence of, and rates of disability and premature deaths attributable to chronic non-communicable diseases.

Physician Responsibilities for Tobacco Cessation H-490.917
Cigarette smoking is a major health hazard and a preventable factor in physicians' actions to maintain the health of the public and reduce the high cost of health care. Our AMA takes a strong stand against smoking and favors aggressively pursuing all avenues of educating the general public on the hazards of using tobacco products and the continuing high costs of this serious but preventable problem. Additionally, our AMA supports and advocates for appropriate surveillance approaches to measure changes in tobacco consumption, changes in tobacco-related morbidity and mortality, youth uptake of tobacco use, and use of alternative nicotine delivery systems. In view of the continuing and urgent need to assist individuals in smoking cessation, physicians, through their professional associations, should assume a leadership role in establishing national policy on this topic and assume the primary task of educating the public and their patients about the danger of tobacco use (especially cigarette smoking). Accordingly, our AMA:
(1) encourages physicians to refrain from engaging directly in the commercial production or sale of tobacco products;

(2) supports (a) development of an anti-smoking package program for medical societies; (b) making patient educational and motivational materials and programs on smoking cessation available to physicians; and (c) development and promotion of a consumer health-awareness smoking cessation kit for all segments of society, but especially for youth;

(3) encourages physicians to use practice guidelines for the treatment of patients with nicotine dependence and will cooperate with the Agency for Health Research and Quality (AHRQ) in disseminating and implementing evidence-based clinical practice guidelines on smoking cessation, and on other matters related to tobacco and health;

(4) (a) encourages physicians to use smoking cessation activities in their practices including (i) quitting smoking and urging their colleagues to quit; (ii) inquiring of all patients at every visit about their smoking habits (and their use of smokeless tobacco as well); (iii) at every visit, counseling those who smoke to quit smoking and eliminate the use of tobacco in all forms; (iv) prohibiting all smoking in the office by patients, physicians, and office staff; and discouraging smoking in hospitals where they work (v) providing smoking cessation pamphlets in the waiting room; (vi) becoming aware of smoking cessation programs in the community and of their success rates and, where possible, referring patients to those programs; (b) supports the concept of smoking cessation programs for hospital inpatients conducted by appropriately trained personnel under the supervision of a physician;

(5) (a) supports efforts to identify gaps, if any, in existing materials and programs designed to train physicians and medical students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (b) supports the production of materials and programs which would fill gaps, if any, in materials and programs to train physicians and medical students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (c) supports national, state, and local efforts to help physicians and medical students develop skills necessary to counsel patients to quit smoking; (d) encourages state and county medical societies to sponsor, support, and promote efforts that will help physicians and medical students more effectively counsel patients to stop smoking; (e) encourages physicians to participate in education programs to enhance their ability to help patients quit smoking; (f) encourages physicians to speak to community groups about tobacco use and its consequences; and (g) supports providing assistance in the promulgation of information on the effectiveness of smoking cessation programs;

(6) (a) supports the concept that physician offices, clinics, hospitals, health departments, health plans, and voluntary health associations should become primary sites for education of the public about the harmful effects of tobacco and encourages physicians and other health care workers to introduce and support healthy lifestyle practices as the core of preventive programs in these sites; and (b) encourages the development of smoking cessation programs implemented jointly by the local medical society, health department, and pharmacists; and
(7) (a) believes that collaborative approaches to tobacco treatment across all points of contact within the medical system will maximize opportunities to address tobacco use among all of our patients, and the likelihood for successful intervention; and (b) supports efforts by any appropriately licensed health care professional to identify and treat tobacco dependence in any individual, in the various clinical contexts in

which they are encountered, recognizing that care provided in one context needs to take into account other potential sources of treatment for tobacco use and dependence.

Health Effects of Radon Exposure H-455.984
It is the policy of the AMA: (1) to continue its surveillance of the growing understanding of the health risks of exposure to radon and contribute to this understanding wherever possible;

(2) that physicians continue to increase their knowledge about radon and its health effects and advise patients and the public in their communities on how to make intelligent decisions and take responsible actions on this issue;

(3) that physicians, when discussing the prevention of lung cancer, place greatest emphasis on the need to stop smoking; measures to decrease radon exposures should be encouraged if appropriate, but be placed in proper perspective, because smoking is a substantially more significant cause of lung cancer;

(4) to emphasize the need for more definitive data concerning the magnitude of the lung cancer risk from radon exposure and encourage the generation of these data as a needed public health measure; and

(5) to continue its efforts to help physicians understand the health risks associated with radon exposure and communicate this understanding to patients and the public.

Reference Committee E

Report(s) of the Council on Science and Public Health

01 Council on Science and Public Health Sunset Review of 2015 House Policies
05 Screening for Image Manipulation in Research Publications
08 Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms
09 Rare Disease Advisory Councils

Resolutions

501 Safer Button / Coin Batteries
502 NIH Grant Funding for Medical Research
503 Safeguarding Neural Data Collected by Neurotechnologies
504 Physician Performed Microscopy Designation for Synovial Fluid Crystal Exam: Modify the Clinical Laboratory Amendment of 1988
505 Mandating Properly Fitting Lead Aprons in Hospitals
506 Opposing the use of harm reduction items as evidence of commercial sex work
507 Clinical and Public Safety Implications of AI-Generated Content and Symbolic Compliance Infrastructure
508 Standardizing Safety Requirements for Traditional and Rideshare-Based Non-Emergency Medical Transportation
509 Allergen Labeling for Spices and Herbs
510 Improving Cybersecurity Standards for Healthcare Entities
511 Increased Transparency Among Psychotropic Drug Administration in Prisons
512 Preventing Drug-Facilitated Sexual Assault in Drinking Establishments
513 Transparency on Comparative Effectiveness in Direct-to-Consumer Advertising
514 Support for a Nicotine Free Generation
515 Nitrous Oxide Abuse
516 Creating a Registry of Potential Side Effects of GIP & GLP-1 Medications
517 In Support of a National Drug Checking Registry
518 Mandatory Accreditation and Regular Inspections of Hyperbaric Chambers
519 Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making
520 Study of Grading Systems in AMA Board Reports
521 Warning labels on OTC sleep aids
522 Access to Important and Essential Drugs

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-A-25

Subject:	Council on Science and Public Health Sunset Review of 2015 House Policies
Presented by:	John T. Carlo, MD, MS, Chair
Referred to:	Reference Committee E

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. This policy reads as follows, laying out the parameters for review and specifying the needed procedures:

1. As the House of Delegates adopts policies, a maximum 10-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
6. Sunset policies will be retained in the AMA historical archives.

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RECOMMENDATION

The Council on Science and Public Health recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: $1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-100.998	Combating Antibiotic Resistance Via Physician Action and Education: AMA Activities	Our AMA will continue to collaborate with the appropriate federal agencies, other medical specialty societies, and other appropriate public health organizations to address the urgent problem of increasing antimicrobial resistance and its impact on public health.	Retain, still relevant.
D-120.953	Treatment of Opioid Dependence	Our AMA will work to end the limitation of 100 patients per certified physician treating opioid dependence after the second year of treatment as currently mandated by the Drug Addiction Treatment Act.	Rescind. This requirement has been removed with the removal of the X-Waiver requirement.
D-120.975	Preserving Patients? Ability to Have Legally Valid Prescriptions Filed	Our AMA will: (1) work with state medical societies to support legislation to protect patients? ability to have legally valid prescriptions filled; (2) enter into discussions with relevant associations (including but not limited to the American Hospital Association, American Pharmacists Association, American Society of Health System Pharmacists, National Association of Chain Drug Stores, and National Community Pharmacists Association) to guarantee that, if an individual pharmacist exercises a conscientious refusal to dispense a legal prescription, a patient's right to obtain legal prescriptions will be protected by immediate referral to an appropriate dispensing pharmacy; and (3) in the absence of all other remedies, work with state medical societies to adopt state legislation that will allow physicians to dispense medication to their own patients when there is no pharmacist within a thirty-mile radius who is able and willing to dispense that medication.	Retain as amended. **Preserving Patients'~~?~~ Ability to Have Legally Valid Prescriptions Filled** Our AMA will: (1) work with state medical societies to support legislation to protect patients'~~?~~ ability to have legally valid prescriptions filled; (2) ~~enter into discussions~~ work with relevant associations (including but not limited to the American Hospital Association, American Pharmacists Association, American Society of Health System Pharmacists, National Association of Chain Drug Stores, and National Community Pharmacists Association) to guarantee that, if an individual pharmacist exercises a conscientious refusal to dispense a legal prescription, a patient's right to obtain legal prescriptions will be protected by immediate referral to an appropriate dispensing pharmacy; and (3) in the absence of all other remedies, work with state medical societies to adopt state legislation that will allow physicians to dispense

			medication to their own patients when there is no pharmacist within a thirty-mile radius who is able and willing to dispense that medication.
D-120.979	DEA Regulations and the Ability of Physicians to Prescribe Controlled Medication Rationally, Safely, and Without Undue Threat of Prosecution	Our AMA supports ongoing constructive dialogue between the DEA and clinicians, including physicians, regarding a proper balance between the needs of patients for treatment and the needs of the government to provide oversight and regulation to minimize risks to public health and safety.	Retain, convert to H-policy.
D-130.966	Domestic Disaster Relief Funding	1. Our American Medical Association lobby Congress to a) reassess its policy for expedited release of funding to disaster areas; b) define areas of disaster with disproportionate indirect and direct consequences of disaster as "public health emergencies"; and c) explore a separate, less bureaucratic process for providing funding and resources to these areas in an effort to reduce morbidity and mortality post-disaster. 2. Our AMA will lobby actively for the recommendations outlined in the AMA/APHA Linkages Leadership Summit including: a) appropriate funding and protection of public health and health care systems as critical infrastructures for responding to day-to-day emergencies and mass causality events; b) full integration and interoperable public health and health care disaster preparedness and response systems at all government levels; c) adequate legal protection in a disaster for public health and healthcare responders and d) incorporation of disaster preparedness and response competency-based education and training in undergraduate, graduate, post-graduate, and continuing education programs.	Retain as amended to remove outdated language (i.e. there is now a statutory definition of "public health emergency" that is not aligned to this recommendation) and references (AMA/APHA Linkages Leadership Summit) and convert to an H-policy. 1. Our American Medical Association lobby Congress to ~~a)~~ reassess its policy for expedited release of funding to disaster areas as well as a~~; b) define areas of disaster with disproportionate indirect and direct consequences of disaster as "public health emergencies"; and c) explore a separate,~~ less bureaucratic process for providing funding and resources to these areas in an effort to reduce morbidity and mortality post-disaster. 2. Our AMA will lobby actively for ~~the recommendations outlined in the AMA/APHA Linkages Leadership Summit including~~: a) appropriate funding and protection of public health and health care systems as critical infrastructures for responding to day-to-day emergencies and mass causality events; b) full integration and interoperable public health and health care disaster preparedness and response systems at all

			government levels; c) adequate legal protection in a disaster for public health and healthcare responders and d) incorporation of disaster preparedness and response competency-based education and training in undergraduate, graduate, post-graduate, and continuing education programs.
D-130.972	All Hazards Disaster Preparedness and Response	Our AMA will work with: (1) subject matter experts at the national level to quickly produce a provider manual on state licensure and medical liability coverage for physicians during disasters; (2) appropriate medical, public health, disaster response and relief organizations to improve plans, protocols, and policies regarding the provision of health care in mass evacuation shelters; and (3) appropriate state and local organizations to develop templates for private practice/office continuity plans in CD-ROM or web-based format that can be stored in state medical association offices on a server in the event of a disaster.	Retain as amended to reflect completed directives and convert to an H-policy. Our AMA encourages ~~will work with: (1) subject matter experts at the national level to quickly produce the creation of a provider manual on state licensure and medical liability coverage for physicians during disasters; (2)~~ appropriate medical, public health, disaster response and relief organizations to improve plans, protocols, and policies regarding the provision of health care in mass evacuation shelters ~~and (3) appropriate state and local organizations to develop templates for private practice/office continuity plans in CD-ROM or web-based a format that can be stored in state medical association offices on a server in the event of a disaster~~.
D-135.971	Evaluation of Canadian Underground Nuclear Waste Repository	Our American Medical Association, along with state and county medical societies, will urge Congress, the President, and the Secretary of State to invoke the participation of the International Joint Commission to evaluate the proposed underground nuclear waste repository in Ontario, Canada, and similar facilities.	Retain, still relevant.
D-135.972	Support Reduction of Carbon Dioxide Emissions	Our AMA will (1) inform the President of the United States, the Administrator of the Environmental Protection Agency (EPA), and Congress that our American Medical Association supports the Administration's efforts to limit carbon dioxide emissions from power plants to protect public health; and (2) working with state medical societies, encourage state governors to support and comply with	Retain as amended to rescind the directive that has been accomplished and convert to an H-policy. Our AMA ~~will (1) inform the President of the United States, the Administrator of the~~

		EPA regulations designed to limit carbon dioxide emissions from coal fired power plants.	~~Environmental Protection Agency (EPA), and Congress that our American Medical Association~~ support ~~the Administration's~~ efforts to limit carbon dioxide emissions from power plants to protect public health; and (2) ~~working with~~ in collaboration with state medical societies, encourages state governors to support and comply with EPA regulations designed to limit carbon dioxide emissions from coal fired power plants.
D-145.996	Preventing Firearm-Related Injury and Morbidity in Youth	Our American Medical Association will identify and support the distribution of firearm safety materials that are appropriate for the clinical setting.	Retain, still relevant.
D-170.994	School Health Mentoring Program	Our AMA (1) encourages the Centers for Disease Control and Prevention (CDC) and other appropriate federal agencies to support the development of school health mentoring programs for allopathic and osteopathic volunteer physicians to work with teachers to educate children in grades K through 4 on the importance of good health habits; and (2) will work in collaboration with the Federation to lobby the US Congress for funds to teach early childhood health education in schools.	Retain, still relevant.
D-30.995	Increasing Taxes on Alcoholic Beverages	Our AMA will: (1) support increases in federal taxes on beer, wine, and liquor, with a substantial portion of the new revenues to be earmarked to the prevention of alcohol abuse and drunken driving, treatment of persons with alcohol use disorders or at-risk drinking patterns, and public health and medical programs that serve vulnerable populations; (2) encourage state and local increases in taxes on beer, wine, and liquor, with a substantial portion of the new revenues to be earmarked to the purposes noted above; (3) support, to the extent possible, state and local efforts to increase taxes on beer, wine, and liquor; (4) collaborate with other national organizations with an interest in this subject, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, Mothers Against Drunk Driving, and the AMA Alliance; and (5) when state legislative efforts to increase alcohol taxes are stymied, encourage state medical societies to give consideration to the use of ballot initiatives in the states that allow such initiatives.	Retain as amended to update language and convert to an H-policy. Our AMA ~~will~~: (1) supports increases in federal taxes on beer, wine, and liquor, with a substantial portion of the new revenues to be earmarked to the prevention of alcohol misuse ~~abuse~~ and ~~drunken~~ driving while intoxicated, treatment of persons with alcohol use disorders or at-risk drinking patterns, and public health and medical programs that serve vulnerable populations; (2) encourages state and local increases in taxes on beer, wine, and liquor, with a substantial portion of the new revenues to be earmarked to the purposes noted above; (3) supports, to the extent possible, state and local efforts to increase taxes on beer, wine, and liquor; (4)

			supports collaboration ~~collaborate~~ with other national organizations with an interest in this subject, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, Mothers Against Drunk Driving, and the AMA Alliance; and (5) when state legislative efforts to increase alcohol taxes are stymied, encourages state medical societies to give consideration to the use of ballot initiatives in the states that allow such initiatives.
D-30.997	Eliminate Underage Alcohol Consumption	Our AMA will support evidence-based public health/environmental policies to curtail destructive and high-risk drinking.	Retain as amended to update language and convert to an H-policy. Our AMA ~~will~~ supports evidence-based public health ~~/~~ and ~~and~~ environmental policies to curtail ~~destructive and~~ high-risk drinking.
D-350.985	Addressing Sexual Violence and Improving American Indian and Alaska Native Women's Health Outcomes	1. Our AMA advocates for mitigation of the critical issues of American Indian/Alaska Native women's health that place Native women at increased risk for sexual violence, and encourages allocation of sufficient resources to the clinics serving this population to facilitate health care delivery commensurate with the current epidemic of violence against Native women. 2. Our AMA will collaborate with the Indian Health Service, Centers for Disease Control and Prevention (CDC), Tribal authorities, community organizations, and other interested stakeholders to develop programs to educate physicians and other health care professionals about the legal and cultural contexts of their American Indian and Alaska Native female patients as well as the current epidemic of violence against Native women and the pursuant medical needs of this population. 3. Our AMA will collaborate with the Indian Health Service, CDC, Tribal authorities, and community organizations to obtain or develop appropriate American Indian and Alaska Native women's health materials for distribution to patients in the spirit of self-determination to improve responses to sexual violence and overall health outcomes.	Retain, still relevant.
D-440.931	Encourage Autism Society to Support Vaccinations	Our American Medical Association will work jointly with the American College of Physicians, American Academy of Pediatrics and American Academy of Family Physicians to encourage the Autism Society of	Rescind, this directive has been accomplished. Other existing AMA policies including H-440.830,

		America to display on their website that based on current scientific evidence, autism is not caused by vaccinations and encourage vaccinations to promote better health for all our population.	"Education and Public Awareness on Vaccine Safety and Efficacy," recognize the substantial body of scientific evidence that has disproven a link between vaccines and autism.
D-440.932	Preventing Allergic Reactions in Food Service Establishments	Our American Medical Association will pursue federal legislation requiring restaurants and food establishments to: (1) include a notice in menus reminding customers to let the staff know of any food allergies; (2) educate their staff regarding common food allergens and the need to remind customers to inform wait staff of any allergies; and (3) identify menu items which contain any of the major food allergens identified by the FDA (in the Food Allergen Labeling and Consumer Protection Act of 2004) and which allergens the menu item contains.	Retain as amended and convert to H-policy. Our American Medical Association supports~~will pursue~~ federal legislation requiring restaurants and food establishments to: (1) include a notice in menus reminding customers to let the staff know of any food allergies; (2) educate their staff regarding common food allergens and the need to remind customers to inform wait staff of any allergies; and (3) identify menu items which contain any of the major food allergens identified by the FDA (in the Food Allergen Labeling and Consumer Protection Act of 2004) and which allergens the menu item contains.
D-440.944	Disease Transmission Via Foods: Public Health Disaster in Waiting	Our AMA: (1) publicly calls for enhancement of the protocols, authority, oversight and funding, as well as encourages public health leadership at the federal agencies charged with regulation of the food industry and maintenance of a safer food supply and will monitor the success of such efforts.	Retain, still relevant.
D-440.961	Establishment of a Network of State Immunization Registries	Our AMA will work with the Centers for Disease Control and Prevention, the Department of Health and Human Services, the Public Health Service and other interested organizations to develop a network of state-based immunization registries that meet a set of minimum standards and allow for access at a national level, while ensuring the protection of the patient-physician relationship.	Retain, still relevant.
D-45.998	Reducing the Risk of Flight-Associated Venous Thrombosis	Our AMA will continue to monitor research on developments concerning the relationship between air travel and venous thromboembolism and respond appropriately when more definitive results become available, and urges the Federal Aviation Administration and individual airlines to provide more comprehensive educational modalities detailing DVT prevention for all long-duration domestic and international airline flights.	Retain, still relevant.

D-460.980	Scientific Integrity	Our AMA advocates the federal government should rely on sound medical science in formulating public health policies.	Retain, still relevant.
D-510.994	Health Care for Veterans and Their Families	Our AMA will: (1) work with all appropriate medical societies, the AMA National Advisory Council on Violence and Abuse, and government entities to assist with the implementation of all recommendations put forth by the President's Commission on Care for America's Wounded Warriors; and (2) advocate for improved access to medical care in the civilian sector for returning military personnel when their needs are not being met by resources locally available through the Department of Defense or the Veterans Administration.	Rescind. The AMA National Advisory Council on Violence and Abuse no longer exists and specific elements of the policy, such as expansion of insurance benefits, recruitment of clinical staff, and support of PTSD and/or TBI research, are captured in other existing AMA policies, such as H-510.985, "Access to Health Care for Veterans," H-510.986, "Ensuring Access to Safe and Quality Care for our Veterans," D-510.990, "Fixing the VA Physician Shortage with Physicians," and H-510.988, "Supporting Awareness of Stress Disorders in Military Members and Their Families."
D-65.995	Health Disparities Among Gay, Lesbian, Bisexual, Transgender and Queer Families	Our AMA supports reducing the health disparities suffered because of unequal treatment of minor children and same sex parents in same sex households by supporting equality in laws affecting health care of members in same sex partner households and their dependent children.	Retain as amended to update language, convert to H-policy. Our AMA supports reducing the health disparities suffered because of unequal treatment of minor children and ~~same sex parents in same sex households~~ their parents in LGBTQ households by supporting equality in laws affecting health care of ~~members~~ LGBTQ families ~~in same sex partner households and their dependent children~~.
H-10.962	Encouraging Protocols to Assist with the Management of Patients with Obesity During Positioning and Transportation	Our American Medical Association encourages health care professionals to learn about techniques and devices to prevent potential injury and to provide safe and effective care for patients with obesity.	Retain, still relevant.
H-10.986	Use of Non-Toxic Aversive Additives	The AMA (1) in conjunction with other professional organizations, encourages individual manufacturers to consider adding non-toxic aversive products to either existent or newly introduced formulations when such have been deemed as having significant toxic potentials in order to provide safety in poison prevention; (2) believes that such actions should be publicized as intended to augment, but in no way	Retain, still relevant.

		replace, other poison prevention programs such as child-resistant containers, appropriate packaging and labeling, parental education, etc; and (3) supports continuing efforts by the household products and drug industries to identify methods of reducing the incidence of accidental poisonings.	
H-100.952	Enhancing Antibiotic Stewardship in the Human Health Care Setting to Improve Patient Outcomes	Our AMA will: (1) support antimicrobial stewardship programs, overseen by qualified physicians, as an effective way to ensure appropriate antibiotic use to reduce the burden of antimicrobial resistance, to improve patient outcomes, and to reduce overall costs for health care facilities and systems. Antibiotic stewardship programs are systematic, multi-faceted, patient safety programs, and use evidence-based approaches to optimize antibiotic prescribing, encompassing components such as policy, guidelines, surveillance, education, epidemiology, process, and outcome measurement. Successful antibiotic stewardship programs monitor and direct antimicrobial use, providing a standard, evidence-based approach to judicious antibiotic use across the spectrum of care, including, but not limited to acute care hospitals, outpatient clinics, emergency departments and long-term care facilities; (2) support the development of antibiotic stewardship programs that allow flexibility so that adherence to national requirements does not limit the ability of providers to design programs based on local variables, such as health care facility size, patient population served, and care delivery setting (e.g., outpatient v. inpatient) and to address local antimicrobial stewardship and infection prevention challenges; (3) urge each health care facility's governing body to promote and support robust, physician-led antimicrobial stewardship and infection prevention programs as critical components of assuring safe patient care; and (4) support continued research into the impact of antibiotic stewardship programs on process outcomes and encourage increased research on the impact of such programs on patient-centered outcomes.	Retain, still relevant.
H-100.953	Establishment of Limited Population Antibacterial Drug Approval Pathway	1. Our AMA supports establishment of the Limited Population Antibacterial Drug (LAPD) mechanism to provide a predictable and feasible Food and Drug Administration approval pathway for pharmaceutical companies seeking to develop antibacterial drugs to treat serious and life-threatening infections where there is a lack of sufficient or satisfactory therapeutic options through legislative or regulatory means. 2. Should the LPAD be established, our AMA shall work with the Infectious Diseases Society of America, other medical societies, and the health care community to educate providers about LPAD products, including their benefits and risks.	Retain as amended with a change in title with recognition that LPAD has been established. ~~Establishment of~~ Limited Population Antibacterial Drug Approval Pathway 1. Our AMA supports ~~establishment of~~ the Limited Population Antibacterial Drug LPAD ~~LAPD~~) mechanism ~~to~~ which provides a predictable and feasible Food and Drug Administration approval

			pathway for pharmaceutical companies seeking to develop antibacterial drugs to treat serious and life-threatening infections where there is a lack of sufficient or satisfactory therapeutic options through legislative or regulatory means. 2. ~~Should the LPAD be established, our~~ Our AMA shall work with the Infectious Diseases Society of America, other medical societies, and the health care community to educate providers about LPAD products, including their benefits and risks.
H-100.960	The 10 x '20 Initiative (10 New Antibiotics by 2020)	Our AMA: (1) supports efforts to educate physicians, the Administration, Congress, and the public about the problem of antimicrobial resistance and the lack of new antibiotics in the drug development pipeline; and (2) endorses the 10 x '20 Initiative (10 new antibiotics by 2020) and supports efforts to bring together experts from the industrial, medical, scientific, policy, regulatory, and financial communities to determine and adopt the right combination of incentives needed to create a sustainable antibiotic research and development enterprise.	Retain as amended with a change in title. ~~The 10 x '20 Initiative (10~~ Incentivizing New Antibiotics ~~by 2020)~~ Our AMA: (1) supports efforts to educate physicians, the Administration, Congress, and the public about the problem of antimicrobial resistance and the lack of new antibiotics in the drug development pipeline; and (2) ~~endorses the 10 x '20 Initiative (10 new antibiotics by 2020) and~~ supports efforts to bring together experts from the industrial, medical, scientific, policy, regulatory, and financial communities to determine and adopt the right combination of incentives needed to create a sustainable antibiotic research and development enterprise.
H-100.971	Preserving the Doctor-Patient Relationship	The AMA and interested physicians will continue to work with the Food and Drug Administration to prevent the unnecessary intrusion of the government and other regulatory bodies into the doctor-patient relationship, especially as it concerns the prescription of medication.	Retain, still relevant.
H-100.973	Combating Antimicrobial Resistance through Education	Our AMA: (1) encourages the federal government, the World Health Organization, the World Medical Association, and the International Federation of Pharmacists to promote more effective education	Retain as amended to update relevant language as the "International Federation of Pharmacists" is now the

		concerning the appropriate use of antibiotics; (2) strongly urges physicians to educate their patients about their antimicrobial therapy, the importance of compliance with the prescribed regimen, and the problem of antimicrobial resistance; (3) will continue to educate physicians and physicians-in-training about the appropriate prescribing of antimicrobial agents; (4) encourages the use of antibiotic resistance management programs; these education-based programs should be multidisciplinary and cooperative (i.e., including infectious disease physicians, infection-control specialists, microbiology laboratory personnel, and clinical pharmacists); and (5) encourages continued scientific research on the issue of antibiotic resistance.	"International Pharmaceutical Federation." Our AMA: (1) encourages the federal government, the World Health Organization, the World Medical Association, and the International Pharmaceutical Federation ~~of Pharmacists~~ to promote more effective education concerning the appropriate use of antibiotics; (2) strongly urges physicians to educate their patients about their antimicrobial therapy, the importance of compliance with the prescribed regimen, and the problem of antimicrobial resistance; (3) will continue to educate physicians and physicians-in-training about the appropriate prescribing of antimicrobial agents; (4) encourages the use of antimicrobial~~biotic~~ resistance management programs; these education-based programs should be multidisciplinary and cooperative (i.e., including infectious disease physicians, infection-control specialists, microbiology laboratory personnel, and clinical pharmacists); and (5) encourages continued scientific research on the issue of antimicrobial~~biotic~~ resistance.
H-115.967	Addressing Drug Overdose and Patient Compliance with Targeted Pharmaceutical Packaging Efforts	Our American Medical Association supports research into, and development of, novel and affordable pharmaceutical packaging for dispensed medications, as well as abuse deterrent formulations in attempts to increase ease of use, improve patient adherence, and decrease the potential for misuse and abuse of controlled substances.	Retain as amended to update language with a change in title. Addressing Drug Overdose and Patient Adherence ~~Compliance~~ with Targeted Pharmaceutical Packaging Efforts Our American Medical Association supports research

			into, and development of, novel and affordable pharmaceutical packaging for dispensed medications, as well as abuse deterrent formulations in attempts to increase ease of use, improve patient adherence, and decrease the potential for the misuse ~~and abuse~~ of controlled substances.
H-115.971	Safety and Efficacy of Selective Serotonin Reuptake Inhibitors (SSRIs) in Children and Adolescents	Our AMA recognizes that the current product labeling (package insert) of antidepressant drugs, including the Black Box warnings, is a precautionary statement intended to reinforce the need for careful monitoring of patients with depression and other psychiatric disorders during the initiation of treatment. This product labeling should not be interpreted in a way that would decrease access for patients who may benefit from these drugs.	Retain, still relevant.
H-115.983	Expiration Dates and Beyond-Use Dates of Prescription and Over-the-Counter Drug Products	Our AMA: (1) supports the inclusion of expiration dates on the containers/labels of prescription and over-the-counter drug products and recommends that expiration dates be determined by pharmaceutical manufacturers using scientifically based stability testing with subsequent approval by the Food and Drug Administration (FDA); (2) urges the pharmaceutical industry, in collaboration with purchasers, the FDA, and the United States Pharmacopeia (USP), to determine whether lengthening of expiration dates will provide clinical and/or economic benefits or risks for patients and, if this is the case, to conduct longer stability testing on their drug products; (3) urges the FDA to work with the pharmaceutical industry and the USP to develop a schedule for the review and re-evaluation of expiration dates of prescription and over-the-counter drug products; (4) recommends that pharmacists place a beyond-use date on the labeling of all prescription medications dispensed to patients, and that the beyond-use date be based on the recommendations in the most recent edition of the United States Pharmacopeia and National Formulary; and (5) encourages the USP, in collaboration with pharmaceutical manufacturers, pharmacy organizations, and the FDA, to continue to explore the development of appropriate stability tests for the determination of scientifically sound beyond-use dates for repackaged products.	Retain, still relevant.
H-115.994	Prescription Product Labeling	1. The official labeling should not be regarded as the sole standard of acceptable or accepted medical practice nor as a substitute for clinical judgment or experience nor as a limitation on usage of the drug in medical practice. The official labeling statements approved by the FDA establish the parameters	Retain, still relevant.

		governing advertising or promotion of the drug product. 2. Our AMA will advocate that the FDA work to establish a process whereby the official drug labeling can be updated in a more expeditious fashion when new evidence becomes available affecting the clinical use of prescription medications and that evidence-based standards or peer-reviewed medical literature can add to legacy information contained in official drug labeling statements to guide drug administration and usage.	
H-120.956	Internet Prescribing	Our AMA will: (1) support the use of the Internet as a mechanism to prescribe medications with appropriate safeguards to ensure that the standards for high quality medical care are fulfilled; (2) work with state medical societies in urging state medical boards to ensure high quality medical care by investigating and, when appropriate, taking necessary action against physicians who fail to meet the local standards of medical care when issuing prescriptions through Internet web sites that dispense prescription medications; (3) work with the Federation of State Medical Boards and others in endorsing or developing model state legislation to establish limitations on Internet prescribing; (4) continue to work with the National Association of Boards of Pharmacy and support their "Verified Internet Pharmacy Practice Sites" program so that physicians and patients can easily identify legitimate Internet pharmacy practice sites; (5) work with federal and state regulatory bodies to close down Internet web sites of companies that are illegally promoting and distributing (selling) prescription drug products in the United States; and (6) keep pace with changes in technology by continually updating standards of practice on the Internet.	Retain as amended to update language. The National Association of Boards of Pharmacy use a different term to describe their accreditation. Our AMA will: (1) support the use of the Internet as a mechanism to prescribe medications with appropriate safeguards to ensure that the standards for high quality medical care are fulfilled; (2) work with state medical societies in urging state medical boards to ensure high quality medical care by investigating and, when appropriate, taking necessary action against physicians who fail to meet the local standards of medical care when issuing prescriptions through Internet web sites that dispense prescription medications; (3) work with the Federation of State Medical Boards and others in endorsing or developing model state legislation to establish limitations on Internet prescribing; (4) continue to work with the National Association of Boards of Pharmacy and support their digital pharmacy accreditation ~~"Verified Internet Pharmacy Practice Sites"~~ program so that physicians and patients can easily identify legitimate Internet pharmacy practice sites; (5) work with federal and state regulatory bodies to close down Internet web sites

			of companies that are illegally promoting and distributing (selling) prescription drug products in the United States; and (6) keep pace with changes in technology by continually updating standards of practice on the Internet.
H-120.965	Medication Errors	The AMA reaffirms its long-standing supportive efforts to curtail the problems of medication errors; and encourages physicians to add a brief notation of purpose (e.g., for cough, for constipation) on prescriptions, where appropriate, to avoid confusion on the part of either the pharmacists or the patients.	Retain, still relevant.
H-130.942	Development of a Federal Public Health Disaster Intervention Team	1. Our AMA supports government efforts to: (a) coordinate and integrate federal medical and public health disaster response entities such as the Medical Reserve Corps, National Disaster Medical System, Public Health Services Commissioned Corps (PHSCC), as well as state-to-state sponsored Emergency Management Compact Systems, to strengthen health system infrastructure and surge capacity for catastrophic disasters (Incidents of National Significance) as defined by the Department of Homeland Security's (DHS) National Response Plan (NRP); and (b) place all federal medical and public health disaster response assets (with the exception of the Department of Defense) under authority of the Secretary of the Department of Health and Human Services (DHHS) to prevent significant delays and ensure coordination during a catastrophic disaster (Incident of National Significance). 2. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will work with the DHHS, PHSCC, DHS, and other relevant government agencies to provide comprehensive disaster education and training for all federal medical and public health employees and volunteers through the National Disaster Life Support and other appropriate programs. Such training should address the medical and mental health needs of all populations, including children, the elderly, and other vulnerable groups. 3. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will monitor progress in strengthening federal disaster medical and public health response capacity for deployment anywhere in the nation on short notice, and report back as appropriate.	Retain as amended to remove reference to the AMA's Center for Public Health Preparedness & Disaster Response and related work, which has ended. 1. Our AMA supports government efforts to: (a) coordinate and integrate federal medical and public health disaster response entities such as the Medical Reserve Corps, National Disaster Medical System, Public Health Services Commissioned Corps (PHSCC), as well as state-to-state sponsored Emergency Management Compact Systems, to strengthen health system infrastructure and surge capacity for catastrophic disasters (Incidents of National Significance) as defined by the Department of Homeland Security's (DHS) National Response Plan (NRP); and (b) place all federal medical and public health disaster response assets (with the exception of the Department of Defense) under authority of the Secretary of the Department of Health and Human Services (DHHS) to prevent significant delays and ensure coordination during a catastrophic disaster (Incident of National Significance).

			~~2. Our AMA, through its Center for Public Health Preparedness and Disaster Response, will work with the DHHS, PHSCC, DHS, and other relevant government agencies to provide comprehensive disaster education and training for all federal medical and public health employees and volunteers through the National Disaster Life Support and other appropriate programs. Such training should address the medical and mental health needs of all populations, including children, the elderly, and other vulnerable groups~~. ~~3~~ 2. Our AMA~~, through its Center for Public Health Preparedness and Disaster Response,~~ will monitor progress in strengthening federal disaster medical and public health response capacity for deployment anywhere in the nation on short notice, and report back as appropriate.
H-130.946	AMA Leadership in the Medical Response to Terrorism and Other Disasters	Our AMA: (1) Condemns terrorism in all its forms and provide leadership in coordinating efforts to improve the medical and public health response to terrorism and other disasters. (2) Will work collaboratively with the Federation in the development, dissemination, and evaluation of a national education and training initiative, called the National Disaster Life Support Program, to provide physicians, medical students, other health professionals, and other emergency responders with a fundamental understanding and working knowledge of their integrated roles and responsibilities in disaster management and response efforts. (3) Will join in working with the Department of Homeland Security, the Department of Health and Human Services, the Department of Defense, the Federal Emergency Management Agency, and other appropriate federal agencies; state, local, and medical specialty societies; other health care associations; and private foundations to (a) ensure adequate resources, supplies, and training to enhance the medical and public health response to terrorism and other disasters;	Retain as amended to remove an initiative the AMA is no longer involved in. Our AMA: (1) Condemns terrorism in all its forms and provide<u>s</u> leadership in coordinating efforts to improve the medical and public health response to terrorism and other disasters. (2) ~~Will work collaboratively with the Federation in the development, dissemination, and evaluation of a national education and training initiative, called the National Disaster Life Support Foundation Program,~~ <u>supports efforts</u> to provide physicians, medical students, other health professionals, and other emergency responders with a

		(b) develop a comprehensive strategy to assure surge capacity to address mass casualty care; (c) implement communications strategies to inform health care professionals and the public about a terrorist attack or other major disaster, including local information on available medical and mental health services; (d) convene local and regional workshops to share "best practices" and "lessons learned" from disaster planning and response activities; (e) organize annual symposia to share new scientific knowledge and information for enhancing the medical and public health response to terrorism and other disasters; and (f) develop joint educational programs to enhance clinical collaboration and increase physician knowledge of the diagnosis and treatment of depression, anxiety, and post traumatic stress disorders associated with exposure to disaster, tragedy, and trauma. (4) Believes all physicians should (a) be alert to the occurrence of unexplained illness and death in the community; (b) be knowledgeable of disease surveillance and control capabilities for responding to unusual clusters of diseases, symptoms, or presentations; (c) be knowledgeable of procedures used to collect patient information for surveillance as well as the rationale and procedures for reporting patients and patient information; (d) be familiar with the clinical manifestations, diagnostic techniques, isolation precautions, decontamination protocols, and chemotherapy/prophylaxis of chemical, biological, and radioactive agents likely to be used in a terrorist attack; (e) utilize appropriate procedures to prevent exposure to themselves and others; (f) prescribe treatment plans that may include management of psychological and physical trauma; (g) understand the essentials of risk communication so that they can communicate clearly and nonthreateningly with patients, their families, and the media about issues such as exposure risks and potential preventive measures (e.g., smallpox vaccination); and (h) understand the role of the public health, emergency medical services, emergency management, and incident management systems in disaster response and the individual health professional's role in these systems. (5) Believes that physicians and other health professionals who have direct involvement in a mass casualty event should be knowledgeable of public health interventions that must be considered following the onset of a disaster including: (a) quarantine and other movement restriction options; (b) mass immunization/chemoprophylaxis; (c) mass triage; (d) public education about preventing or reducing exposures; (e) environmental decontamination and	fundamental understanding and working knowledge of their integrated roles and responsibilities in disaster management and response efforts. (3) Will join in working with the Department of Homeland Security, the Department of Health and Human Services, the Department of Defense, the Federal Emergency Management Agency, and other appropriate federal agencies; state, local, and medical specialty societies; other health care associations; and private foundations to (a) ensure adequate resources, supplies, and training to enhance the medical and public health response to terrorism and other disasters; (b) develop a comprehensive strategy to assure surge capacity to address mass casualty care; (c) implement communications strategies to inform health care professionals and the public about a terrorist attack or other major disaster, including local information on available medical and mental health services; (d) convene local and regional workshops to share "best practices" and "lessons learned" from disaster planning and response activities; (e) organize annual symposia to share new scientific knowledge and information for enhancing the medical and public health response to terrorism and other disasters; and (f) develop joint educational programs to enhance clinical collaboration and increase physician knowledge of the diagnosis and treatment of depression, anxiety, and post traumatic stress disorders associated with exposure to disaster, tragedy, and trauma.

		sanitation; (f) public health laws; and (g) state and federal resources that contribute to emergency management and response at the local level. (6) Believes that physicians and other health professionals should be knowledgeable of ethical and legal issues and disaster response. These include: (a) their professional responsibility to treat victims (including those with potentially contagious conditions); (b) their rights and responsibilities to protect themselves from harm; (c) issues surrounding their responsibilities and rights as volunteers, and (d) associated liability issues. (7) Believes physicians and medical societies should participate directly with state, local, and national public health, law enforcement, and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals, and practices in preparation for terrorism and other disasters. (8) Urges Congress to appropriate funds to support research and development (a) to improve understanding of the epidemiology, pathogenesis, and treatment of diseases caused by potential bioweapon agents and the immune response to such agents; (b) for new and more effective vaccines, pharmaceuticals, and antidotes against biological and chemical weapons; (c) for enhancing the shelf life of existing vaccines, pharmaceuticals, and antidotes; and (d) for improving biological chemical, and radioactive agent detection and defense capabilities.	(4) Believes all physicians should (a) be alert to the occurrence of unexplained illness and death in the community; (b) be knowledgeable of disease surveillance and control capabilities for responding to unusual clusters of diseases, symptoms, or presentations; (c) be knowledgeable of procedures used to collect patient information for surveillance as well as the rationale and procedures for reporting patients and patient information; (d) be familiar with the clinical manifestations, diagnostic techniques, isolation precautions, decontamination protocols, and chemotherapy/prophylaxis of chemical, biological, and radioactive agents likely to be used in a terrorist attack; (e) utilize appropriate procedures to prevent exposure to themselves and others; (f) prescribe treatment plans that may include management of psychological and physical trauma; (g) understand the essentials of risk communication so that they can communicate clearly and nonthreateningly with patients, their families, and the media about issues such as exposure risks and potential preventive measures (e.g., smallpox vaccination); and (h) understand the role of the public health, emergency medical services, emergency management, and incident management systems in disaster response and the individual health professional's role in these systems. (5) Believes that physicians and other health professionals who have direct involvement

			in a mass casualty event should be knowledgeable of public health interventions that must be considered following the onset of a disaster including: (a) quarantine and other movement restriction options; (b) mass immunization/chemoprophylaxis; (c) mass triage; (d) public education about preventing or reducing exposures; (e) environmental decontamination and sanitation; (f) public health laws; and (g) state and federal resources that contribute to emergency management and response at the local level. (6) Believes that physicians and other health professionals should be knowledgeable of ethical and legal issues and disaster response. These include: (a) their professional responsibility to treat victims (including those with potentially contagious conditions); (b) their rights and responsibilities to protect themselves from harm; (c) issues surrounding their responsibilities and rights as volunteers, and (d) associated liability issues. (7) Believes physicians and medical societies should participate directly with state, local, and national public health, law enforcement, and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals, and practices in preparation for terrorism and other disasters. (8) Urges Congress to appropriate funds to support research and development (a) to improve understanding of the epidemiology,

			pathogenesis, and treatment of diseases caused by potential bioweapon agents and the immune response to such agents; (b) for new and more effective vaccines, pharmaceuticals, and antidotes against biological and chemical weapons; (c) for enhancing the shelf life of existing vaccines, pharmaceuticals, and antidotes; and (d) for improving biological chemical, and radioactive agent detection and defense capabilities.
H-130.952	Community-Wide Training in Basic Life Support and First Aid	Our AMA: (1) encourages education in (a) basic life support and first aid, and (b) effective interventions for reducing and preventing injuries and coronary heart disease; (2) urges state and local medical societies to participate in the development and promotion of community programs for adults, children, businesses, community groups, and public servants to increase awareness of the potential benefits of training in basic life support and first aid and to increase public knowledge, confidence, and motivation for responding to serious, or potentially serious illness and injury situations; and (3) encourages physicians to discuss with their patients: (a) how to recognize and respond to emergency situations; (b) proper utilization and activation of the local EMS system; (c) measures for reducing or eliminating potential risk factors for injuries and coronary heart disease; and (d) the availability and appropriateness of community programs in basic life support and first aid.	Retain, still relevant.
H-135.929	Banning Plastic Microbeads in Personal Care Products	Our AMA supports local, state, and federal laws banning the sale and manufacture of personal care products containing plastic microbeads.	Retain, still relevant.
H-135.930	Protecting Public Health from Natural Gas Infrastructure	Our AMA recognizes the potential impact on human health associated with natural gas infrastructure and supports legislation that would require a comprehensive Health Impact Assessment regarding the health risks that may be associated with natural gas pipelines.	Retain, still relevant.
H-135.955	Human Health and the Protection of Biodiversity	The AMA urges physicians and other health care professionals and the public to become more aware of the importance of protecting biological diversity and its relationship to human health.	Retain, still relevant.
H-135.989	Low Level Radioactive Waste Disposal	The AMA (1) believes that each state should be responsible for providing capacity within or outside the state for disposal of commercial, non-military low level radioactive waste generated within its border;	Retain, still relevant.

		and (2) urges Environmental Protection Agency action to ensure capacity for disposal of low level radioactive waste.	
H-145.974	Increasing Toy Gun Safety	Our American Medical Association (1) encourages toy gun manufacturers to take further steps beyond the addition of an orange tip on the gun to reduce the similarity of toy guns with real guns, and (2) encourages parents to increase their awareness of toy gun ownership risks.	Retain, still relevant.
H-15.949	Auto Heat Deaths	Our American Medical Association supports efforts to reduce deaths of children left in unattended vehicles.	Retain, still relevant.
H-15.960	Motor Vehicle and Bicycle Safety	The AMA supports legislation that would make safety belt non-use by any occupants in automobiles and other enclosed motor vehicles a "primary offense" in all states; supports extension of motorcycle helmet laws to include motorized vehicles such as mopeds, scooters and all-terrain vehicles, and to cover all age groups; and supports legislation that would require helmet usage for riders of bicycles, including passengers.	Retain, still relevant.
H-15.988	Modification of Three-Point Shoulder Harness Seat Belt to Enable Use by Small Children	The AMA (1) recognizes the value of using appropriately designed three-point safety belt restraints to reduce auto-related injuries and fatalities; (2) supports auto industry modifications in restraints for safe use by children and small adults; and (3) supports the development of standards required for such modifications by appropriate authorities.	Retain, still relevant.
H-150.941	Banning the Use of Artificial Trans Fat in the United States	Our AMA supports state and federal legislation that bans the use of artificial trans fats in the United States.	Retain, still relevant.
H-150.947	Mercury and Fish Consumption: Medical and Public Health Issues	AMA policy is that: (1) Women who might become pregnant, are pregnant, or who are nursing should follow federal, state or local advisories on fish consumption. Because some types of fish are known to have much lower than average levels of methylmercury and can be safely consumed more often and in larger amounts, women should also seek specific consumption recommendations from those authorities regarding locally caught or sold fish. (2) Physicians should (a) assist in educating patients about the relative mercury content of fish and shellfish products; (b) make patients aware of the advice contained in both national and regional consumer fish consumption advisories; and (c) have sample materials available, or direct patients to where they can access information on national and regional fish consumption advisories. (3) Testing of the mercury content of fish should be continued by appropriate agencies; results should be publicly accessible and reported in a consumer-friendly format.	Retain, still relevant.
H-150.959	Risk of Transmission of Bovine Spongiform Encephalopathy to	The AMA: (1) supports the current FDA guidance/regulations regarding the treatment of products from bovine sources destined for human utilization, and the treatment of blood products from potential Creutzfeld-Jakob disease (CJD) donors; (2)	The AMA: (1) supports the current FDA guidance/regulations regarding the treatment of products from bovine sources destined for

	Humans in the United States	recommends the FDA and the United States Department of Agriculture (USDA) continue to aggressively enforce regulations in place to prevent the occurrence/transmission of bovine spongiform encephalopathy (BSE) in the United States; (3) recommends the FDA, USDA, and Department of Health and Human Services continue to evaluate scientific data on transmissible spongiform encephalopathies (TSEs) and incorporate this information into their guidance and regulations; (4) recommends increased surveillance of new CJD cases as they arise in order to monitor for the possible appearance of new variant Creutzfeldt-Jakob disease (nv-CJD) via: (a) Referral of all deaths due to suspected CJD to an appropriately qualified pathologist for autopsy, with the submission of autopsy reports of confirmed cases to the Prion Disease Pathology Surveillance Center at Case Western Reserve University, which is collaborating with the CDC. (b) Reporting of the diagnosis of CJD on the death certificate in all cases and the strengthening of the current system enabling health authorities to obtain clinical or pathologic data on the CJD cases of greatest public health concern. (c) Prompt notification of any case of new variant Creutzfeldt-Jakob disease to both the appropriate state health department and the CDC; and (5) recommends that well-controlled research be performed in the following areas: (a) Elucidation of the mechanism of disease of TSEs; (b) Elucidation of the infectivity, dose requirements, and clearance of the disease agent to provide more data for adequate risk analyses of disease transmission; (c) The risk of transmission via blood and blood products; (d) Alternatives to the use of bovine-derived products in drug manufacture and other biologic industries; (e) Antemortem diagnosis of BSE and nv-CJD and the detection and inactivation of the disease agent in blood supplies.	human utilization, and the treatment of blood products from potential Creutzfeld-Jakob disease (CJD) donors; (2) recommends the FDA and the United States Department of Agriculture (USDA) continue to aggressively enforce regulations in place to prevent the occurrence/transmission of bovine spongiform encephalopathy (BSE) in the United States; (3) recommends the FDA, USDA, and Department of Health and Human Services continue to evaluate scientific data on transmissible spongiform encephalopathies (TSEs) and incorporate this information into their guidance and regulations; (4) recommends increased surveillance of new CJD cases as they arise in order to monitor for the possible appearance of new variant Creutzfeldt-Jakob disease (nv-CJD) via: (a) Referral of all deaths due to suspected CJD to an appropriately qualified pathologist for autopsy, with the submission of autopsy reports of confirmed cases to the National Prion Disease Pathology Surveillance Center at Case Western Reserve University, which is collaborating with the CDC. (b) Reporting of the diagnosis of CJD on the death certificate in all cases and the strengthening of the current system enabling health authorities to obtain clinical or pathologic data on the CJD cases of greatest public health concern. (c) Prompt notification of any case of new variant Creutzfeldt-Jakob disease to both the appropriate state health department and the CDC; and (5) recommends that well-controlled research be performed in the following

			areas: (a) Elucidation of the mechanism of disease of TSEs; (b) Elucidation of the infectivity, dose requirements, and clearance of the disease agent to provide more data for adequate risk analyses of disease transmission; (c) The risk of transmission via blood and blood products; (d) Alternatives to the use of bovine-derived products in drug manufacture and other biologic industries; (e) Antemortem diagnosis of BSE and nv-CJD and the detection and inactivation of the disease agent in blood supplies.
H-150.961	Irradiation of Food	It is the policy of the AMA to: (1) affirm food irradiation as a safe and effective process that increases the safety of food when applied according to governing regulations; and (2) consider the value of food irradiation to be diminished unless it is incorporated into a comprehensive food safety program based on good manufacturing practices and proper food handling, processing, storage, and preparation techniques.	Retain, still relevant.
H-150.980	Milk and Human Health	The AMA reaffirms its policy that all milk sold for human consumption should be required to be pasteurized.	Retain, still relevant.
H-170.964	Substance Use Education in Schools	Our AMA supports scientifically-based substance use education in schools.	Retain, still relevant.
H-170.980	Health Education	It is the policy of the AMA (1) to urge all state medical societies to urge their respective state departments of education to: implement model health education curricula, act as clearinghouses for data on curriculum development, work with local school districts to implement health education programs and to seek funding for these programs; and (2) that the health education programs contain provisions for educator training and development of local community health advisory committees.	Retain, as amended to update language. ~~It is the policy of~~ The AMA (1) ~~to~~ urges all state medical societies to ~~urge~~ advocate that their respective state departments of education ~~to:~~ implement model health education curricula, act as clearinghouses for data on curriculum development, work with local school districts to implement health education programs and to seek funding for these programs; and (2) that the health education programs contain provisions for educator training and development of local

			community health advisory committees.
H-170.988	Health Education Legislation	The AMA (1) reaffirms current policy which supports the establishment of a comprehensive health education program in the elementary and secondary schools; and (2) encourages state and specialty medical societies to consider the introduction of such model legislation in their state legislatures.	Retain, as amended to update language. The AMA (1) ~~reaffirms current policy which~~ supports the establishment of a comprehensive health education program in ~~the~~ elementary and secondary schools; and (2) encourages state and specialty medical societies to consider the introduction of such model legislation in their state legislatures.
H-170.989	Health Fairs	The AMA (1) urges that the emphasis of health fairs be primarily educational and informative; and (2) encourages the sponsors of health fairs and similar single-purpose screening programs to emphasize the importance of the establishment of a personal doctor-patient relationship.	Retain, still relevant.
H-175.997	Chelation Therapy	The AMA believes that chelation therapy for atherosclerosis is an experimental process without proven efficacy.	Retain, still relevant.
H-225.966	Medical Staff Role in the Development of Substance Abuse Policies and Procedures	1. Our AMA establishes the primacy of medical staff authority in substance abuse policy and procedures covering any pre-employment, credentialing, or other phases of physician evaluation. 2. Policy of the AMA states that medical staff must be involved in the development of the institution's substance abuse policy, including: (a) selection of analytical methods to ensure scientific validity of the test results, (b) determination of measures to maintain confidentiality of the test results, (c) in for-cause post-incident/injury testing, definition of standards for determining whether cause exists and which incidents and/or injuries will result in testing, and (d) development of mechanisms to address the physical and mental health of medical staff members. 3. The AMA believes all drug and alcohol testing must be performed only with substantive and procedural due process safeguards in place.	Retain as amended to update language. Medical Staff Role in the Development of Substance Misuse ~~Abuse~~ Policies and Procedures 1. Our AMA establishes the primacy of medical staff authority in substance misuse ~~abuse~~ policy and procedures covering any pre-employment, credentialing, or other phases of physician evaluation. 2. Policy of the AMA states that medical staff must be involved in the development of the institution's substance misuse ~~abuse~~ policy, including: (a) selection of analytical methods to ensure scientific validity of the test results, (b) determination of measures to maintain confidentiality of the test results, (c) in for-cause post-

			incident/injury testing, definition of standards for determining whether cause exists and which incidents and/or injuries will result in testing, and (d) development of mechanisms to address the physical and mental health of medical staff members. 3. The AMA believes all drug and alcohol testing must be performed only with substantive and procedural due process safeguards in place.
H-235.969	Responsibility for Infection Control	AMA policy states that: (1) the hospital medical staff should have a multidisciplinary committee to oversee the surveillance, prevention and control of infection; (2) the infection control committee should report to the hospital medical staff executive committee; and (3) the medical staff's role, responsibility and authority in the infection control activities should be included in the medical staff bylaws.	Retain, still relevant.
H-25.988	Community-Based Falls Prevention Programs	Our American Medical Association will work with relevant organizations to support community-based falls prevention programs.	Retain, still relevant.
H-25.995	Exercise Programs for the Elderly	The AMA recommends that physicians: (1) stress the importance of exercise for older patients and explain its physiological and psychological benefits; (2) obtain a complete medical history and perform a physical examination that includes exercise testing for quantification of cardiovascular and physical fitness as appropriate, prior to the specific exercise prescription; (3) provide appropriate follow-up of patients' exercise programs; and (4) encourage all patients to establish a lifetime commitment to an exercise program.	Retain, still relevant.
H-295.879	Improving Sexual History Curriculum in the Medical School	Our AMA (1) encourages all medical schools to train medical students to be able to take a thorough and nonjudgmental sexual history in a manner that is sensitive to the personal attitudes and behaviors of patients in order to decrease anxiety and personal difficulty with sexual aspects of health care; and (2) supports public messaging that encourages patients to discuss concerns related to sexual health with their physician and reinforces its commitment to helping patients maintain sexual health and well-being.	Retain, still relevant.
H-30.939	Increasing Taxes on Alcoholic Beverages	It is AMA policy that federal, state, and local tax rates on alcoholic beverages be based on the grams of ethanol present in the beverage, not on the fluid volume of beverages such as beer, wine, and distilled spirits.	Retain, still relevant.
H-30.950	Alcoholism in the Elderly	It is the policy of the AMA to: (1) encourage medical educators to consider expanding instructional material on alcohol and aging at all levels of medical education, particularly in residency and/or postgraduate training; and (2) cooperate with other	Retain as amended to update language.

		groups, such as the American Association of Retired Persons and appropriate government agencies, in public education programs for the elderly concerning alcohol-related problems.	~~Alcoholism~~ Alcohol Use Disorder in Older Adults ~~the Elderly~~ ~~It is the policy of the~~ Our AMA ~~to~~: (1) encourages medical educators to ~~consider~~ expand~~ing~~ instructional material on alcohol and aging at all levels of medical education, particularly in residency and/or postgraduate training; and (2) cooperate with other groups, such as the American Association of Retired Persons and appropriate government agencies, in public education programs for ~~the elderly~~ older adults concerning alcohol-related problems.
H-365.991	NIOSH Cohort Mortality Studies	The AMA believes that physicians should (1) strive conscientiously to become familiar with the medical fitness requirements, the environment and the hazards of the work done by those they serve, and with the health and safety aspects of the products and operations involved; (2) communicate information about health hazards in a timely and effective fashion to individuals or groups potentially affected, and make appropriate reports to the scientific community; and (3) communicate understandably to those they serve any significant observations about their health, recommending further study, counsel, or treatment when indicated.	Retain with change in title from "NIOSH Cohort Mortality Studies" to "Physicians and Occupational Health Hazards" to better reflect content of the policy.
H-373.993	Medication Adherence	Our AMA supports third parties in researching the effectiveness of personalized medication cards and other tools, including electronic reminders, intended to promote safe medication use, improve medication adherence, and improve health outcomes. Reminders should also be available in a variety of languages. Special attention should be devoted to reaching low literacy target audiences.	Retain, still relevant.
H-420.986	Maternal and Child Health Care	The AMA opposes any further decreases in funding levels for maternal and child health programs; encourages more efficient use of existing resources for maternal and child health programs; encourages the federal government to allocate additional resources for increased health planning and program evaluation within Maternal and Child Health Block Grants; and urges increased participation of physicians through advice and involvement in the implementation of block grants.	Retain, still relevant.
H-425.977	Encouraging Vision Screenings for Schoolchildren	Our AMA: (1) encourages and supports outreach efforts to provide vision screenings for school-age children prior to primary school enrollment; (2) encourages the development of programs to improve	Retain, still relevant.

		school readiness by detecting undiagnosed vision problems; and (3) supports periodic pediatric eye screenings based on evidence-based guidelines with referral to an ophthalmologist for a comprehensive professional evaluation as appropriate.	
H-425.986	Challenges in Preventive Medicine	It is the policy of the AMA that (1) physicians should become familiar with and increase their utilization of clinical preventive services protocols; (2) individual physicians as well as organized medicine at all levels should increase communication and cooperation with and support of public health agencies. Physician leadership in advocating for a strong public health infrastructure is particularly important; (3) physicians should promote and offer to serve on local and state advisory boards; and (4) in concert with other groups, physicians should study local community needs, define appropriate public health objectives, and work toward achieving public health goals for the community.	Retain, still relevant.
H-430.998	Use of the Choke and Sleeper Hold in Prisons	The AMA (1) does not regard the choke and sleeper holds as casually applied and easily reversible tranquilizers, but as the use of deadly force with the potential to kill; and (2) advocates that with all incidents involving the application of choke and sleeper holds there should be timely medical surveillance of the inmate.	Retain as amended to update language. Use of the Chokeholds and Carotid Restraints ~~Sleeper Hold~~ in ~~Prisons~~ in People who are Incarcerated The AMA (1) does not regard ~~the~~ chokeholds and ~~sleeper holds~~ carotid restraints as casually applied and easily reversible tranquilizers, but as the use of deadly force with the potential to kill; and (2) advocates that with all incidents involving the application of chokeholds and ~~sleeper holds~~ carotid restraints there should be timely medical surveillance of the ~~inmate~~ individual on which they were used.
H-440.827	Surveillance of Antibiotic Use and Resistance	Our AMA: (1) recognizes the importance of public health and veterinary health surveillance for antimicrobial resistance and antibiotic use; and (2) recommends that public health and veterinary health agencies be adequately funded, as outlined in the President's Council of Advisors on Science and Technology Report, to achieve the surveillance goals and objectives outlined in the National Action Plan for Combating Antibiotic Resistant Bacteria.	Retain as amended to update language. Our AMA: (1) recognizes the importance of public health and veterinary health surveillance for antimicrobial resistance and antibiotic use; and (2) recommends that public health and veterinary health agencies be adequately funded~~, as outlined in the President's Council of Advisors on Science and~~

			~~Technology Report,~~ to achieve the surveillance goals and objectives outlined in the National Action Plan for Combating Antibiotic Resistant Bacteria.
H-440.831	Protecting Patients and the Public Through Physician, Health Care Worker, and Caregiver Immunization	1. AMA policy is that, in the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues or threatens the availability of the health care workforce, particularly a disease that has the potential to become epidemic or pandemic, including influenza, and for which there is an available, safe, and effective vaccine, physicians, health care workers (HCWs), and family caregivers who have direct patient care responsibilities or potential direct exposure have an obligation to accept immunization unless there is a recognized medical reason to not be immunized. In scenarios in which there is a documented medical contraindication to immunization of a physician or HCW, appropriate protective measures should be taken. 2. Our AMA (a) encourages hospitals, health care systems, and health care providers to provide immunizations to HCWs against influenza and other highly transmissible diseases, at no cost to the employee, both for their own protection and to reduce the risk of infectious disease transmission to others; and (b) encourages health care institutions to develop mechanisms to maximize the rate of influenza immunization for HCWs, including the option of making immunization a condition of employment.	Retain, still relevant.
H-440.833	Labeling and Recommended Protection for Sunglasses	Our American Medical Association recognizes, based on current evidence, that sunglasses that protect against 100% of both UVA and UVB radiation are currently the safest choice for consumers and recommends that manufacturers clearly label all sunglasses with the percentage of UVA and UVB radiation blocked so that consumers know the extent to which the glasses protect against both types of UV radiation.	Retain, still relevant.
H-440.834	Next Generation Infectious Diseases Diagnostics	1. Our American Medical Association supports strong federal efforts to stimulate early research and development of emerging rapid ID (infectious disease) diagnostic technologies through increased funding for appropriate agencies. 2. Our AMA supports the reduction of regulatory barriers to allow for safe and effective emerging rapid diagnostic tests, particularly those that address unmet medical needs, to more rapidly reach laboratories for use in patient care. 3. Our AMA supports improving the clinical integration of new diagnostic technologies into patient	Retain, still relevant.

		care through outcomes research that demonstrates the impact of diagnostics on patient care and outcomes, educational programs and clinical practice guidelines for health care providers on the appropriate use of diagnostics, and integration of diagnostic tests results into electronic medical records. 4. Our AMA supports efforts to overcome reimbursement barriers to ensure coverage of the cost of emerging diagnostics.	
H-440.846	Antibiotic Use in Food-Producing Animals	Our AMA supports: (1) federal efforts to ban antibiotic use in food-producing animals for growth promotion purposes, including through regulatory and legislative measures; (2) a strong federal requirement that antibiotic prescriptions for animals be overseen by a veterinarian knowledgeable of the place and intended use of these drugs, under a valid veterinarian-client-patient relationship (VCPR); and (3) efforts to expand FDA surveillance and data collection of antibiotic use in agriculture.	Retain, still relevant.
H-440.851	Influenza Vaccine Availability and Distribution	Our AMA will: (1) continue efforts to communicate strongly to its partners involved in influenza vaccine production and distribution that physicians must receive influenza vaccines in a timely and equitable manner in order to help immunize all patients =6 months of age as recommended by the Center for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP); (2) urge manufacturers and distributors of influenza vaccine to provide a dedicated ordering system for small- and medium-size medical practices to pre-order vaccine up to an appropriate volume threshold; (3) support federal actions to allow physicians (MDs and DOs) to form purchasing alliances to allow for competitive purchasing of influenza vaccine comparable to large purchasers currently supplying pharmacy and grocery chain stores with influenza vaccine; (4) communicate current ACIP recommendations on the influenza vaccine to physicians and assist the CDC in disseminating its informational letters and bulletins to physicians and other providers of the influenza vaccine when they become available in order to ensure compliance with the ACIP recommendations with respect to immunization of patients with influenza vaccine; (5) work with the CDC and other immunization partners to explore options to provide for timely influenza immunization of indigent or underserved populations, including exploring options to provide for the timely redistribution of state and federally funded influenza vaccines to facilities or groups within the state willing to appropriately manage, distribute, and administer the vaccine to indigent or underserved populations; (6) continue its collaboration with the CDC and other stakeholders in influenza vaccination to work to achieve the influenza immunization goals of Healthy	Retain as amended. Our AMA will: (1) continue efforts to communicate strongly to its partners involved in influenza vaccine production and distribution that physicians must receive influenza vaccines in a timely and equitable manner in order to help immunize all patients =6 months of age and older as recommended by the Center for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP); (2) urge manufacturers and distributors of influenza vaccine to provide a dedicated ordering system for small- and medium-size medical practices to pre-order vaccine up to an appropriate volume threshold; (3) support federal actions to allow physicians (MDs and DOs) to form purchasing alliances to allow for competitive purchasing of influenza vaccine comparable to large purchasers currently supplying pharmacy and grocery chain stores with influenza vaccine; (4) communicate current ACIP recommendations on the

		People 2020, with particular attention to improving demand for vaccine and achieving stability in the vaccine supply; (7) work with local public health officers through the Federation to respond to community flu vaccine shortages and possible influenza outbreaks to protect the public health; and, (8) urge the federal government to support, as a national priority, the development of safe and effective influenza vaccines employing new technologies and to continue to support adequate distribution to ensure that there will be an affordable, available and safe supply of influenza vaccine on an annual basis.	influenza vaccine to physicians and assist the CDC in disseminating its informational letters and bulletins to physicians and other providers of the influenza vaccine when they become available in order to ensure compliance with the ACIP recommendations with respect to immunization of patients with influenza vaccine; (5) work with the CDC and other immunization partners to explore options to provide for timely influenza immunization of those unable to pay ~~indigent~~ or underserved populations, including exploring options to provide for the timely redistribution of state and federally funded influenza vaccines to facilities or groups within the state willing to appropriately manage, distribute, and administer the vaccine to those unable to pay ~~indigent~~ or underserved populations; (6) continue its collaboration with the CDC and other stakeholders in influenza vaccination to work ~~to achieve the influenza immunization goals of Healthy People 2020, with particular attention to~~ on improving demand for vaccine and achieving stability in the vaccine supply; (7) work with local public health officers through the Federation to respond to community flu vaccine shortages and possible influenza outbreaks to protect the public health; and, (8) urge the federal government to support, as a national priority, the development of safe and effective influenza vaccines employing new technologies and to continue to support adequate distribution to ensure that there will be an affordable, available and safe supply of influenza vaccine on an annual basis.

H-440.856	Hospital Dress Codes for the Reduction of Health Care-Associated Infection Transmission of Disease	Our AMA encourages: (1) research in textile transmission of health care-associated infections (HAI); (2) testing and validation of research results before advocating for adoption of dress code policies that may not achieve reduction of HAIs; (3) all clinicians to assume "antimicrobial stewardship," i.e., adherence to evidence-based solutions and best practices to reduce of HAIs and HAI infection rates; and (4) all clinicians when seeing patients to wear attire that is clean, unsoiled, and appropriate to the setting of care.	Retain, still relevant.
H-440.881	Liability Protection for Adult Vaccines	Our American Medical Association supports the expansion of the Vaccine Injury Compensation Fund to include any vaccine encouraged or recommended by the Advisory Committee on Immunization Practices for routine use in the adult population.	Retain as amended to update language. Our American Medical Association supports the expansion of the Vaccine Injury Compensation Program ~~Fund~~ to include any vaccine ~~encouraged or~~ recommended by the Advisory Committee on Immunization Practices for routine use in the adult population.
H-440.908	Nosocomial Transmission of Disease via Stethoscope	The AMA advocates that health care providers frequently clean their stethoscopes and take all reasonable precautions with their other hand-held instruments in order to minimize the potential risk of nosocomial infection.	Retain, still relevant.
H-440.918	Improving Public Awareness of Immunization Guidelines	The AMA encourages and supports the frequent and regular dissemination of the Recommended Childhood Immunization Schedule recommendations through appropriate media throughout the US.	Retain, still relevant.
H-440.925	Possible Repeal of the National Vaccine Injury Compensation Program	Our American Medical Association continues to support in principle the National Vaccine Injury Compensation Program.	Retain, still relevant.
H-440.939	Qualifications for State Health Directors	The AMA recommends to state medical societies that they advocate with their respective legislatures the adoption of statutory requirements that the qualifications for State Health Director include a doctoral degree in medicine or osteopathy, public health training or experience, and preparation, both academic and experiential, adequate for the management of a large and complex health agency.	Retain, still relevant.
H-440.941	High Cost and Shortage of Vaccines	The AMA seeks to ensure in an administratively efficient manner the ready availability of vaccines to immunize individuals at reasonable cost.	Retain, still relevant.
H-440.977	Hepatitis B Vaccine	The AMA urges the appropriate use of hepatitis B vaccine and the dissemination of professional educational materials to increase the use of the hepatitis B vaccine by physicians whose patients are in high risk groups, including physicians in training and other medical personnel who come into contact	Retain, still relevant.

		with blood and blood products, tissues, secretions and excretions demonstrated to be potential reservoirs of hepatitis B virus.	
H-440.982	Centers for Disease Control Funding	The AMA supports funding for the Centers for Disease Control that is adequate to support its important and expanding public health activities.	Retain, still relevant.
H-440.991	Immunization Programs for Children	Our AMA (1) continues to support efforts toward the prevention of childhood disease through immunizations; (2) favors using its position in international health organizations to promote appropriate immunization programs for children throughout the world, especially in such critical and cost-effective areas as the prevention of poliomyelitis and measles; and (3) expresses the need for private and public research institutions to help develop more technically advanced products, such as new heat stable vaccines, necessary for the effective immunization of children throughout the world.	Retain, still relevant.
H-440.994	Sexually Transmitted Disease Prevention	Our AMA endorses the use of the condom as an effective method of prevention of sexually transmitted disease and urges state and county medical societies to endorse the display and sale of condoms of assured quality by the usual retail outlets for the prevention of sexually transmitted disease, and suggests that each package contain information about the hazards of sexually transmitted disease.	Retain as amended to remove unclear language. Our AMA endorses the use of the condom as an effective method of prevention of sexually transmitted disease and urges state and county medical societies to endorse the display and sale of condoms of assured quality by ~~the usual~~ retail outlets for the prevention of sexually transmitted disease, and suggests that each package contain information about the hazards of sexually transmitted disease.
H-445.985	Physician and Health Institution Publicity and Responsibility	Our American Medical Association encourages physicians when engaged in public discourse related to health and medical science to disclose whether stated positions are based on peer-reviewed evidence, standard of care, or personal opinion.	Retain, still relevant.
H-45.989	Child Safety Restraint Use in Aircraft	Our AMA supports (1) the use of and education about appropriate restraint systems for all children on all commercial airline flights; and (2) working with the Federal Aviation Administration, International Air Transport Association and other appropriate aviation regulators to establish criteria for appropriate child restraint systems.	Retain, still relevant.
H-45.998	Aircraft Shoulder Harness	The AMA supports the National Transportation Safety Board position that the FAA take action to require the installation of approved shoulder harnesses for all seat locations in general aviation aircraft.	Retain, still relevant.
H-450.945	Science in Medicine and Quality of Care	It is a critical role of the AMA to preserve, protect and enhance the quality of medical care now and in the future by: (1) advancing the art and science of	Retain, still relevant.

	in Health System Reform	medicine and the health of the public; (2) advocating for patients, physicians and the public; (3) enhancing the profile and priority within the AMA of science as the basis of medicine; and (4) bringing science advocacy to the forefront of health system reform.	
H-460.899	The Value of Peer Review in the Scientific Process	Our AMA reaffirms our strong support for the value of peer review system in ensuring openness and fidelity in the scientific process.	Retain, still relevant.
H-460.900	The Value of Independent Scientific Advice	Our AMA reaffirms our strong support for the value of independent scientific advice provided by federal advisory panels.	Retain, still relevant.
H-460.904	The Next Transformative Project: In Support of the BRAIN Initiative	Our AMA: (1) supports the scientific and medical objectives of the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative of mapping the human brain to better understand normal and disease process; (2) encourages appropriate scientific, medical and governmental organizations to participate in and support advancement in understanding the human brain in conjunction with the BRAIN Initiative; and (3) supports the continued Congressional allocation of funds for the BRAIN Initiative, thus providing for research and innovation in technologies that will advance knowledge of neurologic function and disease.	Retain, still relevant.
H-460.912	Principles for Conduct and Reporting of Clinical Trials	Our AMA: (1) endorses the Association of American Medical Colleges' "Principles for Protecting Integrity in the Conduct and Reporting of Clinical Trials"; (2) commends the AAMC, the Centers for Education and Research in Therapeutics and the BlueCross BlueShield Association for the development and dissemination of these principles; (3) supports the timely dissemination of clinical trial data for public accessibility as permitted by research design and/or regulatory protocol; (4) supports the promotion of improved data sharing and the reaffirmation and enforcement of deadlines for submitting results from clinical research studies; (5) encourages the expansion of clinical trial registrants to ClinicalTrials.gov; and (6) will sign the petition titled "All Trials Registered; All Results Reported" at Alltrials.net that supports the registration of all past, present and future clinical trials and the release of their summary reports.	Retain as amended, to remove items that have been accomplished. Our AMA: (1) ~~endorses the Association of American Medical Colleges' "Principles for Protecting Integrity in the Conduct and Reporting of Clinical Trials"; (2) commends the AAMC, the Centers for Education and Research in Therapeutics and the BlueCross BlueShield Association for the development and dissemination of these principles; (3)~~ supports the timely dissemination of clinical trial data for public accessibility as permitted by research design and/or regulatory protocol; (~~4~~ 2) supports the promotion of improved data sharing and the reaffirmation and enforcement of deadlines for submitting results from clinical research studies; and (~~5~~3) encourages the expansion of clinical trial registrants to ClinicalTrials.gov~~; and (6)~~

			~~will sign the petition titled "All Trials Registered; All Results Reported" at Alltrials.net that supports the registration of all past, present and future clinical trials and the release of their summary reports~~.
H-460.943	Potential Impact of Health System Reform Legislative Reform Proposals on Biomedical Research and Clinical Investigation	The AMA, to encourage and support the continuing development of new advances in science and medicine and the development and implementation of meaningful quality assurance programs essential to improving the delivery of medical and health care in the United States, advocates: (1) Strong support and funding for medical education programs at all levels to attract and stimulate gifted students and physicians to receive training and experience in, and to participate in, basic science or clinically-oriented research programs. (2) Strong financial and policy support for all aspects of biomedical science and research, including: basic science research (investigator initiated grant-funded research) in a wide variety of fields; laboratory-based clinical studies (including surgical studies); clinical studies and therapy trials; clinical outcomes research; behavioral science research, including studies to assess implementation of health promotion and/or disease prevention activities; and technology transfer research, with an emphasis on diffusing information about, training personnel in, and encouraging appropriate use of new technologies. (3) Adequate federal funding for biomedical science programs, including an appropriate balance of funding for basic, clinical, health service, and public health/prevention research. (4) Support and funding for evaluation and implementation research, including drug and technology assessment, medical device review, and developing and setting standards for computerized medical records.	Retain, still relevant.
H-460.970	Maintaining Progress in Biomedical Research	Our AMA supports continued leadership by the Association in maintaining progress in biomedical research.	Retain as amended to clarify language. Our AMA supports continued leadership by ~~the~~ our Association in maintaining progress in biomedical research.
H-460.989	Animals as Experimental Subjects	The AMA encourages medical school faculty who use animals in the education of students to continue instruction of students on the appropriate use and treatment of animals.	Retain, still relevant.
H-460.998	Support of Biomedical Research	Our AMA endorses and supports the following ten principles considered essential if continuing support and recognition of biomedical research vital to the delivery of quality medical care is to be a national	Retain, still relevant.

		goal: (1) The support of biomedical research is the responsibility of both government and private resources. (2) The National Institutes of Health must be budgeted so that they can exert effective administrative and scientific leadership in the biomedical research enterprise. (3) An appropriate balance must be struck between support of project grants and of contracts. (4) Federal appropriations to promote research in specifically designated disease categories should be limited and made cautiously. (5) Funds should be specifically appropriated to train personnel in biomedical research. (6) Grants should be awarded under the peer review system. (7) The roles of the private sector and of government in supporting biomedical research are complementary. (8) Although the AMA supports the principle of committed federal support of biomedical research, the Association will not necessarily endorse all specific legislative and regulatory action that affects biomedical research. (9) To implement the objectives of section 8, the Board will establish mechanisms for continuing study, review and evaluation of all aspects of federal support of biomedical research. (10) Our AMA will accept responsibility for informing the public on the relevance of basic and clinical research to the delivery of quality medical care.	
H-470.953	Evaluating Green Space Initiatives	Our AMA supports appropriate stakeholders in conducting studies to evaluate different green space initiatives that could be implemented in communities to improve patients' health and eliminate health disparities.	Retain, still relevant.
H-470.955	Support of Protective Headgear (Helmets) in the Sport of Girls'/Women's Lacrosse	Our American Medical Association supports requiring approved protective headgear for all athletes participating in the sport of girls'/women's lacrosse.	Retain, still relevant.
H-470.956	Injuries in Cheerleading	Our AMA: (1) supports the designation of cheerleading as a sport; and (2) recognizes the potential dangers of cheerleading, including the potential for concussion and catastrophic injury, and	Retain, with editorial amendments.

		supports the implementation of recommendations designed to improve its safety equivalent to those that apply to other athletic activities formally recognized as 'sports' by appropriate accrediting bodies. These include proper training of coaches, avoidance of inappropriate surfaces when performing stunts and adherence to rules for the proper execution of stunts.	Our AMA: (1) supports the designation of cheerleading as a sport; ~~and~~ (2) recognizes the potential dangers of cheerleading, including the potential for concussion and catastrophic injury~~,~~; and (3) supports the implementation of recommendations designed to improve its safety equivalent to those that apply to other athletic activities formally recognized as 'sports' by appropriate accrediting bodies. These include proper training of coaches, avoidance of inappropriate surfaces when performing stunts, and adherence to rules for the proper execution of stunts.
H-470.958	Head Injury Prevention in Hockey	Our AMA will encourage that all levels of hockey effectively prevent head hits and dangerous checking.	Retain, still relevant.
H-470.960	Soccer Injuries	Our AMA recognizes the problem of injuries in soccer and encourages additional studies into the incidence of soccer-related injuries and methods to reduce those injuries.	Retain, still relevant.
H-470.967	Safety in Youth Baseball and Softball	The AMA urges youth baseball and softball organizations to adopt policies for the use of protective equipment and encourages sponsors of organized youth sports activities to adopt written emergency and first responder plans.	Retain, still relevant.
H-470.971	Athletic Preparticipation Examinations for Adolescents	To promote the health and safety of adolescents, our AMA recommends that state medical societies work with appropriate state and local agencies to promote the following: (1) The development of standards for preparticipation athletic examinations that are consistent with consensus recommendations of the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine. (2) Only licensed MDs, DOs, and licensed physician extenders practicing under the supervision of licensed MDs and DOs perform preparticipation examinations. (3) The decision of whether or not an adolescent is healthy and physically mature enough to participate in a particular sport is made by a qualified physician. (4) The decision of when an injured athlete resumes participation is made by a qualified physician.	Retain, still relevant.

		(5) The most current guidelines established by the American Academy of Pediatrics, American College of Cardiology, American College of Sports Medicine, and other appropriate medical specialty societies are used to determine eligibility for sports participation.	
H-470.974	Athletic Helmets	1. Our AMA urges the Consumer Product Safety Commission and other appropriate agencies and organizations to establish standards to ensure that athletic and recreational equipment produced or sold in the United States provide protection against head and facial injury. 2. Our AMA: (a) supports requiring the use of head and facial protection by children and adolescents while engaged in potentially dangerous athletic and recreational activities; (b) encourages the use of head and facial protection for adults while engaged in potentially dangerous athletic and recreational activities; (c) encourages physicians to educate their patients about the importance of head and facial protection while engaged in potentially dangerous athletic and recreational activities; and (d) encourages the availability of rental helmets at all commercial settings where potentially dangerous athletic and recreational activities take place.	Retain, still relevant.
H-470.979	Drugs and Athletes	The AMA favors cooperative efforts with the National Collegiate Athletic Association, the National Intercollegiate Athletic Association, the National Federation of High Schools and all other appropriate organizations to establish drug education, testing and treatment programs in all their respective athletic programs.	Rescind, as mostly accomplished and partly superseded by new data. At the college level, in 2024 the NCAA Sports Science Institute revised their "Substance Misuse Prevention and Intervention: An Athletics Tool Kit." The NCAA Sport Science Institute on behalf of the Committee on Competitive Safeguards and Medical Aspects of Sports issues yearly updates that include prevention, education, treatment, and recovery components. At the adolescent level, the American Society of Addiction Medicine issued guidelines on "Appropriate Use of Drug Testing in Clinical Addiction Medicine". This document includes recommendations about what level of risk justifies testing;

			consent and other procedural safeguards; and appropriate use of test data. At the high school level, the National Federation of State High School Associations (NFHS), published a 2024 opinion, "Revisiting Drug Testing in High Schools – Where Do We Stand" with a nuanced discussion of the "pros and cons" of drug testing in high school athletics and other optional activities. Because relevant organizations have recently published material that covers in detail all areas included in H-470.979, your Council on Science and Public Health recommends that H-470.979 be rescinded.
H-470.994	Non-Therapeutic Use of Pharmacological Agents by Athletes	Our AMA: (1) opposes the use of drugs for the purpose of enhancing athletic performance or sustaining athletic achievement. This action in no way should be construed as limiting a physician's proper use of drugs in indicated treatment of athletic injuries or clinical symptoms of individual athletes; and (2) endorses efforts by state level high school athletic associations to establish programs which include enforceable guidelines concerning weight and body fat changes on a precompetition basis for those sports in which weight management is a concern.	Retain, still relevant.
H-470.995	Athletic (Sports) Medicine	Our AMA believes that: (1) the Board of Education and the Department of Health of the individual states should encourage that an adequate Athletic Medicine Unit be established in every school that mounts a sports program; (2) the Athletic Medicine Unit should be composed of an allopathic or osteopathic physician director with unlimited license to practice medicine, an athletic health coordinator (preferably a NATABOC certified athletic trainer), and other necessary personnel; (3) the duties of the Athletic Medicine Unit should be prevention of injury, the provision of medical care with the cooperation of the family's physician and others of the health care team of the community, and the rehabilitation of the injured;	Retain, still relevant.

		(4) except in extreme emergencies, the selection of the treating physician is the choice of the parent or guardian and any directed referral therefore requires their consent; (5) the Athletic Medicine Units should be required to submit complete reports of all injuries to a designated authority; (6) medical schools, colleges, and universities should be urged to cooperate in establishing education programs for athletic health coordinators (NATABOC certified athletic trainers) as well as continuing medical education and graduate programs in Sports Medicine; (7) high school administrators, athletic directors, and coaches to work with local physicians, medical societies, and medical specialty societies, as well as government officials and community groups to undertake appropriate measures to ensure funding to provide the services of a certified athletic trainer to all high school athletes; and (8) not all high schools have the resources to procure the services of a certified athletic trainer and further recognizing that athletic trainers cannot be present at all practices and competitions, that the AMA encourage high school administrators and athletic directors to ensure that all coaches are appropriately trained in emergency first aid and basic life support.	
H-480.955	"Keepsake" Fetal Ultrasonography	Our AMA: (1) supports the current Food and Drug Administration (FDA) policy on use of non-diagnostic fetal ultrasound, which views "keepsake" fetal videos as an unapproved use of a medical device; and (2) will lobby the federal government to enforce the current FDA position, which views "keepsake" fetal videos as an unapproved use of a medical device, on non-medical use of ultrasonic fetal imaging.	Retain, still relevant.
H-495.978	Proper FDA Authority to Regulate Tobacco	Our AMA will continue to support federal legislation that would give the Food and Drug Administration strong regulatory authority over tobacco products.	Retain, still relevant.
H-495.987	Taxation of All Tobacco Products and Electronic Nicotine Delivery Systems (ENDS)	1. Our AMA will work for and encourages all levels of the Federation and other interested groups to support efforts, including education and legislation, to increase federal, state, and local excise taxes on all tobacco products and electronic nicotine delivery systems (ENDS), including e-cigarettes, in order to discourage use. 2. An increase in federal, state, and local excise taxes for such products should include provisions to make substantial funds available that would be allocated to health care needs and health education, and for the treatment of those who have already been afflicted by	Retain as amended to update language. 1. Our AMA ~~will work for and~~ encourages all levels of the Federation and other interested groups to support efforts, including education and legislation, to increase federal, state, and local excise taxes on all tobacco products and electronic nicotine delivery systems (ENDS), including e-

		tobacco-caused illness, including nicotine dependence, and to support counter-advertising efforts. 3. Our AMA continues to support legislation to reduce or eliminate the tax deduction presently allowed for the advertisement and promotion of all tobacco products; and advocates that the added tax revenues obtained as a result of reducing or eliminating such advertising/promotion tax deduction be utilized by the federal government for expansion of health care services, health promotion and health education.	cigarettes, in order to discourage use. 2. Our AMA supports ~~A~~an increase in federal, state, and local excise taxes for ~~such~~ tobacco products and electronic nicotine delivery systems (ENDS) ~~should~~ that includes provisions to ~~make substantial funds available that would be~~ allocate~~d~~ substantial funds for ~~to~~ health care needs and health education, ~~and for~~ the treatment of those who have already been afflicted by tobacco-caused illness, including nicotine dependence, and to support counter-advertising efforts. 3. Our AMA continues to support legislation to reduce or eliminate the tax deduction presently allowed for the advertisement and promotion of all tobacco products; and advocates that the added tax revenues obtained as a result of reducing or eliminating such advertising/promotion tax deduction be utilized by the federal government for expansion of health care services, health promotion and health education.
H-505.964	International Tobacco Control Efforts	Our AMA: (1) supports the international tobacco control efforts of the World Health Organization and urges the appropriate bodies and persons within the U.S. government (including Congress, the State Department, the Department of Commerce, and the Department of Health and Human Services) to participate fully in international tobacco control efforts, including supporting efforts to bring to fruition a Framework Convention on Tobacco Control; (2) will work for the enactment of federal legislation or regulations that would prohibit the exportation of tobacco products to other countries. Pending the enactment of such legislation or regulation, our AMA (a) urges the U.S. government to alter trade policies and practices that currently serve to promote the	Retain, still relevant.

		world smoking epidemic; (b) continues to support the following activities: (i) federal legislation requiring health warning labels in the appropriate native language or symbolic form to be on packages of cigarettes exported and require foreign advertising by U.S. tobacco producers to be at least as restrictive as types of advertising permitted in the U.S.; (ii) labeling on tobacco products manufactured abroad to be at least as restrictive as those produced in the U.S.; (iii) opposition to efforts by the U.S. government to persuade countries to relax regulations concerning tobacco promotion and consumption; and (iv) encouragement of the World Health Organization to increase its worldwide anti-smoking efforts; (c) supports working with the World Medical Association as well as directly with national medical societies to expand activities by the medical profession to reduce tobacco use worldwide; (d) supports establishing close working relations with the World Health Organization to promote more physician involvement in anti-tobacco activities, particularly in developing and recently developed countries; (e) supports working with the Centers for Disease Control and Prevention's Office on Smoking and Health to promote worldwide anti-tobacco activities; (f) supports periodically monitoring the success of worldwide anti-tobacco efforts to control the growing worldwide smoking epidemic; and (g) supports the right of local jurisdictions to enact tobacco regulations that are stricter than those that exist in state statutes and encourages state and local medical societies to evaluate and support local efforts to enact useful regulations; and (3) opposes any efforts by the government or its agencies to actively encourage, persuade or compel any country to import tobacco products and favors legislation that would prevent the government from actively supporting, promoting or assisting such activities.	
H-515.963	Diagnosis and Management of Family Violence	Our American Medical Association recommends that questions to assess risk for family violence should be included within the context of taking a routine social history, past medical history, history of present illness, and review of systems as part of emergency, diagnostic, preventive, and chronic care management.	Retain as amended to update language. Our American Medical Association recommends that questions to assess risk for family and intimate partner violence should be included within the context of taking a routine social history, past medical history, history of present illness, and review of systems as part of emergency, diagnostic, preventive, and chronic care management.

H-515.973	Memories of Childhood Abuse	The AMA: (1) recognizes that few cases in which adults make accusations of childhood sexual abuse based on recovered memories can be proved or disproved and it is not yet known how to distinguish true memories from imagined events in these cases; (2) encourages physicians to address the therapeutic needs of patients who report memories of childhood sexual abuse and that these needs exist quite apart from the truth or falsity of any claims; and (3) encourages physicians treating possible adult victims of childhood abuse to subscribe to the *Principles of Medical Ethics* when treating their patients and that psychiatrists pay particular attention to the *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*.	Retain, still relevant.
H-515.995	Corporal Punishment in Schools	The AMA (1) supports the abolition of corporal punishment in schools; (2) encourages universities that train teachers to emphasize alternative forms of discipline during their training; (3) encourages physicians to work toward the abolition of corporal punishment in their communities; and (4) encourages state medical societies to support legislation prohibiting corporal punishment in their state.	Retain, still relevant.
H-60.920	Child Resistant Caps on Energy Drinks	Our American Medical Association urges that the US Food and Drug Administration and/or US Congress take legislative or regulatory action on the federal level to require child-resistant packaging on all high energy drinks manufactured in the United States.	Retain, still relevant.
H-60.983	Statement of Concern Regarding Destructive Themes Contained in Music	(1) The AMA is concerned about the possible impact of destructive themes depicted in certain types of popular music. The vivid depiction of drug and alcohol use, suicide, violence, demonology, sexual exploitation, racism and bigotry could be harmful to some young people, especially vulnerable children and adolescents who are socially alienated from traditional value systems and positive support groups. (2) The AMA urges four activities: (a) parents should be aware of the themes depicted in music; monitor the concerts their children attend, the music videos they watch, and the albums they purchase and discuss the potential harmful effects of music themes with their children; (b) physicians should know about potentially destructive themes in some forms of music, and should work to increase awareness of patients and communities about these themes; (c) members of the entertainment industry, including sponsors of concerts, agents, and entertainers, should exercise greater responsibility in presenting music to young people; and (d) all music industry companies should voluntarily label albums in compliance with recently agreed upon labeling standards.	Retain, still relevant.
H-60.994	Herpes Simplex and School Children	The AMA reaffirms the rights of children with herpes infections to a quality education, condemns exclusion of such children from regular classes with other children, and encourages state legislation which	Retain, still relevant.

		would mandate that children with herpes not be excluded from regular classes.	
H-95.979	Curtailing Prescription Drug Abuse While Preserving Therapeutic Use - Recommendations for Drug Control Policy	Our AMA (1) opposes expansion of multiple-copy prescription programs to additional states or classes of drugs because of their documented ineffectiveness in reducing prescription drug abuse, and their adverse effect on the availability of prescription medications for therapeutic use; (2) supports continued efforts to address the problems of prescription drug diversion and abuse through physician education, research activities, and efforts to assist state medical societies in developing proactive programs; and (3) encourages further research into development of reliable outcome indicators for assessing the effectiveness of measures proposed to reduce prescription drug abuse.	Retain, as amended to update language. Curtailing Prescription Drug Misuse ~~Abuse~~ While Preserving Therapeutic Use - Recommendations for Drug Control Policy Our AMA (1) opposes expansion of multiple-copy prescription programs to additional states or classes of drugs because of their documented ineffectiveness in reducing prescription drug misuse ~~abuse~~, and their adverse effect on the availability of prescription medications for therapeutic use; (2) supports continued efforts to address the problems of prescription drug diversion and misuse ~~abuse~~ through physician education, research activities, and efforts to assist state medical societies in developing proactive programs; and (3) encourages further research into development of reliable outcome indicators for assessing the effectiveness of measures proposed to reduce prescription drug misuse ~~abuse~~.
H-95.987	Using Controlled Substance Names in Commercial Products	The AMA opposes the advertising practice of naming products for controlled substances, implying that their use is exciting and desirable.	Retain, still relevant.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 5-A-25

Subject: Screening for Image Manipulation in Research Publications

Presented by: John T. Carlo, MD, MS, Chair

Referred to: Reference Committee E

INTRODUCTION

Resolution 506-A-24, Screening for Image Manipulation in Research Publications," introduced by the Medical Student Section was referred. It stated that "our American Medical Association support the creation of a nationally collaborative database of manipulated images from retracted publications to provide a test bank for researchers developing augmented intelligence-integrated image screening tools." While there was only limited testimony on this item, concerns around the feasibility and scope of the request resulted in its referral for further study. This report serves as the Council on Science and Public Health's response to that referral.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms "image manipulation" and "AI image manipulation screening" and "generative adversarial networks." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

BACKGROUND

In a time of rampant misinformation and disinformation around medical science, the integrity of academic journals is of the utmost importance and allegations of research misconduct should be taken very seriously. As artificial intelligence (AI) tools become more advanced and integrated into the toolkits of researchers, the potential role of AI in research fraud should also receive more scrutiny.

While retractions may be done for a variety of reasons that may not necessarily be caused by research misconduct, many publishers are alarmed by the increasing rate of fraudulent images resulting in retractions.[1,2] Per the publishing watchdog RetractionWatch, the retraction rate in 2014 was 3.5 retracted articles per 10,000 published articles and rose to 11.2 retractions per 10,000 in 2022, with over 10,000 papers being retracted in 2023.[3] Interestingly, the incidences of retractions are relatively centralized, with researchers in Saudi Arabia (30.6 retractions per 10,000 articles), Pakistan (28.1 per 10,000), Russia (24.9 per 10,000), and China (23.5 per 10,000) having more retractions than the global rate.[4] As a result, some countries, such as China, have initiated national audits of research integrity.[5] It should be noted, however, that these statistics reflect retractions for any cause, not just image manipulation.

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Generally, researchers with retractions will only have one retraction in their career, however there are a small-subset of serial offenders with more than ten retractions.[4] For publishers, the inverse appears to be true; in 2022, 51 percent of all retracted articles were published in the same 34 journals, sparking concerns of "paper mills," in which a publisher intentionally maintains low standards to increase publishing fees revenue, or malicious researchers have identified a deficiency in a publisher's review process and specifically target them for fraudulent articles.[3]

Beyond instances of malicious fraud, AI-generated images can also produce misleading or incorrect images in publications even if well-intended. For example, researchers have probed anatomical illustrations created by AI programs and found deficiencies in both their accuracy and level of detail.[6]

The Role of AI

AI can be a powerful tool for helping researchers communicate their message to a broader audience. For example, AI can help generate graphical abstracts, summarize data sets, or make images more readable.[7] As such, many journals maintain policies where authors must disclose where and when they used AI tools for the editors to adjudicate its appropriateness.[8-10]

While these tools are promising, advancements in AI, such as generative adversarial networks (GANs), pose a unique threat to image manipulation detection. GANs were introduced in 2014 and excel in generating highly realistic images known as "deepfakes" (a portmanteau of 'deep learning' and 'fake'). For example, researchers have found that even trained experts only correctly identify whether a Western blot image was real or AI-generated at a 50 percent rate, no better than a random guess.[11] A sample image has been provided in Appendix 1. Even prior to the introduction of GANs, the Department of Health and Human Service (HHS) Office of Research Integrity reported that 67 percent of their closed research misconduct cases between 2011 and 2015 were a result of manipulated images.[12] It is expected that as artificial image generation technology grows more sophisticated and more accessible, its use in research misconduct will similarly increase.

Given that these fraudulent images are not duplicated from existing images in the public domain, modern image integrity detection software may struggle at detecting deepfakes. GANs, and other AI tools, have been used to generate false images or video for a variety of applications beyond research misconduct, including financial fraud, sowing political discontent, and even pornography.[13,14] The programs used to make these images are generally accessible and usable on desktop computers and do not require any specialized equipment.[15]

CURRENT APPROACHES

The original resolution requested a "nationally collaborative database of manipulated images from retracted publications" for researchers developing tools to combat research misconduct. It should be noted that resources which may satisfy these requirements currently exist. For example, the HHS, Office of Research Integrity maintains publicly available resources on image forensics, academic publishers regularly share open-source databases, and non-profit entities such as RetractionWatch maintain searchable databases of retracted publications.[16-18] While these resources may not fully accomplish the goals of the original resolution, they do point to the generally available nature of manipulated images from retracted articles.

Additionally, nearly all major journal publishers currently utilize detection software, suggesting that there are currently market forces to push these kinds of research and development efforts. While the use of AI technologies to conduct research fraud is new, the concept of manipulating

images is not. As such, academic journals have generally been quick to adopt new technologies to keep up with the advances of malicious actors. For example, the AI image detection tool Proofig is currently partnered with journals published by Elsevier, Springer Nature, Science, the American Association of Cancer Research, the Royal Society of Chemistry, the American Society of Clinical Investigation, the Company of Biologists, Mary Ann Liebert, Inc., Compuscript Ltd, Sage Publishing, and the Taylor and Francis publishing group.[19] Proofig claims that approximately 25 percent of all manuscripts screened have been found to have some level of image manipulation, which can then be manually screened by an editor. Other tools, such as ImageTwin or Imachek, are also used by journal publishers to identify image manipulation. Other publishers, such as the PLOS family of journals, additionally require authors to submit raw image files prior to publication to detect image manipulation in their submissions.[20]

Finally, given the widespread accessibility of software to generate falsified images, it is unclear what value a centralized repository of retracted images would be. Technologies such as Deep AI are fully open source, meaning they are broadly available to the public for free use, or other programs such as DALL-E 3 or IMAGEN can be licensed at rates as low as 3 cents per image.[21,22] Particularly if a database were of specifically images from retracted publications, those are more likely to be generated using outdated technology, given the rapid rate of innovation in this space, or they were already detectable, given they were flagged for retraction. Additionally, it is unclear whether journal publishers retain the ownership rights for images after retraction, which may present intellectual property challenges for such a database.

Experts in the field of research misconduct describe the current publishing landscape as an "arms race," wherein generative software and detection software are both rapidly evolving to keep up with the developments of their counterpart.[23] This situation is likely unsustainable, and simply creating more sophisticated detection tools will likely only result in more sophisticated generation tools, and vice versa. Rather, some experts have argued that research misconduct is a symptom of the high pressures placed on researchers by the academic ecosystem, particularly the "publish or perish" mindset coming from the emphasis employers and funders place on academic publishing, and lack of interest in reproducibility.[24]

CURRENT AMA POLICY

Our AMA maintains robust policy on research misconduct, including through the Code of Medical Ethics. Full text of cited policies can be found in the appendix of this report.

Our AMA's opposition to research misconduct can be found in policy H-460.972, "Fraud and Misrepresentation in Science," which notes that "Our AMA supports the promotion, through AMA publications and other vehicles, of (a) A clear understanding of the scientific process, possible sources of error, and the difference between intentional and unintentional scientific misrepresentation. (b) Multidisciplinary discussions to formulate a standardized definition of scientific fraud and misrepresentation that elaborates on unacceptable behavior." This policy also notes that "Our AMA supports the development of specific standardized guidelines dealing with the disposition of primary research data, authorship responsibilities, supervision of research trainees, role of institutional standards, and potential sanctions for individuals proved guilty of scientific misconduct." Additionally, policy H-460.980, "Ethical and Societal Considerations in Research," states that "[e]ach institution should have a system both for monitoring the conduct of biomedical research and for investigating and reporting allegations of research misconduct."

Code of Medical Ethics, opinion 7.1.5, "Misconduct in Research," states "[b]iomedical and health research is intended to advance medical knowledge to benefit future patients. To achieve those

goals physicians who are involved in such research maintain the highest standards of professionalism and scientific integrity." Additional opinions, including 7.1.1, "Physician Involvement in Research," ("[…] physicians who are involved in research should […] [a]dhere to rigorous scientific and ethical standards in conducting, supervising, and disseminating results of the research"), and 7.2.1, "Principles for Disseminating Research Results," ("[…] physicians should […] [r]eport the results of research accurately, including subsequent negative findings. This is particularly important where the findings do not support the research hypothesis") further emphasize the importance of proper conduct by physicians performing research.

CONCLUSION

Research misconduct undercuts trust and has a corrosive impact on the practice of medicine. While cases of fraud have happened infrequently in the past, rising rates of retractions have resulted in concerns that widespread access to AI tools which quickly generate text and images are causing fraud to become more commonplace. Our AMA's stance on research misconduct is clear, robust, and supports the use of a variety of means to reduce its prevalence. While it is possible that the creation of a repository of falsified images for researchers to use may improve AI detection tools, it is also clear that these efforts are already underway, being developed by commercial entities, and utilized by many, if not all major journal publishers.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 506-A-24, and that the remainder of the report be filed:

1. AMA Policy H-460.972, "Fraud and Misrepresentation in Science," be amended by addition to read as follows:

    1. Our American Medical Association supports the promotion of structured discussions of ethics that include research, clinical practice, and basic human values within all medical school curricula and fellowship training programs;
    2. Our AMA supports the promotion, through AMA publications and other vehicles, of
        a. A clear understanding of the scientific process, possible sources of error, and the difference between intentional and unintentional scientific misrepresentation.
        b. Multidisciplinary discussions to formulate a standardized definition of scientific fraud and misrepresentation that elaborates on unacceptable behavior.

       Our AMA supports the promotion of discussions on the peer review process and the role of the physician investigator.
    3. Our AMA supports the development of specific standardized guidelines dealing with the disposition of primary research data, authorship responsibilities, supervision of research trainees, role of institutional standards, and potential sanctions for individuals proved guilty of scientific misconduct.
    4. Our AMA supports the sharing of information about scientific misconduct among institutions, funding agencies, professional societies, and biomedical research journals
    5. Our AMA will educate, at appropriate intervals, physicians and physicians-in-training about the currently defined difference between being an "author" and being a "contributor" as defined by the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors, as well as the varied potential for industry bias between these terms.

6. Our AMA supports policies requiring authors to disclose the use of generative artificial/augmented intelligence programs to best allow for content to be reviewed for intentional and unintentional scientific misrepresentation.
7. Our AMA supports efforts to disseminate accurate and valid research findings, and to combat research and publication fraud, in the face of rapidly advancing technology. (Modify HOD Policy)

2. AMA Policy H-460.980, "Ethical and Societal Considerations in Research" be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: less than $1,000

RELEVANT AMA POLICY

AMA Publications G-630.090

Our American Medical Association policy on its publications includes the following:

1. JAMA and other AMA scientific journals should display a disclaimer in prominent print that the editorial views are not necessarily AMA policy.
2. Our AMA, in all of its publications and correspondence, will use the correct title for the medical specialist.
3. Our AMA recommends that medical journal articles using acronyms should have a small glossary of acronyms and phrases displayed prominently in the article.
4. The House of Delegates affirms that JAMA and The JAMA Network journals shall continue to have full editorial independence as set forth in the AMA Editorial Governance Plan.

Fraud and Misrepresentation in Science H-460.972

8. Our American Medical Association supports the promotion of structured discussions of ethics that include research, clinical practice, and basic human values within all medical school curricula and fellowship training programs;
9. Our AMA supports the promotion, through AMA publications and other vehicles, of
    a. A clear understanding of the scientific process, possible sources of error, and the difference between intentional and unintentional scientific misrepresentation.
    b. Multidisciplinary discussions to formulate a standardized definition of scientific fraud and misrepresentation that elaborates on unacceptable behavior.
10. Our AMA supports the promotion of discussions on the peer review process and the role of the physician investigator.
11. Our AMA supports the development of specific standardized guidelines dealing with the disposition of primary research data, authorship responsibilities, supervision of research trainees, role of institutional standards, and potential sanctions for individuals proved guilty of scientific misconduct.
12. Our AMA supports the sharing of information about scientific misconduct among institutions, funding agencies, professional societies, and biomedical research journals
13. Our AMA will educate, at appropriate intervals, physicians and physicians-in-training about the currently defined difference between being an "author" and being a "contributor" as defined by the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors, as well as the varied potential for industry bias between these terms.

Ethical and Societal Considerations in Research H-460.980

1. Private organizations and academic institutions should jointly develop a means to continue and enhance broadly based study and discussion of ethical and societal issues in biomedical research.
2. The federal government should provide the resources to support new initiatives within the National Institutes of Health for the funding of research studies in bioethics. Existing federal programs that fund bioethical research studies should be preserved. Private foundations should be encouraged to provide resources to support research studies in bioethics.
3. A uniform set of federal regulations governing research with human subjects, based on the core regulations of the Department of Health and Human Services should be adopted by all federal agencies. Uniformity should not preclude additions to Department regulations that do not conflict with the core regulations or that enhance the protection of research subjects.
4. Associations of regional institutional review boards (IRBs) should be formed to enhance IRB performance through the development of educational site visits and local workshops.

5. Each institution should have a system both for monitoring the conduct of biomedical research and for investigating and reporting allegations of research misconduct.
6. All investigators involved in research projects should be responsible for the clear articulation and enforcement of standards that ensure the integrity of scientific data and conclusions. Regardless of whether the research project is a result of individual or collaborative efforts, investigators should thoroughly understand the data and conclusions in research publications and studies.
7. As part of their formal training in research investigation, graduate, medical and postdoctoral students should be instructed on the importance of adhering to the ethical and scientific requirements in research conduct and in the reporting of research results.
8. Our American Medical Association encourages study of the inclusion of Socioeconomic Status (SES) data in clinical and public health research identify appropriate minimum standards for the inclusion of such data in research studies.
9. Our AMA:
    a. opposes policies requiring scientific disclosures of confidential medical records consistent with Policy H-315.983, "Patient Privacy and Confidentiality".
    b. supports the use of all credible scientific data in the development of public policy while safeguarding confidentiality of patient information.

7.1.5 Misconduct in Research

Biomedical and health research is intended to advance medical knowledge to benefit future patients. To achieve those goals physicians who are involved in such research maintain the highest standards of professionalism and scientific integrity.

Physicians with oversight responsibilities in biomedical or health research have a responsibility to ensure that allegations of scientific misconduct are addressed promptly and fairly. They should ensure that procedures to resolve such allegations:

(a) Do not damage science.

(b) Resolve charges expeditiously.

(c) Treat all parties fairly and justly. Review procedures should be sensitive to parties' reputations and vulnerabilities.

(d) Maintain the integrity of the process. Real or perceived conflicts of interest must be avoided.

(e) Maintain accurate and thorough documentation throughout the process.

(f) Maintain the highest degree of confidentiality.

(g) Take appropriate action to discharge responsibilities to all individuals involved, as well as to the public, research sponsors, the scientific literature, and the scientific community.

7.1.1 Physician Involvement in Research

Biomedical and health research is intended to contribute to the advancement of knowledge and the welfare of society and future patients, rather than to the specific benefit of the individuals who participate as research subjects.

However, research involving human participants should be conducted in a manner that minimizes risks and avoids unnecessary suffering. Because research depends on the willingness of participants to accept risk, they must be able to make informed decisions about whether to participate or continue in a given protocol.

Physician researchers share their responsibility for the ethical conduct of research with the institution that carries out research. Institutions have an obligation to oversee the design, conduct, and dissemination of research to ensure that scientific, ethical, and legal standards are upheld. Institutional review boards (IRBs) as well as individual investigators should ensure that each participant has been appropriately informed and has given voluntary consent.

Physicians who are involved in any role in research with human participants have an ethical obligation to ensure that participants' interests are protected and to safeguard participants' welfare, safety, and comfort.

To fulfill these obligations, individually, physicians who are involved in research should:

(a) Participate only in those studies for which they have relevant expertise.

(b) Ensure that voluntary consent has been obtained from each participant or from the participant's legally authorized representative if the participant lacks the capacity to consent, in keeping with ethics guidance. This requires that:

(i) prospective participants receive the information they need to make well-considered decisions, including informing them about the nature of the research and potential harms involved;

(ii) physicians make all reasonable efforts to ensure that participants understand the research is not intended to benefit them individually;

(iii) physicians also make clear that the individual may refuse to participate or may withdraw from the protocol at any time.

(c) Assure themselves that the research protocol is scientifically sound and meets ethical guidelines for research with human participants. Informed consent can never be invoked to justify an unethical study design.

(d) Demonstrate the same care and concern for the well-being of research participants that they would for patients to whom they provide clinical care in a therapeutic relationship. Physician researchers should advocate for access to experimental interventions that have proven effectiveness for patients.

(e) Be mindful of conflicts of interest and assure themselves that appropriate safeguards are in place to protect the integrity of the research and the welfare of human participants.
(f) Adhere to rigorous scientific and ethical standards in conducting, supervising, and disseminating results of the research.

7.2.1 Principles for Disseminating Research Results

Physicians have an ethical responsibility to learn from and contribute to the total store of scientific knowledge. When they engage in biomedical or health research, physicians have obligations as scientists, which include disseminating research findings. Prompt presentation to scientific peers and publication of research findings are foundational to good medical care and promote enhanced patient care, early evaluation of clinical innovations, and rapid dissemination of improved techniques.

To fulfill their ethical responsibilities with respect to sharing research findings for the ultimate benefit of patients, physicians should:

(a) Advocate for timely and transparent dissemination of research data and findings. Physicians should not intentionally withhold information for reasons of personal gain.
(b) Report the results of research accurately, including subsequent negative findings. This is particularly important where the findings do not support the research hypothesis.
(c) Maintain a commitment to peer review.
(d) Disclose sponsorship and conflicts of interest relating to the research, in keeping with ethics guidance.
(e) Be responsible in their release of research results to the media, ensuring that any information the researcher provides is prompt and accurate and that informed consent to the release of information has been obtained from research participants (or participants' legally authorized representative when the participant lacks decision-making capacity) prior to releasing any identifiable information.

In rare circumstances, the potential for misuse of research results could affect the decision about when and whether to disseminate research findings. Physician-researchers should assess foreseeable ramifications of their research in an effort to balance the promise of benefit against potential harms from corrupt application. Only under rare circumstances should findings be withheld, and then only to the extent required to reasonably protect against misuse.

APPENDIX 1

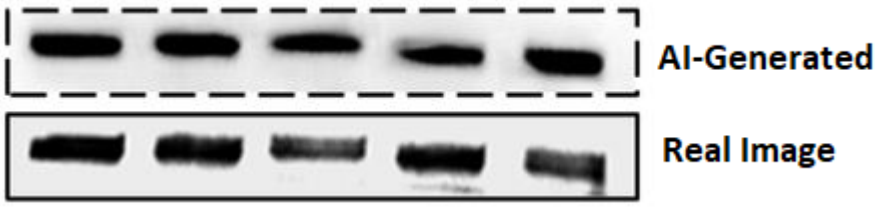


Figure 1. Sample of artificially generated (top) and real (bottom) Western blot images. When this specific image was provided to experts, only 4 of 23 participants were able to correctly identify the artificially generated image. For all images used in this study, experts had a 50 percent accuracy rate for detecting artificially generated images. Adapted from Qi et al.[11]

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REPORT 8 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-25)
Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms
(Reference Committee E)

EXECUTIVE SUMMARY

BACKGROUND. In continuance of the American Medical Association's (AMA) interest in the oversight and regulation of augmented intelligence (AI) and machine learning (ML) algorithms in the medical system, the Council on Science and Public Health has initiated a report to examine the concept of explainability in the context of AI/ML algorithms.

Briefly, "explainable AI" (XAI) describes AI/ML-enabled algorithms whose decisions would be understandable to an expert in the field and can be evaluated for accuracy or other external factors. At its core, the implementation and use of XAI is a question of physician autonomy. In instances where algorithms can explain their decision-making, they are useful tools for scraping huge data sets and recognizing patterns that may have been imperceptible to the clinician. In those cases, those algorithms are augmenting the physician's skillset, and the outputs can be viewed as recommendations, which can be discarded if the physician's training and expertise disagree with the conclusion. However, if clinical AI algorithms are not explainable, the clinician's training and expertise is removed from decision-making, and they are presented with information they may feel compelled to act upon without knowing where it came from or being able to assess accuracy of the conclusion.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms "AI explainability," "black box algorithm," and "white box algorithm." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

DISCUSSION. Generally, humans have low trust of AI, particularly when it is involved in decision-making. One proposed approach for rectifying this lack of trust is through AI devices providing explanations for how it arrived at a conclusion. While XAI is highly appealing for building trust, it is less clear that it is implementable for medical applications. A common fallacy when evaluating AI/ML algorithms is to assume that they approach problems and datasets in the same way that a human would. Algorithms cannot feel, intuit, or infer, but rather perform a series of highly complex calculations. This report discusses several key concepts around explainability, including the motivations for its use, the technical feasibility, regulatory approaches used in both medical and non-medical fields, and recommendations for moving towards more trustworthy AI development.

CONCLUSION. Ironically, the concept of explainability is hard to explain. It is complex, nuanced, and asks profound questions on human cognition and the meaning of trust. The appeal of explainability is clear – particularly in medicine, where decisions can have life or death consequences. Being told a computer has decided you do not qualify for treatment would be disturbing for patients and their physicians. Physicians have trained for decades to utilize context and see the whole patient's clinical picture, and a binary "yes/no" output from a black box may feel restrictive and lacking nuance. Instead, medicine may wish to leverage its experience with other unexplainable phenomena, and push for explainability while requiring safety and efficacy.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 8-A-25

Subject: Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms

Presented by: John T. Carlo, MD, MS, Chair

Referred to: Reference Committee E

INTRODUCTION

In continuance of the American Medical Association's (AMA) interest in the oversight and regulation of augmented intelligence (AI) and machine learning (ML) algorithms in the medical system, the Council on Science and Public Health have has initiated this report to examine the concept of explainability. To keep the focus of this report narrow, it is the Council's intent to regularly examine issues relevant to AI/ML's intersection with science and public health and develop policy recommendations as necessary. This report will also serve as an opportunity to define key concepts related to AI in a field where groups are using different definitions of the same term, leading to confusion.

Briefly, "explainable AI" (XAI) describes algorithms whose decisions would be understandable to an expert in the field and can be evaluated for accuracy or other external factors. AI/ML tools in the medical setting can take a variety of forms, ranging from those which interpret images, make diagnostic recommendations, or have a conversation with a patient using a large-language model (LLM). All of these tools would theoretically be able to be developed using an XAI framework. An example of this includes an algorithm trained to distinguish between pictures of wolves and huskies to help track endangered species.[1] The program became very good at detecting wolves, but when researchers probed deeper, they discovered that their AI had instead learned to identify pictures of snow, which just so happened to be present in every picture of a wolf (see Appendix 1). Had the algorithm been required to present its explanation, any expert would have been able to discard the results as identifying snow. When translating this example to the medical ecosystem, some experts have questioned whether physicians and patients will ever fully be able to trust or implement AI decision-making tools in the clinic if the output is not explainable for fear of misdiagnosis or improper treatment plans.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms "AI explainability," "black box algorithm," and "white box algorithm." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

BACKGROUND

Prior to the 2000s, most augmented/artificial intelligence (AI) applications were a series of "if, then" statements in which an end user could conceivably recreate the program's logic, albeit in a

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more time-intensive manner.[2] In 2000, researchers began to develop what was known as "machine learning" (ML), which was a much more complex network of equations that began to obscure the logic used to arrive at conclusions, even to the designers of ML programs.[3] While orders of magnitude more powerful than previous iterations of AI tools, the inability for many ML tools to describe their decision-making process has resulted in significant discussion as to the value of XAI.

At its core, the implementation and use of XAI places physician autonomy in question. In instances where algorithms can explain their decision-making, they may be useful tools for assessing huge data sets and recognizing patterns that are imperceptible to a clinician. In those cases, those algorithms are augmenting the physician's skillset by consolidating large volumes of data, with outputs which can support a physician's decision-making or be discarded if the physician's training and expertise disagree with the conclusion. However, if clinical AI/ML algorithms are not explainable, the clinician's training and expertise is removed from decision-making, and they are presented with information they may feel compelled to act upon without knowing where it came from or being able to assess quality and accuracy of the conclusion.

To help readers conceptualize the concepts of XAI, this report discusses several simplified, hypothetical scenarios. However, to best convey the utility of XAI, these hypotheticals will often describe instances where AI performed poorly or resulted in negative patient outcomes. This focus, however, should not be construed as a blanket criticism of AI in the clinic, but rather highlight opportunities where the physician voice can be used to push for development of safe, responsible, and impactful products for patients.

TRUSTWORTHINESS OF OUTPUTS

Briefly, trustworthiness describes what a person (or in this case, an AI tool) has done to demonstrate that they can be trusted. Historically, AI developers have used accuracy or other performance measures as a proxy for trustworthiness, but experts have argued that this alone is insufficient.[4] Physicians and their patients may have many concerns about AI in medicine beyond accuracy, including privacy or fairness. One of the steps proposed by ethics researchers and regulatory bodies to demonstrate AI trustworthiness is through explainability.[5]

Take for example, a hypothetical AI/ML algorithm that provides recommendations on whether to prescribe antibiotics for patients with a bacterial infection. If that algorithm were not explainable, also known as a "black box" algorithm, then an output may be a simple 'do not treat' versus 'treat'. In this situation, the physician may feel pressured to defer to the AI/ML algorithm, as a specialized tool designed to determine the appropriateness of an antibiotic and accept the recommendation. If the patient were to ask why they were not getting treatment, the physician would have a challenging time communicating the reasoning due to the lack of explainability of the AI/ML algorithm, undercutting the physician's role as a trusted expert.

By contrast, if that algorithm were explainable, also known as a "white box" or "glass box" algorithm, then the same hypothetical output would provide more context and may read "When compared to 5000 patients of similar age, sex, weight, social history, body temperature, and presence of headache, the patient is 80 percent likely to have a mild viral infection and a five percent chance of having a severe bacterial infection. Given the risk for adverse side effects and antibiotic resistance, it is not recommended to initiate antibiotics." This explanation provides the physician with information about the size of population being compared, the demographics being compared, the inputs it considered, and the risks it balanced – but potentially contains several mistakes, inaccuracies, or extraneous information or misses important context to the patient case. When presented with this explanation, a physician could recognize that a culture is most useful to

differentiate between a viral and bacterial infection, or that locally there has been a significant prevalence of viral infections increasing the likelihood of a viral over bacterial infection where antibiotics may be warranted. In this instance, a physician could give this AI recommendation lower value in their differential diagnosis, but could still glean some useful insights, such as recognizing that in a similar patient population, their patient is generally perceived as low risk for severe infection.

Generally, humans have low trust of AI, particularly when it is involved in decision-making. In one study, even when participants were explicitly told that an automated decision-making tool was performing better than them, 81 percent of participants still chose to ignore the tool's inputs.[6] The researchers posit that this response may come from an innate feeling that humans use "perfected automation," meaning humans perform the same calculations as the AI/ML tool but without error. Thus, the majority of AI tool users will only ever incorporate an AI tool's output into their own decision making, rather than solely rely on it.[7] As such, explainability for AI/ML systems may assist to overcome this hesitance for use. Even when the stakes are far lower than someone's health, studies have found that people are more likely to accept an algorithm's movie recommendation if it comes with an explanation as to why (such as, it is similar to other movies you have watched), and even more when the reason for the recommendation is easily understandableand conveys high value information (it has your most frequently viewed actor in it).[8]

In the hypothetical example of an algorithm recommending against prescribing antibiotics, if the patient were to develop a severe bacterial infection, then the importance of explainability for trustworthiness is further amplified. If the algorithm were a black box algorithm and simply got the recommendation wrong, trust is fractured. Studies have found the human response to AI/ML algorithms is that a single failure from a black box algorithm causes a person to severely underestimate the algorithm's level of accuracy in the future, often fully disregarding recommendations in perpetuity.[6] However, with a white box algorithm, even though the logic may be flawed, the user can see the decision-making process, understand what its limitations are, and may still feel comfortable using it in the future, albeit with more caution.[9] This trend also matches the perceptions of patients; in studies where AI is a black box, or otherwise removes their physician's experience and training from their decision-making, patient trust decreases and concerns about liability increase.[10-12]

It is unclear how the use and recommendations for AI will be disclosed to patients or documented. Current AMA policy calls for "a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient." In instances where AI tools are aiding in diagnosis but do not provide explanations (or the explanation is inadequate for non-experts), disclosure of an AI recommendation into a patient's medical record could have serious implications such as insurance reimbursement or on the patient-physician relationship, particularly in instances where the physician does not agree with the AI recommendation that their patient can view.

This tension further escalates as the conditions of interest become more serious. For example, in the mid-2010s, the electronic health record vendor Epic released a module for the detection of sepsis which utilized a proprietary, black box model. When external researchers probed the performance of the model, they found that while it did detect seven percent of true sepsis cases that clinicians missed, the software had a 67 percent false negative rate across all sepsis cases.[13] Further, the model had a high false-positive rate, generating electronic alerts on 18 percent of *all* hospitalized patients (compared to the true positive sepsis rate of seven percent), resulting in significant "alert fatigue" in clinicians. After working with the model for prolonged periods of

time, it is possible that clinicians would begin to ignore the alerts and instead rely on traditional clinical signs for sepsis diagnosis.

Technical Feasibility

While XAI is highly appealing for building trust in this new technology, it is less clear that it is implementable for medical applications. A common fallacy when evaluating AI/ML algorithms is to assume that it approaches problems and datasets in the same way a human would. While the field of human cognition is vast and complicated, two simple techniques that humans use to assess information and make decisions are linear logic and inference.[14] Briefly, humans often rely on linear logic (if A is true, then B is true) to understand information, then use intuition and experience to fill in (or infer) where there are information gaps. For example, if a 50-year old patient with a family history of colon cancer were to present with occult blood in their stool, a physician is likely to infer from a constellation of risk factors, signs and symptoms to assess that the patient is at high risk of having colon cancer. They would then use a confirmatory test, such as a colonoscopy with biopsy, to create a linear logic chain to confirm their diagnosis.

AI/ML algorithms do not process information in the same way humans do.[15] Thinking is a purely biologic process and cannot currently be replicated by any artificial technique. As such, AI/ML cannot infer. In a typical ML model, every single input is assigned a specific weight, and the output is a sum or other computation of those weights. Weights are based on datasets used to "train" the algorithm and are often dynamic and/or non-linear. These systems are generally referred to as "neural networks" to invoke the imagery of the hundred billion neurons and their interconnectivity similar to the human brain.[16] To help visualize the complexity of these connections, a neural network diagram for a simple AI/ML algorithm used to differentiate between 10 unique digits (0 through 9) from handwriting samples is included as Appendix 2.[17] Due to the complexity of the computations, even the developers of AI/ML algorithms may not fully comprehend how their programs arrived at an output when the process is too complex, and would thus argue that explainability is an unrealistic expectation humans have of AI/ML.[18]

Building Bridges to Explainability

While there may never be a way to truly convert the computation of an AI/ML algorithm into a comprehensible form for human interpretation, there are promising techniques being developed that do provide the user with *more* information to build confidence in AI, albeit incomplete. Some of these techniques include Locally-Interpretable Model-agnostic Explanation (LIME),[19] Gradient-weighted Class Activation Mapping (Grad-CAM),[20] and Occlusion Sensitivity (OS).[21]

Consider a hypothetical AI/ML algorithm that has been designed to detect lung tumors. In this example, the physician inputs a chest MRI for their patient, and the program returns a score for the likelihood a malignant tumor has been detected. In instances where the score is high, the obvious follow-up is: how can you tell? What factors is the algorithm using to distinguish between malignant and benign? In this hypothetical, the algorithm is only trained to calculate a "likelihood of tumor" value from millions of interconnected calculations and report "malignant" if the value is above a pre-determined value, or "benign" if the value is below.

To bridge the gap between the complex AI/ML algorithm and an explainable, interpretable result, a technique such as OS can be utilized. OS analysis highlights the area of an image that is being utilized in a computation for human assessment of accuracy.[21] Using the OS technique, the same MRI is entered into the algorithm hundreds more times, but each time with a slight modification – typically by systematically removing a subunit of the image, like a single pixel. Then, the

"likelihood of tumor" output is compared to the original image; if the modified image has a lower likelihood value than the original image, you can infer that the missing pixel was strongly associated with the tumor. This process is repeated multiple times, with each run removing a different pixel and assessing its impact on the tumor likelihood value. Then, a heat map can be generated and overlaid on the original MRI to highlight what regions of the image were most strongly associated with the tumor by the AI. The physician can then interpret the findings, use their experience, and evaluate whether the highlighted area is in fact likely a tumor. Appendix 3 visualizes a hypothetical workflow for how OS explanations in a program identifying dog breeds from an image can improve useability, accuracy, and trust.

Another model, LIME, uses a similar approach, in which it slightly changes the inputs and assesses how the output changes. However, using LIME, the model then attempts calculate a linear regression between how each new input and the matching output.[19] This allows LIME to then generate a series of numerical weights to convey how important each changed input may be. These weights could be used to generate a similar heat map to OS if the input was an image, but it also allows the user greater flexibility in the inputs it considers, including text. For example, if LIME were used in the above MRI example, it may be possible for it to additionally tell the physician how important factors from the patient's medical record (age, weight, sex, etc.) were to its interpretation of the MRI. While approaches like LIME may be more flexible, they do rely on simplifying the complex calculations of an AI/ML algorithm to simple linear equations, which may make it more prone to failure the further an individual case gets from the typical cases used in the algorithm's training set.

OS and other explainability methods have been utilized for applications such as identifying prostate cancer in histopathological samples, distinguishing lung diseases from a radiograph, predicting risk for psoriatic arthritis from the electronic health record, and more.[22-24] Beyond heat maps or other visualization tools, some tools can also provide simple written outputs (such as "clean margin") or link to data from its training set that the tool found to be most similar to the input. This provides an opportunity for the AI/ML user to utilize their own expertise in deciphering the accuracy of the output. While true explainability may never be possible for AI algorithms, models like OS, LIME, and Grad-CAM are promising efforts to make these systems more trustworthy. However, some experts in the field question: is explainability the right bar to hold AI to?[25]

Other Black Boxes in Medicine

When looking at other aspects of medicine, it is not uncommon to find black boxes or unclear processes that physicians and patients trust. For example, the analgesic mechanism for acetaminophen is not fully known and debated frequently in the literature, yet it is widely available over-the-counter in the United States.[26] Similarly, many genetic tests rely on genome wide association studies (GWAS), which often do not have a known, underlying biologic mechanism, but correlate certain genetic mutations with an increased risk of disease.[27] Yet these, and many other aspects of medicine, are routinely utilized in practice despite not truly being explainable, because they have been found to be safe and effective using rigorous scientific testing.

Randomized clinical trials (RCTs) are recognized as the gold standard or high level for evidence development in medicine, whether the intervention is explainable or not.[28] By carefully controlling variables and often utilizing a placebo, RCTs allow researchers, physicians, and regulators to best assess safety and efficacy of an intervention – but notably they do not necessitate a known mechanism of action, but often a theoretical hypothesis. When evaluating a new drug, the U.S. Food and Drug Administration (FDA) prefers, but ultimately does not require, a drugmaker to know how their drug works; they simply must prove that it is safe and effective for a specific

disease in its target population before approval.[29] True explainability may never be achievable for AI, but there is no reason to believe that an individual AI tool could not be found to be safe and effective using an appropriately designed RCT model. This raises the question as to why humans intrinsically view explainability for AI to be more important than in other black boxes or unexplainable processes in medicine, and if that will always remain a barrier to trust, but that philosophical debate reaches beyond the scope of this report.

Using explainability as a strict requirement for clinical adoption could additionally exclude applications of AI which rely on noticing patterns for which current medical knowledge cannot explain. The hypothetical examples described thus far in this report (antibiotic prescribing recommendations and image interpretation) describe devices that aim to improve or build upon current best practices in medicine. However, there are many researchers actively seeking to discover *new* methods or treatments from the vast amounts of medical data available. For example, one study used a ML algorithm to diagnose patients with type-2 diabetes mellitus (T2DM) based on recordings of their speech – a completely novel approach.[30] The authors of the study hypothesized several potential causes, such as the influence of blood glucose levels on vocal cord elasticity, or pitch modulation caused by myopathy, but as of writing, this correlation would be considered unexplainable using current medical knowledge. Despite that limitation, the authors reported over 70 percent accuracy in detecting T2DM just from audio recordings of a mere 11 words. Given the low level of invasiveness, low cost and prevalence of smart phones, similar tools could be desirable for routine screening applications despite the inability for patients and their physicians to comprehend how T2DM changes the voice. In those instances, transparency around the relative risks and benefits could be more useful for developing trust, which could be derived from a RCT.

CURRENT REGULATORY APPROACHES

In Medicine

As described in BOT 01-I-24, "Augmented Intelligence Development, Deployment, and Use in Health Care," the regulatory landscape for AI in the United States is inconsistent, and relevant health care regulatory agencies do not currently have a comprehensive strategy for oversight of AI. The FDA has been reviewing and approving algorithm-based devices since 1995, with over 1000 devices that utilize AI/ML being approved as of January 2025.[31] Applications for these devices vary, including triage and diagnostics, and cross multiple specialties.

In June 2024, the FDA, in collaboration with Health Canada and the United Kingdom's Medicines and Healthcare Products Regulatory Agency (MHRA), released their 10 guidelines for "good machine learning practice," which have been listed in Appendix 4.[32] These guidelines are non-binding, but give insight as to how regulators are thinking about AI oversight. None of the guidelines specifically mention explainability, however recommendations 7 ("Focus Is Placed on the Performance of the Human-AI Team"), and 9 ("Users Are Provided Clear, Essential Information") are generally supportive of the concept. Of note, under recommendation 9, device manufacturers are suggested to provide "the basis for decision-making when available." Interestingly, this phrasing could have two interpretations: (1) decision-making is not always present in AI tools, but an explanation is required whenever it is; or (2) explanations of decision-making are preferred, but ultimately not required if they are too complex to derive or no external explainability model is available. While ultimately the specific interpretation of this

recommendation is moot, as they are non-binding, it does underscore the level of uncertainty in potential regulations for explainability moving forward.

In January 2025, the FDA released a draft Guidance for Industry that has yet to be formalized at the time of writing.[33] In it, the FDA further describes the types of data they wish to see in submissions from AI tool developers. Within this guidance, the FDA describes explainability as a "risk control" to mitigate potential harm. Additionally, they further expound on explainability and visualization tools such as those described in this report, stating "[…] explainability tools or visualizations can be valuable in increasing model transparency and a user's confidence in a model's output and could be developed as part of the user interface. However, if not well designed and validated for the target user group, explainability tools or visualizations could also significantly mislead users. Therefore, sponsors should develop and validate explainability metrics and visualizations through appropriate testing." However, the guidance does not ultimate require explainability for a device submission.

In a scoping review of FDA-approved AI devices from 1995 to 2023 (692 total devices), researchers found that only 46 percent of device sponsors provided the FDA with the results of performance studies, and only 37 percent provided information on their testing sample size.[34] Given these gaps in disclosed information, the researchers concluded that "[their] current findings suggest that evaluation [of explainability] cannot be comprehensively conducted across approved FDA devices." A similar study, investigating 104 FDA-cleared AI tools to aid in medical imaging interpretation, found that less than half provided an explanation of their output.[35]

At the 2024 Interim Meeting of the House of Delegates, the AMA adopted policy stating that regulation should be "a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences." While a lack of explainability does not increase the risk of a tool per se, removing a physician's ability to contextualize information from the output using their expertise should be considered a risk factor.

In 2024, the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) enacted policies to advance AI transparency through electronic health record (EHR) regulation, requiring disclosure of source attributes, data elements, and decision-making roles in AI technology embedded in EHRs. While not specifically focusing on explainability, ASTP/ONC's intent is to empower physicians to make informed choices, ensuring AI tools enhance rather than override clinical judgment. Eplainability is not explicitly mandated, yet ONC's emphasis on transparency will likely foster trust by clarifying how predictive models operate and assist physicians in interpreting AI outputs. These policies are intended to promote responsible AI adoption, reinforcing physician autonomy and incentivizing the development of fair, effective, and safe AI-driven tools in healthcare.

Some manufacturers and scholars have raised concerns that by disclosing or otherwise visualizing an explanation of AI computational processes, they may be exposing their intellectual property (IP) to competitors.[36,37] There remains ambiguity as to what is patentable with regards to AI-enabled medical devices. For example, the software driving the algorithm is generally patentable, as it is considered a finished product. However, the Supreme Court found in *Gottschalk v. Benson* that mathematical formulas are generally not patentable as they represent abstract concepts, which leave algorithms unprotected.[38] In a January 2025 report on AI and copyrightability, the U.S. Copyright Office concluded that current laws and regulations adequately address AI copyright concerns, and did not recommend any legislative changes.[39] The recent release of the Chinese-based AI DeepSeek has highlighted the difficulty in protecting IP in the rapidly growing AI/ML space. Briefly, the American-based company OpenAI claim that DeepSeek developers used the outputs of

OpenAI models to reverse engineer or otherwise train a model that would be a market competitor.[40] While explanations of AI/ML tool outputs make the outputs more trusted, they may also make the underlying system more vulnerable to rival companies.

As such, other fields which have utilized algorithms (like banking and finance) rely on a "trade secrets" model for protecting their IP, in which algorithms are deemed proprietary and are hidden from the user. This is a similar approach to how food manufacturers protect their recipe yet disclose their ingredients for food products. However, if this approach were to continue, medical AI developers may be pitting innovation against a patient's right to transparency and autonomy in their medical decision-making.

Outside of Medicine

Given the rapid expansion of AI, other fields grapple with similar issues of explainability in their regulatory oversight. For example, the Equal Credit Opportunity Act of 1974 requires that financial institutions provide written descriptions explaining why they made an adverse decision (such as denying a loan application), and explicitly protecting certain traits (such as race or sex) from being the basis for those decisions. However, as financial institutions began incorporating more and more automated AI tools in their decision-making, explanations for adverse decisions became increasingly more abstract, and many worried that protected traits were being used by black box algorithms.

In response, the Consumer Financial Protection Bureau (CFPB) released a memo in 2023 clarifying that even in instances where black box AI tools "[made] it difficult — if not impossible — to accurately identify the specific reasons for denying credit or taking other adverse actions," customers are still legally owed an explanation of those specific reasons they were denied, and thus does not permit unexplainable algorithms to be used.[41] The CFPB went further, stating that even estimations or proxies of the AI tool's logic may not be acceptable if they are not specific enough. For example, if a financial institution did not know the logic their AI tool used to make decisions, a simple explanation of "the applicant has insufficient income" would be deemed inadequate. This approach mirrors legislation in states such as Colorado, New York, California, and Connecticut, which limit insurance companies' ability to use unexplainable, black box algorithms when making insurance coverage determinations.[42]

Outside the United States, the European Union's 2018 General Data Protection Regulation (GDPR) is generally regarded as one of the first attempts at comprehensive regulations of AI and other digital technologies and is the basis for many international regulations. The GDPR contains several regulations for the development and use of algorithms, but its position on explainability is less clear. Under Article 15 of the GDPR, it states that algorithms are required to disclose "meaningful information about the logic involved, as well as the significance and the envisaged consequences of such processing for the data subject."[43] Some scholars have interpreted this text to mean that the GDPR establishes a "right to explanation," however this right has yet to be asserted and adjudicated in a European court.[44]

Additional Considerations

When regulating the explainability of AI, it is critical to establish both who is owed an explanation, and where the explanation comes from. In the medical context, there are several potential audiences, such as the physician, the patient, or external groups such as payors. If, for example, a

"right to explanation" was proposed – who has the right? In the United States, the Health Insurance Portability and Accountability Act (HIPAA) generally establishes that patients have a right to access their clinical data.[45] However, as discussed above, there are significant gaps in the ability of most AI tools to explain their outputs in a layperson fashion, and most models to approximate explanations (such as OS, LIME, and Grad-CAM) are targeted to a physician-type expert for contextualization and action.

When discussing the disclosure of test results, the Code of Medical Ethics states that "[test] results [should be] conveyed sensitively, in a way that is understandable to the patient/surrogate, and the patient/surrogate receives information needed to make well-considered decisions about medical treatment and give informed consent to future treatment[.]" In a hypothetical situation where a physician receives an AI tool's explanation, but then uses their own words to convey that information to their patient, it is unclear if that would suffice under some scholarly interpretations of a GDPR-styled "right to explanation."

CURRENT AMA POLICY

The AMA maintains extensive policy on AI generally. Board of Trustees (BOT) Report 15-I-24, "Augmented Intelligence Development, Deployment, and Use in Health Care," provided a comprehensive overview of the regulatory landscape and the AMA's history in AI governance. A brief summary of relevant sections of AMA policies are as follows (full text of policy available at the end of this report):

H-480.931, "Assessing the Intersection Between AI and Health Care"

- "Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, and transparent."
- "Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce."
- "Clinical decisions influenced by AI must be made with specified human intervention points during the decision-making process. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model."
- "Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain."
- "Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if […] information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of […] information becomes increasingly important."
- "Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used)."

H-480.939, "Augmented Intelligence in Health Care"

- "Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and

reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment."

- "Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux."
- "[Our AMA will advocate that] AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it."

H-480.940, "Augmented Intelligence in Health Care"

- "[Our AMA will seek to promote] development of thoughtfully designed, high-quality, clinically validated health care AI that […] is transparent[.]"

CONCLUSION

Ironically, the concept of explainability is hard to explain. It is complex, nuanced, and asks profound questions on human cognition and the meaning of trust. While this report primarily focused on hypothetical instances where AI/ML performs poorly to highlight the opportunities and challenges for explainability, the responsible usage of well-designed AI/ML tools has already had a profoundly transformative impact on medicine, building efficiency in practice, increasing the breath of data integration, and increasing communication capabilities, such as the use of a LLM. The appeal and need for some level of explainability for AI/ML tools in medicine is clear, where decisions can have life or death consequences. Physicians are trained to utilize a broad compilation of information for medical decision-making, including context and seeing the whole patient's clinical picture; a binary "yes/no" output from an AI/ML tool is restrictive and lacks nuance.

However, explainability struggles in practice in part due to the disconnect between how humans and computers process information. AI does not think, nor can it guess, infer, or intuit, all of which are core processes for how a physician would make a clinical determination. Some models, such as occlusion sensitivity, are being developed to allow for insight into the inner workings of an AI tool, but they generally still require expert interpretation, and risk being an oversimplification of the true computational process.

Medicine is experienced in handling unexplainable phenomena and utilizing data through research and evaluation verify safety and efficacy. Understanding the mechanism of action of a drug, biologic process, or otherwise is crucial for building trust, troubleshooting, and advancing medical practice, but it generally has not been the barrier to clinical *entry*. By the same token, however, physicians should feel confident that the tools they use in the clinic are safe, based on sound science, and can be discussed appropriately with their patients, so they can engage in shared decision-making.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted and that the remainder of the report be filed:

1. To maximize the impact and trustworthiness of augmented intelligence and machine-learning (AI/ML) tools in clinical settings, our AMA recognizes that:
    a. Explainable AI with safety and efficacy data should be the expected form of AI tools for clinical applications, and exceptions should be rare and require at minimum safety and efficacy data prior to their adoption or regulatory approval.

b. To be considered "explainable," an AI device's explanation of how it arrived at its output must be interpretable and actionable by a trained expert. Claims that an algorithm is explainable should be adjudicated only by independent third parties, such as regulatory agencies or appropriate specialty societies, rather than by declaration from its developer.
c. Explainability should not be used as a substitute for other means of establishing safety and efficacy of AI tools, such as through randomized clinical trials.
d. Concerns of intellectual property (IP) infringement, when provided as rationale for not explaining how an AI device created its output, does not nullify a patient's right to transparency and autonomy in medical decision-making. While intellectual property should be afforded a certain level of protection, concerns of infringement should not outweigh the need for explainability for AI with medical applications. (New HOD Policy)

2. That our American Medical Association will collaborate with experts and interested parties to develop and disseminate a list of definitions for key concepts related to medical AI and its oversight. (Directive to Take Action)

3. That policies H-480.931, "Assessing the Intersection Between AI and Health Care," H-480.939, "Augmented Intelligence in Health Care," and H-480.940, "Augmented Intelligence in Health Care" be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note – less than $1000

APPENDIX

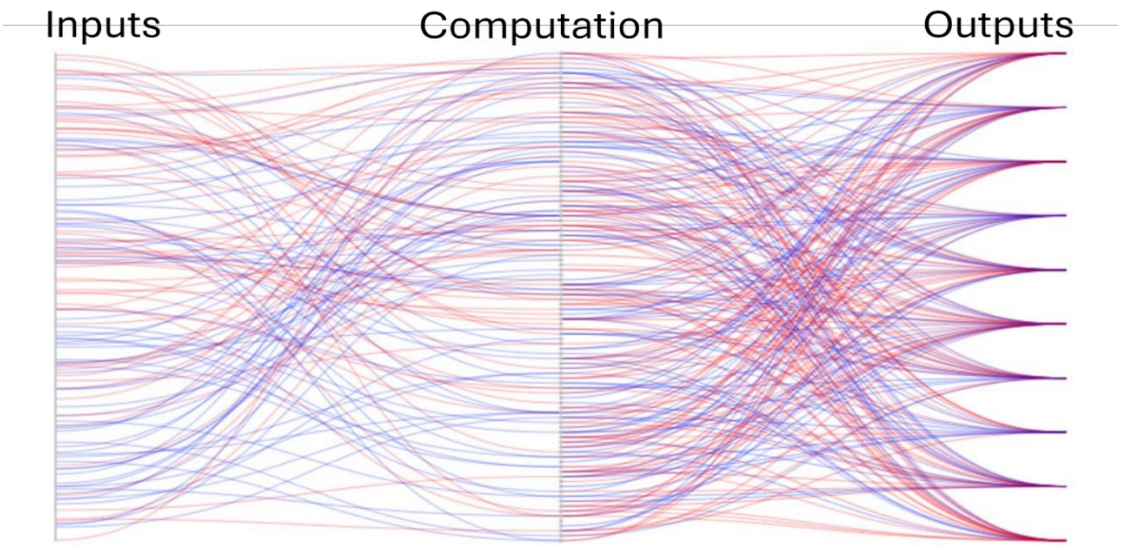
Appendix 1 – Sample AI Explainability



(a) Husky classified as wolf (b) Explanation

Appendix 1 – A sample of an AI system processing an image (left) and providing an explanation (right) for how it determined whether the input was a picture of a husky or a wolf. In this case, the system mistook a husky for a wolf due to the presence of snow, which was present in most images of wolves used for the AI's training set.

Appendix 2 – Visualization of Neural Networks



Appendix 2 – Visualization of the complexity in a sample neural network used to detect the digits 0 through 9 from handwriting samples. Each line on the left side represents an input considered by the algorithm, and each position on the right side represents a potential output (the digits 0 through 9). The middle visualizes the interconnectivity and how the algorithm sorts inputs into outputs. Image adapted from https://www.i-am.ai/neural-numbers.html.

Appendix 3 – Sample Occlusive Sensitivity Workflow

INPUT



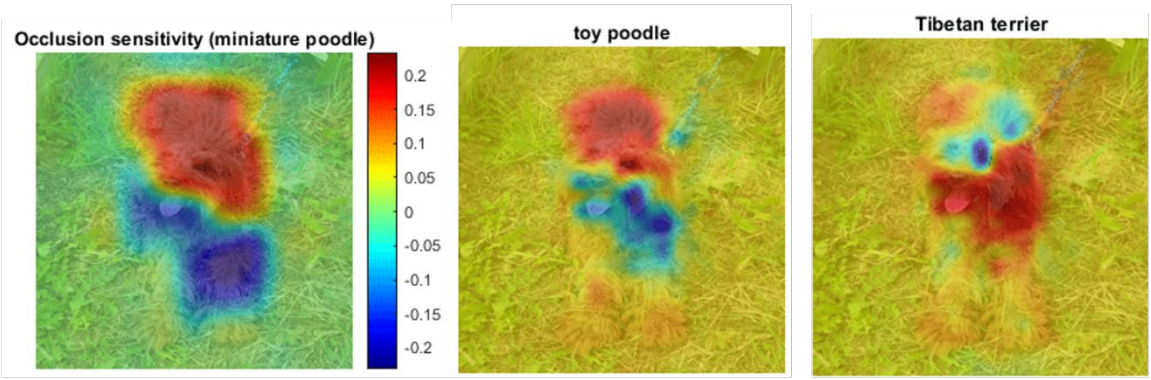
User inputs image of a poodle / cocker spaniel mixed breed dog, and asks AI tool to estimate the breed

OUTPUT

Breed Scores
Miniature Poodle: 23%
Toy Poodle: 17%
Tibetan Terrier: 11%

AI tool outputs ranked scores of dog breeds, struggling to identify the dog's breed. The user wants to troubleshoot and wonders if the dog is blending in with the grass.

OCCLUSION SENSITIVITY "EXPLANATION"



In these images, red coloration indicates the portions of the image that contributed more heavily to the breed's score. The user could thus infer that the algorithm is correctly differentiating grass from fur. However, in the miniature and toy poodle images, the back is likely incorrectly being grouped with the top of the head. The user discards the results and picks a new image from a different angle.

Apendix 3 – Hypothetical workflow of a user using an AI/ML tool to identify a dog breed. By using occlusion sensitivity, the user can identify that the tool was mischaracterizing key body features, thus explaining the poor results but allowing the user to modify their input to improve accuracy. Images adapted from https://www.mathworks.com/help/deeplearning/ug/understand-network-predictions-using-occlusion.html.

Appendix 4 – FDA Good Machine Learning Practice for Medical Device Development: Guiding Principles

Taken from: https://www.fda.gov/medical-devices/software-medical-device-samd/good-machine-learning-practice-medical-device-development-guiding-principles

1. **Multi-Disciplinary Expertise Is Leveraged Throughout the Total Product Life Cycle:** In-depth understanding of a model's intended integration into clinical workflow, and the desired benefits and associated patient risks, can help ensure that ML-enabled medical devices are safe and effective and address clinically meaningful needs over the lifecycle of the device.
2. **Good Software Engineering and Security Practices Are Implemented:** Model design is implemented with attention to the "fundamentals": good software engineering practices, data quality assurance, data management, and robust cybersecurity practices. These practices include methodical risk management and design process that can appropriately capture and communicate design, implementation, and risk management decisions and rationale, as well as ensure data authenticity and integrity.
3. **Clinical Study Participants and Data Sets Are Representative of the Intended Patient Population:** Data collection protocols should ensure that the relevant characteristics of the intended patient population (for example, in terms of age, gender, sex, race, and ethnicity), use, and measurement inputs are sufficiently represented in a sample of adequate size in the clinical study and training and test datasets, so that results can be reasonably generalized to the population of interest. This is important to manage any bias, promote appropriate and generalizable performance across the intended patient population, assess usability, and identify circumstances where the model may underperform.
4. **Training Data Sets Are Independent of Test Sets:** Training and test datasets are selected and maintained to be appropriately independent of one another. All potential sources of dependence, including patient, data acquisition, and site factors, are considered and addressed to assure independence.
5. **Selected Reference Datasets Are Based Upon Best Available Methods:** Accepted, best available methods for developing a reference dataset (that is, a reference standard) ensure that clinically relevant and well characterized data are collected and the limitations of the reference are understood. If available, accepted reference datasets in model development and testing that promote and demonstrate model robustness and generalizability across the intended patient population are used.
6. **Model Design Is Tailored to the Available Data and Reflects the Intended Use of the Device:** Model design is suited to the available data and supports the active mitigation of known risks, like overfitting, performance degradation, and security risks. The clinical benefits and risks related to the product are well understood, used to derive clinically meaningful performance goals for testing, and support that the product can safely and effectively achieve its intended use. Considerations include the impact of both global and local performance and uncertainty/variability in the device inputs, outputs, intended patient populations, and clinical use conditions.
7. **Focus Is Placed on the Performance of the Human-AI Team:** Where the model has a "human in the loop," human factors considerations and the human interpretability of the model outputs are addressed with emphasis on the performance of the Human-AI team, rather than just the performance of the model in isolation.
8. **Testing Demonstrates Device Performance during Clinically Relevant Conditions:** Statistically sound test plans are developed and executed to generate clinically relevant device performance information independently of the training data set. Considerations include the intended patient population, important subgroups, clinical

environment and use by the Human-AI team, measurement inputs, and potential confounding factors.

9. **Users Are Provided Clear, Essential Information:** Users are provided ready access to clear, contextually relevant information that is appropriate for the intended audience (such as health care providers or patients) including: the product's intended use and indications for use, performance of the model for appropriate subgroups, characteristics of the data used to train and test the model, acceptable inputs, known limitations, user interface interpretation, and clinical workflow integration of the model. Users are also made aware of device modifications and updates from real-world performance monitoring, the basis for decision-making when available, and a means to communicate product concerns to the developer.
10. **Deployed Models Are Monitored for Performance and Re-training Risks are Managed:** Deployed models have the capability to be monitored in "real world" use with a focus on maintained or improved safety and performance. Additionally, when models are periodically or continually trained after deployment, there are appropriate controls in place to manage risks of overfitting, unintended bias, or degradation of the model (for example, dataset drift) that may impact the safety and performance of the model as it is used by the Human-AI team.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 9-A-25

Subject: Rare Disease Advisory Councils

Presented by: John T. Carlo, MD, MS, Chair

Referred to: Reference Committee E

INTRODUCTION

Resolution 231-A-24, "Supporting the Establishment of Rare Disease Advisory Councils," was referred by the House of Delegates (HOD). It stated that "that our American Medical Association will support state legislation for the establishment of Rare Disease Advisory Councils in each state." While there was general support for Rare Disease Advisory Councils (RDACs), there was some concern expressed in testimony regarding the undue influence of pharmaceutical companies and the need to help ensure the participation of appropriate physician specialists. This report serves as the Council on Science and Public Health's response to that referral.

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms "rare disease advisory councils." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and applicable organizations were also reviewed for relevant information.

BACKGROUND

In the United States, the term "rare disease" is defined by the Orphan Drug Act of 1983 to mean any disease which impacts fewer than 200,000 people in the country.[1] Despite its name, an estimated 1-in-10 Americans will be diagnosed with a rare disease in their lifetime. Conditions covered by the Orphan Drug Act span from those that are well-studied, such as cystic fibrosis or amyotrophic lateral sclerosis (ALS), to the highly obscure, such as CANDLE syndrome, of which there have only been 30 recorded cases in the world.[2,3] Per a 2024 landscape analysis, approximately 80 percent of rare diseases are believed to be genetic in origin with 70 percent presenting in childhood.[4]

Patients with rare diseases face many unique obstacles to care. First, patients with rare diseases often experience significant delay between symptom onset and a diagnosis, known as the "diagnostic odyssey."[5] Rare disease patient groups estimate that the *average* diagnostic odyssey length is six years, requires an average of seven specialist visits, and typically costs $220,000 from medical expenses and reduced ability to work.[6]

Once a diagnosis has been made, patients may then further struggle to access the care they need. Currently, less than five percent of all rare diseases have a medication approved by the U.S. Food and Drug Administration (FDA).[4] Of those that do, many are amongst the most expensive therapies

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on the market. Per one analysis, 8 of the 10 most expensive drugs in the United States treat rare diseases.[7] For example, an FDA-approved gene therapy for spinal muscular atrophy (SMA), onasemnogene abeparvovec (brand name Zolgensma), costs approximately $2.1 million per dose, which at the time of its FDA approval, set the record for the world's most expensive drug.[8] Given the price tag, access, and coverage to treatment for SMA patients has resulted in ethical controversies. For example, Zolgensma's manufacturer Novartis utilizes a medication lottery to give out 100 doses each year at random.[9] In Brazil, governmental drug reimbursement analysis recommended that the Brazilian government should pay 77 percent less than the manufacturer's price, resulting in Novartis withdrawing Zolgensma from Brazilian markets and subsequent lawsuits.[10]

Additionally, rare disease specialty care can often be geographically centralized, resulting in patients having to travel long distances for care. A study in Europe found that 25 percent of rare disease patients have to leave their geographic region to receive care, with 2 percent having to leave their country entirely.[11]

In a system where resources are limited, investing in research and development for treatments of rare diseases can be too risky and inefficient for some companies. By definition, an individual rare disease has few patients, resulting in fewer opportunities for a company to recoup its investment, but also creates challenges in the design and implementation of clinical trials for recruiting and allocating patients. Clinical trials for rare disease treatments have lower enrollment, and therefore are frequently designed to utilize more nonrandomized, unblinded trial designs or to measure surrogate endpoints rather than patient-centered clinical outcomes. These trial designs, although often necessary in smaller studies, limit regulators' confidence in researchers' efficacy and safety conclusions.[12] As a result, there is an ongoing debate around the development and approval of treatments for rare disease: how can rare disease treatments be given the regulatory flexibility they need around clinical trial design, while avoiding providing patients with false hope at an ultra-high price point?[13]

RARE DISEASE ADVISORY COUNCILS

Given the complexities, nuances, and equity concerns when allocating resources for patients with rare diseases, many state governments have opted to utilize RDACs to provide guidance. The first RDAC was established by the North Carolina legislature in 2015, and while composition of the Council has evolved over time, it currently consists of:[14]

- two physicians,
- one registered nurse,
- one academic researcher,
- a hospital administrator,
- two adults diagnosed with a rare disease,
- two caregivers for patients with rare diseases,
- one representative from a patient advocacy group,
- one pharmacist,
- one member of a pharmaceutical or life sciences company developing rare disease treatments,
- two representatives of payors,
- a genetic counselor,
- and three personal appointees of elected officials

Compositions of RDACs vary from state-to-state but generally have a similar cross-section of representatives. Currently 27 states have formed a RDAC, and at least two others have approved legislation to establish one.[15] After manual review of the current landscape of state authorizing legislation, no RDAC currently requires the participation of a medical ethicist, which could provide value.

RDACs may have different requirements but generally are enacted to provide guidance for the state legislature and its executive branch. RDACs tend to focus on state-level barriers to access, such as reimbursement from state Medicaid or other state-regulated insurance programs, protecting and/or expanding newborn screening programs, out-of-pocket drug prices, telehealth flexibilities, easing of step therapy requirements, and access to medical nutrition, which many rare metabolic syndromes require.[16-18] Other functions of RDACs may include advocacy for research funding, performing state-wide needs assessments, maintaining rare disease patient registries, creating awareness campaigns for clinical trial recruitment, or collaborating with academic centers to align research priorities.

Influence of Pharmaceutical Companies

To help understand the influence of pharmaceutical companies on the outputs of an RDAC, a review of their authorizing laws was conducted (summarized in Appendix). Of the 27 states with an RDAC, only one state (Ohio) had more voting seats designated for pharmaceutical industry representatives than physicians. In that state, the overall voting power of pharmaceutical industry representatives was low (two of 25 total votes, or eight percent of voting share). Nine states had zero voting seats designated for pharmaceutical company representatives.

It should also be noted that this analysis may not represent the actual make-up of any given state's RDAC. Several positions delineated by state law (such as hospital administrator or academic researcher) could also be filled by a licensed physician or someone from a pharmaceutical company. For example, the state of Pennsylvania calls for three physicians and two pharmaceutical industry representatives. However, when looking at the membership of their RDAC (as of January 2025), there are eight members with MD or DO credentials, and an additional policy specialist from the state's medical society.[19] One of the two pharmaceutical industry representatives has been filled by a member of a manufacturer's patient advocacy group. However, it is also difficult to ascertain the level of financial involvement that members have with the pharmaceutical industry, given the intertwined nature of medical research. Despite these limitations, there has been no evidence identified which would suggest that commercial interests have had an outsized, undue, or otherwise problematic influence on the work of RDACs to date, although the risk still exists.

RDACs can also provide an informational venue for representatives to receive scientific and technical knowledge from scientists from the pharmaceutical industry. The risk/reward balance of investing in rare diseases can often result in pharmaceutical companies simply choosing to avoid developing treatments. Additionally, there are serious difficulties in the recruitment and powering clinical trials for rare diseases, which are the kinds of issues that legislatures should be made aware of. By providing a venue for industry to interface with other interested parties, it gives an opportunity for patient advocates and their physicians to have a larger voice in guiding research priorities. Finally, when treatments are available, legislators need to be able to hear about the benefits and make tough decisions when looking to cover the sometimes-ultra-costly rare disease treatments.

CURRENT AMA POLICY

AMA Policy, H-460.880 "Recognizing the Burden of Rare Disease" recognizes the under-diagnosis, under-treatment, and financial burden of rare disease to the health care system and affected individuals. The policy notes the AMA's support of efforts to increase awareness of patient registries, improve diagnostic and genetic tests and incentivize drug and device companies to develop novel treatments.

More broadly, our AMA also generally supports physician participation in decision-making bodies where possible. For example, H-225.983 "Physician Representation on Hospital Governing Boards" and H-405.953 "Participation of Physicians on Healthcare Organization Boards" encourage physician membership in advisory boards and note that conflict-of-interest policies should be robust.

CONCLUSION

Ensuring that patients with rare diseases have access to the diagnosis, specialists, and treatments they need is a delicate balancing act. States may struggle to identify who and what conditions require prioritization within their borders and often benefit from external advisement. Rare Disease Advisory Councils (RDACs) are a useful tool for states and other entities to adopt to provide a wide array of voices for decision makers. It should be noted that while the original resolution sought support for solely state-based RDACs, it is possible that similarly beneficial groups could exist in other forms, including municipal, regional, multi-state, or federal.

After reviewing the current landscape, there has been no evidence to suggest that those with monetary interests have an outsized or unethical voice in RDACs, but legislatures should be cognizant of the risk and include appropriate guardrails to maintain the goal of RDACs serving the public interest. With such guardrails in place, RDACs provide the opportunity to best support patients with rare disease by removing barriers across the spectrum, from diagnosis to reimbursement.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted and that the remainder of the report be filed:

That Policy H-460.880, "Recognizing the Burden of Rare Disease" be amended by addition to read as follows:

H-460.880, "Recognizing the Burden of Rare Disease"

1. Our American Medical Association recognizes the under-treatment and under-diagnosis of orphan diseases, the burden of costs to health care systems and affected individuals, and the health disparities among patients with orphan diseases.
2. Our AMA supports efforts to increase awareness of patient registries, to improve diagnostic and genetic tests, and to incentivize drug companies and medical device companies to develop novel therapeutics and devices to better understand and treat orphan diseases.
3. Our AMA supports the study, approval, and coverage of implantable medical devices and therapeutics via FDA Humanitarian Device Exemption for treatment of orphan diseases.
4. <u>Our AMA supports the establishment of Rare Disease Advisory Councils to inform policymakers and other interested parties about the unique challenges faced by patients</u>

with rare diseases and their caregivers. Rare Disease Advisory Councils should include voting representation from patients with rare disease and physicians who specialize in the diagnosis and/or treatment of rare disease, among other interested parties.

5. Our AMA recommends Rare Disease Advisory Councils should develop guidance on management of conflicts of interest (especially financial conflicts) and appropriate conditions for recusal from discussions and decisions. (Modify Current HOD Policy)

Fiscal Note – less than $1000

APPENDIX – OVERVIEW OF PHYSICIAN AND PHARMACEUTICAL INDUSTRY MEMBERSHIP OF RDACS

State	Total RDAC Members	Number of Physicians* (%)	Number of Pharmaceutical Industry (%)
Alabama	17	6 (35%)	0 (0%)
Colorado	12	2 (17%)	1 (8%)
Connecticut	12	2 (17%)	1 (8%)
Delaware	14	2 (14%)	1 (7%)
Florida	22	3 (14%)	1 (5%)
Georgia	16	3 (19%)	1 (6%)
Illinois	11	3 (27%)	0 (0%)
Indiana	15	1 (7%)	1 (7%)
Kentucky	20	NR	NR
Louisiana	12	3 (25%)	0 (0%)
Maine	20	4 (20%)	1 (5%)
Maryland	21	2 (10%)	1 (5%)
Massachusetts	28	3 (11%)	2 (7%)
Minnesota	24	4 (17%)	1 (4%)
Missouri	11	6 (55%)	0 (0%)
Nevada	15	3 (20%)	0 (0%)
New Hampshire	11	1 (9%)	0 (0%)
New Jersey	20	2 (10%)	1 (5%)
New York	NR	NR	NR
North Carolina	21	2 (10%)	1 (5%)
Ohio	25	1 (4%)	2 (8%)
Pennsylvania	24	3 (13%)	2 (8%)
South Carolina	11	1 (9%)	1 (9%)
Tennessee	11	3 (27%)	0 (0%)
Utah	16	5 (31%)	0 (0%)
Virginia	21	3 (14%)	1 (5%)
West Virginia	11	3 (27%)	0 (0%)

NR = No Restriction

***** = Includes positions described as board-certified geneticists

CITED AMA POLICY

Recognizing the Burden of Rare Disease H-460.880

1. Our American Medical Association recognizes the under-treatment and under-diagnosis of orphan diseases, the burden of costs to health care systems and affected individuals, and the health disparities among patients with orphan diseases.
2. Our AMA supports efforts to increase awareness of patient registries, to improve diagnostic and genetic tests, and to incentivize drug companies and medical device companies to develop novel therapeutics and devices to better understand and treat orphan diseases.
3. Our AMA supports the study, approval, and coverage of implantable medical devices and therapeutics via FDA Humanitarian Device Exemption for treatment of orphan diseases.

Physician Representation on Hospital Governing Boards H-225.983

1. It is the policy of the AMA that physicians who are members of the medical staff shall be eligible for, and should be included in, full membership on hospital governing bodies and their action committees in the same manner as are other knowledgeable and effective individuals. Other physicians also should be considered eligible for membership on the governing body. The hospital medical staff should have the right of representation at all meetings of the governing body by medical staff members elected by the medical staff having the right of attendance, voice and vote. Compensation to medical staff members for service to the hospital should not preclude the physician's membership on the hospital governing board.
2. Hospital conflict of interest policies should include physician medical staff members of hospital governing boards.

Participation of Physicians on Healthcare Organization Boards H-405.953

1. Our American Medical Association will advocate for and promote the membership of physicians on the boards of healthcare organizations including, but not limited to, acute care providers; insurance entities; medical device manufacturers; and health technology service organizations.
2. Our AMA will promote educational programs on corporate governance that prepare and enable physicians to participate on health organization boards.
3. Our AMA will provide physicians, the public, and health care organizations information on the positive impact of physician leadership.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 501
(A-25)

Introduced by: American Academy of Otolaryngology – Head and Neck Surgery

Subject: Safer Button / Coin Batteries

Referred to: Reference Committee E

Whereas, button, or coin cell, batteries can lead to life-threatening injuries of the esophagus, trachea or major vasculature in children when ingested[1-3]; and

Whereas, button batteries are in ubiquitous use in household items such as remote controls, toys, decorations and key fobs; and

Whereas, no battery manufacturer currently produces a safe button or coin cell battery; and

Whereas, it is estimated that a child is taken to the emergency room every 75 minutes with a battery-related injury, a rate that has doubled within the last decade[3]; and

Whereas, the American Academy of Otolaryngology-Head and Neck Surgery, the American Academy of Pediatrics, the American College of Surgeons and nine other medical organizations have joined to call on battery manufacturers to introduce safer alternatives to current button batteries[5]; therefore be it

RESOLVED, that our American Medical Association promote a definition of safer button or coin cell battery as one which will not cause significant tissue injury if lodged in the body but will still adequately function to power electronic devices (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for industry development and employment of safer button battery technology. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/14/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 502
(A-25)

Introduced by: American College of Rheumatology, American Academy of Physical Medicine and Rehabilitation, American Psychiatric Association, American Society of Gastrointestinal Endoscopy, American College of Physicians, American Academy of Allergy, Asthma, and Immunology

Subject: NIH Grant Funding for Medical Research

Referred to: Reference Committee E

Whereas, in February 2025, the National Institutes of Health (NIH) issued a notice (NOT-OD-25-068) stating it would cap indirect cost rates for all NIH grants at 15%, replacing the previously negotiated rates; and

Whereas, NIH grant funding plays a crucial role in advancing medical research and has historically supported negotiated indirect cost rates averaging nearly 30% at research universities, with some institutions having rates exceeding 50% or even 60%, which are essential for sustaining critical research infrastructure; and

Whereas, chronic diseases, including rheumatoid arthritis, lupus, psoriatic arthritis, scleroderma, and others, have high prevalence, chronicity, and disability burdens on both patients and healthcare systems, but research on them is often underfunded relative to their impact; and

Whereas, current levels of NIH funding of medical research are already not sufficient to address the growing needs and unmet challenges in chronic diseases; and

Whereas, such drastic cuts risk upending the paradigm that underpins American leadership in medical research; and

Whereas, direct costs are expenditures directly attributable to a specific research project (such as salaries, equipment, and supplies), while indirect costs (also known as facilities and administrative (F&A) costs) fund the essential infrastructure and administrative support necessary for effective research; moreover, indirect cost rates—calculated as the ratio of indirect costs to direct costs—are negotiated between research institutions and the NIH (or other federal grant organizations); and

Whereas, indirect costs help fund the infrastructure that makes research possible, which includes laboratories and equipment, utilities and maintenance, computational resources, and administrative support; and

Whereas, indirect costs help maintain institutional support for medical research by enabling the hiring and training of research staff and personnel; and

Whereas, indirect costs enable researchers to effectively manage the legal and regulatory frameworks that govern research and clinical trial monitoring; and

Whereas, indirect costs help ensure continuity in medical research, which often requires long-term commitment, as many diseases are chronic and involve complex, multi-phase studies; and

Whereas, indirect costs facilitate collaboration, which is often vital in complex medical fields that involve multidisciplinary approaches, including immunology, genetics, pharmacology, and clinical care; and

Whereas, without adequate indirect funding, it would be difficult for researchers to access the resources necessary to carry out the full scope of research needed to improve the understanding, treatment, and care of patients with chronic diseases; and

Whereas, small research institutions rely on indirect funds to support key staff whose costs could be spread across more grants at larger institutions; and

Whereas, large research institutions will also be significantly impacted by cuts to indirect costs due being located in high cost areas; and

Whereas, indirect costs represent an investment in the research infrastructure that underpins high-risk, innovative, and early-stage investigations, and are critical for sustaining both established and independent research initiatives; and

Whereas, recent research indicates that investigators spend approximately 42% of their time on administrative compliance, a burden compounded by an expanding web of federal regulations that diverts valuable resources from research, thereby necessitating regulatory reforms that could safely reduce unnecessary administrative overhead without compromising research quality; therefore be it

RESOLVED, that our American Medical Association will work with the National Institutes of Health (NIH) and other relevant stakeholders to 1) oppose caps on indirect costs, including facilities and administrative reimbursements, in federal grants (including NIH grants) or any funding policy that restricts critical early-stage and independent research, and 2) protect the ability of research institutions to negotiate indirect cost rates to ensure researchers can recover the full cost of conducting federally funded research (Directive to Take Action); and be it further

RESOLVED, that our AMA will advocate for targeted reforms to streamline administrative and regulatory requirements in order to achieve sustainable cost reductions while preserving essential research infrastructure. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/22/25

RELEVANT AMA POLICY

Funding of Biomedical, Translational, and Clinical Research H-460.926
Our AMA: (1) reaffirms its long-standing support for ample federal funding of medical research, including basic biomedical research, translational research, clinical research and clinical trials, health services research, outcomes research, and prevention research; and (2) encourages the National Institutes of Health, the Agency for Healthcare Research and Quality and other appropriate bodies to develop a mechanism for the continued funding of translational research.
Sub. Res. 507, I-97; Reaffirmed: CSA Rep. 13, I-99; Modified: Res. 503, and Reaffirmation A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 503
(A-25)

Introduced by: Colorado Delegation

Subject: Safeguarding Neural Data Collected by Neurotechnologies

Referred to: Reference Committee E

Whereas, neurotechnologies refer to devices capable of recording, interpreting, or altering the response of an individual's central or peripheral nervous system to its internal or external environment[1]; and

Whereas, neural data captured by neurotechnologies is information coming from the measurement of the activity of the central or peripheral nervous system, is extremely sensitive, and can reveal intimate information about individuals, including information about health, mental states, emotions, and cognitive functioning[2]; and

Whereas, rapid advances in neurotechnologies present great promise and potential risks but have also outpaced regulatory governance at all levels[1]; and

Whereas, neurotechnologies have long been used in medical and research contexts but are rapidly being developed and deployed outside clinical settings[3]; and

Whereas, consumer neurotechnology products have a range of health-related applications, including at-home treatment for ADHD, anxiety, depression, and other mental disorders[4]; and

Whereas, consumer neurotechnology products are generally medical-grade but are not regulated as medical devices, nor is the data they collect protected under the Health Insurance Portability and Accountability Act (HIPAA) or state health data privacy laws[1]; and

Whereas, the growth of the consumer neurotechnology market will contribute to the building of enormous datasets of neural data that will allow for longitudinal insights about both patients and consumers; and

Whereas, consumer neurotechnologies and the data they collect will unlock new insights into brain health when integrated into clinical research; and

Whereas, neurotechnologies raise particularly pressing privacy concerns given their ability to monitor, decode, and manipulate neural activity; and

Whereas, boundaries must be developed to prohibit neurotechnologies from disrupting individual identity and sense of self[5]; and

Whereas, individuals must also have ultimate control over their own decision-making, without manipulation by neurotechnologies[5]; and

Whereas, the principle of non-discrimination should be built into algorithms for the development and application of neurotechnologies[6]; and

Whereas, there should be established guidelines, based on principles of justice and fair access, for regulating neurotechnologies that provide mental augmentation; therefore be it

RESOLVED, that our American Medical Association recognizes and supports the extraordinary developments in neurotechnologies and the promise they hold for building understanding of how the brain and nervous system work, for the treatment and curing of neurological diseases, and for helping all people achieve their maximum potential (New HOD Policy); and be it further

RESOLVED, that our AMA support legislative and regulatory efforts to protect patients and all people in the United States from risks to mental privacy, identity, and agency, as well as from discrimination and inequality that may be caused by neurotechnologies (New HOD Policy); and be it further

RESOLVED, that our AMA reaffirm that neural data is information obtained by measuring the activity of a person's central or peripheral nervous system through the use of neurotechnologies and neural data does not include inferential data from nonneural information (New HOD Policy); and be it further

RESOLVED, that our AMA oppose any efforts to broaden the consensus medical definition of neural data to include data inferred from nonneural information gathered by biosensors (including biometric devices), as this is a distinct category of data with its own independent qualities and regulatory needs. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/22/25

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RELEVANT AMA POLICY

The Next Transformative Project: In Support of the BRAIN Initiative H-460.904

Our AMA: (1) supports the scientific and medical objectives of the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative of mapping the human brain to better understand normal and disease process; (2) encourages appropriate scientific, medical and governmental organizations to participate in and support advancement in understanding the human brain in conjunction with the BRAIN Initiative; and (3) supports the continued Congressional allocation of funds for the BRAIN Initiative, thus providing for research and innovation in technologies that will advance knowledge of neurologic function and disease. Citation: (Res. 522, A-13; Modified: Res. 514, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 504
(A-25)

Introduced by: Georgia, American College of Rheumatology

Subject: Physician Performed Microscopy Designation for Synovial Fluid Crystal Exam: Modify the Clinical Laboratory Amendment of 1988

Referred to: Reference Committee E

Whereas, there are certain microscopy tests that a physician may perform under CLIA regulations that are designated as Physician Performed Microscopy Procedures (PPMP); and

Whereas, designation as a PPMP applies to specimens subject to loss of specimen integrity, such as may occur with analysis of very small fluid volumes or the very tip of a needle used to probe a tophaceous deposit; and

Whereas, designation as a PPMP applies to specimens tested during a patient visit to allow rapid definitive diagnosis, as is true for synovial fluid crystal analysis; and

Whereas, designation as a PPMP applies to specimens that require limited specimen handling/processing, as applies to synovial fluid crystal analysis; and

Whereas, designation as a PPMP applies to tests for which commercial control materials are not available, as applies to crystal analysis; and

Whereas, designation as a PPMP has bene used for specimens such as certain wet mount microscopic procedures that are similar to synovial fluid crystal analysis; and

Whereas, synovial fluid crystal analysis is part of the specialized training required for rheumatologists and is included in the standard curriculum of rheumatology training programs and selected other training programs; therefore be it

RESOLVED, that our American Medical Association adopt the position that the CLIA Laboratory Amendment of 1988 should be modified to categorize synovial fluid crystal analysis as a permitted PPMP, to be performed by appropriately trained physicians. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 505
(A-25)

Introduced by: Indiana

Subject: Mandating Properly Fitting Lead Aprons in Hospitals

Referred to: Reference Committee E

Whereas, health care workers are the largest occupational group exposed to radiation in the world and medical specialties like radiology, nuclear medicine, and surgery that use interventional fluoroscopy are ranked among the highest risk cohorts, consisting of 48% of occupational radiation exposure in the U.S. alone; and

Whereas, ionizing radiation, which is emitted during fluoroscopy procedures, increases cancer risk in a dose-dependent manner, specifically cancers of the breast, bladder, colon, liver, lung, esophagus, and ovaries; and

Whereas, female orthopedic surgeons have a 189% higher risk of all cancers and a four times higher risk of breast cancer as compared to the general population; and

Whereas, lead aprons are mandatory for medical staff during any procedure that emits ionizing radiation and are designed to protect tissues susceptible to oncogenic DNA damage, including the thyroid gland, chest, abdomen, and pelvis; and

Whereas, time spent performing procedures, including fluoroscopy, is longer earlier in medical training; and

Whereas, up to 72% of hospitals do not carry an appropriate range or lead apron sizes at the facility, requiring medical students and residents to borrow aprons from other staff members; and

Whereas, ill-fitting lead aprons, either too large or too small, fail to adequately cover the outer upper quadrant of the breast, where approximately 50% of breast cancers occur, and have been attributed to the increased prevalence of breast cancer in female orthopedic surgeons; and

Whereas, routine examination of lead aprons includes verifying adequate lead thickness, but does not involve evaluating whether it effectively covers the intended parts of the body; and

Whereas, the fit of a lead apron has been shown to be more important than lead thickness in protecting against radiation damage; and

Whereas, the lead apron should extend from the neck down to within 10 centimeters above the knees in the front and also cover the sides from the shoulders to below the buttocks; and

Whereas, in the United States there have been limited investigations regarding the availability of lead aprons in hospitals, but a study in Ireland found a lack of extra small and extra large aprons at radiological facilities; and

Whereas, lead aprons are relatively inexpensive, starting at $200 per apron, so it would not pose a significant financial burden on hospitals to ensure a range of sizes in stock for rotating staff members; therefore be it

RESOLVED, that our American Medical Association collaborate with relevant stakeholders to ensure:

(1) Adequate stocking of diverse lead apron sizes for all radiation-exposed personnel and medical trainees, and

(2) Consistent implementation of evidence-based radiation safety principles to keep exposure as low as reasonably achievable in accordance with specialty society guidelines, in order to promote optimal protection practices. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/16/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 506
(A-25)

Introduced by: LGBTQ+ Section

Subject: Opposing the use of Harm Reduction Items as Evidence of Commercial Sex Work

Referred to: Reference Committee E

Whereas, the selling of sex is illegal in 49 states, and sentencing is decided at the state level; and[1,2]; and

Whereas, the selling of sex may be punishable with fines, arrests, jail time, criminal records, and deportation[3]; and

Whereas, the number of arrests for prostitution is positively associated with sexually transmitted infection (STI) rates[4]; and

Whereas, sex workers are disproportionately affected by STIs[5]; and

Whereas, condom usage is the most effective contraceptive in preventing STIs and HIV besides abstinence[6,7]; and

Whereas, studies demonstrate that sex workers are discouraged to use condoms and STI protection by their clientele and are often disempowered to protect their bodily autonomy in this way, putting themselves at even greater risk for HIV and other STIs[8]; and

Whereas, the enactment of France's law no. 2016-444, intended to combat the commercial sex work system and disenfranchise sex workers, has been associated with a significant deterioration in the living and working conditions of sex workers, as evidenced by a qualitative study revealing that 38% of sex workers find it increasingly difficult to demand condom use, alongside a worrying decline in overall condom usage and increased challenges in maintaining HIV treatment due to reduced client numbers and diminished negotiating power[9]; and

Whereas, sex workers in New York, California, and other US and international jurisdictions have historically been punished for carrying condoms as they were used as evidence of illegal commercial sex work[10]; and

Whereas, anecdotes from sex workers among cities including New York, Washington, DC, Los Angeles, and San Francisco have expressed fear in carrying condoms due to police harassment and criminalization with worrying fears of vulnerability to STIs among marginalized groups including sex workers, transgender women, and lesbian, gay, bisexual, and transgender (LGBT)[10]; and

Whereas, reports have come out of California of sex workers being harassed by police for carrying condoms, lube, and PrEP, and those items being used by police as increased suspicion of commercial sex work, opening these individuals up to invasive lines of questioning[11]; and

Whereas, California passed a law prohibiting the use of condoms as evidence of sex work in 2019[12]; and

Whereas, the American Medical Association similarly advocates for the protection of those carrying and disseminating drug paraphernalia and harm reduction materials, such as needles, from prosecution on drug possession related charges[13]; and

Whereas, the protection of sex workers' ability to use and carry condoms can protect them from multiple abuses, such as in New Zealand where the Prostitution Reform Act has empowered sex workers by legally protecting their right to safer sex practices, as demonstrated by the prosecution of individuals who violate these rights, including a landmark case where a sex worker successfully pursued criminal charges against a client for "stealthing"—the non-consensual removal of a condom during sex—resulting in a conviction and prison sentence for rape[14,15]; therefore be it

RESOLVED, that our American Medical Association supports the availability and access to harm reduction tools for sex workers to protect their health and well-being; and be it further (New HOD Policy); and be it further

RESOLVED, that our AMA opposes the use of harm reduction tools as evidence in the prosecution of sex workers. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

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RELEVANT AMA POLICY

Improving the Health and Safety of Individuals Who Offer Sex in Return for Money, Goods or Other Considerations H-65.948

1. Our American Medical Association recognizes the adverse health outcomes of criminalizing individuals who offer sex in return for money, goods or other considerations.
2. Our AMA:
    a. supports legislation that decriminalizes individuals who offer sex in return for money, goods, or other considerations.
    b. opposes legislation that decriminalizes the purchase of sex services, as well as ownership and operation of brothels and other entities that provide such services.
    c. supports the expungement of criminal records of those previously convicted of sex work, including **trafficking** survivors.
3. Our AMA supports research on the long-term health, including mental health, impacts of decriminalization of the sex trade.

Syringe and Needle Exchange Programs H-95.958
Our AMA: (1) encourages all communities to establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 507
(A-25)

Introduced by: Mississippi

Subject: Clinical and Public Safety Implications of AI-Generated Content and Symbolic Compliance Infrastructure

Referred to: Reference Committee E

Whereas, artificial intelligence (AI) systems—including large language models (LLMs) and generative platforms—are increasingly deployed in clinical decision support, patient communications, education, documentation, and public health messaging; and

Whereas, AI-generated outputs may be indistinguishable from human content, and failure to visibly identify, watermark, or attribute AI authorship can lead to patient confusion, medical misinformation, reduced trust in clinical encounters, or misinterpretation of responsibility for medical decisions; and

Whereas, symbolic safety mechanisms—such as runtime policy enforcement, fallback systems under uncertainty, mirroring control, pediatric safety filters, authorship attribution, and verifiable audit trails—are emerging as critical components for ensuring that AI-generated content remains safe, ethical, age/context-appropriate, and compliant with regulatory and clinical standards; and

Whereas, the integration of such symbolic compliance infrastructure has been identified by regulatory and academic bodies as a necessary step toward mitigating AI-related harm, particularly in public-facing health applications and among vulnerable populations; and

Whereas, existing American Medical Association policy supports the responsible deployment of AI in medicine, including requirements for transparency, explainability, and physician oversight (H-480.940, H-480.931), but does not yet address runtime symbolic safety infrastructure or the need for consistent authorship enforcement, pediatric safeguards, or fallback systems; therefore be it

RESOLVED, that our American Medical Association recognize symbolic safety mechanisms—including watermarking, authorship attribution, pediatric safety filtering, public safety modes, mirroring control, fallback logic, and symbolic audit trails—as critical infrastructure components for the safe use of AI-generated content in clinical and public health settings (New HOD Policy); and be it further

RESOLVED, that our AMA request that the Council on Science and Public Health (CSAPH) prepare a report evaluating the clinical, scientific, and public health implications of symbolic safety infrastructure for AI-generated content, including its role in protecting patient trust, minimizing medical misinformation, ensuring age-appropriate communication, and preserving accountability in health-related decision making (Directive to Takek Action); and be it further

RESOLVED, that our AMA advocate for public and private entities developing or deploying generative AI in healthcare, education, and public communication to include symbolic safety

features such as authorship attribution, pediatric safeguards, fallback systems, and traceability mechanisms to ensure ethical and regulatory alignment across all deployment contexts. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/25

RELEVANT AMA POLICY

H-480.940 Augmented Intelligence in Health Care
As a leader in American medicine, our American Medical Association has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.
To that end our AMA will seek to:
1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
b. is transparent;
c. conforms to leading standards for reproducibility;
d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

BOT Rep. 41, A-18 Reaffirmed: CMS Rep. 07, A-24

H.480.931 Assessing the Intersection Between AI and Health Care
1. General Governance
    a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
    b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
    c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
    d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
    e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduc [See also Augmented Intelligence in Health Care H-480.939 at (1)]

f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
g. Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.
i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
    a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
        i. AI disclosure should align and meet ethical standards or norms.
        ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
        iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
        iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
    b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.
    c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
    d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.
3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies
    a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
        i. Regulatory approval status.

ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.
iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.
iv. Intended population and intended practice setting.
v. Clear description of any limitations or risks for use, including possible disparate impact.
vi. Description of how impacted populations were engaged during the AI lifecycle.
vii. Detailed information regarding data used to train the model:
    1. Data provenance.
    2. Data size and completeness.
    3. Data timeframes.
    4. Data diversity.
    5. Data labeling accuracy.
viii. Validation Data/Information and evidence of:
    1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
    2. Constraint to evidence-based outcomes and mitigation of "hallucination"/"confabulation" or other output error.
    3. Algorithmic validation.
    4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
    5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
    6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
    7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.
ix. Data Use Policy:
    1. Privacy.
    2. Security.
    3. Special considerations for protected populations or groups put at increased risk.
x. Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.
xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.

b. Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

4. Generative Augmented Intelligence
    a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
    b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
        i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
        ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
        iii. Lack of regulatory or clinical oversight to ensure performance of the tool.

iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
v. Data privacy.
vi. Cybersecurity.
vii. Physician liability associated with the use of generative AI tools.

c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.

5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies
    a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
        i. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
        ii. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
        iii. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
    b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.
    c. Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.

6. Data Privacy and Augmented Intelligence
    a. Entity Responsibility:
        i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.
        ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
        iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.
    b. User Education:

i. Users should be provided with training specifically on generative AI. Education should address:
    1. Legal, ethical, and equity considerations.
    2. Risks such as data breaches and re-identification.
    3. Potential pitfalls of inputting sensitive and personal data.
    4. The importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

7. Augmented Intelligence Cybersecurity
    a. AI systems must have strong protections against input manipulation and malicious attacks.
    b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
    c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
    d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.

8. Mitigating Misinformation in AI-Enabled Technologies
    a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training dat Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
    b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
    c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
    d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
    f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.

9. Payor Use of Augmented Intelligence and Automated Decision-Making Systems
    a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
    b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific

medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.

c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 508
(A-25)

Introduced by: Medical Student Section

Subject: Standardizing Safety Requirements for Traditional and Rideshare-Based Non-Emergency Medical Transportation

Referred to: Reference Committee E

Whereas, each year, approximately 6 million Americans delay medical care due to lack of transportation, and transportation barriers are estimated to contribute to at least 25% of all missed clinic appointments annually[1-4]; and

Whereas, traditional Non-Emergency Medical Transportation (NEMT) programs offer Medicaid beneficiaries insured transportation to healthcare services via taxi, van, or bus, serving as a crucial resource for vulnerable populations, including individuals with disabilities, the elderly, solitary individuals, and those in rural areas[3-11]; and

Whereas, issues such as limited ride coverage, late pick-ups, and absent drivers discourage the use of traditional NEMT, but optimizing these systems can improve service quality, enhance continuity of care, and reduce emergency room visits, hospitalizations, and preventable healthcare costs for vulnerable populations[12-14]; and

Whereas, rideshare-based NEMT (RB-NEMT) programs hire rideshare drivers to use personal vehicles to provide NEMT services, broadening NEMT's accessibility, which is currently in regular use in multiple states[15,16]; and

Whereas**,** compared to traditional NEMT, RB-NEMT options increase patient attendance at health appointments, while decreasing average wait times, costs per ride, annual costs, and improving reliability and patient satisfaction rates11,[17-19]; and

Whereas**,** rideshare companies hire RB-NEMT drivers as independent contractors who typically have limited or no training in patient confidentiality or basic life support, and offered little agency to transport patients[19]; and

Whereas**,** despite established partnerships between digital transportation network companies and NEMT brokers, there is a lack of standardized trainings for drivers, as well as concerns ranging from credentialing to information sharing to medical liability[17,20]; therefore be it

RESOLVED, that our American Medical Association study and report back with recommendations on appropriate minimum safety requirements/certifications (e.g., vehicle, Basic Life Support, Health Insurance Portability and Accountability Act) for non-emergency medical transportation (NEMT) and rideshare-based non-emergency medical transportation (RB-NEMT). (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Date Received: 04/10/2025

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RELEVANT AMA POLICY

H-130.954 Non-Emergency Patient Transportation Systems
Our AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients. [Sub. Res. 812, I-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed in lieu of Res. 101, A-12; Modified: CMS Rep. 02, I-18]

H-90.978 Community Mobility Devices
The AMA urges physicians, who treat patients with impaired mobility outside the home, to work with state medical associations and appropriate medical specialty societies to identify state agencies and community service organizations that provide local transportation assistance to disabled individuals, and that such information be made readily accessible to disabled patients. [CMS Rep. 10, A-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17]

H-425.993 Health Promotion and Disease Prevention
The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; (5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and preferably clean-energy public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention. [Presidential Address, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: BOT Rep. 8, I-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: Res. 923, I-19]

H-330.960 Cost of Medically Related Services and Supplies
Our American Medical Association legislative or other appropriate department will seek a requirement that CMS and/or their contracted home health agencies, durable medical equipment suppliers, and non-emergency transportation services, provide cost estimates to physicians, to be provided along with the physician authorization form. [Res. 812, A-92; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-99Reaffirmation A-04; Reaffirmation A-08; Reaffirmed: BOT Rep. 14, A-13; Reaffirmed: BOT Rep. 09, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 509
(A-25)

Introduced by: Medical Student Section

Subject: Allergen Labeling for Spices and Herbs

Referred to: Reference Committee E

Whereas, food allergies affect an estimated 33 million Americans, posing significant risks such as severe reactions, diminished quality of life, and substantial economic costs due to medical care and avoidance measures[1-14]; and

Whereas, the U.S. Food and Drug Administration (FDA) requires food manufacturers to list ingredients and specify common allergens, with allergy labels playing a crucial role in preventing allergic reactions[1, 5-11]; and

Whereas, the FDA allows vague labeling of food seasonings as "spices and herbs," which can include a variety of components, limiting complete ingredient transparency, while manufacturers are not required to report changes in aromatic vegetable blends classified as "spices" or "herbs"[6,7,10,11]; and

Whereas, individuals with allergies may experience cross-reactivity to compounds in spices and herbs due to shared allergenic epitopes across related families, leading to reactions in foods that seem allergen-free[9,11,12]; and

Whereas, the FDA classifies aromatic vegetables like fenugreek as "spices," which can cause anaphylactic cross-reactivity in individuals with peanut allergies, a phenomenon also observed with other common allergens like tree nuts[11,13]; and

Whereas, aeroallergens like pollen can cause sensitization to food allergens, contributing to pollen-food syndrome, which includes allergic reactions to spices from the Apiaceae family[2,12,14]; and

Whereas, an estimated 1.3 million Americans are affected by spice allergies, complicating avoidance due to ambiguous labeling and cross-contamination risks, with certain Apiaceae vegetables known to cause severe anaphylactic reactions[2,9,15]; and

Whereas, under the Fair Packaging and Labeling Act, food manufacturers must provide accurate allergen information though it protects trade secrets such as spice blends, resulting in additional efforts to improve labeling transparency, through acts like the Food Allergen Labeling and Consumer Protection Act (FALCPA) and the FASTER Act[10,16-22]; and

Whereas, clearer labeling would enhance diagnostic accuracy for physicians and help individuals with spice allergies avoid accidental exposure, thereby improving their ability to make informed food choices[9-11,15,20,23;] therefore be it

RESOLVED, that our American Medical Association support requirements for transparent disclosure of individual ingredients in aggregate categories, such as “spices and herbs,” and regular U.S. Food and Drug Administration (FDA) evaluation of labeling exemptions. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/17/25

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RELEVANT AMA POLICY

H-150.924 Allergen Labeling on Food Packaging
Our AMA encourages food manufacturers to pursue more obvious packaging distinctions between products that contain the most common food allergens identified in the Food Allergen Labeling and Consumer Protection Act and products that do not contain these allergens. [Res. 918, I-18]

D-440.932 Preventing Allergic Reactions in Food Service Establishments
Our American Medical Association will pursue federal legislation requiring restaurants and food establishments to: (1) include a notice in menus reminding customers to let the staff know of any food allergies; (2) educate their staff regarding common food allergens and the need to remind customers to inform wait staff of any allergies; and (3) identify menu items which contain any of the major food allergens identified by the FDA (in the Food Allergen Labeling and Consumer Protection Act of 2004) and which allergens the menu item contains. [Res. 416, A-15]

H-150.948 Increasing Awareness of Nutritional Information and Ingredient Lists
Our American Medical Association supports legislation or rules requiring restaurants, retail food establishments, **and** vending machine operators that have menu items common to multiple locations, as well as all school **and** workplace cafeterias, especially those located in health care facilities, to have available for public viewing **ingredient lists**, nutritional **information**, **and** standard **nutrition** labels for all menu items. [Sub. Res. 411, A-04; Reaffirmation A-07; Reaffirmed in lieu of Res. 413, A-09, Res. 416, A-09 and Res. 418, A-09; Modified: BOT Rep. 1, A-14; Modified: CSAPH Rep. 01, A-24]

H-150.926 Product Date Labels
Our AMA will support federal standardization of date labels on food products to ensure that the labels address safety concerns. [Res. 421, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 510
(A-25)

Introduced by: Medical Student Section

Subject: Improving Cybersecurity Standards for Healthcare Entities

Referred to: Reference Committee E

Whereas, healthcare increasingly relies on electronic infrastructure in the form of Electronic Health Records (EHR) systems, telehealth platforms, implantable devices, patient monitoring devices, and billing systems[1,2]; and

Whereas, the doubling of healthcare cyberattacks from 2016 to 2021 has exposed vulnerabilities that lead to care errors, delays, increased mortality, and disproportionate harm to minority patients, exacerbated by insufficient regulations and optional industry standards[3-8]; and

Whereas, the largest healthcare cyberattack in U.S. history at Change Healthcare, which compromised one-third of all medical records, underscored the absence of multi-factor authentication (MFA), a critical security measure capable of preventing 99.9% of automated cyberattacks and significantly reducing data breaches[9-12]; and

Whereas, the lack of original equipment manufacturer (OEM) support, timely updates, and the inconsistent use of readily available security measures like disk encryption in medical devices are significant vulnerabilities that increase the risk of cyberattacks[2,14-19]; and

Whereas, solo practitioners and rural hospitals often lack resources for cybersecurity, while larger entities like independent software vendors (ISVs), independent hardware vendors (IHVs), and OEMs, such as Google and Microsoft, have the capacity to address these challenges[20–24]; and

Whereas, healthcare cybersecurity is a focus of active regulation, with agencies like the Food and Drug Administration (FDA) introducing updated device requirements, the Department of Health and Human Services (HHS) investing in initiatives, and The White House recommending minimum standards in its National Cybersecurity Strategy[25–29]; therefore be it

RESOLVED, that our American Medical Association support the establishment of minimum cybersecurity standards, including, but not limited to, the use of multi-factor authentication, timely updates, and encryption for HIPAA covered entities. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/17/25

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RELEVANT AMA POLICY

D-478.957 Establish a Cyber-Security Relief Fund

Our American Medical Association, through appropriate channels, advocates for a 'Cyber Security Relief Fund" to be established by Congress. Our AMA advocates that the "Cyber Security Relief Fund" be funded through contributions from health insurance companies and all payers - as a mandated

requirement by each of the payer. Our AMA advocates that the “Cyber Security Relief Fund” only be utilized for ‘uninterrupted’ payments to all providers- in a structured way, in the event of future cyber-attacks affecting payments. [Res. 235, A-24]

H-515.950 Protecting Physicians and Other Healthcare Workers in Society
Our American Medical Association acknowledges and will act to reduce the incidence of antagonistic actions against physicians as well as other health care workers including first responders and public health officials, outside as well as within the workplace, including physical violence, intimidating actions of word or deed, and cyber-attacks, particularly those which appear motivated simply by their identification as health care workers. [Res. 413, I-20 Reaffirmed: CSAPH Rep. 7, I-23]

D-478.959 Ransomware Prevention and Recovery
Our AMA will: (1) work with other stakeholders to seek legislation or regulation that supports resources to cover cyberattack prevention and recovery expenses for physician practices, hospitals, and healthcare entities to ensure continuity of optimal patient care; and (2) in collaboration with appropriate stakeholders, develop a toolkit for physician practices, hospitals, and healthcare entities to include best practices on preventing cyberattacks and a plan of action for when such an attack happens to their practice or institution; the toolkit should include guides to financial resources. [Res. 240, I-21]

D-478.960 Ransomware and Electronic Health Records
Our American Medical Association acknowledges that healthcare data interruptions are especially harmful due to potential physical harm to patients and calls for prosecution to the fullest extent of the law for perpetrators of ransomware and any other malware on independent physicians and their practices, healthcare organizations, or other medical entities involved in providing direct and indirect care to patients. Our AMA will: (a) advocate for federal legislation which provides for the prosecution of perpetrators of ransomware and any other malware on any and all healthcare entities, involved in direct and indirect patient care, to the fullest extent of the law; (b) encourage health care facilities and integrated networks that are under threat of ransomware attacks to upgrade their cybersecurity and to back up data in a robust and timely fashion; (c) advocate that the security of protected healthcare information be considered as an integral part of national cybersecurity protection; and (d) seek inclusion of federal cybersecurity resources allocated to physician practices, hospitals, and health care entities sufficient to protect the security of the patients they serve, as part of infrastructure legislation. [Res. 210, A-21 Reaffirmation: Res. 241, A-24]

3.3.3 Breach of Security in Electronic Medical Records
When there is reason to believe that patients’ confidentiality has been compromised by a breach of the electronic medical record, physicians should: (a) Ensure that patients are promptly informed about the breach and potential for harm, either by disclosing directly (when the physician has administrative responsibility for the EMR), participating in efforts by the practice or health care institution to disclose, or ensuring that the practice or institution takes appropriate action to disclose. (b) Follow all applicable state and federal laws regarding disclosure. [Issued: 2016]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 511
(A-25)

Introduced by: Medical Student Section

Subject: Increased Transparency Among Psychotropic Drug Administration in Prisons

Referred to: Reference Committee E

Whereas, the prevalence of mental health disorders among incarcerated individuals is disproportionately higher than the general population (22.8% in 2021), with 64% of jail inmates, 54% of state prisoners, and 45% of federal prisoners reporting mental health concerns, 37% of federal prisoners and 44% of jail inmates having a prior mental health diagnosis, and 14% of federal prisoners and 26% of jail inmates having serious psychological distress;[1-3,10] and

Whereas, psychotropic drugs, such as antipsychotics, antidepressants, mood stabilizers, and tranquilizers have significant adverse side effects, suggesting the need for close monitoring if these drugs are used;[4,5] and

Whereas, these medications are frequently used on incarcerated patients, yet prisons are known to have staffing deficiencies in their medical units, often resulting in fatal delays to accessing care;[4,6,7] and

Whereas, inmates can be involuntarily medicated if the state has clear, cogent, and convincing evidence that it is in the state's interest at that time, such as for the safety of the inmate or others, bypassing the assessment for capacity and leading to abundant opportunities for abuse and control of incarcerated populations;[4,8] and

Whereas, many state and federal prisons currently lack transparency regarding their policies and protocols for psychotropic drug administration, including, but not limited to, administration, duration, side effects, and drug(s) of choice;[4,9] and

Whereas, there are limited data surrounding the incarcerated patients' experience with mental illness and treatment, as well as side effects and complications of use of psychotropic drugs in incarcerated populations due to the regular exclusion of this population from large scale population health surveys;[6] and

Whereas, the limited access to these data impedes research and advocacy efforts for this patient population, who are at high risk of adverse health outcomes; therefore be it

RESOLVED, that our American Medical Association study issues surrounding the use of psychotropic medications in the carceral system, including inconsistencies in dosage, frequency, duration, allowed formularies, side effects, and oversight by a psychiatrist or another physician with expertise in mental illness (Directive to Take Action); and be it further

RESOLVED, that our AMA support increased transparency from state and federal jails and prisons surrounding protocols pertaining to the administration of psychotropic medications, including components such as dosage, frequency, duration, allowed formularies, management

of side effects, and requirements for oversight by a psychiatrist or another physician with expertise in mental illness. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Date Received: 4/21/25

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RELEVANT AMA POLICY

H-430.987 Medications for Opioid Use Disorder in Correctional Facilities
Our AMA advocates for legislation, standards, policies and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting. [Res. 443, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Appended: Res. 223, I-17; Modified: Res. 503, A-21]

H-430.986 Health Care While Incarcerated
Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing. [CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21; Modified: Res. 127, A-22; Appended: Res. 244, A-23; Appended: Res. 429, A-23]

D-430.997 Support for Health Care Services to Incarcerated Persons
Our AMA will express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities; [Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep, 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19; Reaffirmed: CSAPH Rep. 06, A-23]

H-130.932 Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting
Our AMA:
1. Believes that current evidence does not support “excited delirium” or “excited delirium syndrome” as a medical diagnosis and opposes the use of the terms until a clear set of diagnostic criteria are validated.
2. Recognizes that the treatment of medical emergency conditions outside of a hospital is usually done by a subset of healthcare practitioners who are trained and have expertise as emergency medical service (EMS) practitioners. It is vital that EMS practitioners and systems are overseen by physicians who have specific experience and expertise in providing EMS medical direction.
3. Is concerned about law enforcement officer use of force accompanying “excited delirium” that leads to disproportionately high mortality among communities of color, particularly among Black men, and denounces “excited delirium” solely as a justification for the use of force by law enforcement officers.
4. Opposes the use of sedative/hypnotic and dissociative agents, including ketamine, as a pharmacological intervention for agitated individuals in the out-of-hospital setting, when done solely for a law enforcement purpose and not for a legitimate medical reason.
5. Recognizes that sedative/hypnotic and dissociative pharmacological interventions for agitated individuals used outside of a hospital setting by non-physicians have significant risks intrinsically, in the context of age, underlying medical conditions, and also related to potential drug-drug interactions with agents the individual may have taken.
6. Encourages the continued use of the necessary and effective dual-response method of communication between law enforcement and EMS to appropriately care for all patients encountered by first responders, including those patients demonstrating agitated or combative behavior.
7. Calls for comprehensive, independent analysis of law enforcement agencies to:
a. Review cases labeled as “excited delirium” to determine frequency of use of the term, including prevalence of its use by race, ethnicity, gender, age, and other demographic factors;
b. Assess the available training and guidelines used to prepare law enforcement first responders to respond to individuals with agitated or combative behavior, including de-escalation training;
c. Assess efforts to ensure adherence to approved training on an ongoing basis.
8. Calls for comprehensive, independent analysis, performed by appropriate medical and behavioral health professionals, of EMS agencies to:
a. Review the usage of ketamine and other sedative-hypnotic medications used to sedate patients with agitated or combative behavior and correlation of the tern “excited delirium” with race, ethnicity, gender, age or other demographic factors;
b. Assess whether existing training and guidelines, including continuous quality improvement processes, have been properly established by supervising EMS medical directors and behavioral health specialists, to:
i. Require appropriate monitoring of any patient who receives sedative/hypnotic and dissociative pharmacological interventions for treatment in the out-of-hospital setting;
ii. Ensure proper use of ketamine and other sedative/hypnotic and dissociative pharmacological interventions under defined protocols/guidelines after appropriate education on indications, usage and complications;
iii. Include an appropriate stepwise approach to the treatment of patients in the out-of-hospital setting, including de-escalation training, that provides safety to the patient and providers; and
c. Assess, on an ongoing basis, that personnel are conducting themselves according to guidelines and training.
9. Urges law enforcement and frontline emergency medical service personnel, who are a part of the “dual response” in emergency situations, to participate in appropriate training, overseen by EMS medical directors. The training should minimally include de-escalation techniques and the appropriate use of pharmacological intervention for agitated individuals in the out-of-hospital setting.

10. Urges medical and behavioral health specialists, not law enforcement, to serve as first responders and decision makers in medical and mental health emergencies in local communities and that administration of any pharmacological treatments in the out-of-hospital setting be done equitably, in an evidence-based, anti-racist, and stigma-free way. [CSAPH Rep. 2, A-21; Appended: BOT Action in response to referred for decision: CSAPH Rep. 2, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 512
(A-25)

Introduced by: Medical Student Section

Subject: Preventing Drug-Facilitated Sexual Assault in Drinking Establishments

Referred to: Reference Committee E

Whereas, an estimated 1 in 5 women have experienced completed or attempted rape, and 1 in 4 men have experienced some variation of sexual violence in their lifetime, with nearly half of all sexual assaults involving alcohol consumption by the survivor, perpetrator, or both[1-3]; and

Whereas, alcohol is identified as the most commonly detected substance in drug-facilitated sexual assaults (DFSA) globally, with a significant portion of survivors reporting the use of substances such as MDMA, GHB, ketamine, methamphetamine, and Rohypnol by perpetrators[4–7]; and

Whereas, college students and young adults are highly vulnerable to drug-facilitated sexual assault (DFSA), with over 60% of incidents occurring in social settings like parties, bars, or clubs, and only 20% of all survivors reporting assaults due to fear, shame, or impaired memory, underscoring the urgent need for targeted preventive interventions[8-11]; and

Whereas, due to the prolonged time frame between an assault and its reporting and the rapid clearance of many of these substances from the blood and urine, testing of drink samples has been found to grant investigators much-needed insight[12]; and

Whereas**,** various drug detection devices, such as GHB and ketamine test kits, Drink Check Wristbands, and Personal Drink IDs, have been developed and sold at relatively low costs for the express purpose of preventing DFSA[13–18]; and

Whereas, cities such as San Diego have recognized the importance of preventing DFSA by requiring alcohol-selling establishments to have drug detection devices available under Assembly Bill No. 1013, reflecting a growing trend in policy aimed at proactive prevention rather than reactive response[19]; and

Whereas, the American Medical Association has existing policy addressing sexual assault prevention on college campuses and education on sexual assault prevention and violence but lacks policy supporting efforts to prevent DFSA; therefore it be

RESOLVED, that our American Medical Association support federal, state, and local efforts to prevent drug-facilitated sexual assault, including provision of drug detection equipment in establishments that sell alcohol and through public education campaigns. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/21/25

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RELEVANT AMA Policy

H-515.956 Addressing Sexual Assault on College Campuses

Our AMA: (1) supports universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting; (2) will work with relevant stakeholders to address the issues of rape, sexual abuse, and physical abuse on college campuses; and (2) will strongly express our concerns about the problems of rape, sexual abuse, and physical abuse on college campuses. [Res. 402, A-16; Appended: Res. 424, A-18]

Preventing, Identifying and Treating Violence and Abuse 8.10
All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse.
To protect patients' well-being, physicians individually should:
(a) Become familiar with:
(i) how to detect violence or abuse, including cultural variations in response to abuse;
(ii) community and health resources available to abused or vulnerable persons;
(iii) public health measures that are effective in preventing violence and abuse;
(iv) legal requirements for reporting violence or abuse.
(b) Consider abuse as a possible factor in the presentation of medical complaints.
(c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history.
(d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in "normal" families, is a private matter best resolved without outside interference, or is caused by victims' own actions.
(e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.
(f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.
(g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should:
(i) inform patients about requirements to report;
(ii) obtain the patient's informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.
(h) Protect patient privacy when reporting by disclosing only the minimum necessary information.
Collectively, physicians should:
(i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.
(j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.
(k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.
(l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.
(m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.
AMA Principles of Medical Ethics: I,III Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 513
(A-25)

Introduced by: Medical Student Section

Subject: Transparency on Comparative Effectiveness in Direct-to-Consumer Advertising

Referred to: Reference Committee E

Whereas, studies show that direct-to-consumer advertising (DTCA) significantly influences patient and provider perceptions of medications, sometimes leading to overestimation of benefits and underestimation of risks, underscoring the need for more stringent regulation and accurate representation of clinical data in drug advertisements[1,3]; and

Whereas, physicians are substantially likelier to prescribe DTCA medications when requested by their patients, despite having reservations about their clinical appropriateness[2]; and

Whereas, countries such as France, Germany and Canada have assigned health technology assessment (HTA) agencies to classify drugs based on their added clinical benefit, prioritizing evidence from randomized trials that compare the new drug to an existing treatment, with studies showing a strong agreement between these agencies on assessments of comparative effectiveness, especially of ultra-expensive drugs[4-7, 8]; and

Whereas, Section 1194(e) of the Inflation Reduction Act requires the Centers for Medicare and Medicaid Services to consider comparative effectiveness in Medicare Drug Price Negotiations, a principle that should also apply to DTCA, which is not currently addressed in AMA policy H-105.988 regarding the assessment or advertisement of a drug's comparative effectiveness or added clinical benefit within its class or purpose[9]; and

Whereas, The Effective Health Care Program funds individual researchers, research centers, and academic organizations to work with the Agency for Healthcare Research and Quality (AHRQ) to produce effectiveness and comparative effectiveness research for clinicians, consumers, and policymakers[10]; and

Whereas, by presenting comparative effectiveness data clearly and with guidance from healthcare professionals, patient education materials could improve understanding and adherence to treatment plans, enhancing care quality and helping physicians tailor drug choices to individual patient needs[11-13]; therefore be it

RESOLVED, that our American Medical Association supports the designation of an appropriate government health agency, such as the Agency for Healthcare Research and Quality (AHRQ), to:

a. review data on diagnostic and treatment modalities, prioritizing evidence from randomized controlled clinical trials;

b. evaluate their comparative effectiveness when compared to existing standard of care and other benefits such as convenience, formulation, and route of administration;
c. require that any corporate advertisements for a modality include agency-approved information on comparative effectiveness. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 4/22/25

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RELEVANT AMA POLICY

H-105.988 Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices
Our AMA: … 2.That until such a ban is in place, our American Medical Association opposes product-claim DTCA that does not satisfy the following guidelines: a.The advertisement should be indication-specific and enhance consumer education about the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used. b.In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing. … g.The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition. [BOT Rep. 38, A-99; Sub. Res. 513, A-99; Reaffirmed: CMS Rep. 9, I-99; Amended: Res. 509, I-99; Appended & Reaffirmed: Sub. Res. 503, A-01; Reaffirmed: Res. 522, A-02; Reaffirmed: Res. 914, I-02; Reaffirmed: Sub. Res. 504, A-03;

Reaffirmation A-04; Reaffirmation A-05; Modified: BOT Rep. 9, A-06; Reaffirmed in lieu of Res. 514, A-07; BOT Action in response to referred for decision: Res. 927, I-15; Modified: BOT Rep. 09, I-16; Appended: Res. 236, A-17; Reaffirmed in lieu of: Res. 223, A-17; Reaffirmed in lieu of: Res. 112, A-19; Reaffirmed in lieu of: Res. 810, I-22; Reaffirmation A-23]

Direct-to-Consumer Advertisement of Prescription Drugs, 9.6.7

Direct-to-consumer advertising may raise awareness about diseases and treatment and may help inform patients about the availability of new diagnostic tests, drugs, treatments, and devices. However, direct-to-consumer advertising also carries the risk of creating unrealistic expectations for patients and conflicts of interest for physicians, adversely affecting patients' health and safety, and compromising patient physician relationships.
(Issued: 2016)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 514
(A-25)

Introduced by: New England, The American Thoracic Society

Subject: Support for a Nicotine Free Generation

Referred to: Reference Committee E

Whereas, the addictive nature of nicotine is established[1]; and

Whereas, the combustible form of nicotine delivery has serious morbidity and mortality consequences in that "smoking kills more people in this country than HIV, drug overdoses, alcohol use, motor vehicle crashes, and firearm-related injuries combined";[2] and

Whereas, there is evidence that non-combustible forms of nicotine delivery systems have cancer-causing chemicals and precursors similar to combustible forms — "E-cigarette devices and vaping fluids demonstrably contain a series of both definite and probable oncogens including nicotine derivatives (e.g., nitrosnornicotine, nitrosamine ketone), polycyclic aromatic hydrocarbons, heavy metals (including organometal compounds) and aldehydes/other complex organic compounds. These arise both as constituents of the e-liquid (with many aldehydes and other complex organics used as flavorings) and as a result of pyrolysis/complex organic reactions in the electronic cigarette device (including unequivocal carcinogens such as formaldehyde — formed from pyrolysis of glycerol). Various studies demonstrate in vitro transforming and cytotoxic activity of these derivatives";[3] and

Whereas, there is a concerning prevalence of noncombustible addictive nicotine delivery system use in this country by children and adolescents — 5.9% use e-cigarettes and 1.8% use addictive nicotine pouches, for a combined total of 1,600,000 children;[4] and

Whereas, every day, almost 2,500 children under 18 years of age try their first cigarette, more than 400 of them will become new, regular daily smokers, and half of them will ultimately die from their habit;[5,6] and

Whereas, cigarette smoking causes about one out of every three cancer deaths in the United States;[7] and

Whereas, the nicotine-free generation (NFG) concept is a relatively new tobacco control strategy that phases in an end to commercial nicotine use by prohibiting the sale of nicotine products to anyone born after a chosen date (e.g., January 1, 2004), while permitting those born before that date to be sold products indefinitely, thereby preventing sales to the next generation and phasing out sales slowly over time;[8] and

Whereas, in New England the Massachusetts Medical Society supported the town of Brookline, Massachusetts, by signing on to an amicus brief in SIX BROTHERS, INC. vs. TOWN OF BROOKLINE, wherein the bylaw prohibits the sales of nicotine products to anyone born on or

after January 1, 2000. The MA Supreme Judicial Court unanimously supported Brookline in its decision;[9] and

Whereas, as of April 2, 2025, the following Massachusetts cities and towns have adopted NFG policy: Brookline via by-law, Stoneham, Wakefield, Melrose, Malden, Winchester, Reading, Concord, Manchester, Chelsea, Belchertown, Needham, and Newton via city ordinance, and Pelham via resolution; and

Whereas, legislation has been filed in the Massachusetts State House and Senate, An Act *to create a nicotine free generation* (HD2372 and SD1317);[10, 11] therefore be it

RESOLVED, that our American Medical Association advocate for legislation establishing a "Nicotine Free Generation" through the prohibition on sale of addictive nicotine products to anyone born after a chosen date (Directive to Take Action); and be it further

RESOLVED, that our AMA alert its members to current opportunities to create "Nicotine Free Generation" policies through the prohibition on sale of addictive nicotine products to anyone born after a chosen date within the towns, cities, and states where they practice and live. (Directive to Take Action)

Fiscal Note: Resolve 1: Modest – between $1,000 - $5,000
Resolve 2: Minimal – less than $1,000

Date Received: 4/15/25

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10. The 194th General Court of the Commonwealth of Massachusetts. Bill HD2372. An Act to create a nicotine-free generation. https://malegislature.gov/Bills/194/HD.2372
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RELEVANT AMA POLICY

H-30.958. Ethyl Alcohol and Nicotine as Addictive Drugs.
The AMA (1) identifies alcohol and nicotine as drugs of addiction which are gateways to the use of other drugs by young people; (2) urges all physicians to intervene as early as possible with their patients who use tobacco products and have problems related to alcohol use, so as to prevent adverse health effects and reduce the probability of long-term addition; (3) encourages physicians who treat patients with alcohol problems to be alert to the high probability of co-existing nicotine problems; and (4) reaffirms that

individuals who suffer from drug addiction in any of its manifestations are persons with a treatable disease.

H-490.911. Smoke-Free America.
Our AMA makes the passage of legislation for a smoke-free America, that includes all public and workplaces and includes provisions for support of smoking cessation programs, a legislative priority for the AMA until such legislation is passed.

D-490.998. Tobacco Control and Settlement
Our AMA: (1) will undertake action to publicize, support and implement the elements of its policies that have not been adequately addressed by the Master Settlement Agreement and other agreements, including but not limited to:

(a) A complete ban on tobacco industry promotion and advertising;
(b) Regulation of tobacco sales, including a ban on vending machines and a mandate for behind the counter sales;
(c) Tax increases on tobacco products;
(d) Protection from environmental tobacco smoke;
(e) Regulation of nicotine as a drug by the Food and Drug Administration; and
(f) Look back provisions; and

(2) will work with Congress, the Administration and other groups to achieve public health goals and accomplish the issues addressed by our AMA policies through federal and state tobacco control legislation.

H-495.977. Banning the Sale of Tobacco Products in Pharmacies and Health Care Facilities
Our AMA supports efforts to ban the sale of tobacco products meeting the definition of "tobacco product" under the Family Smoking Prevention and Tobacco Control Act, with the exception of medicinal nicotine products approved by the FDA, where health care is delivered or where prescriptions are filled, including retail outlets housing store-based health clinics.

H-495.983 Tobacco Litigation Settlements
1. Our American Medical Association strongly supports the position that all monies paid to the states in the Master Settlement Agreement and other agreements be utilized for research, education, prevention and treatment of nicotine addiction, especially in children and adolescents, and for treatment of diseases related to nicotine addiction and tobacco use.
2. Our AMA supports efforts to ensure that a substantial portion of any local, state or national tobacco litigation settlement proceeds be directed towards preventing children from using tobacco in any form, helping current tobacco users quit, and protecting nonsmokers from environmental tobacco smoke, and that any tobacco settlement funds not supplant but augment health program funding.
3. Our AMA strongly supports efforts to direct tobacco settlement monies that are not directed to other specific tobacco control activities to enhance patient access to medical services.
4. Our AMA strongly supports legislation codifying the position that all monies paid to the states through the various tobacco settlements remain with the states; and that none be reimbursed to the Federal government on the basis of each individual state's Federal Medicaid match.
5. Our AMA opposes any provision of tort reform legislation that would grant exclusion from liability or special protection to tobacco companies or tobacco products.

H-495.986. Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes
1. Our American Medical Association recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;

2. Our AMA encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;
3. Our AMA supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;
4. Our AMA requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;
5. Our AMA opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;
6. Our AMA seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;
7. Our AMA opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;
8. Our AMA:
    a. publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products;
    b. encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores;
    c. urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and
    d. encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members.
9. Our AMA opposes the sale of tobacco at any facility where health services are provided; and
10. Our AMA supports that the sale of tobacco products be restricted to tobacco specialty stores.
11. Our AMA supports measures that decrease the geographic density of tobacco retail stores, including but not limited to, preventing retailers from selling tobacco products in stores in close proximity to schools.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 515
(A-25)

Introduced by: New York

Subject: Nitrous Oxide Abuse

Referred to: Reference Committee E

Whereas, nitrous oxide is a colorless gas used as a sedative for medical/dental procedures well known to the medical profession; and

Whereas, abuse of nitrous oxide is known to impair the body's metabolism of vitamin B12, causing combined degeneration of the spinal cord as well as peripheral neuropathies. Neuropsychiatric symptoms can include depression, anxiety, aggressive behaviors, hallucinations and delusions; and

Whereas, there has been a massive increase in the recreational use of nitrous oxide, often being sold in smoke shops marketed to teenagers; and

Whereas, as detailed in a recent article in the December 30, 2024, edition of New York Magazine called "The Next Drug Epidemic is Blue Raspberry Flavored", speaks to how the industry comes up with flavors, and clever social media campaigns but tries to dodge legal responsibility by having people sign waivers that they plan to use for culinary purposes to give whipped cream the fluffy consistency found in store-bought cans; and

Whereas, a small greedy group profits off Americans while the regulatory process of the government is slow to react. There is no meaningful federal regulation. Some states have taken action. In March 2024, Michigan passed a law making it unlawful to sell nitrous paraphernalia for recreational use. Two months later, Louisiana became the first state to ban commercial sales of the gas entirely. Other states have proposed banning smoke shops from selling nitrous entirely; therefore be it

RESOLVED, that our American Medical Association support efforts on the federal level to educate the public regarding the harmful effects of inhaled nitrous oxide use and work with local stakeholders to limit the ability to acquire nitrous oxide for inhalation purposes. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 516
(A-25)

Introduced by: Organized Medical Staff Section

Subject: Creating a Registry of Potential Side Effects of GIP & GLP-1 Medications

Referred to: Reference Committee E

Whereas, gastric inhibitory polypeptide (GIP) and glucagon-like peptide-1 (GLP-1) medications continue to be heavily advertised and touted as some kind of miracle drug for weight loss—besides their main indication as treatment for diabetes, there are limited studies on the potential side-effects—especially those involving the senior (65 years and older) population, such as muscle loss and bone density loss; and

Whereas, the costs of these medications continue to be high and they can potentially cost the healthcare system a lot of money over the long run; and

Whereas, there are no clear guidelines of how long patients should be taking these medications, which are meant to be long-term and potentially life-long weight management medications, and whether the weight loss will be maintained if patients ever want to come off them; and

Whereas, there are no long-term studies of the potential side effects of these medications while many side effects have been seen; and

Whereas, there are no current recommendations to better safeguard patients taking these medications and patients are not required to be monitored by qualified health professionals, such as obesity specialists, endocrinologists, or gastroenterologists, while taking these medications; therefore be it

RESOLVED, that our American Medical Association support and call for a registry of GIP and GLP-1 receptor agonists' side effects, as well as potential impacts on pregnancy (Directive to Take Action).

Fiscal Note: Minimal – less than $1,000

Received: 2/28/2025

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 517
(A-25)

Introduced by:	Resident and Fellow Section, American Academy of Addiction Psychiatry, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Association for Geriatric Psychiatry, American Academy of Psychiatry and the Law, Academy of Consultation-Liaison Psychiatry
Subject:	In Support of a National Drug Checking Registry
Referred to:	Reference Committee E

Whereas, recreational substance use is becoming increasingly more common, with 13.3% of respondents to a 2020 CDC survey reporting that they either started or increased substance use to help deal with stress related to COVID-19;[1] and

Whereas, recreational drugs have been found to be contaminated with adulterants at a rate up to nearly 80%;[2–4] and

Whereas, fentanyl was present in 77% of adolescent overdose deaths in 2021;[5] and

Whereas, nearly two-thirds of all overdose deaths in the United States from 2019-2020 involved synthetic opioids;[6] and

Whereas, drug checking services are point-of-care tests provided at events with high recreational drug use that can rapidly provide information to a user on the composition of the drug they intend to take;[7] and

Whereas, 94% of users of drug checking services reported they would not take a drug whose test results were unexpected;[8] and

Whereas, 32% of users of drug checking services reported that they would not take a drug if it was found to contain adulterants;[8] and

Whereas, a majority of users of drug checking services intended to share the results of the test with others;[9] and

Whereas, drug checking services can also serve as a point of contact with users of recreational drugs for other harm reduction services, and accessibility to these resources through drug checking services is overwhelmingly supported by the target market;[10] and

Whereas, availability of drug checking services does not lead to an increase in intent to use recreational drugs;[11] and

Whereas, drug checking services are supported by over 80% of the target population;[12] and

Whereas, the Department of Health and Human Services reports that efforts to provide drug checking services have been largely effective in changing intended and actual drug use behavior;[13] and

Whereas, drug-checking services in the United States today do not have an established way to communicate trends in their results with one another; and

Whereas, a network of drug-checking services across the country could be an alternative source of information to DEA seizures to help identify early trends in supply contamination and provide education on upcoming contamination concerns to users, such as the rise of new contaminants like xylazine;[14] therefore be it

RESOLVED, that our American Medical Association study the creation of a national drug-checking registry that would provide a mechanism whereby community-run drug-checking services may communicate their results. (Directive to Take Action)

Fiscal note: Modest – between $1,000 - $5,000

Received: 4/21/25

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RELEVANT AMA POLICY:

Prevention of Drug-Related Overdose D-95.987
1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.

2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies. [Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21; Appended: Res. 513, A-22; Modified: Res. 211, I-22; Appended: Res. 221, A-23; Reaffirmation: A-23; Modified: Res. 505, A-23; Reaffirmed: BOT Rep. 18, A-24]

Pilot Implementation of Supervised Injection Facilities H-95.925
Our AMA supports the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use. [Res. 513, A-17; Reaffirmation: A-23]

Harmful Drug Use in the United States - Strategies for Prevention H-95.978
Our AMA: (1) Urges the Substance Abuse and Mental Health Administration to support research into special risks and vulnerabilities, behavioral and biochemical assessments and intervention methodologies most useful in identifying persons at special risk and the behavioral and biochemical strategies that are most effective in ameliorating risk factors.
(2) Urges the Center for Substance Abuse Prevention to continue to support community-based prevention strategies which include: (a) Special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level. (b) Changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of harmful drug and alcohol use prevention and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction. (c) Development of innovative programs that train and involve parents, educators, physicians, and other community leaders in "state of the art" prevention approaches and skills.
(3) Urges major media programming and advertising agencies to encourage the development of more accurate and prevention-oriented messages about the effects of harmful drug and alcohol use.
(4) Supports the development of advanced educational programs to produce qualified prevention specialists, particularly those who relate well to the needs of economically disadvantaged, ethnic, racial, and other special populations.
(5) Supports investigating the feasibility of developing a knowledge base of comprehensive, timely and accurate concepts and information as the "core curriculum" in support of prevention activities.
(6) Urges federal, state, and local government agencies and private sector organizations to accelerate their collaborative efforts to develop a national consensus on prevention and eradication of harmful alcohol and drug use. [BOT Rep. H, A-89; Reaffirmed: CSA Rep. 12, A-99; Reaffirmation I-01; Reaffirmed: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21; Reaffirmed: Res. 523, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 518
(A-25)

Introduced by: Undersea and Hyperbaric Medical Society, Laurie Gesell, MD, Jayesh Shah, MD

Subject: Mandatory Accreditation and Regular Inspections of Hyperbaric Chambers

Referred to: Reference Committee E

Whereas, a recent tragic incident in Michigan resulted in the death of a child due to a chamber explosion in an unaccredited hyperbaric facility; and

Whereas, hyperbaric chambers pose significant risks, including fire hazards due to high oxygen concentrations, which can be mitigated by adherence to rigorous safety standards; and

Whereas, currently there is no uniformity in state regulations, with most states lacking requirements for accreditation or regular inspections of hyperbaric chambers; and

Whereas, the Food and Drug Administration recommends that patients being referred for hyperbaric oxygen therapy go to a hospital or facility that has been “inspected and is properly accredited by the Undersea and Hyperbaric Medical Society”; and

Whereas, the Undersea and Hyperbaric Medical Society is the only organization that conducts hyperbaric facility accreditations to ensure facilities meet high safety and patient care standards; and

Whereas,The Joint Commission recognizes the UHMS accreditation program as the only Complementary Accrediting Organization under their Cooperative Agreement; and

Whereas, ensuring the safety of patients undergoing hyperbaric oxygen therapy is paramount; therefore be it

RESOLVED, that our American Medical Association recommend that all states within the United States require hyperbaric chamber facilities to be accredited by the Undersea and Hyperbaric Medical Society (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for at least annual inspections of hyperbaric chambers by the manufacturer or other approved biomedical equipment personnel to ensure compliance with safety standards (Directive to Take Action); and be it further

RESOLVED, that our AMA support legislative efforts to establish uniform national standards for the operation and maintenance of hyperbaric chambers. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/25

REFERENCES

1. FDA: Hyperbaric Oxygen Therapy: Get the Facts https://www.fda.gov/consumers/consumer-updates/hyperbaric-oxygen-therapy-get-facts
2. The Joint Commission: Complementary Agreements https://www.jointcommission.org/resources/news-and-multimedia/fact-sheets/facts-about-cooperative-accreditation-initiative/
3. UHMS Hyperbaric Facility Accreditation Program https://www.uhms.org/accreditation/accreditation-for-hyperbaric-medicine.html
4. National Board of Boiler and Pressure Vessel Inspectors https://www.nationalboard.org/PrintPage.aspx?pageID=164&ID=202
5. Hyperbaric Chambers: What they are, what they treat, risks, and accreditation https://www.clickondetroit.com/news/local/2025/01/31/hyperbaric-chambers-what-they-are-what-they-treat-risks-and-accreditation/
6. National Board of Diving and Hyperbaric Medical Technology https://nbdhmt.org/

RELEVANT AMA POLICY

D-270.986 Oppose Unsafe Use of "Mild Hyperbaric Therapy"
Our American Medical Association opposes the operation of "mild hyperbaric facilities" unless and until effective treatments can be delivered safely in facilities with appropriately trained staff including physician supervision and prescription and only when the intervention has scientific support or rationale.

Our AMA will work with the U.S. Food and Drug Administration and other regulatory bodies to close facilities offering "mild hyperbaric therapy" until and unless they adopt and adhere to all established safety regulations, adhere to the established principles of the practice of hyperbaric oxygen under the prescription and oversight of a licensed and trained physician, and ensure that staff are appropriately trained and adherent to applicable safety regulations.

D-160.916 Safe Supervision of Complex Radiation Oncology and Hyperbaric Oxygen Therapeutic Procedures
Our AMA will advocate that: (1) radiation therapy services and hyperbaric oxygen services should be exempted from the Hospital Outpatient Prospective Payment System (HOPPS) rule requiring only general supervision of hospital therapeutic services; and (2) direct supervision of hyperbaric oxygen therapy services by a physician trained in hyperbaric oxygen services should be required by the Centers for Medicare and Medicaid Services.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 519
(A-25)

Introduced by:	Washington State, Montana, Arizona, Mississippi, Utah, American Academy of Family Physicians
Subject:	Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making
Referred to:	Reference Committee E

Whereas, there are estimates that medical knowledge doubles every 73 days[1] and that 30 percent of all the data generated worldwide is estimated to be healthcare related[2]; and

Whereas, large language models utilize vast amounts of data and algorithm development is frequently proprietary and challenging to discern especially during point-of-care encounters; and

Whereas, augmented intelligence (AI) in healthcare varies from technologies with lower risk to patient safety including administrative tasks, data collection, and scribing to technologies with higher risk to patient safety including triage, chatbots, and—finally—clinical decision support; and

Whereas, the integration of AI into healthcare has the potential to enhance clinical decision-making, patient outcomes, and operational efficiencies in healthcare delivery and "Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based[3,4];" and

Whereas, our AMA Report of the BOT previously noted, "To best foster trust, both between physicians and developers/deployers, and between physicians and patients, use of AI that may directly impact medical decision making should be communicated to parties involved in that decision making"[3]; and

Whereas, the pace of progress in health AI will be determined by the pace of trust; and

Whereas, evidence-based medicine (EBM) is the use of high-quality clinical research in making decisions about the care of patients in which strength of recommendation taxonomy (SORT) has been used as a mechanism to convey quality of evidence[5] and Open Ethics Label (OEL) has been described as a "nutrition label" for digital products to make these products transparent and safe for consumers[6]; and

Whereas, the current Trump administration repealed President Biden's signature October 2023 AI executive order which aimed to promote safe and secure use of AI; and

Whereas, the Bipartisan House Task Force on AI emphasizes the need for a thoughtful, risk-based approach to AI governance and recommends adopting sector-specific policies and standards to address unique challenges in healthcare[7]; and

Whereas, evidence-based medicine is foundational to clinical decision-making, and AI tools should integrate and prioritize validated EBM guidelines while being rigorously tested to ensure their real-world clinical utility[8 9]; and

Whereas, evidence-based AI systems must meet rigorous criteria for clinical effectiveness, cost efficiency, and health equity to earn the trust and widespread adoption among physicians and their patients[10]; and

Whereas, there is a lack of a comprehensive framework for integrating evidence-based AI tools into clinical workflows to ensure effective implementation and to address potential risks of misinformation or misuse[3 10]; and

Whereas, the need for collaboration among healthcare delivery organizations, regulatory agencies, and technology developers has been highlighted as essential for responsible AI development and deployment[3 4]; therefore be it

RESOLVED, that our American Medical Association collaborate with stakeholders, including physicians, academic institutions, and industry leaders, to create a report by A-26 with recommendations for how AI tools used in clinical decision support convey transparency in the quality of medical evidence and the grading of medical evidence to physicians and advanced care practitioners so clinical recommendations can be accurately verified and validated. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/9/25

REFERENCES

1. Densen, Peter. "Challenges and opportunities facing medical education." Transactions of the American Clinical and Climatological Association 122 (2011): 48.
2. Markets, R.C., 2021. The healthcare data explosion [online], https://www.rbccm.com/en/gib/healthcare/episode/the_healthcare_data_explosion.
3. American Medical Association. (2024) Assessing the Intersection Between AI and Health Care H-480.931. AMA PolicyFinder. Retrieved 27 January 2025, from https://policysearch.ama-assn.org/policyfinder/detail/H-480.931?uri=%2FAMADoc%2FHOD.xml-H-480.931.xml.
4. Coalition for Health AI, T. "Blueprint for trustworthy AI implementation guidance and assurance for healthcare." (2023).
5. Ebell MH, Siwek J, Weiss BD, Woolf SH, Susman J, Ewigman B, et al. Strength of Recommendation Taxonomy (SORT): a patient-centered approach to grading evidence in the medical literature. Am Fam Physician 2004;69:549-557.
6. Open Ethics Label: AI nutrition labels – Open Ethics Initiative.
7. 118th Congress (2023-2024): "Bipartisan House Task Force Report on Artificial Intelligence," accessed from speaker.gove, 2 January 2025, https://www.speaker.gov/wp-content/uploads/2024/12/AI-Task-Force-Report-FINAL.pdf.
8. Longhurst, Christopher A., et al. "A call for artificial intelligence implementation science centers to evaluate clinical effectiveness." *NEJM AI* 1.8 (2024): AIp2400223.
9. Blumenthal, David, and Bakul Patel. "The regulation of clinical artificial intelligence." *Nejm Ai* 1.8 (2024): AIpc2400545.
10. Abramoff, Michael D., Tinglong Dai, and James Zou. "Scaling Adoption of Medical AI—Reimbursement from Value-Based Care and Fee-for-Service Perspectives." *NEJM AI* 1.5 (2024): AIpc2400083.

RELEVANT AMA POLICY

H-480.935 Assessing the Potentially Dangerous Intersection Between AI and Misinformation

1. Our American Medical Association will study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24.
2. Our AMA will work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice.

3. Our AMA will encourage physicians to educate our patients about the benefits and risks of consumers facing LLMs including GPTs.
4. Our AMA will support publishing groups and scientific journals to establish guidelines to regulate the use of augmented intelligence in scientific publications that include detailing the use of augmented intelligence in the methods, exclusion of augmented intelligence systems as authors, and the responsibility of authors to validate the veracity of any text generated by augmented intelligence.

D-480-956 Use of Augmented Intelligence for Prior Authorization
Our American Medical Association advocates for greater regulatory oversight of the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers are using a thorough and fair process that:

1. is based on accurate and up-to-date clinical criteria derived from national medical specialty society guidelines and peer reviewed clinical literature.
2. includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise for the service under review.
3. requires such reviews include human examination of patient records prior to a care denial.

H-480-940 Augmented Intelligence in Health Care
As a leader in American medicine, our American Medical Association has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.
To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
    a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
    b. is transparent;
    c. conforms to leading standards for reproducibility;
    d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
    e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

H-480-939 Augmented Intelligence in Health Care
Our American Medical Association supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing

patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.

3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on
    a. clinical validation.
    b. alignment with clinical decision-making that is familiar to physicians.
    c. high-quality clinical evidence.
4. Payment and coverage for health care AI systems must
    a. be informed by real world workflow and human-centered design principles.
    b. enable physicians to prepare for and transition to new care delivery models.
    c. support effective communication and engagement between patients, physicians, and the health care team.
    d. seamlessly integrate clinical, administrative, and population health management functions into workflow.
    e. seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
    a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
    b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
    a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
    b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations:
    a. Identify areas of medical practice where AI systems would advance the quadruple aim.
    b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts.
    c. Outline new professional roles and capacities required to aid and guide health care AI systems.
    d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 520
(A-25)

Introduced by: Young Physicians Section

Subject: Study of Grading Systems in AMA Board Reports

Referred to: Reference Committee E

Whereas, the American Medical Association is committed to promoting the highest standards in patient care and medical practice; and

Whereas, evidence-based medicine is paramount to the decision-making processes that influence clinical practice and health policy; and

Whereas, the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system is an example of an internationally recognized method for assessing the quality of evidence and the strength of recommendations in healthcare; and

Whereas, evidence of grading and assessment systems provide a transparent and systematic framework for ranking the quality of evidence and the strength of clinical recommendations; and

Whereas, the use of evidence grading and assessment systems would ensure that AMA board reports are based on the best available evidence, promoting trust and credibility among its members and the general public; and

Whereas, adopting a consistent method for analyzing medical evidence ensures fairness and uniformity across different reports and recommendations; therefore be it

RESOLVED, that our American Medical Association study the use of a system for assessing the quality of evidence and the strength of recommendations in board reports when appropriate. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 04/21/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 521
(A-25)

Introduced by: New York

Subject: Warning Labels on OTC Sleep Aids

Referred to: Reference Committee E

Whereas, over the counter (OTC) medications promoted for insomnia often contain antihistamines; and

Whereas, OTC antihistamines are documented to have severe side effects in older persons including slowing of motor reflexes leading to falls, and anticholinergic effects leading to impaired memory and possible dementia; therefore be it

RESOLVED, that our American Medical Association advocate for legislation or mandate from the appropriate regulators that over the counter (OTC) sleep medications containing antihistamines carry a warning label for adverse effects including, but not limited to for dizziness, risk of falling, and, with long term use, memory impairment, when used by elderly persons. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/22/25

REFERENCES

1. https://www.verywellhealth.com/why-older-people-shouldnt-use-diphenhydramine-to-sleep-3015319#:~:text=Diphenhydramine%20can%20cause%20decreased%20reaction,fractures%20is%20a%20notable%20concern

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 522
(A-25)

Introduced by: Association for Clinical Oncology, American College of Rheumatology

Subject: Access to Important and Essential Drugs

Referred to: Reference Committee E

Whereas, persistent shortages of essential drugs have regularly occurred for the past 10-15 years and are currently impacting patients and their care teams, particularly pediatric patients; and

Whereas, lack of predictability in the generic drug supply chain is negatively impacting patients, including disruptions or delays in treatment, potentially leading to irreversible disease progression; and

Whereas, current regulatory and market uncertainties are impacting the global supply chain and could impact access to essential drugs, increase out-of-pocket costs, and exacerbate shortages; and

Whereas, Baxter International's North Cove manufacturing plant in North Carolina was significantly impacted by Hurricane Helene in 2024, leading to shortages of IV fluids and peritoneal dialysis solutions as the plant produced about 60% or 1.5 million bags of the IV fluid used by U.S. hospitals; therefore be it

RESOLVED, that our American Medical Association work with policymakers, regulatory bodies, drug manufacturers, and the health care community to address access issues and drug shortages by identifying solutions to ensure long-term stability and preserve patient access to treatments (Directive to Take Action); and be it further

RESOLVED, that our AMA urges Congress to pass comprehensive legislation to mitigate existing drug shortages and prevent future shortages of lifesaving and life-prolonging drugs. A comprehensive approach would:

- Address economic factors that drive generic manufacturers out of the market and consider stabilizing the market with long-term contracts and guaranteed prices.
- Reward reliable U.S. manufacturing of critical and supportive medications through prices that support continued quality production and investment in continuous manufacturing or other advanced manufacturing for critical drugs and active pharmaceutical ingredients (APIs), which could include onshoring or nearshoring as components of a solution.
- Recognize potential shortages earlier by increasing the Food and Drug Administration’s (FDA) visibility into the supply chain so the agency can predict and respond to potential shortages earlier.
- Relay information about potential shortages to health systems and providers to help them prepare for and mitigate possible supply challenges. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/22/25

REFERENCES
1. Drug Shortages in Oncology: ASCO Clinical Guidance for Alternative Treatments | JCO Oncology Practice
2. Advocates on Capitol Hill and Across the Country Urge Congress to Prioritize Research Funding, Fix Prior Authorization, Help End Drug Shortages - ASCO
3. HHS needs a drug shortage plan, watchdog says - Axios
4. IV shortage update: Baxter facility damage after hurricane in North Carolina 2024 | AMA Update Video | AMA

RELEVANT AMA POLICY

National Drug Shortages H-100.956

1. Our American Medical Association considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.
2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.
6. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), pharmacy benefit managers, and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers, and supports efforts by the Federal Trade Commission to oversee and regulate such forces.
7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market or caused to stop production due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.
11. Our AMA urges the FDA to require manufacturers and distributors to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, any unpredicted changes in product demand, and provide more detailed information regarding the causes and anticipated duration of drug shortages.
12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages.

13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of global reporting requirements for indicators of drug shortages.
14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing, and supports the use of incentives such as prioritized regulatory review, reduction of user fees, and direct grant opportunities for manufacturers seeking to invest in manufacturing processes.
15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling.
16. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.
17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.
18. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.
19. Our AMA urges the Drug Enforcement Agency and other federal agencies to regularly communicate and consult with the FDA regarding regulatory actions which may impact the manufacturing, sourcing, and distribution of drugs and their ingredients.
20. Our AMA supports innovative approaches for diversifying the generic drug manufacturing base to move away from single-site manufacturing, increasing redundancy, and maintaining a minimum number of manufacturers for essential medicines.
21. Our AMA supports the public availability of FDA facility inspection reports to allow purchasers to better assess supply chain risk.
22. Our AMA opposes the practice of preferring drugs experiencing a shortage on approved pharmacy formularies when other, similarly effective drugs are available in adequate supply but otherwise excluded from formularies or coverage plans.
23. Our AMA shall continue to monitor proposed methodologies for and the implications of a buffer supply model for the purposes of reducing drug shortages and will report its findings as necessary.
24. Our AMA opposes increasing drug prices or waiving fee exemptions in a manner that incentivizes a drug manufacturer to have its drug be declared in shortage.
25. Our AMA opposes the use of punitive fees on physician practices that do not maintain buffer supplies of drugs.
26. Our AMA encourages the FDA, the FTC, or other relevant oversight entities, to examine the practice of compounding pharmacies and the entities that utilize them advertising drugs actively in shortage, particularly when targeted to new patients.
27. Our AMA supports federal drug shortage prevention and mitigation programs that create payer incentives to enable practitioners and participating entities to voluntarily enter contracts directly with manufacturers that will pay more than prevailing market price for generic sterile injectable drugs at high risk of shortage to promote stable manufacturing and reliability of these products.

Non-Profit or Public Manufacturing of Drugs to Address Generic Drug Shortages H-100.942

1. Our American Medical Association supports activities which may lead to the stabilization of the generic drug market by non-profit or public entities. Stabilization of the market may include, but is not limited to, activities such as government-operated manufacturing of generic drugs, the manufacturing or purchasing of the required active pharmaceutical ingredients, or fill-finish. Non-profit or public entities should prioritize instances of generic drugs that are actively, at-risk of, or have a history of being, in shortage, and for which these activities would decrease reliance on a small number of manufacturers outside the United States.
2. Our AMA encourages government entities to stabilize the generic drug supply market by piloting innovative incentive models for private companies which do not create artificial shortages for the purposes of obtaining said incentives.

Drug Manufacturing Safety H-100.945

1. Our American Medical Association supports efforts to ensure that the U.S. Food and Drug Administration (FDA) resumes inspections of all drug manufacturing facilities on a frequent and rigorous basis, as done in the past.
2. Our AMA will call for the FDA to:
    a. assure the safety of the manufacture of drugs, drug ingredients and precursors.
    b. work proactively with industry to prevent or minimize drug shortages.
    c. work with the industry to oversee the adequacy of product in the pipeline.

Reference Committee F

Report(s) of the Board of Trustees

01 Annual Report
04 AMA 2026 Dues
22 Ranked Choice Voting
23 Financial Assistance to Facilitate Attendance at MSS Meetings
24 Creation of an AMA Council with a Focus on Digital Health Technologies and AI

Report(s) of the Council on Constitution and Bylaws and the Council on Long Range Planning and Development

01 Joint Council Sunset Review of 2015 House Policies

Report(s) of the Council on Long Range Planning and Development

01 International Medical Graduates Section Five-Year Review
02 Organized Medical Staff Section Five-Year Review

Report(s) of the HOD Committee on Compensation of the Officers

01 Report of the House of Delegates Committee on Compensation of the Officers

Resolutions

601 AMA To Develop Patient Educational Materials Regarding Ultra-processed Foods for Distribution by AMA members
602 Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations
603 Renaming the Minority Affairs Section to the Underrepresented in Medicine Advocacy Section
604 Advisory Committee on Tribal Affairs

REPORT OF THE BOARD OF TRUSTEES

B of T Report 01-A-25

Subject: Annual Report

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee F

The Consolidated Financial Statements for the years ended December 31, 2024 and 2023 and the Independent Auditor's report have been included in the 2024 Annual Report, that is included in the Handbook mailing to members of the House of Delegates.

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AMA
AMERICAN MEDICAL ASSOCIATION

WHY WE FIGHT

2024 ANNUAL REPORT

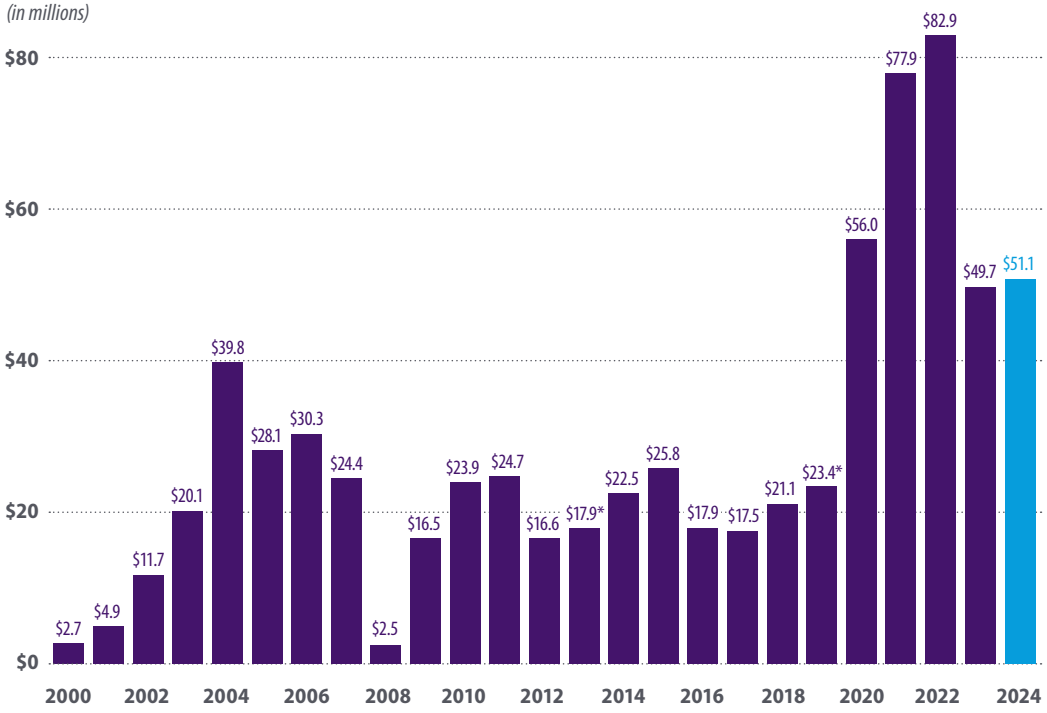


Financial highlights

(Dollars in millions)	2024	2023
Revenues	$ 513.2	$ 495.1
Cost of products sold and selling expense	23.7	27.8
General and administrative expenses	434.3	412.5
Net operating results	51.1	49.7
Non-operating items	74.1	101.7
Changes in defined benefit postretirement plans, other than periodic expense, net of tax	2.0	(17.3)
Change in association equity	127.2	134.1
Change in association equity – donor restricted	0.1	(0.1)
Change in total association equity	$ 127.3	$ 134.0
Association equity at year-end	$ 1,150.7	$ 1,023.4
Employees at year-end	1,331	1,314

Association operating results

(in millions)



* Pro forma operating results: 1) 2013 excludes $33 million in nonrecurring charges relating to AMA's headquarters relocation and 2) 2019 excludes $36.2 million noncash pension termination expense reclassification from non-operating results.

2020 through 2022 results were impacted by a lack of travel due to the pandemic, as well as a hiring freeze and subsequent tight labor market. These savings were temporary in nature.

Letter to stakeholders

During an important election year, in which the public's attention was often frayed, the American Medical Association remained hyper focused on priorities critical to supporting and strengthening our nation's physician workforce and improving the lives of patients. **This is why we fight**.

Grounding our work in the Principles of Medical Ethics and the policies of the AMA House of Delegates, the AMA was resolute in its fight to repair a broken health care system—one that is threatening the viability of physician practices and patient access to care, contributing to alarming rates of burnout and dissatisfaction, and placing enormous pressure on an already strained public health infrastructure.

The AMA's advocacy campaign to reform the onerous prior authorization process, including its "Fix Prior Auth" grassroots campaign, resulted in important reforms—both at the federal level and in more than a dozen states—that are expected to save physician practices billions over the next decade.

The AMA's "Fix Medicare Now" grassroots campaign, which received widespread media attention, generated more than a half-million contacts to members of Congress and helped secure introduction of two important pieces of federal legislation to reform the Medicare payment system.

Thanks to the AMA's relentless year-long push to reform an unsustainable Medicare reimbursement model, policymakers in Washington, D.C. now understand and acknowledge the Medicare physician payment crisis and are working in a bipartisan fashion for permanent solutions aligned with AMA recommendations to fix the problem that has cut physician payment by 33 percent since 2001.

Support for physician mental health and well-being expanded in 2024 as the AMA led, funded or contributed to 38 research projects to address burnout, promote digital health solutions and aid the long-term sustainability of physician practices. The AMA also recognized 62 health systems for implementing evidence-based strategies to improve physician and health provider well-being through the AMA's Joy in Medicine™ Health System Recognition Program.

In the courts, the AMA was a critical voice for physicians and organized medicine on a broad range of public health issues, including restricting access to e-cigarettes, tougher regulation of unlicensed and untraceable "ghost" guns, and expanding access to care. In addition to defending physicians from criminal and civil penalties for providing necessary care, the AMA was a plaintiff in a major antitrust case against MultiPlan, a data analytics company accused of creating a price-fixing conspiracy with the largest commercial health insurance companies in the country.

The AMA continued its work to ensure the physician's perspective is represented in the design, implementation and evaluation of new health care technologies, while helping physicians make sense of the risks and opportunities of augmented intelligence (AI) in medicine.

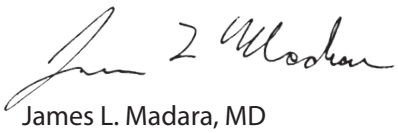
The AMA's advocacy and mission activities were fueled by another year of strong financial performance and continued membership growth, putting the AMA in the position to support physicians today and well into the future. AMA dues-paying membership has increased 40 percent in the last 15 years—with a 3.1 percent increase in 2024 alone—as more physicians, medical students and residents recognize our efforts and want the AMA fighting on their behalf.



Michael Suk, MD, JD, MPH, MBA
Chair, Board of Trustees



Madelyn E. Butler, MD
Finance Committee Chair, Board of Trustees



James L. Madara, MD
CEO and Executive Vice President

Why we fight

As the unified voice for physicians from every state and every specialty, the AMA *can* create a better future for patients, the practice of medicine and the health care system. By working together, we can make it happen. **This is why we fight**.

While 2024 had its challenges, it also had its victories. The AMA continued to advocate for physicians and patients and saw progress in each of our top priorities:

- Reforming Medicare payment
- Fixing prior authorization
- Fighting scope creep
- Reducing physician burnout
- Making technology work for physicians

This year's report highlights these accomplishments and much more as we continue our work to remove obstacles that interfere with patient care.

#FightingForDocs



Reforming Medicare payment

33% decline in Medicare physician pay since 2001

In 2024 our work to reform the Medicare physician payment system continued. Fueled in part by the AMA garnering more than 550,000 contacts to Congress as part of our "**Fix Medicare Now**" grassroots campaign, the AMA spurred legislators and policymakers to work in bipartisan fashion to introduce two important pieces of legislation:

- H.R. 2474, which would enact an annual, permanent inflationary payment update in Medicare that is tied to the Medicare Economic Index
- H.R. 6371, which would reform the budget neutrality policies that have been producing across-the-board payment cuts

The AMA will not stand for practices needing to close and patient access to care being threatened. Medicare payment reform will remain the AMA's top advocacy priority until meaningful reforms are achieved.



"Through our efforts, legislators in Congress are listening, and there is bipartisan support for a need to fix the Medicare payments problem."

Bruce A. Scott, MD
AMA president

Fixing prior authorization

64% of physicians report that prior authorization can **destabilize a patient** whose condition was previously stabilized on a specific treatment.

When a sustained, coordinated push was needed to take on prior authorization issues, the AMA leaned into its "**Fix Prior Auth**" grassroots campaign. This, combined with powerful AMA advocacy applied pressure on federal and state legislators and policymakers to act in passing meaningful prior authorization reforms that included:

- The Centers for Medicare & Medicaid Services (CMS) released final regulations to cut patient care delays and electronically streamline the prior authorization process for physicians—**saving physicians billions over 10 years according to CMS.**
- More than a dozen states enacting prior authorization reform laws guided and supported by the AMA and multiple state medical associations.

The AMA will continue to advocate for prior authorization reforms and to challenge insurance companies to eliminate care delays, patient harms and practice hassles.



"**The AMA is the voice of physicians to legislators, to regulators, to insurance companies.** There's no one else who speaks with such a powerful megaphone on prior authorization."

Jordan Warchol, MD, MPH
AMA member

Fighting scope creep

95% of surveyed patients want physicians to be involved in their health care diagnosis and treatment.

The AMA worked alongside state medical associations from across the country to oppose inappropriate scope expansions in more than 40 states in 2024. Much of the success was driven by the **AMA Scope of Practice Partnership**—an initiative that has provided millions in grants since its inception—and the remarkable expertise and dedication of the **AMA Advocacy Resource Center** lawyers and staff.

The AMA delivered concrete results including the defeat of more than 80 bills across the country that, if passed, would have allowed:

- Physician assistants and nurse practitioners to independently practice medicine
- Pharmacists to independently diagnose and prescribe medications to patients
- Naturopaths to prescribe legend drugs or perform surgical procedures
- Optometrists to perform surgery
- Nurse anesthetists to provide anesthesia services without physician supervision
- Psychologists to independently prescribe medications

Expanding non-physicians' scope of practice puts patients at risk. The AMA will vigorously defend the practice of medicine and advocate for physician-led team-based care, where the complementary skill sets of all health care professionals provide the best possible care to patients.



"**The AMA Scope of Practice Partnership has been invaluable to my work** fighting inappropriate scope of practice legislation in South Dakota."

Mary S. Carpenter, MD
AMA member

Reducing physician burnout

More than 45% of physicians are experiencing symptoms of burnout.

As the leader in physician well-being and innovative burnout research, the AMA is fighting against physician burnout, and in 2024 we made significant progress.

As of the end of 2024, the AMA had helped 34 licensure boards—including 29 medical boards—and more than 425 hospitals and health systems revise their licensing or credentialing applications to remove intrusive mental health questions and stigmatizing language. This important step forward could only have happened through ongoing partnerships with organizations like the Dr. Lorna Breen Heroes' Foundation.

Our accomplishments didn't stop there. In 2024 the **AMA's Joy in Medicine™ Health System Recognition Program** recognized 62 health systems that met the evidenced-based criteria demonstrating their commitment to organizational well-being—these additions brought the list of currently recognized organizations to 130 across 35 states.

The AMA will continue to address and combat the drivers of physician burnout so that physicians receive the support they need to thrive.



"Physicians deserve to practice in an environment where they can take care of their patients *and* take care of themselves."

Claude Brunson, MD, MS
AMA member

Making technology work for physicians

Technology should be an asset to physicians and patients—not a burden.

Technology is engrained in virtually all aspects of health care, yet it can feel cumbersome, costly and inefficient when put into practice. From AI implementation to EHR usability, the AMA is dedicated to ensuring technology works *for* physicians—not the other way around.

In 2024, underscoring its commitment to making sure the physician voice is ever-present as AI in health care expands, the AMA released "**The emerging landscape of AI in health care**," a report that provides an overview of current and future AI use cases, potential applications, opportunities and risks.

The AMA will fight to make sure the physician voice is integrated into the creation and refinement of all health care technology.



"**Physicians need to be involved in developing new technologies** because we are the ones who use them. The AMA makes sure we have a seat at the table."

Joshua Lesko, MD
AMA member

Additional 2024 highlights

As physicians' powerful ally in patient care, the AMA focuses on providing solutions to issues that matter most to physicians. Care delivery, practice efficiency support, educational resources, representation in the courts, improving health outcomes and so much more—across a broad range of challenges and opportunities, the AMA celebrated numerous successes.



From the U.S. Supreme Court to state courts, the AMA was a powerful, unifying voice for physicians and organized medicine. In addition to leading the **antitrust lawsuit** against MultiPlan, the data analytics company that allegedly conspired with major health insurers to force physicians to accept lower reimbursement rates, the AMA filed *amicus* briefs on a broad range of public health issues, including e-cigarettes, firearm safety and access to care.

More than 1.1 million physicians and other licensed/credentialed health care professionals benefited from the AMA and partnering organizations' efforts into ending stigmatizing questions on medical licensing and credentialing applications.



The AMA received a record-breaking number of abstract submissions—1,300—for the **AMA Research Challenge**—the largest national, multi-specialty medical research conference for medical students and residents to showcase and present research featuring a $10,000 grand prize, presented by Laurel Road.

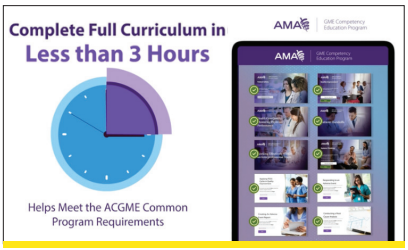
Following the Change Healthcare cyberattack, which demonstrated the need to enhance cybersecurity in health care, the AMA took a leading role in advocating at all levels of government and across the payer community to **strengthen cybersecurity** and find solutions that will allow physician practices to maintain financial stability.

31M the number of readers, listeners and viewers who consumed AMA digital content
(excluding JAMA® and AMA Ed Hub™)



The AMA partnered with more than 100 health systems to identify and assess system-level drivers of well-being through the **AMA's Organizational Biopsy® validated well-being assessment**.

The AMA concluded the 2024 AMA ChangeMedEd® Innovation Grant Program that awarded grants to 13 organizations whose work is part of a two-year effort that is culminating with the launch of the AMA's **new precision education portfolio** in 2025.



The AMA launched our **Foundations of Quality Improvement and Patient Safety (QIPS) curriculum** through our GME Competency Education Program (GCEP). The curriculum has already received a Brandon Hall Group award for Excellence in Online Courses and a Digital Health Award for digital health/media publications in health education. This is the fifth time that the GCEP program has taken home a Digital Health Award.

The AMA developed more than 90 new or updated **AMA STEPS Forward® resources** including toolkits, webinars and podcast episodes focused on improving practice efficiency, preventing physician burnout and creating the organizational foundation for joy in medicine.

The AMA helped physicians stay on top of rapidly evolving health care technology by presenting several webinars including "Digital empathy," "The human factor in solving problems" and "Navigating AI in health care."

3.3M physicians and health care team members have used AMA STEPS Forward® since 2015.

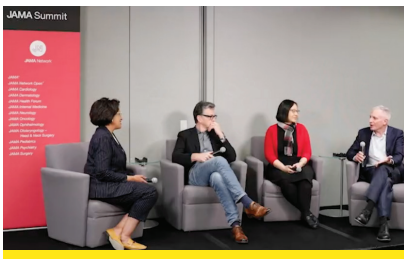


AMA Ed Hub™, the AMA's online education platform, continued to experience high engagement:

8K+	475K+	4M	600K
education activities	registered users	visitor sessions	courses completed

The AMA reaffirmed its commitment to health equity by updating our multi-faceted equity strategic plan through 2025. This work spans state and federal advocacy, education and training for physicians and community investments that target the root causes of inequities in medicine.

The AMA conducted research exploring the role of Current Procedural Terminology (CPT®) in value-based care. The effort identified crucial ways to help ensure the CPT code set remains a crucial resource as **value-based care** continues to evolve in health care delivery.



JAMA® hosted the second annual ***JAMA* Summit™**, convening leaders from across sectors and around the world to discuss critical issues in medicine and health care. This year's event focused on the integration of AI in clinical medicine.

JAMA+ AI launched as a premier resource for authors and readers seeking the latest science and commentary on AI and its application to medicine and public health.



An additional 281 health care organizations used **AMA hypertension solutions** to help their physicians and care teams improve blood pressure control in patients. Through our collaboration with these organizations, we reached more than 2.5 million patients with hypertension.

To expand insight into burdensome EHR systems, the AMA awarded grants to five organizations through the **AMA Electronic Health Record Use Research Grant Program** to study EHR usage and improve workflow and resource allocation at the practice and system levels.

In collaboration with more than 20 organizations, the AMA hosted **two National Health Equity Grand Rounds that reached over 24,000 viewers** and featured more than a dozen national experts who discussed transformative change in health care.

The AMA launched **VeriCre™**, to streamline the credentialing process and reduce redundancy for physicians, hospitals and health plans, helping patients to receive care sooner.

14B media impressions on priority topics such as Medicare payment reform

The AMA generated more than 14 billion media impressions on priority topics with 3.8 billion on Medicare payment reform—nearly double the total from 2023.

The AMA, in collaboration with the Centers for Disease Control and Prevention (CDC), launched a new online toolkit to help physicians and other health care professionals **increase routine screenings for HIV, STIs, viral hepatitis and latent tuberculosis**—this in response to rising rates of sexually transmitted infections and viral hepatitis across the United States.

The CDC's National Partners Cooperative Agreement **awarded the AMA $2.45 million** to support our efforts in advancing hypertension and cholesterol care in communities across the United States.

The AMA won the American Association of Medical Society Executives (AAMSE) **Profile of Excellence Award** for its communications campaign to "Protect Medicine from Government Interference."



The AMA was recognized as "Best Customer Experience Team of the Year" with the "Best Employee-Driven Customer Experience" at the 2024 U.S. Customer Experience (CX) Awards, based on the AMA's use of data, design tools and best practices to make accessing and consuming AMA products and services easy for our members.

Management's discussion and analysis



Management's discussion and analysis

Introduction

The objective of this section is to help American Medical Association (AMA) members and other readers of our financial statements understand management's views on the AMA's financial condition and results of operations. This discussion should be read in conjunction with the audited consolidated financial statements and notes to the consolidated financial statements.

Improving the health of the nation is at the core of the AMA's work. As the physicians' powerful ally in patient care, the AMA delivers on this mission by representing physicians with a unified voice in courts and legislative bodies across the nation, removing the largest governmental and private sector obstacles that interfere with optimal patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care and training the leaders of tomorrow. AMA's strategic arcs are supported by improving health outcomes, lifelong medical education and enhancing physician professional satisfaction and practice sustainability. Our advocacy, health equity and innovation initiatives function as accelerators across all arcs. AMA's foundation is built on science, membership, financial performance, marketing and communication, and talent and engagement.

2024 priorities are focused on five key goals to rebuild health care so that it works better for physicians and all those they serve: 1) reforming Medicare payment to promote thriving physician practices and innovation; 2) fixing prior authorization to reduce the burden on practices and minimize care delays for patients; 3) promoting physician-led care as health care teams working together—with physicians in the lead—is critical to having the best and safest outcomes for patients; 4) reducing physician burnout and addressing the stigma around mental health; and 5) working to ensure physician voices are integrated into the creation and refinement of all medical technology to make technology an asset to physicians, not a burden.

For example, through research, advocacy and education, the AMA continued to defend the practice of medicine against scope of practice expansions that threaten patient safety. AMA efforts helped deliver concrete results in protecting patients from inappropriate scope of practice expansions, including the defeat of over 80 problematic bills. Spurred by over 550,000 contacts to Congress as part of the AMA's "Fix Medicare Now" grassroots campaign, policymakers are acknowledging the Medicare physician payment crisis and acting toward making permanent payment system solutions in line with AMA recommendations.

The results for 2020 through 2022 were dramatically impacted by the COVID-19 pandemic. Early in 2020, the AMA, like all other organizations, recognized that there was substantial uncertainty about the effects and risk of COVID-19 on our funding, financial condition, and results of operations. As a result, AMA took steps to ensure that programmatic activities and employment levels would be protected during a sustained pandemic, knowing the potential for economic uncertainty. AMA lifted a freeze on hiring in the spring of 2021, but the level of open positions remained high through 2022 as the job market was very tight. Vacancies and limited travel for most of the three years garnered substantial savings that were temporary in nature resulting in unusually high operating income for AMA. Results began to normalize in 2023 and 2024, although better than expected revenue growth and a slower ramp up in operating expenses than expected continue to drive a higher level of net operating income than in the past.

The AMA is committed to its responsibility of ensuring that the organization focuses its finite resources on strategic arcs, accelerators and core mission activities while improving the quality and breadth of products and services for physicians and medical students. Our physicians' and medical students' voices are central to AMA's overall success.

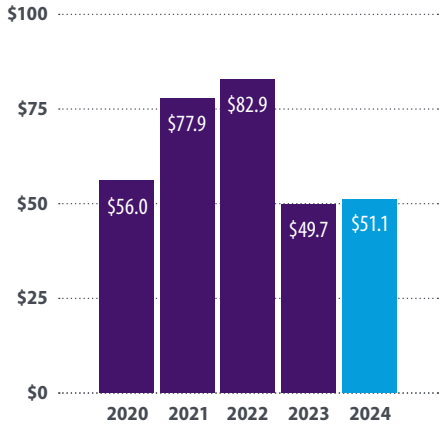
The following pages discuss the 2024 consolidated financial results as compared to 2023. Additional detailed discussion of operating unit results is included in the section titled "Group Operating Results."

Consolidated financial results

Results from operations

Net operating results

(in millions)



As noted above, the hiring freezes and work from home during 2020 through 2021 and the unusually tight labor market that adversely impacted hiring and limited travel and in-person meetings through the first half of 2022 were major factors in spending levels running substantially less than budgets. Spending levels began to normalize in 2023 although open positions remained higher than previously experienced.

In 2024, revenue growth more than offset a continued increase toward normalized spending levels, resulting in a slight improvement in operating results when compared to 2023.

Revenues

In 2024, total revenue increased $18.1 million over the prior year. Continued growth in AMA's royalties and increased investment income were partially offset by declines in publishing advertising, coding book sales and insurance commission revenue.

Consolidated investment income, which is dividend and interest income, net of management fees, increased in 2024, impacted in large part by higher interest rates and a larger invested asset base. Market gains or losses are not included in investment income and are reported as non-operating results.

The number of AMA dues paying members increased by 3.1 percent in 2024, the 13th year of growth in the past 14 years. During that 14-year period, AMA dues paying membership increased by over 89,000. Dues revenue declined 2.4 percent in 2024 as growth in lower dues paying categories such as group memberships and sponsored memberships partially offset the decline in individual direct member categories.

Most other revenue categories were largely unchanged for the year.

Cost of products sold and selling expenses

All variable expenses related to production, distribution and sale of periodicals, books, coding products and licensed products are included in the cost of products sold and selling expense categories. Examples include paper, sales commissions, promotional activities, distribution costs and third-party editorial costs.

In 2024, cost of products sold and selling expenses decreased $4.1 million from the prior year. In late 2023, Publishing eliminated distribution of print journals to a controlled population of physicians who were included in measuring journal readership scores, a key indicator for ad placement. This change substantially reduced production and distribution costs in 2024 and partially offset the historical advertising revenue decline. A reduction in coding book sales volume also led to a reduction in related production and selling expenses.

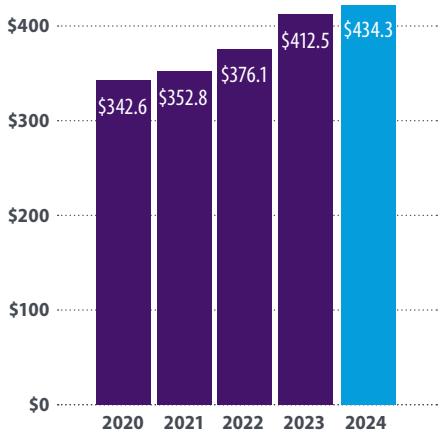
Contribution to general and administrative expenses

Cost of products sold and selling expenses are deducted from revenues to determine the amount of money available for the general and administrative expenses of the organization. Contribution to general and administrative expenses measures the gross margin derived from revenue-producing activities.

The contribution to general and administrative expenses increased $22.2 million to $489.5 million in 2024, a combination of the $18.1 million revenue improvement coupled with the savings from eliminating publishing-controlled circulation and lower production costs from reduced coding book sales.

General and administrative expenses

(in millions)



General and administrative expenses rose $21.8 million in 2024, or 5.3 percent, when compared to 2023. This was substantially less than the $48.9 million budgeted increase for 2024, with over $27 million in savings related to technology, marketing, professional services, and travel impacting results.

Compensation and benefits increased $17.4 million in 2024, up 6.6 percent. Compensation, including temporary help, was $7.9 million higher in 2024, a 3 percent increase, which was a function of annual merit increases, as expense for filling open positions was largely offset by savings from terminations. Fringe benefit costs increased $4.7 million in total primarily due to higher medical, 401(k) plan and payroll tax expenses. Incentive compensation increased $4.6 million as key performance indicators were achieved or exceeded in 2024.

Occupancy costs were down $1.4 million, driven by a reduction in depreciation as certain assets acquired during the move to new headquarters were fully depreciated. In late 2022, AMA exercised a contraction option in the main headquarters lease whereby AMA relinquished one full floor of office space beginning in 2023 upon payment of a termination penalty. In late 2023, AMA negotiated an extension of the current headquarters lease in return for future contraction options and lease incentives. The impact will be amortized over the life of the lease and there was largely no change in rent expense in 2024.

Travel and meeting costs increased by $0.5 million in 2024 due to inflationary cost pressures. Technology costs were largely unchanged. As more technology moves to the cloud, costs associated with the technology platforms will be reflected in operating expense instead of capitalized as an asset and depreciated. This model has the benefit of reducing the need for in-house development expertise but also exposes AMA to more price risk from vendors.

Marketing and promotion costs increased $3.4 million in 2024, as Advocacy expanded its grassroots and media campaign activity on Medicare payment reform.

Outside professional services increased $5.5 million in 2024, primarily in Health Solutions, Strategic Arcs, and Enterprise Planning, led by a $2 million increase in Health Solutions for strategy, market research and platform development as well as over $1 million in Strategic Insights and Planning for research on health care organizations and AMA's mission impact.

Other operating expenses declined $4.1 million in 2024 due to the absence of a software write-off associated with exiting the Integrated Health Model Initiative and costs related to liquidating a Health2047 affiliate in 2023.

Operating results before income taxes

The AMA reported $55.2 million in pre-tax operating income in 2024 compared to $54.8 million in 2023. The current year results include over $18 million in revenue growth that was largely offset by higher spending, the latter a continuation toward normal budgeted expense levels.

Income taxes

Taxes decreased $1 million in 2024 when compared to 2023, reflecting lower taxable income in one of the subsidiaries.

Net operating results

Net operating income was $51.1 million in 2024 compared to $49.7 million in 2023, as revenue growth was largely offset by higher spending.

Non-operating items

The AMA reported a $79.7 million gain in the fair value of its portfolio during 2024. Additional portfolio performance information is discussed in the group operating results section.

As a result of an accounting standard adopted in 2019 for postretirement benefit plans, non-operating results include $5.7 million and $3.9 million in postretirement plan interest expense and recognized actuarial losses and gains for 2024 and 2023, respectively.

Revenue in excess of expenses

Revenues exceeded expenses by $125.2 million in 2024, a combination of $51.1 million in operating income, a $79.7 million gain in fair value in the portfolio and $5.6 million in other non-operating expenses. In 2023, revenues exceeded expenses by $151.4 million, a combination of $49.7 million in operating income, a $105 million gain in fair value in the portfolio and $3.3 million in other non-operating expenses.

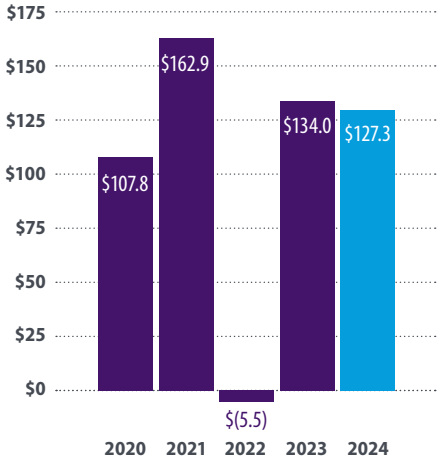
Accounting standards require organizations to recognize deferred actuarial losses and prior service credits or charges for defined benefit postretirement plans as a charge or credit to equity.

In 2024, AMA recorded a $2 million credit to equity reflecting an actuarial gain for the postretirement health care plan, net of a reclassification of actuarial gains to operating expense and income tax. The gain resulted primarily from a change in interest rates from 5 percent to 5.7 percent which reduces the present value of projected liabilities, offset by higher claims cost experience.

In 2023, AMA recorded a $17.3 million charge to equity reflecting an actuarial loss for the postretirement health care plan, net of a reclassification of actuarial gains to operating expense and income tax. The loss resulted primarily from a change in the initial health care cost trend from 7 percent to 8.5 percent and less favorable claims cost experience.

Change in total association equity

(in millions)



The AMA reported a $127.3 million increase in association equity in 2024. This reflects the amount by which revenues exceeded expenses, plus the credit to equity for changes in defined benefit postretirement plans discussed above, as well as a slight increase in donor-restricted equity.

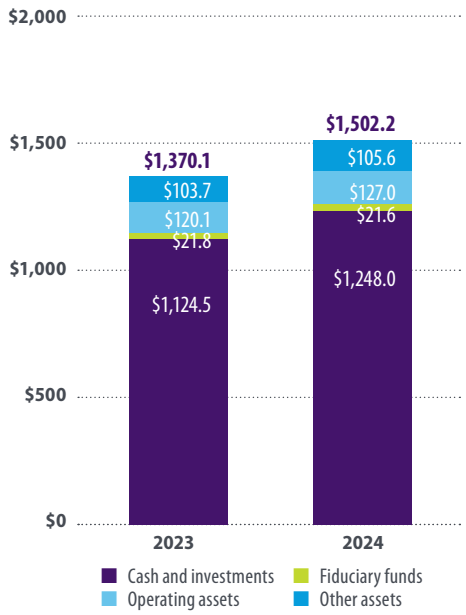
The AMA reported a $134 million increase in association equity in 2023. This reflects the amount by which revenues exceeded expenses, less the charge to equity for changes in defined benefit postretirement plans discussed above, as well as a small decrease in donor-restricted equity.

Financial position and cash flows

The AMA's assets include cash, cash equivalents and investments; operating assets such as accounts receivable, inventory and prepaid expenses; fixed capital such as equipment, information technology hardware and software; and other assets. AMA assets are supported by association equity, operating liabilities, and deferred revenue.

Assets

(in millions)



The AMA's total assets increased $132.1 million in 2024. This includes a $123.5 million increase in cash and investments resulting from $48 million in free cash flow plus a $79.7 million gain in the fair value of investment securities less $4.2 million for investments in affiliates.

Fiduciary funds are premium payments from insurance customers not yet remitted to the carriers and funds held by the AMA for third parties for future use as approved by the third parties. This approximates the offsetting liability titled insurance premiums and other fiduciary funds payable.

Operating assets increased $6.9 million in 2024, primarily due to an increase in accounts receivable. Changes in operating assets from year to year are largely due to timing of cash flows.

Other assets include operating lease right-of-use assets, property and equipment, investment in affiliates and investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Property and equipment net book value decreased as new capital spending was exceeded by annual depreciation and amortization of existing capital assets while AMA's investment in affiliates increased by $4.1 million as new investments and interest on convertible notes were reduced by AMA's share of the affiliates' operating losses.

Operating liabilities increased $9.9 million in 2024, led by increases in accrued payroll and employee benefits. A $3.7 million increase in accrued expenses was offset by a $3.7 million reduction in lease liability from cash payments exceeding rent expense.

Deferred revenue represents funds received during the year that will not be recognized as income until the following year or thereafter. These amounts vary, as well as accounts payable and accrued expenses, depending on the timing of cash receipts and payments.

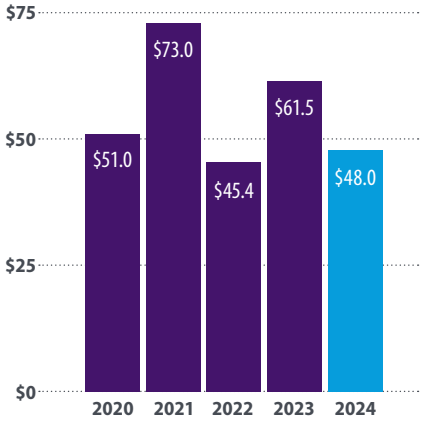
Cash flows

Cash, cash equivalents and donor-restricted cash increased $3.5 million and $2.6 million in 2024 and 2023, respectively. This comparison may cause misleading conclusions, as the change in cash and cash equivalents includes reductions for amounts invested in marketable securities, as well as cash inflows from non-operating activities.

Free cash flow measures the AMA's ability to fund operations, capital expenses and major programmatic initiatives from funds generated from operations. This measure excludes non-operating gains and losses.

Free cash

(in millions)

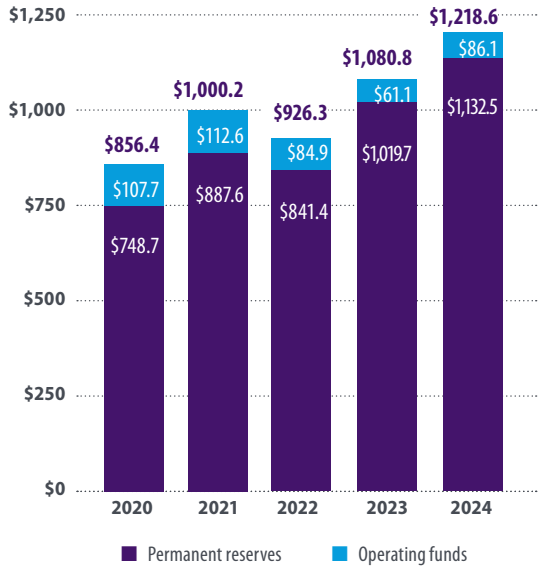


Free cash in 2024 totaled $48 million, $13.5 million less than 2023, a result of changes in operating assets and liabilities.

Reserve portfolio

Reserves and operating funds

(in millions)



The reserve and operating fund portfolios above do not include cash and investments in the for-profit subsidiaries and reflect only the not-for-profit entity's cash and investment portfolio values.

As of year-end 2024, the reserve portfolio's value was $1,132.5 million compared to $1,019.7 million in 2023, a $112.8 million increase. That increase was mainly the result of an $80.3 million gain in the fair value of the reserve portfolio plus a $30 million transfer of 2023 excess operating funds to reserves. Operating funds totaled $86.1 million in 2024, up $25 million from 2023.

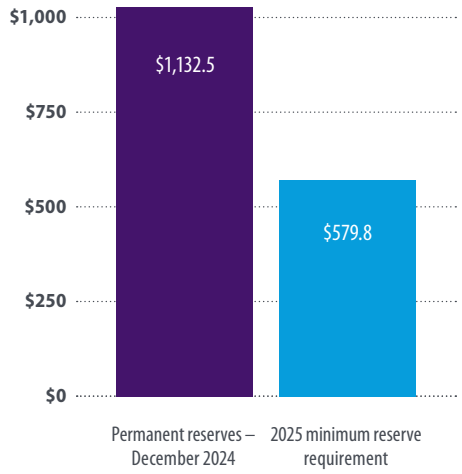
The AMA has established a required minimum reserve investment portfolio level that is adequate to cover 100 percent of annual general and administrative expenses (excluding grant expenses) plus an amount sufficient to pay long-term postretirement and lease liabilities (net of the right-of-use asset value). Operating funds, coupled with operating assets, are to be maintained at a level that allows payment of all operating liabilities.

AMA's reserves provide the backbone for the organization's long-term viability and independence, currently operating as a quasi-endowment fund, with a goal of achieving levels that could generate adequate funding to ensure the long-term future of the organization. Building these reserves to function as an endowment fund will provide considerable protection against future loss of revenue and maintain AMA's independence over the long term.

Reserve portfolio funds also provide the AMA with the ability to fund major strategic spending initiatives not within the operating budget. Spending from reserve funds is limited to dollar-or time-limited initiatives and capped at the amount by which reserves exceed the minimum requirement. Reserves may not be used for ongoing operating expenses. The Board of Trustees must authorize any use of reserves.

Permanent reserves and minimum reserve requirement

(in millions)



Group operating results

The AMA is organized into various operating groups: Membership; Publishing, Health Solutions & Insurance; Strategic Arcs, Accelerators & Core Mission Activities; Administration and Operations; Affiliated Organizations; Unallocated Overhead; and Health2047 (including subsidiary). Revenues and expenses directly attributed to those units are included in the group operating results. A financial summary of group operating results is presented at the end of this section. The prior year financial results have been updated to be consistent with the current year reported results for each group.

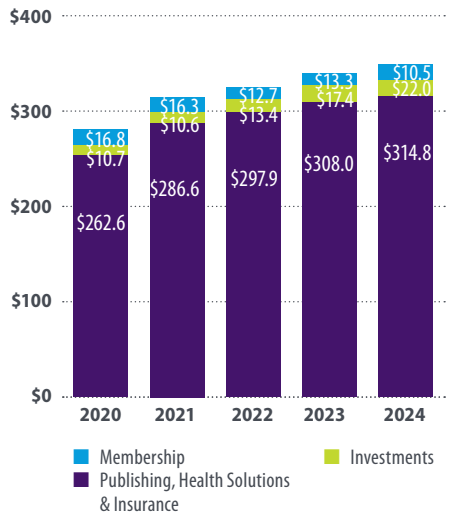
Contribution margin (net expenses)

Contribution margin equals individual group revenues minus cost of products sold, selling expenses, and direct general and administrative expenses such as compensation, occupancy, travel and meetings, technology costs and professional services.

Net expenses equals total spending, net of any revenue produced by the group, such as grants or other fee income. Total contribution margin and net expenses equals consolidated operating results before income taxes. The charts below separate groups with contribution margin from groups with net expenses.

Contribution margin

(in millions)



The contribution margin generated by Membership; Publishing, Health Solutions & Insurance; as well as Investments, provides the funding for all mission-related activities of the AMA as well as funding for all administration and support operations required to run the organization.

Membership

The Membership group's net membership dues revenue includes the gross dues revenue collected, reduced by any commissions paid to state societies, and equals the membership dues revenue reported on the statement of activities.

In 2024, AMA again reported an increase in the number of dues-paying members, up 3.1 percent from 2023. In 13 of the last 14 years, AMA has reported increases in the number of dues-paying members, a major accomplishment. Membership continues to focus on broad use of digital tools to engage physicians and retain them as lifelong members, group membership marketing, and expanding AMA's reach to physicians through programmatic mission-based activities.

Dues revenue was $32.5 million, a $0.8 million decrease from 2023. Although the number of physician members increased, most of the growth was in lower dues paying categories. In addition, revenue from lifetime memberships was fully amortized in 2023, the absence of which accounted for $0.3 million of the 2024 decrease. Membership expenses are up $2 million from staff expansion and higher membership solicitation costs. As a result, Membership's contribution margin decreased $2.8 million in 2024.

Publishing, Health Solutions & Insurance

Publications in the JAMA Network® include the *Journal of the American Medical Association (JAMA®)* and the JAMA Network specialty journals. In the last decade, the JAMA Network has launched four new journals: *JAMA Oncology* in 2015 and *JAMA Cardiology* in 2016, which are hybrid journals offering open access options for research articles; *JAMA Network Open* in 2018, a fully open access journal; and *JAMA Health Forum* in 2021, a peer-reviewed, open-access, online journal focused on health policy, health care systems, and global and public health.

Publishing revenues are derived from advertising, subscriptions, site licensing, reprints, electronic licensing, open access fees and royalties. Publishing revenues decreased $2.1 million in 2024, largely a function of a $1.9 million decline in print advertising. In late 2023, Publishing eliminated distribution of print journals to a controlled population of physicians who were included in measuring journal readership scores, a key indicator for ad placement, and expected a large drop in advertising as a result. This change reduced production and distribution costs by amounts greater than the advertising revenue loss, but inflationary price increases for printing and production offset some of the benefit. Expenses in total declined $1.1 million during 2024, as the cost of filling open positions partially offset the savings in production and distribution costs. The contribution margin declined by $1 million to break-even.

Health Solutions includes two major lines: Database Products, and Books and Digital Content.

Database Products includes royalties from licensed data sales and credentialing products revenue. Revenues increased in 2024, up $0.5 million when compared to 2023, driven by small price increases for licensed data and growth in credentialing revenues, including initial revenues from a new credentialing product, VeriCre™. This is a credentials wallet that streamlines credentialing by pre-filling physician applications with authoritative, verified AMA data, reducing administrative burden for physicians and medical staff professionals. Total expenses were up $2.4 million, of which $0.9 million relates to development of the new physician credentialing product. The remaining $1.5 million cost increase was driven by filling open positions, and market research and product development projects. The resulting contribution margin declined by $1.9 million in 2024 to $52.6 million.

AMA-published books and coding products, such as coding books and tools, workshops, and licensed data files, make up the Books and Digital Content unit. Royalties and digital content sales drove a $15.9 million revenue increase, as the market for electronic use of digital coding products continues to expand. A three percent price increase as well as phasing in previous pricing

model changes were also factors. Coding book sales declined $1.7 million in 2024 continuing the move from print products to digital. Expenses were up $2.6 million, driven by increased compensation from filling open positions and a $1.6 million increase in professional services for projects related to content and product strategy, market research and project management. The contribution margin increased by $13.3 million to $252 million.

The AMA has two active for-profit subsidiaries, the AMA Insurance Agency (Agency) and Health2047. The latter is discussed separately at the end of this discussion and analysis.

The Agency's revenue declined by $2.7 million in 2024, due to lower commissions and interest income. The Agency, as broker, receives a commission on insurance policies sold. The commission reduction was mainly due to the effect of continued decreases in commission rates to protect the viability of the plan, which allowed the Agency to avoid charging higher premiums to physician customers coupled with a reduction in coverages written. A dividend from the Agency to AMA reduced the investible funds balance, with a resulting decline in investment income. Expenses were up $0.8 million mainly due to filling open positions and merit increases. The contribution margin decreased to $13.8 million from $17.3 million in the prior year.

Other business operations net expenses were up slightly in 2024.

In total, Publishing, Health Solutions & Insurance contribution margin was $314.8 million, up $6.8 million from 2023.

Investments (AMA-only)

AMA-only investment income includes dividend and interest earnings on AMA's portfolio. Investment income in AMA's for-profit subsidiaries is included as part of the group results for Publishing, Health Solutions & Insurance and Health2047.

Investments' revenue was $22.9 million in 2024, a $4.8 million increase over the prior year. Dividend and interest income continued to improve in 2024, impacted in large part by higher interest rates as well as an increased level of investible funds. The contribution margin increased by $4.6 million as expenses were largely unchanged.

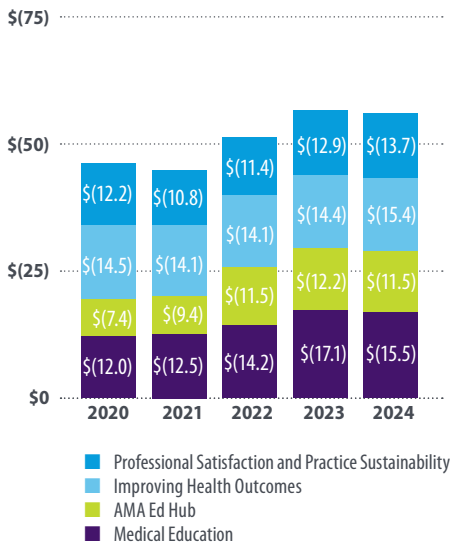
The net gain or loss on the market value of investments is not included in operating results but reported as a non-operating item. This amount is in addition to the investment income discussed above.

In 2024, AMA reported a net gain of $79.7 million. The total investment return, including investment income, on the reserve portfolios was 9.4 percent, slightly less than the 9.8 percent gain in the composite benchmark index.

Net expenses

Strategic Arcs

(in millions)



The Strategic Arcs include direct costs associated with the groups for Improving Health Outcomes (IHO), Medical Education (Med Ed), the AMA Ed Hub™ and Professional Satisfaction and Practice Sustainability (PS2).

IHO has developed empirically validated tools such as its AMA MAP™ Solutions (for hypertension control) and dashboards that, in conjunction with its well-established partnerships with the American Heart Association (AHA), Centers for Disease Control and Prevention (CDC), and the Ad Council, have positioned the initiative for national scaling and impact.

The main focus during 2024 was on hypertension outcome goals as progress continues on implementation of cloud-based MAP BP (a three-step program that works to diagnose and manage patients with hypertension) dashboards at health care organizations (HCOs), providing a visual representation of their performance on five key blood pressure metrics, including stratification by ethnicity, race and gender. IHO engaged 281 additional HCOs and reached an additional 774 thousand patients with hypertension through its solutions that helped physicians and care teams achieve blood pressure goals. In addition, the Student Blood Pressure Measurement eLearning Series received the Silver Award for excellence in design. AMA's Validated Device List, provided as a public service to help increase the use of validated blood pressure devices, had over one million viewers. In 2024, net expenses increased by $1 million, largely due to the use of outside professional services for content strategy development, point of care metrics and reporting and e-learning content.

Advancing Professional Development includes Med Ed and the AMA Ed Hub.

While the Accelerating Change in Medical Education (ACE) undergraduate medical school grants successfully concluded in 2018, AMA has continued to drive multi-school implementation of ACE innovations through ongoing support of the medical education community (ACE Consortium) via scholarly publications, and a disciplined, planned approach to spreading innovation. The five-year Reimagining Residency grants, designed to improve the transition from undergraduate to graduate medical education and to maintain and reinforce the positive changes initiated by the undergraduate consortium work, ended in 2024. Building upon the learning and momentum gained from these two programs, Med Ed will repurpose the residency grant funds to extend its efforts to apply precision education to the full continuum of professional lifelong learning and to foster diversity in the medical student and ultimately the practicing physician population. Now titled ChangeMedEd®, this initiative has inspired a community of innovation in medical education that works collaboratively to create a workforce better prepared to meet the needs of patients and communities, driving change to reduce barriers to lifelong learning, advance health equity and improve patient outcomes. One of the key outcomes of the ACE consortium was the development of Health Systems Science, a foundational platform and framework for the study and understanding of how care is delivered, how health professionals work together to deliver that care, and how the health system can improve patient care and health care delivery.

In 2024, Med Ed expanded its efforts on precision education, a system that can leverage technology and data to improve education personalization and learning efficiency across the continuum, in support of students, residents, fellows, physicians, and ultimately the needs of patients. Innovation Grants were awarded to 13 sites applying precision education approaches in medical school, residency and continuing professional development. The necessary groundwork was laid to launch the AMA Transforming Lifelong Learning Through Precision Education portfolio that will cultivate and promote democratization of the precision education ecosystem to offer individualized learning that aligns physician education with the needs of patients both now and in the future. This will include a four-year, $12 million Precision Education grant program to start in 2025. Med Ed is also responsible for defining or influencing standards for undergraduate, graduate and continuing medical education and providing support for the Council on Medical Education. Net expenses decreased $1.6 million in 2024, reflecting the end of the Reimagining Residency grant program in mid-2024.

The AMA Ed Hub, formally launched in 2018, is a multi-sided platform providing physicians and other health care providers content and educational services that support lifelong professional development. The Ed Hub has unified the AMA education portfolio and has piloted integration of external content providers, launched new content sets, and established internal development plans enterprise wide, including the Health Equity Education Center and the UME Curricular Enrichment Program. The Ed Hub also gives physicians and other health professionals a streamlined way to earn, track and report continuing medical education activities spanning clinical, practice transformation and professionalism topics. The number of external education providers on the platform grew by ten organizations to 60 organizations and the Ed Hub exceeded user engagement goals and met expectations in growth in new users. AMA's continuing medical education (CME) program achieved Accreditation with Commendation from the ACCME, the highest accreditation standard that a CME provider can receive, distinguishing the AMA as a top-tier source of trusted medical education. Net expenses were down $0.7 million in 2024 due largely to a reduced level of technology development as the Ed Hub platform has reached a stable state.

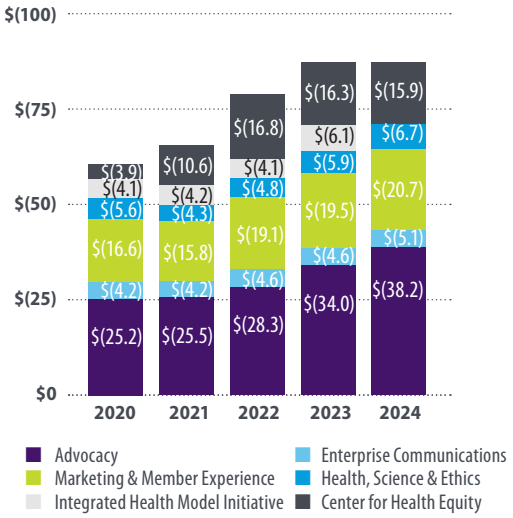
PS2 includes three major streams of work: professional satisfaction/practice transformation, practice sustainability, and digital health, all designed to improve the day-to-day practice and professional experience of physicians and remove obstacles to care. The goals of this group are to promote successful models in both the public and private sectors. This includes expanding research of credible practice science, creating tools and other solutions to help guide physicians, care teams and health system leaders on developing and implementing strategies to optimize practice efficiencies, reduce burnout and improve professional well-being; ensuring the physician perspective is represented in the design, implementation and evaluation of new health care technologies; and shaping the evolution of payment models for sustainability and satisfaction.

In 2024, the PS2 resources such as the Organizational Biopsy®, STEPS Forward®, the Joy in Medicine™ Health System Recognition Program, webinars, podcasts, coaching and learning collaboratives increased the impact of PS2 efforts with physicians as measured by the number of physicians served and the assessment of high value reflected in post-engagement surveys.

PS2 led, funded or contributed to 38 research projects on physician and practice issues, burnout, and digital health solutions and published 17 peer-reviewed studies on physician and practice issues, strengthening the evidence base for AMA solutions. The AMA Joy in Medicine Health System Recognition Program recognized 62 health systems who met the evidence-based criteria representing their commitment to organizational well-being. Providing over 90 new or updated AMA STEPS Forward resources (toolkits, webinars, podcasts, and playbooks) helped drive the user growth to over three million. AMA also co-sponsored the 2024 International Conference on Physician Health with the Canadian Medical Association and the British Medical Association with over 550 participants. In 2024, net expenses increased $0.8 million, driven almost entirely by staffing increases.

Accelerators & Core Mission Activities

(in millions)



Accelerators & Core Mission Activities currently includes five groups: Advocacy; Health, Science & Ethics; Center for Health Equity (CHE); Enterprise Communications; and Marketing & Member Experience (MMX). The Integrated Health Model Initiative, focused on technology innovation, was closed in 2023 as it became clear that the projects developed failed to achieve traction in the market.

Advocacy includes federal and state level advocacy to enact laws and advance regulations on issues important to patients and physicians; economic, statistical and market research to support advocacy efforts; political education for physicians; grassroots advocacy; and maintaining relations with the federation of medicine. This ensures that AMA's critical voice is represented in federal and state courts around the country on a broad range of issues, working with state and federal policymakers to oppose legislation and laws that interfere with the practice of medicine and elevating the voice of physician leadership on critical issues of public health.

Advocacy led the launch of a major media and grassroots campaign, "Fix Medicare Now", to urge Congress to address long-term, systemic reform of Medicare payments through the AMA's coalition. Through this campaign, policymakers are acknowledging the Medicare physician payment crisis and acting toward making permanent payment system solutions in line with AMA recommendations. In response to AMA advocacy, two important pieces of legislation were introduced that would provide crucial reforms to the Medicare physician payment system: H.R. 2474, which would enact an annual, permanent inflationary payment update in Medicare that is tied to the Medicare Economic Index and H.R. 6371, which would reform the budget neutrality policies that have been producing across-the-board payment cuts.

AMA's "Fix Prior Auth" grassroots campaign and sustained advocacy led to the Centers for Medicare & Medicaid Services releasing final regulations making important reforms to prior authorization, federal lawmakers pursuing legislative solutions, and over a dozen states enacting prior authorization reform laws supported by the AMA and state medical associations.

AMA efforts helped deliver concrete results in protecting patients from inappropriate scope of practice expansions, including the defeat of over 80 problematic bills. In 2024, Advocacy net spending increased $4.2 million, led by $2.9 million in additional media and professional service costs for the Medicare reform campaign. Use of outside professional services for other projects such as physician surveys, health legislation strategy and quality measures, accounted for most of the remaining increase.

Health, Science & Ethics is involved in developing AMA policies on scientific, public health and ethical issues for the House of Delegates; providing leadership, subject matter expertise and scientifically sound content and evidence that underpins and informs both current and future AMA initiatives in areas such as infectious disease, drug policy and opioid prescribing; overseeing maintenance of the AMA *Code of Medical Ethics* and publication of the *AMA Journal of Ethics®*, AMA's online ethics journal; and managing the United States Adopted Names (USAN) program, responsible for selecting generic names for drugs by establishing logical nomenclature classifications based on pharmacological or chemical relationships (reported separately in group operating results).

In 2024, this group provided critical expertise for updating the World Medical Association Declaration of Helsinki which sets ethical principles for biomedical research, published issues examining topical areas such as harm reduction in opioid use disorders to evidence-based architectural design in health care, supported the Firearm Injury Prevention Task Force and launched online toolkits with the CDC to help physicians and other health care professionals increase routine screenings for sexually transmitted infections and viral hepatitis. Net expenses increased $0.8 million in 2024, mainly due to staffing costs.

CHE was created in response to a Board sponsored 2018 taskforce that identified a continuing and urgent need for the AMA to play a leading and public role in eliminating health care disparities and promoting health equity through all segments of our society. In 2024, CHE devoted significant effort to working with HCOs through the Equitable Professional Societies Network under the Rise to Health Coalition of which AMA is a founding member; launched the third cohort of the Medical Justice and Advocacy Fellowship, bringing the total number of fellows to 33; held the first hybrid National Health Equity Grand Rounds; and continued engagement of Federation members, completing the second Health Equity in Organized Medicine survey. CHE continued its educational work, establishing and embedding equity education and training curriculum for AMA staff.

Additionally, CHE staff supported the Board's Truth, Reconciliation, Healing and Transformation Task Force and, with grant funding in partnership with Harvard University, initiated a multi-year archival research project that as part of its purpose will inform Task Force deliberations. CHE has largely achieved its planned level of growth and net expenses declined slightly in 2024.

MMX extends the reach and impact of AMA's mission and advocacy initiatives, builds and executes programs to grow and retain members and strengthens the AMA brand. MMX continues to take on increased oversight for managing the quality, timing and relevance of the experience physicians have at each point of interaction through AMA's digital publishing, health system engagement and member programs. MMX creates or packages AMA's content into digital formats and distributes AMA resources and thought leadership to intended audiences through owned and paid channels, raising awareness of AMA initiatives, resources and accomplishments and elevating the voice of AMA and physicians. Key results in 2024 included the launch of the "Why We Fight" campaign focused on reforming Medicare payment, fighting scope creep, fixing prior authorization, reducing physician burnout, and making technology work for physicians. MMX also focused on working collaboratively with key business units (PS2, IHO, CHE, Med Ed, Ed Hub) to expand delivery of mission value to existing and potential new health system partners and developing a pragmatic and growth-oriented marketing program for AMA's Health Equity work. AMA's audience of readers, watchers and listeners totaling 31 million in 2024.

Net expenses increased $1.2 million in 2024, with increased spending on marketing and technology to support delivery of AMA's message.

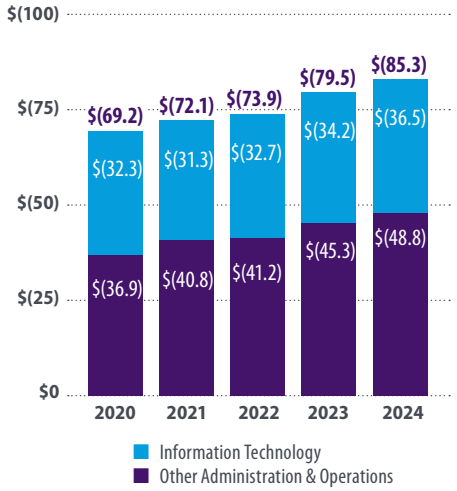
Ongoing responsibilities of the Enterprise Communications area include amplifying the work of individual operating units among their core audiences while providing consistency and alignment with the AMA narrative. Enterprise Communications distinctly communicates AMA's leading voice in science and evidence to embed equity, innovation, and advocacy across the AMA's strategic work throughout health care. Net expenses were up $0.5 million in 2024, largely due to increased staffing costs.

Governance

Governance includes the Board of Trustees and Officer Services, the House of Delegates (HOD), Sections and Special Constituencies & International units. The Board of Trustees unit includes costs related to governance activities as well as expenses associated with support of the Strategic Arcs, Accelerators and Core Mission Activities. The HOD, Sections and Special Constituencies & International unit includes costs associated with annual and interim meetings, groups, sections and other HOD activities, as well as costs associated with AMA's involvement in the World Medical Association. In 2024, Governance net spending was up $1.1 million, mainly recruiting and relocation costs.

Administration and Operations

(in millions)



These units provide administrative and operational support for Publishing & Health Solutions, Membership, Strategic Arcs, Accelerators and Core Mission Activities, as well as other operating groups. Net expenses were up 7.3 percent in 2024, an increase of $5.8 million, due to compensation costs from staff additions, filling open positions and merit increases; increased technology costs and over $1 million for use of outside resources on projects related to AMA mission-based impact and HCO research.

Affiliated Organizations

Affiliated Organizations represent either grant or in-kind service support provided by the AMA to other foundations and societies. In some cases, the AMA is reimbursed for services provided. No net expenses were reported in 2024.

Unallocated Overhead

The net expenses in this area include costs not allocated back to operating units such as corporate insurance and actuarial services, employee incentive compensation, valuation allowances or other reserves. In 2024, these expenses total $35.6 million, up $6.3 million from 2023. Higher incentive and other compensation were the main factors in the increase.

Health2047 and Subsidiary

AMA owns a business formation and commercialization enterprise designed to enhance AMA's ability to define, create, develop and launch, with partners, a portfolio of products and technologies that will have a profound impact on many aspects of the U.S. health care system and population health, with a central goal of helping physicians in practice. The AMA Board of Trustees approved the use of reserves to establish this subsidiary with plans to use third-party resources to assist in funding spinoffs with commercial potential in future years. These liquidity events generally occur somewhere between eight and twelve years after the initial spinoff.

Health2047's mission is to advance the AMA's strategic arcs by developing early-stage companies that will attract third-party investment as they mature to successful financial exits. Health2047 operates with two critical venture industry expectations: one that only a minority of early-stage start-up companies will reach maturity and consequently that it is important to aggressively manage investments and second that the industry expected timeframe for successful exit is between 8 and 12 years.

To date, twelve spinout companies have been launched, nine of which continue to operate and are attracting outside interest and investment. Given the relative youth of Health2047, none of these spinout companies have yet achieved a final financial exit. The nine spinout companies reflect a wide range of physician centric solutions including community-based diabetes prevention, Medicare Advantage for underserved populations, effective data extraction for health care enterprises, decentralized and diverse clinical trials, obesity phenotyping for precision medicine, evidence-based point of care insight, a digital learning platform for medical and health professional schools, and augmented intelligence applied to medical images.

Net expenses decreased by $3.5 million in 2024 as reductions in compensation and benefits and marketing were partially offset by increased use of consultants. In addition, the 2023 results included a $2.2 million loss on the liquidation of one of the spinout companies, which did not recur in 2024.

The summary of group operating results is included on the following page.

American Medical Association group operating results

	Revenues		Margin (Net Expenses)	
(in millions)	2024	2023	2024	2023
Membership	**$ 32.5**	$ 33.3	**$ 10.5**	$ 13.3
Publishing, Health Solutions & Insurance				
Publishing	**61.7**	63.8	**-**	1.0
Books and Digital Content	**281.4**	265.5	**252.0**	238.7
Database Products	**68.2**	67.7	**52.6**	54.5
Insurance Agency/Affinity Products	**34.4**	37.1	**13.8**	17.3
Other business operations	**-**	-	**(3.6)**	(3.5)
	445.7	434.1	**314.8**	308.0
Investments (AMA-only)	**22.9**	18.1	**22.0**	17.4
Strategic Arcs, Accelerators & Core Mission Activities				
Improving Health Outcomes	**-**	-	**(15.4)**	(14.4)
Medical Education	**0.2**	0.4	**(15.5)**	(17.1)
AMA Ed Hub	**0.4**	0.3	**(11.5)**	(12.2)
Professional Satisfaction and Practice Sustainability	**-**	0.6	**(13.7)**	(12.9)
Advocacy	**0.9**	1.0	**(38.2)**	(34.0)
Health, Science & Ethics	**2.9**	2.4	**(6.7)**	(5.9)
Center for Health Equity	**0.7**	-	**(15.9)**	(16.3)
Integrated Health Model Initiative	**-**	-	**-**	(6.1)
Marketing and Member Experience	**-**	-	**(20.7)**	(19.5)
Enterprise Communications	**-**	-	**(5.1)**	(4.6)
United States Adopted Names Program	**4.7**	3.4	**3.8**	2.6
	9.8	8.1	**(138.9)**	(140.4)
Governance				
Board of Trustees and Officer Services	**-**	-	**(7.8)**	(6.8)
House of Delegates, Sections, Special Constituencies & International	**0.1**	0.1	**(11.1)**	(11.0)
	0.1	0.1	**(18.9)**	(17.8)
Administration and Operations				
Information Technology	**-**	-	**(36.5)**	(34.2)
Senior Executive Management	**-**	-	**(7.4)**	(7.5)
General Counsel	**-**	-	**(6.6)**	(6.3)
Finance & Risk Management	**-**	-	**(9.8)**	(9.0)
Human Resources	**-**	-	**(8.9)**	(8.2)
Corporate Services	**-**	-	**(6.2)**	(6.2)
Customer Service	**-**	-	**(3.7)**	(3.6)
Strategic Insights and Planning	**-**	-	**(6.2)**	(4.5)
	-	-	**(85.3)**	(79.5)
Affiliated Organizations	**0.1**	0.1	**-**	-
Unallocated Overhead	**2.1**	1.6	**(35.6)**	(29.3)
Health2047 & Subsidiary	**-**	(0.3)	**(13.4)**	(16.9)
Consolidated revenue and income before tax	**$ 513.2**	$ 495.1	**55.2**	54.8
Income taxes			**(4.1)**	(5.1)
Consolidated net operating income			**$ 51.1**	$ 49.7

Consolidated financial statements



American Medical Association and Subsidiaries

Consolidated statements of activities

Years ended December 31

(in millions)	2024	2023
Revenues		
Membership dues	$ 32.5	$ 33.3
Advertising	7.8	11.0
Journal print subscription revenues	2.2	2.7
Journal online revenues	32.2	31.6
Other publishing revenues	18.8	18.0
Books, newsletters and online product sales	22.1	23.8
Royalties and credentialing products	326.0	308.0
Insurance commissions	29.7	31.6
Investment income (Note 4)	25.7	21.3
Equity in losses of affiliates (Note 2)	(0.5)	(1.2)
Grants and other income	16.7	15.0
Total revenues	**513.2**	**495.1**
Expenses		
Cost of products sold and selling expenses	23.7	27.8
Contribution to general and administrative expenses	**489.5**	**467.3**
General and administrative expenses		
Compensation and benefits	279.4	262.0
Occupancy	19.8	21.2
Travel and meetings	20.4	19.9
Technology costs	34.4	33.9
Marketing and promotion	24.1	20.7
Professional services	35.2	29.7
Other operating expenses	21.0	25.1
Total general and administrative expenses	**434.3**	**412.5**
Operating results before income taxes	55.2	54.8
Income taxes (Note 10)	4.1	5.1
Net operating results	**51.1**	**49.7**
Non-operating items		
Net gain on investments (Note 4)	79.7	105.0
Defined benefit postretirement plan non-service periodic expense (Note 9)	(5.7)	(3.9)
Other non-operating income	0.1	0.6
Total non-operating items	**74.1**	**101.7**
Revenues in excess of expenses	**125.2**	**151.4**
Changes in defined benefit postretirement plans, other than periodic expense, net of tax (Notes 9 and 10)	2.0	(17.3)
Change in association equity	**127.2**	**134.1**
Change in donor restricted association equity		
Restricted contributions	0.7	0.6
Net assets released from restriction	(0.6)	(0.7)
Change in association equity – donor restricted	**0.1**	**(0.1)**
Change in total association equity	**127.3**	**134.0**
Total association equity at beginning of year	1,023.4	889.4
Total association equity at end of year	**$ 1,150.7**	**$ 1,023.4**

See accompanying notes to the consolidated financial statements.

American Medical Association and Subsidiaries

Consolidated statements of financial position

As of December 31

(in millions)	2024	2023
Assets		
Cash, cash equivalents and donor-restricted cash	$ 39.6	$ 36.1
Fiduciary funds (Note 2)	21.6	21.8
Investments in affiliates (Note 2)	19.4	15.3
Accounts receivable and other receivables, net of an allowance for doubtful accounts of $0.1 in 2024 and $0.3 in 2023	110.2	104.5
Inventories	1.7	2.1
Prepaid expenses and deposits	11.6	10.5
Deferred income taxes (Note 10)	3.5	3.0
Investments (Note 4)	1,208.4	1,088.4
Property and equipment, net (Note 7)	24.7	27.3
Operating lease right-of-use assets (Note 11)	50.2	51.3
Other assets (Note 6)	11.3	9.8
	$ 1,502.2	$ 1,370.1
Liabilities, deferred revenue and association equity		
Liabilities		
Accounts payable, accrued expenses and other liabilities	$ 18.8	$ 15.1
Accrued payroll and employee benefits (Note 8)	63.9	54.9
Accrued postretirement healthcare benefits (Note 9)	108.8	107.8
Insurance premiums and other fiduciary funds payable (Note 2)	21.5	21.6
Operating lease liability (Note 11)	67.4	71.1
	280.4	270.5
Deferred revenue		
Membership dues	11.5	13.2
Subscriptions, licensing, insurance commissions and royalties	56.6	59.9
Grants and other	3.0	3.1
	71.1	76.2
Association equity	1,150.6	1,023.4
Donor-restricted association equity	0.1	-
Total association equity	1,150.7	1,023.4
	$ 1,502.2	$ 1,370.1

See accompanying notes to the consolidated financial statements.

American Medical Association and Subsidiaries

Consolidated statements of cash flows

Years ended December 31

(in millions)	2024	2023
Cash flows from operating activities		
Change in total association equity	$ 127.3	$ 134.0
Adjustments to reconcile change in association equity to net cash provided by operating activities		
Depreciation and amortization	10.0	11.7
Postretirement health care expense	6.2	4.4
Noncash operating lease expense	8.9	8.9
Net gain on investments	(79.7)	(105.0)
Equity in losses of affiliates	0.5	1.2
Noncash (credit) charge for changes in defined benefit plans other than periodic expense net of tax	(2.0)	17.3
Noncash loss upon liquidation of affiliate or subsidiary	-	2.2
Loss on disposal of property and equipment	-	1.5
Bad debt expense	0.1	0.1
Other	(0.3)	(1.3)
Changes in assets and liabilities		
Accounts receivable and other receivables	(5.8)	(3.1)
Inventories	0.4	0.7
Prepaid expenses and deposits	(1.1)	1.2
Accounts payable, accrued liabilities and income taxes	(2.0)	(8.9)
Accrued postretirement benefit costs	(3.0)	(3.0)
Deferred revenue	(5.1)	5.8
Net cash provided by operating activities	54.4	67.7
Cash flows from investing activities		
Purchase of property and equipment	(6.4)	(6.2)
Investment in affiliates	(4.2)	(8.7)
Purchase of investments	(1,228.6)	(876.0)
Proceeds from sale of investments	1,188.3	825.8
Net cash used in investing activities	(50.9)	(65.1)
Net change in cash, cash equivalents and donor restricted cash	**3.5**	**2.6**
Cash, cash equivalents and donor restricted cash at beginning of year	36.1	33.5
Cash, cash equivalents and donor restricted cash at end of year	**$ 39.6**	**$ 36.1**
Noncash operating activities		
Right-of-use assets obtained in exchange for lease obligation	$ 3.1	$ 17.8
Noncash investing activities		
Accounts payable for property and equipment additions	$ 2.3	$ 1.3

See accompanying notes to the consolidated financial statements.

Notes to consolidated financial statements

For the years ended December 31, 2024 and 2023
(Columnar amounts in millions)

1. Nature of operations

The American Medical Association (AMA) is a national professional association of physicians with approximately 291 thousand members. The AMA serves the medical community and the public through standard setting and implementation in the areas of science, medical education, improving health outcomes, health equity, delivery and payment systems, ethics, representation and advocacy, policy development, and image and identity building. The AMA provides information and services to hundreds of thousands of physicians and includes journal and book publishing, physician credentialing, database licensing, insurance and other professional services for physicians.

The AMA classifies all operating results as revenues and expenses in the consolidated statements of activities. Non-operating items include net realized and unrealized gains and losses on investments, defined benefit postretirement plan non-service expense and other non-recurring income or expense.

Donor-restricted association equity includes contributions restricted for use for a scope of practice program which are not available for general use by AMA.

2. Significant accounting policies

Consolidation policy

The accompanying consolidated financial statements include the accounts of the AMA and its subsidiaries, AMA Services, Inc., American Medical Assurance Company (AMACO) and Health2047 Inc. (collectively, the AMA).

AMACO, a reinsurer for physician medical professional liability coverage, ceased accepting new and renewal business in 1986 and began running off claims under existing contracts. Since 1986, AMACO pursued the commutation of various treaties and the final treaties were commuted in 2024, with all related exposures eliminated. AMACO obtained approval from the Illinois Insurance Commissioner for a plan of dissolution and implemented that plan in 2024, with no material impact on the consolidated financial results.

AMA, through its wholly owned subsidiary, Health2047 Inc. (Health2047), has investments in nine companies or limited partnerships as of December 31, 2024.

Health2047 controls and consolidates the results of one company, First Mile Care, Inc.

The equity method of accounting is used to account for investments in companies or limited partnerships in which the AMA has significant influence but not overall control. The investments are initially recorded at the original amounts paid for common and convertible preferred stock, and subsequently adjusted for the AMA's share of undistributed earnings and losses from the underlying entities from the dates of formation. Each investment will be increased or reduced by any future additional contributions and distributions received, respectively. The cost method of accounting is used to account for investments in companies in which the AMA has neither significant influence nor overall control and where the fair value is not readily determinable.

The results of one company, Heal Security, Inc. (formed in February 2021) are accounted for under the equity method. At December 31, 2024, AMA ownership interest is 33.3% in Heal Security, Inc. The book value of the investment, net of convertible debt, at December 31, 2024 is $1 million.

In addition, at December 31, 2024, AMA has an ownership interest in seven companies or limited partnerships. The investments in these entities are accounted for using the cost method, as AMA holds less than a 20% ownership and does not exercise significant influence over the entities. This includes ownership interests of 2.9% in Zing Health Enterprises, LP (formed in May 2020), 16.4% in Medcurio Inc., (formed in February 2020), 18.7% in Phenomix Sciences, Inc. (formed in August 2020), 13.2% in Evidium, Inc. (formerly Recovery Exploration Technologies, Inc., formed in August 2021), 18.4% in Sitebridge Research, Inc. (formed in January 2021), 6% in Scholar Rx, Inc. (formed in December 2022) and 5.4% in IntellixAI, Inc. (formed in May 2023). The book value of the seven investments carried at cost at December 31, 2024 is $18.4 million.

Health2047 had investments in nine companies or limited partnerships as of December 31, 2023. Health2047 controlled and consolidated the results of one company, First Mile Care, Inc.

The companies accounted for under the equity method of accounting during 2023 were: Emergence Healthcare Group, Inc., (formed in January 2021 and liquidated in September 2023), and Heal Security, Inc.

At December 31, 2023, AMA ownership interest was 33.3% in Heal Security, Inc. The book value of the investment accounted for under the equity method, net of convertible debt, at December 31, 2023 was $0.9 million.

In addition, at December 31, 2023, AMA had ownership interest of 3.3% in Zing Health Enterprises, LP, 16.7% in Medcurio Inc., 19.1% in Phenomix Sciences, Inc., 11.3% in Evidium, Inc., 18.4% in Sitebridge Research, Inc., 6% in ScholarRx, Inc. and 6.1% in IntellixAI, Inc. The investments in these entities were accounted for using the cost method, as AMA held less than a 20% ownership and did not exercise significant influence over the entities. The book value of the seven investments carried at cost at December 31, 2023 was $14.4 million.

Use of estimates

Preparation of consolidated financial statements in conformity with accounting principles generally accepted (GAAP) in the United States of America requires management to make estimates and assumptions that affect reported amounts of assets, liabilities, revenues and expenses as reflected in the consolidated financial statements. Actual results could differ from estimates.

Cash equivalents

Cash equivalents consist of liquid investments with original maturities of three months or less and are recorded at cost, which approximates fair value.

Fiduciary funds

One of the AMA's subsidiaries, the AMA Insurance Agency, Inc., in its capacity as an insurance broker, collects premiums from the insured and, after deducting its commission, remits the premiums to the underwriter of the insurance coverage. Unremitted insurance premiums are invested on a short-term basis and are held in a fiduciary capacity. The AMA also collects and holds contributions on behalf of a separate unincorporated entity with $2.4 million held at December 31, 2024 and December 31, 2023.

Inventories

Inventories, consisting primarily of books and paper for publications, are valued at the lower of cost or net realizable value.

Property and equipment

Property and equipment are carried at cost, less accumulated depreciation and amortization. Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the assets. Furniture and office equipment, hardware and software are depreciated or amortized over three to 10 years. Leasehold improvements are depreciated over the shorter of the estimated useful lives or the remaining lease term.

Revenue recognition

Revenue is recognized upon transfer of control of promised products or services to customers in an amount that reflects the consideration that AMA expects to receive in exchange for those products or services. AMA enters into contracts that generally include only one product or service and as such, are distinct and accounted for as separate performance obligations. Revenue is recognized net of allowances for returns and any taxes collected from customers, which are subsequently remitted to governmental authorities.

Membership dues are deferred and recognized as revenue in equal monthly amounts during the applicable membership year, which is a calendar year.

Licensing and subscriptions to scientific journals, site licenses, newsletters or other online products are recognized as revenue ratably over the terms of the subscriptions or service period. Advertising revenue and direct publication costs are recognized in the period the related journal is issued. Book and product sales are recognized at the time the book or product is shipped or otherwise delivered to the customer. Royalties are recognized as revenue over the royalty term. Insurance brokerage commissions on individual policies are recognized as revenue on the date they become effective or are renewed, to the extent services under the policies are complete. Brokerage commissions or plan rebates on the group products are recognized as revenue ratably over the term of the contract as services are rendered.

Contract balances

AMA records a receivable when the performance obligation is satisfied and revenue is recognized. For agreements covering subscription or service periods, AMA generally records a receivable related to revenue recognized for the subscription, license or royalty period. For sales of books and products, AMA records a receivable at the time the product is shipped or otherwise delivered to the customer. These amounts are included in accounts receivable on the consolidated statements of financial position and the balance, net of allowance for doubtful accounts, was $103.8 million and $98.4 million as of December 31, 2024 and December 31, 2023, respectively.

The allowance for doubtful accounts reflects AMA's best estimate of probable losses inherent in the accounts receivable balance. The allowance is based on historical experience and other currently available evidence.

Payment terms and conditions vary by contract type, although terms generally include a requirement of payment within 30 to 60 days. Some annual licensing agreements carry longer payment terms. In instances where the timing of revenue recognition differs from the timing of invoicing, AMA has determined that these contracts generally do not include a significant financing component.

Prepaid dues by members are included as deferred membership dues revenue in the consolidated statements of financial position. Prepayments by customers in advance of the subscription, royalty or insurance coverage period are recorded as deferred subscriptions, licensing, insurance commissions and royalty revenue in the consolidated statements of financial position.

Income taxes

The AMA is an exempt organization as defined by Section 501(c)(6) of the Internal Revenue Code and is subject to income taxes only on income determined to be unrelated business taxable income. The AMA's subsidiaries are taxable entities and are subject to income taxes. See footnote 10.

Changes in presentation

In 2024, AMA realigned its business units to reflect the current operations of the organization. As a result, the presentation of the functional expenses for 2023 in footnote 15 has been updated to be consistent with the current presentation.

3. New accounting standards update

In December 2023, Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. 2023-09, *Improvements to Income Tax Disclosures*. This requires an entity to report the amount of income taxes paid disaggregated by federal, state, and foreign taxes as well as the amount of income taxes paid disaggregated by individual jurisdictions in which income taxes paid is equal to or greater than five percent of total income taxes paid. The new standard is effective for AMA for annual periods beginning after December 15, 2025. The adoption of the standard will expand certain footnote disclosures but will not have an impact on the AMA's consolidated financial statements.

4. Investments

Investments include marketable securities and venture capital and private equity investments that are carried at fair value.

In determining fair value, the AMA uses various valuation approaches. The FASB's Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements and Disclosures*, establishes a hierarchy for inputs used in measuring fair value that maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the most observable inputs be used when available. Observable inputs are inputs that market participants would use in pricing the asset based on market data obtained from sources independent of the organization. Unobservable inputs are inputs that would reflect an organization's assumptions about the assumptions market participants would use in pricing the asset developed based on the best information available in the circumstances. The hierarchy is broken down into three levels based on the observability of inputs as follows:

Level 1—Valuations based on quoted prices in active markets for identical assets that the organization has the ability to access. Since valuations are based on quoted prices that are readily and regularly available in an active market, valuation of these products does not entail a significant degree of judgment.

Level 2—Valuations based on one or more quoted prices in markets that are not active or for which all significant inputs are observable, either directly or indirectly.

Level 3—Valuations based on inputs that are unobservable and significant to the overall fair value measurement.

The availability of observable inputs can vary from instrument to instrument and is affected by a wide variety of factors, including, for example, the liquidity of markets and other characteristics particular to the transaction. To the extent that valuation is based on models or inputs that are less observable or unobservable in the market, the determination of fair value requires more judgment.

The AMA uses prices and inputs that are current as of the measurement date, obtained through a third-party custodian from independent pricing services.

A description of the valuation techniques applied to the major categories of investments measured at fair value is outlined below.

Exchange-traded equity securities are valued based on quoted prices from the exchange. To the extent these securities are actively traded, valuation adjustments are not applied and they are categorized in Level 1 of the fair value hierarchy.

Mutual funds are open-ended Securities and Exchange Commission (SEC) registered investment funds with a daily net asset value (NAV). The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy.

The fair value of corporate debt securities is estimated using recently executed transactions, market price quotations (where observable) or bond spreads. If the spread data does not reference the issuer, then data that reference a comparable issuer are used. Corporate debt securities are generally categorized in Level 2 of the fair value hierarchy.

U.S. government agency securities consist of two categories of agency issued debt. Non-callable agency issued debt securities are generally valued using dealer quotes. Callable agency issued debt securities are valued by benchmarking model-derived prices to quoted market prices and trade data for identical or comparable securities. Agency issued debt securities are categorized in Level 2 of the fair value hierarchy.

U.S. government securities are valued using quoted prices provided by a vendor or broker-dealer. These securities are categorized in Level 2 of the fair value hierarchy, as it is difficult for the custodian to accurately assess at a security level whether a quoted trade on a bond represents an active market.

Foreign and U.S. state government securities are valued using quoted prices in active markets when available. To the extent quoted prices are not available, fair value is determined based on interest rate yield curves, cross-currency basis index spreads, and country credit spreads for structures similar to the bond in terms of issuer, maturity, and seniority. These investments are generally categorized in Level 2 of the fair value hierarchy.

Investments also include investments in a diversified closed end private equity fund with a focus on buyout and secondary market opportunities in the United States and the European Union, as well as an investment in a venture capital fund focused on companies developing promising health care technologies that can be commercialized into revolutionary products and services that improve the practice of medicine and the delivery and management of health care. The investments are not redeemable and distributions are received through liquidation of the underlying assets of the funds. It is estimated that the underlying assets will be liquidated over the next four to ten years. The fair value estimates of these investments are based on NAV as provided by the investment managers. Unfunded commitments as of December 31, 2024, and December 31, 2023 totaled $76.1 million and $81.1 million, respectively.

The AMA manages its investments in accordance with Board-approved investment policies that establish investment objectives of real inflation-adjusted growth over the investment time horizon, with diversification to provide a balance between long-term growth objectives and potential liquidity needs.

The following table presents information about the AMA's investments measured at fair value as of December 31. In accordance with ASC Subtopic 820-10, investments that are measured at fair value using the NAV per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated statements of financial position.

	2024	2023
Level 1 – Quoted prices in active market for identical securities		
Equity securities	$ 588.1	$ 544.3
Fixed-income mutual funds	13.8	19.4
	601.9	563.7
Level 2 – Significant other observable inputs		
Debt securities		
Corporate	139.2	126.0
U.S. government and federal agency	275.9	254.3
Foreign government	39.4	28.3
U.S. state government	0.1	0.1
	454.6	408.7
Other investments measured at NAV – Private equity and venture capital funds	151.9	116.0
Investments	$1,208.4	$ 1,088.4

Interest and dividends are included in investment income as operating revenue while realized and unrealized gains and losses are included as a component of non-operating items.

Investment income consists of:

	2024	2023
Investment dividend and interest income	$ 30.1	$ 25.0
Management fees	(4.4)	(3.7)
	$ 25.7	$ 21.3

Investment non-operating items include:

	2024	2023
Realized gains on investments, net	$ 69.8	$ 15.2
Unrealized gains on investments, net	9.9	89.8
	$ 79.7	$ 105.0

5. Derivative instruments

In 2024, AMA began using exchange-traded U.S. Treasury note future contracts in order to efficiently manage duration of fixed income investments in the portfolio. These transactions do not qualify for hedge accounting. The fair value of the futures contracts is recognized as part of investments in the consolidated statements of financial position and changes in the fair value of these futures contracts are recognized as a component of net gain or loss on investments included in non-operating items in the consolidated statements of activities. The fair value as of December 31, 2024 and changes in fair value during 2024 were not material.

6. Other assets

Other assets include investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Mutual funds are open-ended SEC registered investment funds with a daily NAV. The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy. The investments totaled $11.3 million and $9.8 million as of December 31, 2024 and December 31, 2023, respectively.

7. Property and equipment

Property and equipment at December 31 consists of:

	2024	2023
Leasehold improvements	$ 36.1	$ 36.2
Furniture and office equipment	17.6	17.5
Information technology		
Hardware	11.4	11.6
Software	100.9	96.6
	166.0	161.9
Accumulated depreciation and amortization	(141.3)	(134.6)
Property and equipment, net	$ 24.7	$ 27.3

8. Retirement savings plan

The AMA has a 401(k) retirement and savings plan, which allows eligible employees to contribute up to 75 percent of their compensation annually, subject to Internal Revenue Service (IRS) limits. The AMA matches 100 percent of the first three percent and 50 percent of the next two percent of employee contributions. The AMA may, at its discretion, make additional contributions for any year in an amount up to two percent of the compensation for each eligible employee. Compensation is subject to IRS limits and excludes bonuses and severance pay. AMA matching and discretionary contribution expense totaled $9.8 million and $9.2 million in 2024 and 2023, respectively.

9. Postretirement health care benefits

The AMA provides health care benefits to retired employees who were employed on or prior to December 31, 2010. After that date, no individual can become a participant in the plan. Generally, qualified employees become eligible for these benefits if they retire in accordance with the plan provisions and are participating in the AMA medical plan at the time of their retirement. The AMA shares the cost of the retiree health care payments with retirees, paying approximately 60 to 80 percent of the expected benefit payments. The AMA has the right to modify or terminate the postretirement benefit plan at any time. Other employers participate in this plan and liabilities are allocated between the AMA and the other employers.

The AMA has applied for and received the federal subsidy to sponsors of retiree health care benefit plans that provides a prescription drug benefit that is actuarially equivalent to Medicare Part D under the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*. In accordance with ASC Topic 958-715, *Compensation-Retirement Benefits*, the AMA initially accounted for the subsidy as an actuarial experience gain to the accumulated postretirement benefit obligation.

The postretirement health care plan is unfunded. In accordance with ASC Topic 958-715, the AMA recognizes this liability in its consolidated statements of financial position.

The following reconciles the change in accumulated benefit obligation and the amounts included in the consolidated statements of financial position at December 31:

	2024	2023
Benefit obligation at beginning of year	$ 107.8	$ 88.1
Service cost	0.5	0.5
Interest cost	5.5	4.4
Benefits paid	(4.4)	(4.4)
Participant contributions	1.2	1.2
Federal subsidy	0.2	0.2
Actuarial (gain) loss	(2.0)	17.8
Accrued postretirement benefit costs	$ 108.8	$ 107.8

The postretirement health care plan accumulated actuarial losses not yet recognized as a component of periodic postretirement health care expense but included as an accumulated charge to equity are $6.4 million and $8.6 million at December 31, 2024 and December 31, 2023, respectively.

Actuarial assumptions used in determining the accumulated benefit obligation at December 31 are:

	2024	2023
Discount rate	5.7%	5.0%
Initial health care cost trend	8.4%	8.5%
Ultimate health care cost trend	4.0%	4.0%
Year that the rate reaches the ultimate trend rate	2048	2047

The change in the discount rate from 5.0% at the end of 2023 to 5.7% in 2024, offset by the impact of higher claims cost experience, was the major driver of the $2 million actuarial gain in 2024. The change in the initial health care cost trend from 7.0% to 8.5% and claims cost experience were the major drivers of the $17.8 million actuarial loss in 2023.

AMA recognizes postretirement health care expense in its consolidated statements of activities. The service cost component is included as part of compensation and benefits expense and the other components of expense are recognized as a non-operating item:

	2024	2023
Service cost	$ 0.5	$ 0.5
Non-service costs		
Interest cost	5.5	4.4
Amortization of actuarial loss (gain)	0.2	(0.5)
Total non-service costs	5.7	3.9
	$ 6.2	$ 4.4

Postretirement health care-related changes, other than periodic expense, that have been included as a charge or credit to unrestricted equity consist of:

	2024	2023
Actuarial gain (loss) arising during period	$ 2.0	$ (17.8)
Reclassification adjustment for recognition of actuarial loss (gain)	0.2	(0.5)
Change in association equity	$ 2.2	$ (18.3)

Actuarial assumptions used in determining postretirement health care expense are the same assumptions noted in the table above for determining the accumulated benefit obligation, except as follows:

	2024	2023
Discount rate	5.0%	5.2%
Initial health care cost trend	8.5%	7.0%

The following postretirement health care benefit payments are expected to be paid by the AMA, net of contributions by retirees and federal subsidies:

2025	$ 4.1
2026	4.6
2027	5.0
2028	5.3
2029	5.7
2030 – 2034	33.4

10. Income taxes

The provision for income taxes includes:

	2024	2023
Operating		
Current	$ 4.8	$ 4.4
Deferred	(5.2)	(4.6)
Valuation allowance	4.5	5.3
	4.1	5.1
Tax expense (benefit) related to credits or charges to equity		
Deferred	0.2	(1.0)
	$ 4.3	$ 4.1

As prescribed under ASC Topic 740, *Income Taxes*, the AMA determines its provision for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for future tax effects of temporary differences between the consolidated financial statement carrying amounts of existing assets and liabilities and their respective tax basis.

The deferred tax benefit or expense from credits or charges to equity represents the estimated tax benefit from recording unrecognized actuarial losses and prior service credits for the postretirement health care plan, pursuant to ASC Topic 958-715.

Valuation allowances are provided to reduce deferred tax assets to an amount that is more likely than not to be realized. The AMA evaluates the likelihood of realizing its deferred tax assets by estimating sources of future taxable income and assessing whether or not it is likely that future taxable income will be adequate for the AMA to realize the deferred tax asset. The valuation allowance reflects the fact that deferred tax assets include future expected benefits largely related to net operating or capital losses where recoverability will not occur until future taxable income is generated, as well as retiree health care payments that may not be deductible due to a projected lack of taxable advertising income in future years. Increases or decreases in deferred tax assets, where future benefits are considered unlikely, will result in an equal and offsetting change in the valuation reserve. If the AMA were to make a determination in future years that these deferred tax assets would be realized, the related valuation allowance would be reduced and a benefit to earnings recorded.

Deferred income taxes recognized in the consolidated statements of financial position at December 31 include the following deferred tax assets and (liabilities):

	2024	2023
Net operating and capital loss carryforward	$ 30.6	$ 26.5
Benefit plans and compensation	6.0	5.9
Right-of-use assets	(1.9)	-
Lease liabilities	2.1	-
Other	0.5	(0.1)
	37.3	32.3
Valuation allowance	(33.8)	(29.3)
	$ 3.5	$ 3.0

Cash payments for income taxes were $4.3 million and $4.4 million in 2024 and 2023, respectively, net of refunds.

AMA's federal taxes are open to examination by taxing authorities from 2021 through 2024. AMA's state taxes are open to examination for various years depending on the jurisdiction.

11. Leases

AMA leases office space at a number of locations and the initial terms of the office leases range from four years to 15 years. Most office space leases have options to renew at then prevailing market rates, or, in one circumstance, early terminate or contract with appropriate notice and termination payments. As any renewal, termination, or contraction is at the sole discretion of AMA, and at this date is not certain, renewal and termination options are not included in the right-of-use asset (ROU asset) or lease liability. AMA also leases copiers and printers in several locations, with initial terms generally of four years.

The lease agreements do not contain variable lease payments, residual value guarantees or material restrictive covenants. All leases are classified as operating leases.

AMA leases do not provide an implicit interest rate and as such, AMA calculates the lease liability at lease commencement or remeasurement date as the present value of unpaid lease payments using an estimated incremental borrowing rate. The incremental borrowing rate represents the rate of interest that AMA estimates it would have to pay to borrow an amount equal to the lease payments on a collateralized basis over a similar term, based on information available at the time of commencement or remeasurement.

During 2024, AMA entered into a new office space lease which resulted in a $3.1 million increase in the ROU asset and corresponding lease liability.

During 2023, AMA extended the term of the main headquarters lease for an additional seven years in return for certain concessions. The ROU asset and lease liability were remeasured as of the modification date and the impact of the extension is a $17.7 million increase in the ROU asset and corresponding lease liability. In addition, AMA exercised early termination options of two small satellite office leases, with a termination penalty. The impact of the early terminations was not material.

Operating lease costs totaled $8.9 million in both 2024 and 2023. Cash paid for amounts included in the measurement of lease liabilities totaled $11.5 million in 2024 and $15.3 million in 2023.

The remaining weighted-average lease term is 9.9 years and 11.1 years as of December 31, 2024 and December 31, 2023, respectively. The weighted-average discount rate used for operating leases is 6.9% and 7.2% for 2024 and 2023, respectively.

The maturity of lease liabilities as of December 31, 2024:

2025	$ 8.9
2026	2.6
2027	2.6
2028	6.4
2029	13.1
2030 and beyond	68.0
Total lease payments	101.6
Less imputed interest	(34.2)
Present value of lease obligations	$ 67.4

12. Financial asset availability and liquidity

AMA has a formal reserve policy that defines the reserve investment portfolios as pools of liquid net assets that can be accessed to mitigate the impact of undesirable financial events or to pursue opportunities of strategic importance that may arise, as well as provide a source of capital appreciation. The policy establishes minimum required dollar levels required to be held in the portfolios (defined as an amount equal to one-year's general and administrative operating expenses plus long-term liabilities). The policy also covers the use of dividend and interest income, establishes criteria for use of the funds and outlines the handling of excess operating funds on an annual basis.

Dividend and interest income generated from the reserve portfolios are transferred to operating funds monthly and used to fund operations. The formal reserve policy contemplates use of reserve portfolio funds for board approved time- or dollar-limited strategic outlays, to the extent that the reserve portfolio balances exceed the minimum amount established by policy.

All surplus funds generated from operations annually (defined as operating cash plus other current assets minus current liabilities and deferred revenue at year end) are transferred to the reserve portfolios after year-end. The reserve policy does not cover the for-profit subsidiaries' activities.

AMA invests cash in excess of projected weekly requirements in short-term investments and money market funds. AMA does not maintain any credit facilities as the reserve portfolios provide ample protection against any liquidity needs.

The following reflects AMA's financial assets as of December 31 reduced by amounts not available for general use that have been set aside for long-term investing in the reserve investment portfolios or funds subject to donor restrictions. AMA's financial assets include cash, cash equivalents and donor restricted cash, short-term investments and long-term investments in the reserve portfolios.

	2024	2023
Financial assets	$1,248.0	$1,124.5
Less assets unavailable for general expenditures:		
Restricted by donor with purpose restrictions	(0.1)	-
Restricted by governing body primarily for long-term investing or for governing body approved outlays	(1,132.5)	(1,021.2)
Financial assets available to meet cash needs for general expenditures within one year	$ 115.4	$ 103.3

In addition to financial assets available to meet general expenditures over the next 12 months, the AMA operates under a policy that requires an annual budget surplus, excluding time- or dollar-limited strategic expenditures approved by the board, and anticipates generating sufficient revenue to cover general ongoing expenditures on an annual basis.

13. Contingencies

In the opinion of management, there are no pending legal actions for which the ultimate liability will have a material effect on the equity of the AMA.

14. Subsequent events

ASC Topic 855, *Subsequent Events*, establishes general standards of accounting for and disclosure of events that occur after the consolidated balance sheet date but before consolidated financial statements are issued or are available to be issued.

For the year ended December 31, 2024, the AMA has evaluated all subsequent events through February 14, 2025, which is the date the consolidated financial statements were available to be issued, and concluded no additional subsequent events have occurred that would require recognition or disclosure in these consolidated financial statements that have not already been accounted for.

15. Functional expenses

The costs of providing program and other activities have been summarized on a functional basis in the consolidated statements of activities. Certain costs have been allocated among the Membership; Publishing, Health Solutions and Insurance; Strategic Arcs and Core Mission Activities and other supporting services.

The expenses that are allocated and the method of allocation include the following: fringe benefits based on percentage of compensation and occupancy based on square footage. All other expenses are direct expenses of each functional area.

	Membership	Publishing, Health Solutions and Insurance	Investments (AMA only)	Strategic Arcs and Core Mission Activities	Governance, Administration and Operations	Health2047 and Subsidiaries	Total
Cost of products sold and selling expense	$ -	$ 23.7	$ -	$ -	$ -	$ -	$ 23.7
Compensation and benefits	7.4	72.6	-	86.3	105.4	7.7	279.4
Occupancy	0.6	5.5	-	6.8	6.1	0.8	19.8
Travel and meetings	0.1	3.9	-	7.5	8.5	0.4	20.4
Technology costs	1.1	12.5	-	7.4	13.2	0.2	34.4
Marketing and promotion	11.5	0.9	-	11.5	-	0.2	24.1
Professional services	0.4	6.5	0.2	19.4	5.1	3.6	35.2
Other operating expense	0.9	5.3	0.7	9.8	3.8	0.5	21.0
2024 total expense	**$ 22.0**	**$ 130.9**	**$ 0.9**	**$ 148.7**	**$ 142.1**	**$ 13.4**	**$ 458.0**
Cost of products sold and selling expense	$ -	$ 27.8	$ -	$ -	$ -	$ -	$ 27.8
Compensation and benefits	6.7	66.5	-	86.6	93.7	8.5	262.0
Occupancy	0.5	5.5	-	7.0	7.3	0.9	21.2
Travel and meetings	0.1	3.4	-	7.9	8.0	0.5	19.9
Technology costs	1.1	12.2	-	8.3	12.2	0.1	33.9
Marketing and promotion	10.5	1.2	-	8.3	-	0.7	20.7
Professional services	0.2	4.4	0.3	18.3	3.4	3.1	29.7
Other operating expense	0.9	5.1	0.4	12.1	3.8	2.8	25.1
2023 total expense	**$ 20.0**	**$ 126.1**	**$ 0.7**	**$ 148.5**	**$ 128.4**	**$ 16.6**	**$ 440.3**

Independent auditor's report

The Board of Trustees of American Medical Association

Opinion

We have audited the consolidated financial statements of American Medical Association (the "AMA") and subsidiaries, which comprise the consolidated statements of financial position as of December 31, 2024 and 2023, and the related consolidated statements of activities and cash flows for the years then ended, and the related notes to the consolidated financial statements (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the AMA as of December 31, 2024 and 2023, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the AMA and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the AMA's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Deloitte & Touche LLP
Chicago, Illinois
February 14, 2025

Written statement of certification of Chief Executive Officer and Chief Financial Officer

The undersigned hereby certify that the information contained in the consolidated financial statements of the American Medical Association for the years ended December 31, 2024 and 2023 fairly present, in all material respects, the financial condition and the results of operations of the American Medical Association.

James L. Madara, MD
Executive Vice President and Chief Executive Officer

Denise M. Hagerty
Senior Vice President and Chief Financial Officer

February 14, 2025

Officers and trustees



Standing committees

Executive Committee

Dr. Suk, chair
Dr. Aizuss
Dr. Scott
Dr. Mukkamala
Dr. Ehrenfeld
Dr. Ajayi
Dr. Egbert
Dr. Underwood

Audit Committee

Dr. Ding, chair
Ms. Breig
Dr. Butler
Dr. Egbert
Dr. Ehrenfeld
Dr. Ferguson
Dr. Underwood
Dr. Aizuss
Dr. Scott
Dr. Suk

Awards and Nominations

Dr. Heine, chair
Dr. Ajayi
Dr. Armstrong
Dr. Garretson
Dr. Jeffers
Ms. Siddiqui
Dr. Welsh
Dr. Scott
Dr. Aizuss
Dr. Suk
Dr. Underwood



Compensation Committee

Dr. Mukkamala, chair
Dr. Aizuss
Dr. Ajayi
Dr. Levin
Dr. Butler
Dr. Suk
Dr. Underwood
Dr. Scott

Governance and Self-Assessment Committee

Dr. Ehrenfeld, chair
Dr. Ding
Dr. Butler
Dr. Heine
Dr. Mukkamala
Dr. Suk
Dr. Aizuss
Dr. Underwood
Dr. Scott

Finance Committee

Dr. Butler, chair
Dr. Ding
Dr. Fryhofer
Dr. Ferguson
Dr. Koirala
Dr. Levin
Dr. Mukkamala
Dr. Scott
Dr. Suk
Dr. Underwood
Dr. Aizuss

Note: Drs. Suk, Aizuss and Underwood serve on all committees, except where otherwise noted, as ex-officio members without vote.
Dr. Scott serves on all committees as an ex-officio member with vote.

AMA
AMERICAN MEDICAL ASSOCIATION

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 04-A-25

Subject: AMA 2026 Dues

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee F

Our American Medical Association (AMA) last raised its dues in 1994. The AMA continues to invest in improving the value of membership. As our AMA's membership benefits portfolio is modified and enhanced, management will continuously evaluate dues pricing to ensure optimization of the membership value proposition.

RECOMMENDATION

2026 Membership Year

The Board of Trustees recommends no change to the dues levels for 2026, that the following be adopted and that the remainder of this report be filed:

Regular Members	$ 420
Physicians in Their Fourth Year of Practice	$ 315
Physicians in Their Third year of Practice	$ 210
Physicians in Their Second Year of Practice	$ 105
Physicians in Their First Year of Practice	$ 60
Physicians in Military Service	$ 280
Semi-Retired Physicians	$ 210
Fully Retired Physicians	$ 84
Physicians in Residency/Fellow Training	$ 45
Medical Students	$ 20

(Directive to Take Action)

Fiscal Note: No significant fiscal impact.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 22-A-25

Subject: Ranked Choice Voting

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee F

INTRODUCTION

Policy G-610.009 adopted at A-23, directs our AMA to study ranked choice voting. This report fulfills that directive.

> Our American Medical Association study ranked-choice voting for all elections within the House of Delegates.

BACKGROUND

Ranked choice voting (RCV) is a system of voting in which voters rank all candidates in order of preference rather than voting for an individual candidate. The winner is then identified with one ballot based on the number of votes received. There are two methods that could be used to calculate results with RCV. For the purposes of this discussion, we will describe them as the rank one system and the points system.

Rank one system with one open position

The rank one system assigns one vote to each first rank choice. The winning vote getter is the candidate who receives 50% + 1 of total votes cast. If the position is not filled based on the first-ranked ballots, the lowest vote getter is dropped, and there is a redistribution of the lowest ranked candidate's votes to the second-place ranked candidate on those ballots. If a winner is still not identified, another candidate is dropped with redistribution of those votes and so forth as necessary. This process is repeated until a candidate is elected.

Rank one system with multiple open positions

When there are multiple candidates for multiple positions, as occurs in HOD elections, a threshold (quota) is set to determine how many votes a candidate needs in order to win a seat. The most common formula is the Droop quota:

$$\text{Quota} = (\text{Total Votes}/\text{Positions}+1)+1$$

If a candidate reaches the quota by counting the first-ranked votes, they win a position. If a candidate has more votes than needed, their extra votes are redistributed to voters' next choices, using one of the following proportional transfer methods:

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- Fractional Transfer Method in which all votes for the elected candidate are transferred to the next preferred candidates at a reduced value, known as the transfer value. This value is calculated by dividing the surplus by the total number of votes the candidate received, ensuring that the total value of transferred votes equals the surplus.

- Random Selection Method in which a random sample of the elected candidate's ballots, equal to the number of surplus votes, is selected and transferred at full value to the next preferred candidates on those ballots.

If no candidate reaches the quota, the lowest-ranked candidate is eliminated, and their votes are transferred to the next choice on each ballot. This process continues until all positions are filled.

Points system

For the second method used in determining winners in RCV, a point value is attributed to each rank with the winning candidate/s having the highest point total. This system uses a majority of points earned not a tally of votes. Therefore, verifying a candidate has received a majority +1 of votes cast is not possible as each voter casts a "vote" for each candidate by assigning each a rank. Further complicating this methodology, the value assigned to each rank could be a source of considerable debate and lead to potential gaming of the system as voters consider how to rank the candidates.

Current RCV use

RCV has been used by a handful of American municipalities and in some international countries for decades. In recent years, some U.S. states and cities have considered or implemented RCV with varying degrees of acceptance and success. Internationally, Australia uses RCV for federal and state elections while Ireland uses it for presidential elections and parliamentary elections. The United Kingdom and New Zealand uses RCV for some local elections, with New Zealand exploring it further for other races. In the United States, Maine uses RCV for all statewide elections, while Alaska adopted RCV for both state and federal elections starting in 2022. Cities who have implemented RCV include Sante Fe, NM; Portland, ME; New York, NY; Minneapolis, MN and San Francisco, CA. Some state Democratic and Republican parties use RCV for their primaries or conventions. Several places have considered and ultimately decided not to implement it or have repealed it after initially adopting it including Massachusetts; Burlington, VT; Aspen, CO; North Dakota; and Tennessee.

Per their Internal Operating Procedures, the AMA Medical Student Section has utilized RCV as of their A-23 elections. In their brief experience, it worked well for contests with three or less candidates. However, with more than three candidates, the complexity of applying this methodology took considerable time to determine the winner. Note that the AMA MSS does not have multi-seat positions to fill as each position is singular.

DISCUSSION

Elections in our AMA HOD have multiple complexities that would preclude the application of ranked choice voting. Per our bylaws, candidates must receive a majoritiy+1 of votes cast to be elected. This would preclude the application of the RCV points system, previously described. In addition, AMA policy G-610.090 states that "the final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House." Given that RCV necessarily requires each voter to rank each candidate on their ballot, compliance with this policy would not be possible, even when utilizing the rank one system.

Our current electronic voting system provider, LUMI, indicated that their system could accommodate RCV, but the specific methodology would need to be defined, point vs rank one system. Additionally, for rank one multi-seat contests, the quotient (such as the Droop quota formula) and the redistribution method to be utilized would also need to be predetermined.

When queried about the possibility of using RCV, our LUMI providers specifically pointed out that applying either RCV methodology would significantly increase the time necessary to determine and verify each election outcome when compared to our current method, giving an immediate result followed by run-off votes as needed, as utilized in our Election Session.

CONCLUSION

The voting system used in our HOD should be fair, simple to administer and with easily verified results that can later be made public per our rules. Our current electronic system accomplishes these goals and has performed expediently at our recent Election Sessions. For elections such as ours, which include multiple candidates for multiple seats, RCV is considerably more complicated to administer. Additionally, using RCV would make it impossible to make public the results of our secret ballots as required in our policy. Therefore, your Board believes the additional complexities that RCV brings to the voting and tabulation processes would not benefit our HOD and recommends that we retain our current system.

RECOMMENDATION

The Board recommends that Policy G-610.009 be rescinded having been accomplished by this report and that the remainder of the report be filed.

Fiscal Note: Minimal

RELEVANT AMA POLICY

HOD Policy G-610.090 - AMA Election Rules and Guiding Principles

VIII. Election process

1. At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place their name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker.
2. Nominating speeches for unopposed candidates for office, except for President-elect, will not be heard.
3. AMA elections will be held on Tuesday at each Annual Meeting.
4. Voting for all elected positions including runoffs will be conducted electronically during an Election Session to be arranged by the Speaker.

5. All delegates eligible to vote must be seated within the House at the time appointed to cast their electronic votes.
6. The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.
7. The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 23-A-25

Subject: Financial Assistance to Facilitate Attendance at MSS Meetings

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee F

American Medical Association (AMA) Policy G-665.998, Mitigating the Cost of Medical Student Participation in AMA Meetings, directs the AMA in part to "explore alternate mechanisms to provide financial assistance to facilitate attendance at MSS meetings with a report back at the 2025 Annual Meeting."[1] As noted in BOT Report 35-A-24, from which AMA Policy G-665.998 originated, there are tax implications for AMA and for medical students of any travel assistance provided directly by AMA. For this reason, and as directed by AMA Policy G-665.998, this report provides an update solely on ongoing efforts to identify "alternate" funding mechanisms, which are sources of travel assistance apart from direct AMA funding. AMA Policy G-665.998 separately directs the AMA to "promote the value of membership and meeting attendance to encourage financial support by medical schools and other funding sources" and to "explore mechanisms to mitigate the cost of meeting attendance for medical students." While this work is also ongoing, it also is not the subject of this report.

BACKGROUND

BOT Report 35-A-24 examined the estimated costs and funding opportunities for medical student travel to AMA meetings. The report concluded that funding is available from a variety of sources, and that where funding is available, out-of-pocket student spending is modest. However, for students who cannot access funding, travel costs present a substantial barrier to meeting attendance.

BOT Report 35-A-24 also detailed existing sources of funding for student travel to AMA meetings, which include:

- The AMA Section Involvement Grant (SIG) program provides each local MSS section (i.e., medical school chapter) with up to two travel grants of up to $250 each per academic year. To receive a travel grant, the local section must have already submitted a SIG application for a recruitment, engagement, or community service event in the same program year. 61 SIG travel grants were awarded in 2024 (38 for Annual/Interim meetings and 23 for the Medical Student Advocacy Conference). Additionally, local MSS sections may use their AMA membership commission dollars (i.e., a portion of AMA membership revenue shared with them in exchange for recruiting new members) to fund member travel to MSS meetings. Both of these funding opportunities remain in place for 2025.

- AMA funds travel to Annual/Interim meetings for a select group of medical students who attend schools with historically low attendance at MSS meetings and who identify with

[1] See Appendix for full text of AMA Policy G-665.998.

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groups that are underrepresented or disadvantaged in medicine. In 2025, AMA will continue to award 28 of these travel grants of up to $500 each.

- Common non-AMA travel funding sources include medical schools, local MSS sections, and state/specialty medical societies.

UPDATE

Since the 2024 Annual Meeting, the AMA has collaborated with the AMA Foundation to develop a new leadership development program for medical trainees. Beginning in 2025, the Foundation's Leadership Development Institute (LDI) will include a new Health Policy and Patient Advocacy (HPPA) cohort. This new cohort will provide a year-long opportunity for medical students and residents/fellows to gain insight into health policy processes in organized medicine and state/federal government, as well as to develop leadership skills and competencies to become health policy and patient advocates. Benefits of participation include virtual education sessions and mentorship opportunities with seasoned physician members of the AMA, as well as funding support to attend select AMA meetings. These meetings include the AMA Medical Student Advocacy Conference (for medical student cohort members) or the AMA National Advocacy Conference (for resident/fellow cohort members) in the Spring, and culmination activities in conjunction with the AMA Annual Meeting in June. A total of 10 positions will be available in the inaugural HPPA cohort. Additional information about this opportunity is available at https://amafoundation.org/programs/leadership/. To be clear, this AMA Foundation initiative is not a travel funding opportunity. It serves as a unique example of an alternative way to engage more medical students in AMA advocacy.

Other alternate travel funding mechanisms remain to be explored, and the Board looks forward to providing an additional update in the future.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and the reminder of the report be filed:

1. That AMA policy G-665.998(3), Mitigating the Cost of Medical Student Participation in AMA Meetings, be amended by addition and deletion:

   (3) Our AMA will explore alternate mechanisms to provide financial assistance to facilitate attendance at MSS meetings with a report back at the ~~2025~~ 2026 Annual Meeting. (Modify HOD Policy)

Fiscal Note: Modest – between $1,000 and $5,000

Appendix: Relevant AMA Policy

G-665.998 Mitigating the Cost of Medical Student Participation in AMA Meetings

1. Our American Medical Association will promote the value of membership and meeting attendance to encourage financial support by medical schools and other funding sources.

2. Our AMA will explore mechanisms to mitigate the cost of meeting attendance for medical students.

3. Our AMA will explore alternate mechanisms to provide financial assistance to facilitate attendance at MSS meetings with a report back at the 2025 Annual Meeting.

REPORT OF THE BOARD OF TRUSTEES (A-25)
Creation of an AMA Council with a Focus on Digital Health Technologies and AI
Reference Committee F

EXECUTIVE SUMMARY

At the 2024 Annual Meeting of the House of Delegates, Policy G-615.998, "Creation of an AMA Council with a Focus on Digital Health Technologies and AI," was adopted, which directed the American Medical Association (AMA) to establish a task force by the 2024 Interim Meeting focused on digital health, technology, informatics, and augmented/artificial intelligence with the potential to transition of this task force to a new council and report back at the 2025 Annual Meeting on this transition.

In September 2024, a task force charter was proposed to and approved by the AMA Board of Trustees. The AMA Task Force on AI, Digital Health, and Informatics was set to be established by the 2024 Interim Meeting and remain active through 2026 to assess long-term HOD input on AI, digital health, and informatics, identify resource and policy gaps, and amplify physicians' voices in health care technology advancements. It was determined that a decision would be made on the long-term model for HOD input after two years.

The task force was launched at the 2024 Interim meeting and comprised 22 individuals including members from the Board, AMA councils, delegate and alternate delegates, AMA group members, and members from the public.

The task force held its inaugural meeting in February 2025 to introduce members, establish goals, and outline key needs for developing recommendations. Members received an overview of the AMA's structure and its ongoing work in digital health, AI, and informatics. Discussions centered on defining success, setting priorities, and identifying necessary resources for informed recommendations by the end of the two-year charter period. The task force is reflecting on these initial discussions to refine its focus and informational needs, with the next meeting set for June 2025 and additional virtual sessions to occur as needed.

This report also provides relevant AMA resources and policy. Resources include research, educational content, specialty collaboratives, networking communities comprising physicians and leadership across the health care technology industry, and events. AMA policy areas include electronic health records (meaningful use, interoperability, and documentation), AI (misinformation, medical education, and prior authorization), data privacy, payment for electronic communications, the use of mobile health technology in practices, and telehealth (ethics, licensure, equity, coding, and reimbursement).

The Board of Trustees recommends that Policy G-615.998, "Creation of an AMA Council with a Focus on Digital Health Technologies and AI," be rescinded as having been fulfilled by this report.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 24-A-25

Subject: Creation of an AMA Council with a Focus on Digital Health Technologies and AI

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee F

INTRODUCTION

At the 2024 Annual Meeting of the House of Delegates (HOD), Policy G-615.998, "Creation of an AMA Council with a Focus on Digital Health Technologies and AI," was adopted and directed the AMA to establish a task force by I-24 focused on digital health, technology, informatics, and augmented/artificial intelligence (AI) with the potential to transition of this task force to a new council and report back at A-25 on this transition.

BACKGROUND:

Management (MGMT) report 9-I-24

While the AMA has internal staff focused on supporting physicians with optimizing existing technology and preparing for the future of health care technology, the AMA currently does not have an advisory body that is dedicated to guiding the success of technology adoption. With the volume of resolutions around the topic of technology over the last few years, the HOD called for the creation of a task force focused on digital health technologies, AI, and clinical informatics.

A task force charter (MGMT Report 9-I-24) was proposed and approved by the AMA Board of Trustees in September 2024. The AMA Task Force on AI, Digital Health, and Informatics was set to be established by the 2024 Interim Meeting and remain active through 2026 to assess long-term HOD input on AI, digital health, and informatics, identify gaps in resources and AMA policy, and ensure physicians' voices shape health care technology advancements. It was determined that after two years, a decision would be made on the long-term model for HOD input.

As outlined in the charter, the 22-member task force would include representation from the AMA board of trustees (BOT), council, and HOD, in addition to two to four members of the public. The task force would have two co-chairs. Councils would nominate representatives, with additional suggestions from the Senior Management Group. HOD members were permitted to self-nominate, and final approval rested with the AMA Board Chair.

Members would commit to four in-person meetings over two years in addition to two to three virtual meetings per year. Regular updates were scheduled to be presented at AMA Annual and Interim Meetings, with reports provided to the AMA BOT as requested.

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DISCUSSION

Task force members

The AMA Task Force on AI, Digital Health, and Informatics was launched at the 2024 Interim meeting. The following 22 individuals were selected to serve on the task force:

Michael Suk, MD, JD, MPH, MBA and David Aizuss, MD from the BOT serve as Task Force Co-Chairs. They are joined by fellow BOT and task force member Lynn Jeffers, MD. Representation from AMA councils include: Rebecca Brendel, MD, JD from the AMA Council on Ethics and Judicial Affairs who has observer status; Seema Sidhu, MD from the Council on Medical Education; Steven L. Chen, MD, MBA from the AMA Council on Medical Service; Tripti Kataria, MD, MPH, MBA, FASA from the Council on Legislation; Padmini Ranasinghe, MD, MPH, FACP, FACPM from the Council on Science and Public Health; Gary R. Katz, MD, MBA, FACEP who represents the Council on Long Range Planning & Development; and Jerry Abraham, MD, MPH, CMQ, Chair of the Council on Constitution and Bylaws.

Delegate task force members include: Ohio delegate, Robyn Chatman, MD, MPH, FAAFP, CPHIMS, CHEP; Young Physicians Section alternate delegate, Christopher Libby, MD, MPH, FACEP; Medical Student Section alternate delegate, Druv Bhagavan; American College of Radiology alternate delegate, Adam Prater, MD, MPH; College of American Pathologists delegate, Mark Synovec, MD; and Department of Veterans Affairs delegate, Carolyn Maureen Clancy, MD, MACP.

Representatives from AMA Group Members include Sanford Health's Roxana Lupu, MD, MBA and Kaiser Permanente's Vincent Liu, MD, MSc.

Lastly, the task force includes members of the public: Tom Lawry from Second Century Tech, LLC, Eric Langshur of Abundant Ventures, Lisa Dykstra of CHIME, and John Whyte, MD, MPH of WebMD.

Status update

The task force held its inaugural formal meeting on February 16, 2025. This meeting provided an opportunity to introduce members, establish initial goals and objectives, and discuss the key needs required to develop informed recommendations.

During the session, members received an overview of the AMA's organizational structure and existing AMA work related to digital health, AI, and informatics, including available resources, content, advocacy efforts, and collaborations. Additionally, an expert guest speaker delivered a presentation on AI deployment within Advocate Health, outlining key areas of focus, risk mitigation strategies, current use cases, and potential opportunities for the AMA to enhance its leadership in the AI landscape.

The task force has divided its objectives into two primary focus areas:

1. Positioning the AMA as the Critical Voice for Physicians in AI and Digital Health: Identifying key opportunities for the AMA to assert itself as the definitive and unique representative of physicians in the evolving landscape of AI, digital health, and informatics.

2. Developing Cross-Organizational Governance Concepts: Creating appropriate governance frameworks that span the AMA's organizational structure to ensure a cohesive and strategic approach to AI and digital health initiatives.

To further refine these focus areas, task force members engaged in discussions centered on the following key questions:

1. What does success look like for this task force?
2. What should be the key priorities and action items?
3. What is needed to make a well-informed recommendation at the end of the two-year charter period?

The task force is currently synthesizing insights from the initial meeting and working to define specific areas of focus and additional informational needs that will guide its final recommendations. The next meeting is scheduled for June 12, 2025, with additional virtual meetings to be scheduled as needed.

In the interim, AMA staff will continue to provide updates on existing AMA initiatives related to AI, digital health, and clinical informatics, ensuring the task force has a comprehensive understanding of ongoing internal efforts.

AMA research and resources on AI, digital health, and clinical informatics

The AMA is committed to researching health care technology, including AI and digital health landscape, and developing resources and programming to support physicians in getting involved in the design, development, and deployment of these tools across the industry.

In February 2024, the AMA released a foundational AI landscape report as part of its Future of Health work titled, "The Emerging Landscape of Augmented Intelligence in Health Care". The report aims to create a common lexicon for AI in health care, explore the risks, identify current and future use cases, and provide guidance for physicians looking to leverage these tools in practice today.

In November 2024, the AMA repeated its AI Physician Sentiments survey to continue to understand physician sentiments around AI, including opportunities, current use cases and needs around education and support for the implementation and use of AI. Compared to 2023, we saw a significant increase in physician excitement over AI and current use of AI.

The AMA ChangeMedEd initiative works with partners across the medical education continuum to help produce a physician workforce that meets the needs of patients today and in the future. As part of these efforts, an Artificial Intelligence in Health Care learning series was recently published on the AMA EdHub. These modules are geared towards medical students and physician learners, and introduce key concepts related to artificial intelligence and machine learning in health care.

The AMA has also crafted a framework to promote the development and use of responsible, evidence-based, unbiased and equitable health care AI. This ethics-evidence-equity framework envisions the use of AI to advance the quadruple aim – enhancing patient care, improving population health and clinician work life and reducing costs – and defines the responsibilities of developers, health care organizations (deployers), and physicians to put the framework into action. In 2024, the AMA created an AI Specialty Collaborative with over 22 specialty associations signing up to participate. The goal of the collaborative is to ensure the physician voice is leading in

a united way as AI in health care continues to expand. This group will continue to come together in 2025 following strong interest in keeping this collaborative going for another year. Additionally, The AMA Physician Innovation Network (PIN) is a network of physicians that aims to connect them with research-driven content and programs to make clinical technology work for them.

The AMA's Digital Health Implementation Playbooks help physicians better integrate technology solutions into clinical practice and extend care beyond the exam room. Developed in collaboration with more than 30 partners, the Playbooks offers medical care teams and administrators a guide to the most efficient path for applying digital health solutions, including key steps, best practices, and resources to accelerate and achieve technology adoption. Current playbooks and reports cover telehealth, remote patient monitoring, and health at home, with others in development focused on clinical informatics, AI governance, and creating an integrated technology roadmap.

AMA's Future of Digital Health Blueprint is an initiative developed to establish standards for optimized digital health, including re-centering care around the patient-physician relationship, adopting payment models that support high-value care, designing with an equity lens, and creating technologies that reduce fragmentation. This body of work includes real-world case studies, a Return on Health framework, and various issue briefs, all designed to advance digitally enabled care.

The AMA STEPS Forward Innovation Academy has tools, resources, and programming designed to guide physicians, practices, and health systems in optimizing and sustaining telehealth and other clinical technologies at their organizations. This includes an upcoming AI Governance Learning Collaborative kicking off in April 2025.

The AMA developed the CPT® Developer Program to assist developers in translating ideas into innovations. The program is dedicated to developers' needs and providing them with access to high quality AMA CPT content and resources.

AMA POLICY

The AMA has a significant amount of existing policies relevant to topics impacting health care technology, AI, and digital health (including telehealth).

Electronic Health Records (EHR) Policies

Redefining "Meaningful Use" of Electronic Health Records

The AMA will work with the federal government and the Department of Health and Human Services to: (1) set realistic targets for meaningful use of EHRs such as percentage of computerized order entry, electronic prescribing, and percentage of inclusion of laboratory values; and (2) improve the EHR incentive program requirements to maximize physician participation.

In addition, AMA will continue to advocate that, within existing AMA policies, the Centers for Medicare and Medicaid Services (CMS) suspend penalties to physicians and health care facilities for failure to meet Meaningful Use criteria (Policy D-478.982, "Redefine "Meaningful Use" of Electronic Health Records").

EHR Interoperability

Our AMA will enhance efforts to accelerate development and adoption of universal, enforceable EHR interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System.

AMA supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange.

Our AMA will: (1) develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges; (2) continue efforts to promote interoperability of EHRs and clinical registries; (3) seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates; and (4) seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private.

Additionally, AMA will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care.

AMA will also seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology (ONC) to establish regulations that require universal and standard interoperability protocols for EHR vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data.

Further, AMA will review and advocate for the implementation of appropriate recommendations from the "Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care," a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the ONC, and the CMS (Policy D-478.972, "EHR Interoperability").

Physician Time Spent with Patients and on Hospital Documentation

AMA policy on the time physicians spend with their patients and on hospital documentation is as follows:

1. AMA advocates for continued research into quality determinants--including time spent with patients--and lead the effort to develop and appropriately implement quality indicators, i.e., clinical performance measures;
2. AMA will continue to work with (1) accrediting bodies and government agencies to substantially reduce hospital paperwork; and (2) EHR system developers to ensure that the perspectives of practicing physicians are adequately incorporated, to ensure the standardization and integration of clinical performance measures developed by physicians for physicians, and to ensure a seamless integration of the EHR into the day-to-day practice of medicine (Policy D-450.980, "Physician Time Spent with Patients and with Hospital Documentation")

Health Information Technology (HIT) Principles

Our AMA will: promote the development of effective EHRs in accordance with the following HIT principles. Effective HIT should:

1. Enhance physicians' ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.

Our AMA will also utilize HIT principles to:

1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of "Information Blocking."

It is AMA policy that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules (Policy H-478.981, "Health Information Technology Principles").

Technology and the Practice of Medicine

Further, AMA encourages the collaboration of existing AMA Councils and working groups on matters of new and developing technology, particularly EHRs and telemedicine (Policy G-615.035, "Technology and the Practice of Medicine").

AI Policies

The Potentially Dangerous Intersection Between AI and Misinformation

Regarding the potentially dangerous intersection between AI and misinformation, AMA (1) will study and develop of recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other AI-generated medical advice or content, and that our AMA propose appropriate state and federal regulations; (2) work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice; (3) encourage physicians to educate our patients about the benefits and risks of consumers facing LLMs including GPTs; and (4) support publishing groups and scientific journals to establish guidelines to regulate the use of AI in scientific publications that include detailing the use of AI in the methods, exclusion of AI systems as authors, and the responsibility of authors to validate the veracity of any text generated by AI (Policy H-480.935, "Assessing the Potentially Dangerous Intersection Between AI and Misinformation").

AI in Medical Education

Further, AMA encourages: (1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards; (2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI; (3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes; (4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules; (5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems; (6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies; (7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients; (8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies; (9) institutional leaders and academic deans to proactively accelerate the inclusion of non-clinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and (10) close collaboration with and oversight by practicing physicians in the development of AI applications (Policy H-295.857, "Augmented Intelligence in Medical Education").

Use of AI for Prior Authorization

Regarding the use of AI for prior authorization, AMA advocates for greater regulatory oversight of the use of AI for review of patient claims and prior authorization requests, including whether insurers are using a thorough and fair process that:

1. Is based on accurate and up-to-date clinical criteria derived from national medical specialty society guidelines and peer reviewed clinical literature;
2. Includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise for the service under review; and
3. Requires such reviews include human examination of patient records prior to a care denial (Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization).

AI in Health Care

As a leader in American medicine, AMA has a unique opportunity to ensure that the evolution of AI in medicine benefits patients, physicians, and the health care community. To that end, AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that: (1) is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team; (2) is transparent; conforms to leading standards for reproducibility; (3) identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including

when testing or deploying new AI tools on vulnerable populations; and (4) safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.

4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI (Policy H-480.940, "Augmented Intelligence in Health Care").

The AMA also supports the use and payment of AI systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end, AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on clinical validation, alignment with clinical decision-making that is familiar to physicians, and high-quality clinical evidence.
4. Payment and coverage for health care AI systems must be informed by real world workflow and human-centered design principles; enable physicians to prepare for and transition to new care delivery models; support effective communication and engagement between patients, physicians, and the health care team; seamlessly integrate clinical, administrative, and population health management functions into workflow; and seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, AMA opposes:
    a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage
    b. The imposition of costs associated with acquisition, implementation, and maintenance of health care AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. The AMA will further advocate:

a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.

8. Alongside national medical specialty societies and state medical associations, AMA will: (1) identify areas of medical practice where AI systems would advance the quadruple aim; (2) leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts; (3) outline new professional roles and capacities required to aid and guide health care AI systems; and (4) develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders.
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it (Policy H-480.939, "Augmented Intelligence in Health Care").

Data Privacy & Payment Policies

Supporting Improvements to Patient Data Privacy

The AMA will strengthen patient and physician data privacy protections by advocating for legislation that reflects the AMA's Privacy Principles with particular focus on mobile health apps and other digital health tools, in addition to non-health apps and software capable of generating patient data. Further, the AMA will work with appropriate stakeholders to oppose using any personally identifiable data to identify patients, potential patients who have yet to seek care, physicians, and any other health care providers who are providing or receiving health care that may be criminalized in a given jurisdiction (Policy D-315.968, "Supporting Improvements to Patient Data Privacy").

Clinical Information Technology Assistance

The AMA supports a full refundable federal tax credit or equivalent financial mechanism to indemnify physician practices for the cost of purchasing and implementing clinical information technology, including EHR systems, e-prescribing and other clinical information technology tools, in compliance with applicable safe harbors (Policy D-478.990, "Clinical Information Technology Assistance").

Payment for Electronic Communications

Moreover, the AMA will: (1) advocate that pilot projects of innovative payment models be structured to include incentive payments for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, and email and telephone communications; (2) continue to update its guidance on communication and information

technology to help physicians meet the needs of their patients and practices; and (3) educate physicians on how to effectively and fairly bill for electronic communications between patients and their physicians (Policy H-385.919, "Payment for Electronic Communication").

Mobile Health Technology

Regarding the integration of mobile health technology into practice, AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that:

1. Support the establishment or continuation of a valid patient-physician relationship;
2. Have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness;
3. Follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive health outcomes;
4. Support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication;
5. Support data portability and interoperability in order to promote care coordination through medical home and accountable care models;
6. Abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app;
7. Require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and
8. ensure that the delivery of any services via the app be consistent with state scope of practice laws.

AMA also supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information.

AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.

AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.

The AMA encourages physicians to (1) consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws; and (2) alert patients to the potential privacy and security risks of any mHealth apps that they prescribe or recommends, and document the patient's understanding of such risks.

Additionally, AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy, and encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and

associated devices into care delivery (Policy H-480.943, "Integration of Mobile Health Applications and Devices into Practice").

Telehealth Policies

Ethical Practice in Telemedicine

The AMA also has an array of policies regarding telehealth including ethics, equity, reimbursement, licensure, and coding.

Physicians who respond to individual health queries or provide personalized health advice electronically through a telehealth service in addition should:

1. Inform users about the limitations of the relationship and services provided.
2. Advise site users about how to arrange for needed care when follow-up care is indicated.
3. Encourage users who have primary care physicians to inform their primary physicians about the online health consultation, even if in-person care is not immediately needed.
4. Physicians who provide clinical services through telehealth/telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. In the context of telehealth/telemedicine they further should:
5. Be proficient in the use of the relevant technologies and comfortable interacting with patients and/or surrogates electronically.
6. Recognize the limitations of the relevant technologies and take appropriate steps to overcome those limitations. Physicians must ensure that they have the information they need to make well-grounded clinical recommendations when they cannot personally conduct a physical examination, such as by having another health care professional at the patient's site conduct the exam or obtaining vital information through remote technologies.
7. Be prudent in carrying out a diagnostic evaluation or prescribing medication by: (1) establishing the patient's identity; (2) confirming that telehealth/telemedicine services are appropriate for that patient's individual situation and medical needs; (3) evaluating the indication, appropriateness and safety of any prescription in keeping with best practice guidelines and any formulary limitations that apply to the electronic interaction; and (4) documenting the clinical evaluation and prescription.
8. When the physician would otherwise be expected to obtain informed consent, tailor the informed consent process to provide information patients (or their surrogates) need about the distinctive features of telehealth/telemedicine, in addition to information about medical issues and treatment options. Patients and surrogates should have a basic understanding of how telemedicine technologies will be used in care, the limitations of those technologies, the credentials of health care professionals involved, and what will be expected of patients for using these technologies.
9. As in any patient-physician interaction, take steps to promote continuity of care, giving consideration to how information can be preserved and accessible for future episodes of care in keeping with patients' preferences (or the decisions of their surrogates) and how follow-up care can be provided when needed. Physicians should assure themselves how information will be conveyed to the patient's primary care physician when the patient has a primary care physician and to other physicians currently caring for the patient.
10. Collectively, through their professional organizations and health care institutions, physicians should:

a. Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care.
b. Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically.
c. Routinely monitor the telehealth/telemedicine landscape to:
d. Identify and address adverse consequences as technologies and activities evolve; and
e. Identify and encourage dissemination of both positive and negative outcomes (Policy 1.2.12, "Ethical Practice in Telemedicine").

Evolving Impact of Telemedicine

Our AMA:

1. Will evaluate relevant federal legislation related to telemedicine;
2. Urges (1) CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship; and (2) professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
3. Encourages (1) professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice; and development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
4. Will work with (1) CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms; and the Federation of State Medical Boards (FSMB) and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries;
5. Will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine; and
6. Will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted (Policy H-480.974, "Evolving Impact of Telemedicine").

Licensure and Telehealth

Additionally, the AMA will work with the FSMB, state medical associations and other stakeholders to encourage states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient in the state without penalty if the following conditions are met:

1. The physician has an active license to practice medicine in a state or US territory and has not been subjected to disciplinary action.
2. There is a pre-existing and ongoing physician-patient relationship.
3. The physician has had an in-person visit(s) with the patient.
4. The telehealth services are incident to an existing care plan or one that is being modified.

5. The physician has verified that the telehealth services are covered under the physician's medical liability insurance policy that satisfies applicable state legal requirements.
6. Telehealth use complies with Health Insurance Portability and Accountability Act privacy and security rules.

It is the policy of our AMA that a state with a patient compensation fund should consider the impact on the fund of telehealth use by out-of-state physicians providing continuity of care to existing patients in the fund's state. Physicians and patients should be made aware that a state's patient compensation fund may not be applicable when care using interstate telehealth is provided (Policy D-480.960, "Licensure and Telehealth").

Equity in Telehealth and Health Technology

The AMA also recognizes access to broadband internet as a social determinant of health.

The AMA encourages (1) initiatives to measure and strengthen digital literacy, with appropriate education programs, and with an emphasis on programs designed with and for historically marginalized and minoritized populations; and (2) telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations.

AMA supports efforts to design and to improve the usability of existing EHR and telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with other mental or physical disabilities.

AMA encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.

AMA supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations. AMA also supports efforts to ensure payers allow all contracted physicians to provide care via telehealth.

AMA is opposed to efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians.
AMA will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

The AMA encourages the development of improved solutions to incorporate structured advance care planning (ACP) documentation standards that best meet the requisite needs for patients and physicians to easily store and access in the EHR complete and accurate ACP documentation that maintains the flexibility to capture unique, patient-centered details.

Further, AMA encourages hospitals, health systems, and physician practices to provide a method other than electronic communication for patients who are without technological proficiency or access (Policy H-480.937, "Addressing Equity in Telehealth and Health Technology").

Standardized Coding for Telehealth Services

Regarding coding, AMA policy supports legislation, regulation and/or advocacy to public and private payors, whichever is relevant, to ensure that payors utilize consistent reporting and coding rules to identify telehealth services in claims (Policy H-190.954, "Standardized Coding for Telehealth Services").

Reimbursement for Telehealth

Related to reimbursement, AMA will work with third-party payers, CMS, Congress and interested state medical associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians (Policy D-480.965, "Reimbursement for Telehealth").

CONCLUSION

Given the task force has a two-year term, this report serves as an update on progress to-date. The task force members continue to discuss areas of focus and identify key needs required to develop an informed recommendation by the 2026 Interim meeting.

RECOMMENDATIONS

The Board of Trustees recommends that Policy G-615.998, "Creation of an AMA Council with a Focus on Digital Health Technologies and AI," be rescinded as having been fulfilled by this report and that the remainder of this report be filed.

Fiscal Note: $330,000

JOINT REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS AND THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CCB/CLRPD Report 1-A-25

Subject: Joint Council Sunset Review of 2015 House Policies

Presented by: Jerry P. Abraham, MD, MPH, Chair, Council on Constitution and Bylaws
Michelle A. Berger, MD, Chair, Council on Long Range Planning and Development

Referred to: Reference Committee F

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.110 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates (House) adopts policies, a maximum 10-year time horizon shall exist. A policy will typically sunset after 10 years unless action is taken by the House to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy (per Policy G-600.111(4), The consolidation process permits editorial amendments for the sake of clarity, so long as the proposed changes are transparent to the House and do not change the meaning); (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

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6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

The Councils on Constitution and Bylaws and Long Range Planning and Development recommend that the House policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-350.984	Reducing Discrimination in the Practice of Medicine and Health Care Education	Our American Medical Association will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.	1. Retain D-350.984 as editorially amended for accuracy; 2. Consolidate D-350.984 with H-65.952 as follows: H-69.952, Racism as a Public Health Threat. 1. Our American Medical Association 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 encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: The causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; How to prevent and ameliorate the health effects of racism. 4. Our AMA: supports the development of policy to combat racism and its effects; 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. 5. ~~D-350.984~~ Our American Medical Association ~~will pursue avenues to~~

Policy Number	Title	Text	Recommendation
			supports collaborating ~~collaborate~~ with public health organizations ~~the American Public Health Association's National Campaign Against Racism~~ on their campaigns against racism ~~in those areas~~ where aligned with AMA's current activities ~~align with the campaign~~. 6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies. *Note:* The APHA's Campaign Against Racism, conceived by APHA past president Dr. Camara Jones, transitioned from APHA to EqualHealth.
D-445.998	Confusion Regarding Use of the Term "Doctor"	Our AMA will strongly encourage the media to require that the actual degree be affixed to the name of all who endorse health-related products.	Retain D-445.998. Still Relevant.
D-630.968	Donating Reimbursements to the American Medical Association Foundation	Our AMA will add verbiage to its non-staff expense form directing individuals to the AMA Foundation's website should they wish to make a contribution.	Sunset D-630.968. The action requested was accomplished. Beginning in 2015, expense reimbursement forms have included the following language, "Please consider a donation to the AMA Foundation [website and phone # provided.]"
G-615.035	Technology and the Practice of Medicine	Our AMA encourages the collaboration of existing AMA Councils and working groups on matters of new and developing technology, particularly electronic medical records (EMR) and telemedicine.	Sunset G-615.035. Superseded by more recent policies including G-615.998, Creation of an AMA Council with a Focus on Digital Health Technologies and AI. [The task force includes leadership from all AMA Councils.]
G-640.005	AMA Advocacy Analysis	Our AMA Board of Trustees will provide a report to the House of Delegates at each Interim Meeting highlighting the prior year advocacy activities to include efforts, successes, challenges, and recommendations / actions to further optimize advocacy efforts.	Retain. Still Relevant.

Policy Number	Title	Text	Recommendation
H-140.840	Filming Patients for News or Entertainment	American Medical Association policy is that efforts to disguise a patient (such as blurring the face, changing the voice, or any other technique) do not substitute for the need to obtain consent, as outlined in AMA Ethical Opinion E-5.045, for publication of any material related to the treatment of a patient.	Retain H-140.840 as editorially amended for accuracy as follows: H.140.840, Filming Patients for News or Entertainment. American Medical Association policy is that efforts to disguise a patient (such as blurring the face, changing the voice, or any other technique) do not substitute for the need to obtain consent, as outlined in the AMA Code of Medical Ethics Ethical Opinion-E-3.1.4, Audio or Visual Recording of Patients for Public Education ~~E-5.045, for publication of any material related to the treatment of a patient~~. *Note:* When the AMA Code of Medical Ethics was modernized in 2016, Opinion #s changed.
H-140.997	Patient Advocacy	Our AMA believes that physicians are the primary patient advocates, are not rationers of medical care, and will continue to utilize diagnostic and therapeutic measures and facilities in the best interest of the individual patient.	Retain H-140.997. Still Relevant.
H-175.972	Plea Bargaining and Immunity from Prosecution	Our AMA opposes the use of harassment and coercive plea bargaining by prosecutors to pressure physicians.	Retain Policy H-175.972. Still Relevant.
H-265.990	Expert Witness Affirmation	AMA policy is that all physicians, serving as expert witnesses in medical liability litigation, voluntarily sign an expert witness affirmation explicitly stating that they will adhere to the AMA's principles guiding expert witness testimony.	Sunset. This policy dates back to 2004; AMA legal counsel notes that once such an affirmation is signed, it is likely discoverable and would be an opening for opposing counsel to question the credibility of the witness. Conceivably, it might also disqualify the witness. *Note*: AMA has more recent policy related to expert witnesses, including H-265.992, Expert Witness Testimony, H-265.994, Expert Witness Testimony, and H-265.995, Guidelines for Expert Witness. The AMA Code of Medical Ethics also addresses expert witness testimony.
H-40.966	Military Medical Policies Affecting Transgender Individuals	Our American Medical Association affirms that there is no medically valid reason to exclude transgender individuals from service in the US military and	Retain Policy H-40.960. Still Relevant.

Policy Number	Title	Text	Recommendation
		affirms transgender service members be provided care as determined by patient and physician according to the same medical standards that apply to non-transgender personnel.	
H-480.988	Allocation of Privileges to Use Health Care Technologies	The AMA (1) affirms the need for the Association and specialty societies to enhance their leadership role in providing guidance on the training, experience and knowledge necessary for the application of specific health care technologies; (2) urges physicians to continue to ensure that, for every patient, technologies will be utilized in the safest and most effective manner by health care professionals; and (3) asserts that licensure of physicians by states must be based on scientific and clinical criteria.	Retain Policy H-480.988. Still Relevant.
H-520.995	Nuclear Weapons Reduction	The AMA supports continued efforts to publicize its position that there is no adequate medical response to nuclear war.	1. Retain Policy H-520.995; 2. Consolidate with Policy H-520.999 into a single comprehensive policy as follows: H-520.999, Opposition to Nuclear War. (1). The AMA recognizes the catastrophic dangers to all life in the event of nuclear war and supports efforts for the prevention of such a nuclear holocaust. ~~H-520.995, Opposition to Nuclear War Nuclear Weapons Reduction.~~ (2) The AMA supports continued efforts to publicize its position that there is no adequate medical response to nuclear war.
H-520.996	Arms Reduction	The AMA encourages the President and Congress to continue the process of bilateral and verifiable nuclear arms reduction.	1. Retain Policy H-520.996; 2. Consolidate with H-520.994 and H-520.988 into a single comprehensive policy as follows: H-520.996, Arms Reduction. (1) ~~H-520.994, Nuclear Test Ban.~~ The AMA acknowledges the threat from nuclear weapons to the health of the people of the world and favors the establishment of a mutual, verifiable, and comprehensive nuclear test ban. (2) ~~H-520.988, Abolition of Nuclear Weapons and Other Weapons of Mass and Indiscriminate Destruction.~~ The AMA supports the elimination by all nations of nuclear weapons and other weapons

Policy Number	Title	Text	Recommendation
			of mass and indiscriminate destruction. (3) The AMA encourages the President and Congress to continue the process of bilateral and verifiable nuclear arms reduction.
H-65.966	Physicians Response to Victims of Human Trafficking	1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking. Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims. The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children. The Polaris Project - In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project: - Operates a 24-hour National Human Trafficking Hotline - Maintains the National Human Trafficking Resource Center, which provides a. An assessment tool for health care professionals b. Online training in recognizing and responding to human trafficking in a health care context	1. Retain H-65.966. 2. Sunset D-170.992, Human Trafficking / Slavery Awareness (as it is superseded by more current policy; 3. Consolidate H-65.966 and H-440.814 into a single comprehensive Policy as follows: H-65.966,Physicians Response to Victims of Human Trafficking. 1. Our AMA encourages its ~~Member Groups and Sections~~ members, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking. Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims. ~~The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.~~ ~~The Polaris Project -~~ ~~In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:~~ ~~- Operates a 24-hour National Human Trafficking Hotline~~

Policy Number	Title	Text	Recommendation
		c. Speakers and materials for in-person training d. Links to local resources across the country The Rescue & Restore Campaign - The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals. 2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.	~~- Maintains the National Human Trafficking Resource Center, which provides~~ ~~a. An assessment tool for health care professionals~~ ~~b. Online training in recognizing and responding to human trafficking in a health care context~~ ~~c. Speakers and materials for in-person training~~ ~~d. Links to local resources across the country~~ ~~The Rescue & Restore Campaign - The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.~~ 2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs. 3. ~~H-440.814, Distribution and Display of Human Trafficking Aid Information in Public Places~~ ~~1.~~ Our AMA policy is that readily visible signs, notices, posters, placards, and other readily available educational materials providing information about reporting human trafficking activities or providing assistance to victims and survivors be permitted in local clinics, emergency departments, or other medical settings. 4. ~~2.~~ Our AMA, through its website or internet presence, will provide downloadable materials displaying the National Human Trafficking Hotline number to aid in displaying such information in local clinics, emergency departments, or other medical settings and advocate that other recognized medical professional organizations do the same.

Policy Number	Title	Text	Recommendation
			5. ~~3.~~ Our AMA urges the federal government to make changes in laws to advocate for the broad posting of the National Human Trafficking Hotline number in areas such as local clinics, emergency departments, and other medical settings. *N*ote: US Department of State website includes definitions/details about what specific bureaus are doing to support this policy issue. The definition of human trafficking continues to evolve. The AMA *Code of Medical Ethics* offers physicians guidance on their obligation to take appropriate action. AMA's website provides additional resources.
H-65.997	Human Rights	Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.	Sunset. Duplicative of Policy H.65.991 (see below).
H-65.981	Human Rights and Health Professionals	The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims.	1. Retain. 2. Consolidate with H-65.991 into a single comprehensive policy (see below)
H-65.991	Persecution of Physicians for Political Reasons and Participation by Doctors in Violations of Human Rights	The AMA (1) reiterates its endorsement of the 1975 World Medical Association Declaration of Tokyo which provides guidelines for physicians in cases of torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment; (2) opposes participation by physicians in the torture or inhuman treatment or punishment of individuals in relation to detention and imprisonment; and (3) expresses its sympathy to those physicians who have been subject to imprisonment or torture because of their	1. Retain. 2. Consolidate with H-65.981 as editorially amended as follows: H-65.981, Human Rights and Health Professionals. 1. The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims. 2. ~~H-65.991~~ The AMA ~~(1)~~ reiterates its endorsement of the ~~1975~~ World Medical Association Declaration of Tokyo: Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or

Policy Number	Title	Text	Recommendation
		humanitarian efforts to improve the health of their patients.	Punishment in Relation to Detention and Imprisonment, which ~~provides guidelines for physicians in cases of torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment;~~ ~~(2)~~ opposes participation by physicians in ~~the~~ torture or other forms of cruel, inhuman or degrading procedures on detainees or prisoners. ~~inhuman treatment or punishment of individuals in relation to detention and imprisonment; and~~ ~~(3)~~ The AMA expresses its sympathy to those physicians who have been subject to imprisonment or torture because of their humanitarian efforts to improve the health of their patients. *Note:* Link to WMA Declaration of Tokyo: Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment (which has been amended several times since 1975). The AMA Code of Medical Ethics also addresses this issue.

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-A-25

Subject: International Medical Graduates Section Five-Year Review

Presented by: Michelle Berger, MD, Chair

Referred to: Reference Committee F

The Council on Long Range Planning and Development (CLRPD) analyzed information from a letter of application submitted in June 2024 from the International Medical Graduates Section (IMGS) for renewal of delineated section status and representation in the American Medical Association (AMA) House of Delegates (HOD). The letter focuses on activities beginning in June 2019.

AMA Bylaw 7.0.9 states, "A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every five years that it continues to meet the criteria adopted by the House of Delegates." AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is "to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates."

APPLICATION OF CRITERIA

Criterion 1: Issue of Concern – Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

Since its transition from the IMG Advisory Committee to a Section in 1997, The IMGS has worked to fulfill the objectives of its mission statement:

1. Increase the impact of IMG viewpoints in organized medicine
2. Promote IMG participation and visibility at all levels of organized medicine
3. Establish two-way communication between grassroots IMGs and organized medicine
4. Represent the views of IMGs in the AMA HOD

The IMGS is the only group within the AMA that represents and promotes the interests of physicians who have graduated from medical schools outside the United States or Canada. The IMGS serves its constituents by bringing critical IMG professional issues to the forefront of organized medicine and by providing targeted educational and policy resources.

Over the past five years, the Section has focused on core issues affecting IMGs in the United States including licensure parity, immigration, graduate medical education expansion and discrimination. The IMGS collaborates with the AMA Advocacy unit to work toward uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating

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disparity in the years of GME required for licensure and a uniform standard for the allowed number of administrations of licensure examinations. The IMGS works with the AMA Washington D.C. office to stay abreast of the immigration issues that affect the J-1 Visa Waiver and Conrad 30 Waiver programs for IMGs practicing in underserved areas. IMGS members contributed to the AMA's testimony before the National Academy of Medicine Graduate Medical Education (GME) Financing Committee on the issue of GME expansion. Discriminatory issues have been addressed by the IMGS through policy initiatives, educational sessions, open forums, immigration webinars, employment contract guidelines, amicus briefs, and advocacy for equity in leadership positions. Some professional issues addressed include the Bachelor of Medicine, Bachelor of Surgery (MBBS) degree equivalent, licensure disparity, disparities in the residency selection process, and visa issues related to delays, denials, caps and green card backlogs. The IMGS has worked with AMA Washington D.C. office staff to communicate to the United States Citizenship Immigration Services, U.S. Senators and Representatives regarding these issues. Additionally, the Section has identified and worked to affect the following issues of concern for IMGs:

Providing ongoing support on issues affecting IMGs

The IMGS receives many inquiries regarding immigration, J-1 visa issues, licensure, residency positions, observerships, and mentoring. In response to these requests, in addition to providing direct support, the Section developed an IMG Toolkit, which is posted on the AMA website and is updated regularly. Staff of the Section keep track of all inquiries and work with the Governing Council (GC) on how to best provide the appropriate resources to assist IMGs.

Mentorship

The Section regularly receives communications from its members requesting mentors or a mentorship program. IMG students and early residents are often unfamiliar with the requirements and challenges of practicing medicine in the United States. In response, the IMGS has developed a listing of over 65 volunteer mentors to assist in this regard. IMG staff have also worked with the Governance and Policy Group Committee to determine how to develop an AMA mentorship program.

IMG representation in leadership positions

IMGs have historically been underrepresented in leadership positions in organized medicine, and the IMGS consistently encourages its core members to apply for leadership positions. The Section has also included a Section on Board/Council Endorsements in its Internal Operating Procedures (IOP), which was approved in 2022, as an offering to those IMGs who are interested in applying for an endorsement.

Inclusion of IMGs in the AMA's Equity Strategic Plan

The IMGS collaborated with the Center for Health Equity (CHE) to integrate IMG issues into the AMA's Organizational Strategic Plan to Advance Health Equity. This led to a pull-out section on IMGs in the Strategic Plan and participation in the A-24 Health Equity forum panel discussion. The IMGS GC and staff work with CHE on a regular basis to provide IMG insights for the Center's work.

Many IMGs in the United States are still unaware that the AMA has an IMGS and subject matter experts to assist them. Once they became aware of this information, many IMG physicians and residents have joined the AMA as demonstrated by the increased membership numbers in the past

five years. There are also U.S. citizens attending Caribbean medical schools that have an interest in joining the AMA; however, current AMA policy and bylaws prohibit this until they have become ECFMG-certified, an issue the IMGS hopes to address.

Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

The IMGS works with its GC to align its work with the AMA's and the Section's Strategic Plan and to inform members and non-members how the AMA has worked to remove obstacles that interfere with patient care, confront chronic disease and eliminate health disparities, and drive the future of medicine by reimagining medical education. The IMGS has collaborated with the Council on Medical Education, CHE, Advocacy and other units, sections and special groups on its priority issues to maximize impact and avoid duplicative effort. Since its inception, the IMGS has submitted more than 125 resolutions to the HOD, including 19 since 2019, on topics relevant to IMGs, while also contributing and providing input to HOD reports when appropriate. The IMGS also reviews and revises its strategic plan on an annual basis to ensure relevance and alignment with AMA priorities.

Criterion 3: Appropriateness – The structure of the group will be consistent with its objectives and activities.

Each year the Section works with its GC to develop its Strategic Plan to focus on priority initiatives. GC and committee meetings are held on a regular basis. In 2024, the Section began "Conversation Circles" on topics of interest suggested by its IMGS membership. To date, the Section has held two sessions attended by over 30 participants. The GC meets four to six times a year. Committees meet quarterly and as needed to address issues of immediate concern. Email inquiries received via the IMG mailbox deemed important to address are shared with the GC. Issues addressed and success stories are shared via the IMGS communication vehicles, including newsletters, email, Facebook and LinkedIn.

The IMGS provides direct opportunities for its members to participate in the policymaking process twice a year. These opportunities are announced in advance of annual and interim meetings to allow members time for comment and ratification of reports and resolutions via the Section's online member forum. The Section makes the resolution guidelines and checklist available to members via its newsletters, website and Facebook group. All resolutions are vetted by the Section's Delegates, the Resolution and Policy Committee, followed by the GC and Congress Assembly.

The IMGS GC election is held annually, with calls for nominations announced in December and accepted through February 22. Nominations are reviewed and scored by the IMGS Nominating Committee members, who discuss all candidate nomination materials and perform category rankings to build the slate of candidates for each election. An election announcement is sent via all communication vehicles to Section members, allowing opportunities for all members to consider running for open positions. IMGS members are also invited to participate in IMG Committees including the diversity, equity and inclusion Committee, social media, resolutions & policy, the IMG Bylaws Committee, IMGS Leadership Development; United States International Medical Graduate Liaison Committee and other ad hoc committees as deemed appropriate.

The most recent changes to the Section's IOP were made in 2021 to include the Section's policy on the GC's role in endorsing AMA Board of Trustees and Election Council Candidates each year.

The IMGS GC believed this was important for inclusivity and offering support to IMGs and other candidates. In 2023, the Section and its assigned Bylaws Committee members began working on a complete review and update of its IOP. Once this IOP has completed its revisions, it will be reviewed and approved by Section members, provided to the Council on Constitution and Bylaws and subsequently provided for the Board of Trustees' approval.

Criterion 4: Representation Threshold – Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members.

The IMGS is comprised of graduates of medical schools outside the United States or Canada as identified in the AMA Masterfile. IMGs who join the AMA automatically become members of the IMGS. The core members of the Section are those that participate in the IMGS Congress and online member forum. IMG physicians represent approximately 25 percent of the U. S. physician workforce, and the Section has a potential membership of over 324,000 physicians

Involvement in the IMGS GC, committees, meetings and events, requires that a physician be a current AMA member. Membership of the IMGS increased from 43,554 in 2019 to 53,023 when the letter of application was submitted in June 2024.

Criterion 5: Stability – The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body.

The IMGS was established in 1997 and has demonstrated consistent growth in membership and engagement. From the 2019 Annual Meeting to the 2024 Annual Meeting the IMGS averaged 153 attendees at each IMGS meeting. From 2015 to 2019 attendance at the same meetings averaged 77 members; the last five years have shown a nearly 100 percent increase in attendance over the five years prior. This substantial increase means that the deliberations of the HOD and resulting AMA policy incorporates the perspectives of a significantly increased number of IMGs.

The IMGS attributes this increased participation to continuous communication with current and potential members via newsletters, the IMGS Facebook page, surveys, emails, and specific campaigns, e.g. IMGS Recognition Week and Research Challenge, state IMG Chair Groups and ethnic societies. The Section has also collaborated with other organizations to increase engagement and membership and attended special meetings such as Project IMG—an exclusive network connecting, resourcing and supporting international medical students and graduates—to assist in this effort. This outreach has increased engagement, promoted more interest in the Section as well the AMA.

Criterion 6: Accessibility – Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the AMA HOD.

IMGs make up 7.9 percent of delegates in the AMA HOD and 10.5 percent of Alternate Delegates. Comparatively, according to CLRPD Report 1-A-23, IMGs make up 18.1 percent of AMA members and 22.3 percent of all physicians and medical students, demonstrating a significant level of underrepresentation in the AMA's policymaking body.

Through the Section, IMGs can participate in the AMA's policymaking process during business meetings, reference committee hearings and IMGS caucuses, as well as making use of the IMGS online member forum to debate and ratify resolutions submitted to annual and interim meetings. Other opportunities to contribute to AMA policymaking include participation in the Resolutions & Policy Committee, the IMGS GC (including delegate and alternate delegate positions) and other committee/webinar discussions. The IMGS also provides an opportunity for other sections and councils to provide input on resolutions being considered by the Section for annual and interim meetings, which are shared with the IMGS GC.

The Section identifies its active core members through participation in Section meetings, webinars, Facebook discussions, the AMA Members Move Medicine campaign, and others that engage in committees and mentoring activities. Additional core members include those who participate in newsletter review, online member forums, and vote in the annual GC elections, which at the time of application consisted of over 105 members and 63 mentors.

The IMGS ensures accessibility through a transparent process that aligns with the principles of equity, enhanced decision-making through diverse perspectives, addressing systemic barriers of participation and strengthening governance and policy. The Section is committed to offering a positive member experience, while increasing member engagement on IMG issues, developing new AMA resources and working with new and present partners to increase the AMA Section value and obtain actionable insights.

DISCUSSION

The IMGS continues to focus on issues pertaining to international medical graduates not only within the AMA but throughout the United States. No other existing group within the AMA specifically focuses on these issues, and the Section collaborates with other AMA units when appropriate. Over the past five years, the Section has participated, often in collaboration with other AMA units, in substantial outreach to legislative and regulatory bodies on issues and legislation relevant to all IMGs, including both houses of Congress, the Department of Homeland Security, and the Department of State, demonstrating the Section's role as an important advocate for IMGs in the United States. These efforts have contributed to a number of successes including the creation of pathways and alternative methods to ensure that IMGs receive equitable access to patient care, the addition of one thousand Medicare-funded residency slots through the Inpatient Prospective Payment System, ensuring that IMGs maintained their immigration status during the COVID-19 pandemic, and obtaining licensure parity in several states including Louisiana, Minnesota and Pennsylvania.

The initiatives of the IMGS are consistent with those of the AMA, in particular, IMGS activities focus on practice sustainability and satisfaction for IMG physicians and the patients they serve. Of equal significance, with IMGs making up approximately one-quarter of physicians in the United States, the IMGS provides the AMA with a necessary pipeline for obtaining insight on the challenges and needs of a major segment of the U.S. health care delivery system, which can then be incorporated into AMA policy and strategic planning.

The structure of the Section enables its constituents to participate in both policymaking activities and section leadership; IMGS members have numerous opportunities to actively participate in the resolution development and review to affect changes on issues significant to members of the Section. As the IMG population continues to grow, the Section provides valuable support to its members and IMGs across the country. The IMGS membership has grown by 11 percent since its previous review in 2020, and average meeting participation has nearly doubled, demonstrating both

the effectiveness of the Section's outreach efforts and the need for its continued role in AMA activities and member support. Additionally, it should be reiterated that IMGs remain significantly underrepresented when compared with all members of the HOD, demonstrating even further the need for the Section's continued voice in the AMA policymaking process to ensure that the issues of concern of IMGs have a forum to be deliberated and addressed.

The Council appreciates the thorough work of IMGS leadership and staff in completing this letter of application and follow-up communications, as well as the deliberation of the Section as it looks to improve upon its already commendable work in the future.

CONCLUSION

The CLRPD has determined that the IMGS meets all criteria; therefore, it is appropriate to renew the delineated section status of the section, allowing the continued focused representation of IMGS members in the HOD.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the International Medical Graduates Section through 2030 with the next review no later than the 2030 Annual Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 2-A-25

Subject: Organized Medical Staff Section Five-Year Review

Presented by: Michelle Berger, MD, Chair

Referred to: Reference Committee F

The Council on Long Range Planning and Development (CLRPD) analyzed information from a letter of application submitted in September 2024 from the Organized Medical Staff Section (OMSS) for renewal of delineated section status and representation in the American Medical Association (AMA) House of Delegates (HOD). The letter focused on activities beginning in June 2019.

AMA Bylaw 7.0.9 states, "A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every five years that it continues to meet the criteria adopted by the House of Delegates." AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is "to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates."

APPLICATION OF CRITERIA

Criterion 1: Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

The OMSS is the recognized center of expertise within the AMA and the house of medicine for matters concerning hospital and health system medical staffs and issues facing physicians practicing within the hospital setting. Medical staff leaders, other physician members of the medical staff, hospital/health system administrators, health care law attorneys, medical staff professionals, state/specialty medical society leadership and staff, and other stakeholders look to the OMSS for guidance on these and other issues. OMSS works closely with the National Association of Medical Staffing Services (NAMSS) on credentialing and privileging issues to ensure that physician and resident interests are protected and the processes become as streamlined as possible. Colleague medical societies like the American College of Surgeons regularly seek the OMSS' advice on issues impacting OMSS members and their medical staff colleagues.

Over the past five years, OMSS has identified and worked to affect the following issues of concern:

<u>Medical staff unification and systematization</u>

Since 2014, the Medicare Conditions of Participation have permitted unification of multiple medical staffs across multi-hospital systems. The OMSS has provided comprehensive education

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and resources on this topic going back to 2014. In 2021, OMSS updated its Guide to Medical Staff Organization Bylaws, re-publishing the guide in its seventh edition. The Guide contains new sections on gender-neutral language, pandemic preparedness, right to practice, exclusion from Medicare, criminal clearance and background checks, Board certification and equivalency, and many others. The updated guide also comes with a variety of toolkits developed to provide practical illustrations of the new concepts and guidelines.

Physician-hospital relations

The OMSS has worked to reframe the relationship between physicians and hospitals as one of partners rather than adversaries, while explicitly advocating for medical staff self-governance. The AMA Guide to Medical Staff Bylaws incorporates several previously adopted OMSS resolutions designed to strengthen these perspectives as well as toolkits to help guide physicians around topics such as gender disparity, pandemic preparedness, and others. In 2022, the OMSS revised its model physician-hospital employment contract and made these available to members. The OMSS Plans to revise an additional model contract for group practices within the next two to three years.

Physician voice in development of accreditation standards

OMSS leadership regularly communicates with AMA-appointed representatives to The Joint Commission (e.g., AMA-appointed members of the Joint Commission Board of Commissioners), as well as with Joint Commission senior staff leadership. Through these interactions, the OMSS has influenced key decisions on Joint Commission hospital accreditation matters. OMSS has also worked to expand physician influence in accreditation matters by engaging AMA members in Joint Commission field reviews and related opportunities.

Support for physicians during hospital closures

When Philadelphia's Hahnemann University Hospital closed in September of 2019, it left more than five hundred residents and fellows without an accredited program they could use to continue their medical education. The OMSS was a key player in drafting policy and resolutions to protect physicians affected by Hahnemann's closure and establish a playbook for the closure or significant reduction in services of hospitals in the future. Those actions included working with other stakeholder organizations to develop proactive processes in the event of sudden teaching hospital closures and promoting funds from health care facilities that ensure professional liability coverage in the event of closures.

Connecting physicians to the personal protective equipment they needed during Covid-19

As the COVID-19 pandemic surged in 2020, physicians across the country were left with substandard options for obtaining and maintaining personal protective equipment. The OMSS was the key initiator of a partnership with a non-profit, Project N95, to coordinate efforts to provide physicians with the masks, face shields, and other products they needed to maintain their safety in the face of the pandemic.

Support for physician collective action

Unionization and collective action have grown as areas of interest for OMSS members, partially spurred on by the COVID-19 pandemic. OMSS members have expressed a desire to better understand how collective action can be accomplished relative to the obligations of the practice of medicine. Since 2022, the Section has sponsored two webinars focused on developing a critical

understanding of how collective bargaining and action works in a medical setting and has advanced two resolutions directing the AMA to develop policies and procedures around physician collective action. The efforts to provide education and perspective building are ongoing.

Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

OMSS aligns its focus areas and activities with AMA's strategic priorities. The OMSS has a two-fold mission: To improve the practice experience, and, by doing so, to positively impact patient outcomes. OMSS advocates for physicians and medical staff by removing obstacles to patient care and improving engagement, while also reporting key challenges to the AMA. Medical staff feedback has led to the creation of multiple resolutions adopted by the Section and advanced to the HOD on better compensation for time spent on prior authorization, creating stronger protections against adverse effects from corporate buyouts of practices, and fighting scope creep by improving patient awareness of care delivered through non-physician extenders. In all, the OMSS has sponsored nearly forty resolutions since its last review in 2019, making significant impact on AMA policy and the Association's strategic direction.

OMSS-member medical staffs and their physicians will continue to be significant players in determining how the transition from a volume-based to a value-based care delivery and payment system is managed in the United States. Chronic disease is tailor-made for a value-based environment because it is managed rather than cured. As the entities responsible for patient care quality and safety within health facilities, medical staffs and their physicians are positioned to substantially and positively impact a patient's long-term health status in the management of one or more chronic diseases, while input from OMSS-member medical staff representatives will continue to assist in guiding the AMA's work in this critical area.

Criterion 3: Appropriateness – The structure of the group will be consistent with its objectives and activities.

Section members have a wide range of opportunities to participate in the activities of the OMSS. Although annual and interim meetings are the most obvious of these opportunities, the Section actively promotes that one need not attend meetings to contribute to the work of the Section and provides a variety of opportunities for engagement between meetings, including:

- OMSS committees (e.g., Education Committee, Policy Committee, Membership and Engagement Committee)
- The online member forum enables all representatives to contribute to the policymaking activities of the Section, regardless of whether they can attend meetings.
- Participation in the Section's Reference Committee and Late Resolution Committee for both annual and interim meetings
- Surveys to gauge representatives' interest in potential topics for future education programs and provide a voice to representatives in the Section's strategic planning activities
- Peer-to-peer outreach program for representatives who wish to contribute to the Section's recruitment efforts
- Calls to action on vital legislative and regulatory issues (e.g., Joint Commission field reviews)
- Monthly newsletters (sent to approximately 1,400 subscribers) with relevant medical staff news and announcements.

Criterion 4: Representation Threshold – Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members.

Since the Section's last renewal of delineated section status, the OMSS has seen an increase of 17 representatives, reaching 178 by September 2024, an increase of 10.6 percent from the 161 OMSS representatives certified in 2019. The Section estimates that it now directly represents approximately 4,000 AMA member physicians based on the following assumptions:

- Approximately 15 percent of practicing physicians are currently AMA members,
- The average medical staff size is 150, and
- There is minimal staff membership overlap between represented hospitals.

By comparison, using the same calculation, OMSS covered 3,600 AMA member physicians in 2019, showing a steady increase in participation.

The total number of AMA member physicians who could potentially be represented in OMSS is uncertain, as the AMA has no robust data on how many members have been appointed to at least one hospital/health system medical staff. However, using a conservative estimate that 60 percent of all practicing physicians (i.e., not including medical students, residents, or retired physicians) are part of at least one medical staff, and referencing CLRPD's 2023 demographic report, the total potential representation in the OMSS is approximately 88,543 AMA practicing physician members.

Criterion 5: Stability – The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body.

Since its inception in 1983, the OMSS has played a vital role in helping the AMA address matters concerning hospital and health system medical staffs and issues facing physicians, whether employed or in private practice, who practice within the hospital setting.

Since its last five-year review, OMSS meetings held in conjunction with AMA annual and interim meetings have averaged 37 credentialed representatives and 68 total attendees. OMSS measures meeting participation with two metrics: (1) Section members credentialed to vote at the meeting, and (2) all meeting attendees, regardless of member/voting status. This distinction is made because OMSS typically draws non-OMSS-member attendees to its education programs and other non-business activities at each annual and interim meeting (e.g., individuals from stakeholder organizations such as The Joint Commission, the NAMSS, federation staff, health law attorneys, etc.). OMSS meeting participation has fluctuated over the last five years, due in large part to the effects of the COVID public health emergency.

The OMSS traditionally has communicated with its members and other individuals interested in medical staff topics through a monthly email newsletter with approximately 1,400 subscribers. In 2017, the OMSS launched a Facebook group and continues to post updates on joining, running for the Governing Council (GC) and promoting webinars. Facebook currently has 289 members, up from 210 from the 2019 report and provides a platform for members to discuss relevant topics, stay connected personally, and provides another communication link for AMA announcements. Finally, the Section created a GroupMe chat allowing members to discuss important topics including activities by peers not in the OMSS.

Criterion 6: Accessibility - Provides opportunity for members of the constituency, who are otherwise under-represented, to introduce issues of concern and to be able to participate in the policymaking process within the HOD.

The OMSS offers a unique perspective on the relationship between physicians (whether independent or employed) and the health systems in which they provide services and provides a crucial link between physicians and the facilities where they practice, filling a niche that might not be available to physicians elsewhere. The OMSS serves as an entry point for most resolutions addressing medical staff and hospital issues, which directly affect a large percentage of AMA delegates. On average, the OMSS submits five to seven resolutions for the consideration of the HOD at each meeting, greater than 90 percent of which are eventually adopted in some form. Most OMSS resolutions are introduced by individual Section representatives who, through the experiences of the medical staffs they represent, have identified pressing needs for AMA policy or action. Additionally, resolutions are introduced by OMSS representatives acting on behalf of their state level OMSS groups whose medical societies are not well positioned to address the identified problem.

At the beginning of 2023, the OMSS established an Employed Physicians Caucus to provide advice and counsel to the OMSS and to AMA staff on policy matters that bear directly on employed physicians and their patients. The current roster has an active population of 28 physicians who add to the potential representation of the OMSS. The Caucus convenes two meetings per year, held in conjunction with the annual and interim meetings of the HOD, with additional meetings scheduled throughout the year as necessary. Starting at the 2024 Interim Meeting, the Employed Physician Caucus joined the OMSS Policy Committee for its handbook review.

In addition to providing an opportunity for members to introduce issues of concern, the Section reviews resolutions and reports under consideration at each meeting and, in a democratic process led by the GC, determines which items the Section should take positions on, and what those positions should be. Additionally, the OMSS provides its members with an opportunity to become involved in the Section's HOD activities, such as providing testimony on behalf of the Section at reference committee hearings. The OMSS holds a briefing/strategy session before the Sunday-morning HOD reference committee hearings and a post-reference committee hearing debriefing, both of which are open to all OMSS representatives and other AMA members interested in medical staff matters.

DISCUSSION

The OMSS provides a voice for staff physician interests, as the evolution of staff structures and functions continues to change the landscape of hospital medical staffs. The Section is uniquely focused on addressing the needs and issues of physicians on medical staffs. Through wide-ranging activities, the OMSS strives to improve medical staff relations and empower physicians to lead, direct, and ensure the success of those staffs. The OMSS is in alignment with the AMA's strategic foci, evidenced by the Section's efforts to remove barriers to patient care and joy in medical practice, treat chronic diseases and remove inequities in health care, and provide opportunities for its members to enhance their participation in AMA activities and deliberations.

As physician modes of practice continue to evolve, it is increasingly vital for the AMA to have a conduit to employed physicians, who are now the majority stakeholder in the physician population. The Section's development and incorporation of its Employed Physicians Caucus established a direct path for the needs and priority issues of employed physicians to be incorporated into OMSS, and, subsequently, the AMA's policy and strategic decision-making. This development also

demonstrated the Section's desire and ability to evolve within the changing landscape of health care delivery and willingness to adapt to the needs of its constituents. In addition to the fact that a majority of AMA members are likely to be members of at least one medical staff, the OMSS representatives themselves represent thousands of AMA members in their own medical staffs. The OMSS has demonstrated strong continuity since its founding over 40 years ago.

The unique relationship between physician staffs and organizations incorporates many issues and the OMSS is an appropriate means for members to focus on and address these topics in a holistic fashion and create needed policy. The OMSS provides a crucial link between physicians and the facilities where they practice, and the Section provides the necessary perspective for members to address critical issues related to physician and hospital matters.

The Council appreciates the thorough work of OMSS leadership and staff in completing this letter of application and follow-up communications, as well as the deliberation of the Section as it looks to improve upon its already commendable work in the future.

CONCLUSION

The CLRPD has determined that the OMSS meets all required criteria; therefore, it is appropriate to renew the delineated section status of the OMSS.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Organized Medical Staff Section through 2030 with the next review no later than the 2030 Annual Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500

REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report, June 2025

Subject: REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Presented by: Evelyn Lewis, MD, Chair

Referred to: Reference Committee F

BACKGROUND

At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on Trustee Compensation, currently named the Committee on Compensation of the Officers (the "Committee"). The Officers, defined in the American Medical Association's (AMA) Constitution and Bylaws, consist of all 21 members of the Board of Trustees, including the President, President-Elect, Immediate Past President, Secretary, and Speaker and Vice Speaker of the HOD, and are collectively referred to in this report as Officers. The composition, appointment, tenure, vacancy process and reporting requirements for the Committee are covered under the AMA Bylaws. Bylaw 2.13.4.5 provides:

> The committee shall present an annual report to the House of Delegates recommending the level of total compensation for the Officers for the following year. The recommendations of the report may be adopted, not adopted, or referred back to the committee, and may be amended for clarification only with the concurrence of the committee.

At A-00, the Committee and the Board jointly adopted the American Compensation Association's definition of "Total Compensation" which was added to the Glossary of the AMA Constitution and Bylaws. Total Compensation is defined as the complete reward/recognition package awarded to an individual for work performance, including: (a) all forms of money or cash compensation; (b) benefits; (c) perquisites; (d) services; and (e) in-kind payments.

Since the inception of this Committee, its reports have documented the process the Committee follows to ensure that current or recommended Officer compensation is based on sound, fair, cost-effective compensation practices as derived from research and use of independent external consultants, expert in Board compensation. Reports beginning in December 2002 documented the principles the Committee followed in creating its recommendations for Officer compensation.

METHODOLOGY

The Committee recently commissioned Willis Towers Watson (WTW), a major compensation consulting firm with expertise in board compensation, to review the Speaker and Vice Speaker Governance Honorariums and consider if a separate larger Honorarium would better recognize the considerable amount of work required of these positions and that the work is different from regular board members. As a result of this review, the Committee also considered if the Per Diem for Internal Representation should be eliminated for all non-leadership board members.

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FINDINGS

WTW analyzed the Speaker and Vice Speaker compensation data for the past three terms, 2021/2022, 2022/2023 and 2023/2024. The analysis demonstrated that the Speaker and Vice Speaker roles require a significant time commitment given the volume of work required of each. Based on the analysis, WTW supports a higher honorarium of $125,000 for the Speaker and $115,000 for the Vice Speaker. The increased honorarium would cover all internal representation.

In addition, WTW's analysis also raised questions about the need for a Per Diem for Internal Representation for non-leadership board members. The current Governance Honorarium includes 11 days of internal representation per term. Review of the past three terms showed all board members except the Speakers (and only once for one board member and one medical student) were under the 11 days that are compensated by the Governance Honorarium as currently defined. This Committee recommends eliminating the Internal Representation for all board members and revising the Governance Honorarium definition for all non-officer board members to state that all internal representation days are included in the Honorarium, resulting in a per diem only for External Representation, thus providing greater clarity and simplification of Board compensation.

RECOMMENDATIONS

The Committee on Compensation of the Officers recommends the following recommendations be adopted effective July 1, 2025, and the remainder of this report be filed:

1. That the Governance Honorarium for the Speaker and Vice Speaker be increased to $125,000 and $115,000 respectively and include all internal representation days.

2. That the definition of the Governance Honorarium be revised as follows:

   The purpose of this payment is to compensate Officers, excluding Board Chair, Chair-Elect and Presidents, for all Chair-assigned internal AMA work and related travel. This payment is intended to cover the yearly slate of meetings as approved by the Board, which include: Board meetings and additional meetings including but not limited to: State Advocacy Summit, National Advocacy Conference, and Annual and Interim meetings; special Board or Board committee, subcommittee and task force meetings**;** Board orientation, Board development and media training**;** and Board conference calls. This includes any associated review or preparatory work, and all travel days related to all such meetings. The Governance Honorarium also covers all internal representation, such as section and council liaison meetings, any associated review or preparatory work, and all travel days related to all such meetings. ~~The Governance Honorarium also covers Internal Representation, such as section and council liaison meetings (and associated travel) or calls, up to eleven (11) Internal Representation days.~~

3. That the definition of the Per Diem for External Representation and the related Telephonic Per Diem Representation be revised as follows:

   The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is ~~either~~ external to the AMA, or organizations with which the AMA has a key role in creating/partnering/facilitating, achievement of the respective organization goals such as the AMA Foundation. ~~PCPI, etc. or for Internal Representation days above eleven (11).~~ The Board Chair may also approve a per diem for special circumstances

that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is $1,550 per day.

Definition of Telephone Per Diem for External Representation ~~effective July 1, 2017~~:

Officers, excluding the Board Chair and the President(s), who are assigned by the Board Chair as the AMA representative to outside groups as one of their specific Board assignments ~~or assigned Internal Representation days above eleven (11)~~, receive a per diem for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for those meetings would require the approval of the ~~Chair of the~~ Board Chair. The amount of the Telephonic Per Diem will be ½ of the full Per Diem which is $775.

4. That the remainder of the report be filed.

Fiscal Note: minimal

1 APPENDIX

Board Leadership Compensation

POSITION	**GOVERNANCE HONORARIUM**
President	$298,865
Immediate Past President	$290,659
President-Elect	$290,659
Chair	$285,886
Chair-Elect	$211,630

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(A-25)

Introduced by: American College of Lifestyle Medicine, Minority Affairs Section

Subject: AMA To Develop Patient Educational Materials Regarding Ultra-processed Foods for Distribution by AMA members

Referred to: Reference Committee F

Whereas, poor dietary practices are recognized as a major contributor of non-communicable diseases and identified top dietary factors as diets high in sodium and low in whole plant foods (i.e., whole grains, fruits, nuts and seeds and vegetables);[1] and

Whereas, poor diet is responsible for more deaths globally than tobacco, high blood pressure or any other health risk;[1] and

Whereas, dietary habits account for one in every five deaths globally;[1] and

Whereas, the Standard American Diet is low in whole plant foods but high in red and processed meats, fat, sodium, ultra-processed foods, added sugar and calories and contributes to an overall increase in chronic disease and the US obesity epidemic;[2] and

Whereas, food processing is the alteration of a raw ingredient from its natural state to one where desirable nutrients are removed or destroyed and/or undesirable nutrients are added and may have negative or positive effects on overall health status;[3] and

Whereas, ultra-processed foods are made through industrial methods/techniques and include any foods that are modified with artificial colors and flavoring, emulsifiers, preservatives, added fat, salt or sweeteners;[4] and

Whereas, from natural foods and tend to have undesirable additives that would not otherwise be used in homemade food preparation - supplemented ingredients such as added sugar, artificial sweeteners, hydrogenated oils, nitrites, fats, artificial colors and preservatives;[4] and

Whereas, additives and preservatives in ultra-processed foods have been associated with increased incidence of auto immune illness, gut microbiome dysbiosis, and hyper palatability by improving food appearance and taste;[4] and

Whereas, ultra-processed foods contribute to 70% of sodium intake in US foods coming from purchased foods and restaurant foods and make up about 60% of energy intake;[5] and

Whereas, ultra-processed foods intake leads to greater consumption of refined carbohydrates, added sugars, saturated fats and sodium (i.e., markers of poor diet quality associated with cardiovascular disease, obesity and hypertension);[6] and

Whereas, ultra-processed foods consumption leads to a greater risk of a diet lacking in essential nutrients (i.e., dietary fiber, zinc, potassium, phosphorus, magnesium, calcium and vitamins A, C, D and E);[6] and

Whereas, each 10-gram increase in daily fiber intake results in a 10% decreased risk of all-cause mortality;[7] and

Whereas, ultra-processed foods consumption is associated with long-term weight gain as obesity via excess calories (about 500kcal per day) from carbohydrates and fats and weight gain of about 2 lbs. after 2 weeks;[8] and

Whereas, each additional daily serving of ultra-processed foods is associated with a 9% increased risk of cardiovascular disease mortality;[9] and

Whereas, ultra-processed foods consumption has been shown to be directly associated with high all-cause mortality;[10] and

Whereas, modification of ultra-processed foods consumption is possible through lifestyle changes in dietary content and nutritional behavior and can reduce and even reverse the signs and symptom of chronic diseases (such as diabetes, hypertension, hypercholesterolemia, metabolic syndrome, cardiovascular disease and others);[11-12] and

Whereas, modification of ultra-processed foods consumption is best accomplished through a collaborative relationship between a committed, trusting patient and knowledgeable, caring practitioner;[13] and

Whereas, all American Medical Association members will have the occasion to counsel and educate laypersons and patients about avoidance or reversal of dietary consumption of ultra-processed foods; therefore be it

RESOLVED, that for all American Medical Association-sponsored receptions or meals, our AMA will offer food options of minimally processed fiber-rich foods and that AMA meeting staff will work with select organizations of the HOD to develop such options; (Directive to Take Action); and be it further

RESOLVED, that our AMA work with select organizations in the HOD to develop patient educational materials in English and Spanish with regards to the health impact of ultra-processed foods as well as pathways for personal dietary options as alternatives to ultra-processed foods; and, that such developed materials will be provided by the AMA to members who request them for distribution to their patients. (Directive to Take Action)

Fiscal Note: $65,179 annually to develop educational materials

Received: 4/18/25

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RELEVANT AMA POLICY

AMA Support for Nutrition Research H-150.921

1. Our American Medical Association will support additional funding for National Institutes of Health's (NIH's) Office of Nutrition Research (ONR) to enable ONR to secure the leadership, organizational structure, and resources to effectively fulfill its important mission.
2. Our AMA encourages the NIH to prioritize research with maximal applicability to human health conditions, and that it seek input from physicians and the public regarding research priorities and maintain transparency in its planning processes.

Reduction in Consumption of Processed Meats H-150.922

Our AMA supports:
1. reduction of processed meat consumption, especially for patients diagnosed or at risk for cardiovascular disease, type 2 diabetes, and cancer;
2. initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition;
3. public awareness of the risks of processed meat consumption; and
4. educational programs for health care professionals on the risks.

Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake H-150.929

1. Our American Medical Association calls for a step-wise, minimum 50% reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade.
2. Our AMA urges the FDA to publish future editions of their voluntary targets expeditiously to make further progress on sodium reduction.
3. Our AMA supports federal, state, and local efforts to set robust targets for reducing sodium levels in school meals, meals in health care facilities, and other meals provided by daily meal providers.
4. Our AMA will advocate for federal, state, and local efforts to reduce sodium levels in products from food manufacturers and restaurants to the greatest extent possible, without increasing levels of other unhealthy ingredients, such as added sugars or artificial ingredients.
5. Our AMA supports federal, state, and local efforts to require front-of-package warning labels for foods that are high in sodium based on the established recommended daily value.
6. Our AMA will assist in achieving the Healthy People 20302010 goal for sodium consumption, by will working with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, Academy of Nutrition and Dietetics, and other interested partners to educate consumers about the benefits of reductions in sodium intake and other dietary approaches to reduce hypertension.
7. Our AMA supports the continuing education of physicians and other members of the health care team on counseling patients on lifestyle modification strategies to manage blood pressure, advocating for culturally relevant dietary models that reduce sodium intake.
8. Our AMA recommends that the FDA consider all options to promote reductions in the sodium content of processed foods.
9. Our AMA supports further study and evaluation of national salt reduction programs to determine the viability, industry engagement, and health and economic benefits of such programs.

10. Our AMA supports federal, state, and local efforts to regulate advertising of foods and products high in sodium, especially advertising targeted to children.

Accurate Reporting of Fats on Nutritional Labels H-150.939
1. Our AMA urges the Food and Drug Administration to require the use of more precise processes to measure the fat content in foods, particularly trans fats and saturated fats, and to require that the most accurate fat content information based on these processes be included on food labels.

Healthful Food Options in Health Care Facilities H-150.949
1. Our American Medical Association encourages healthful food options be available, at reasonable prices and easily accessible, on the premises of health care facilities. Providing a variety of healthy food, including plant-based meals, and meals that are low in saturated and trans-fat, sodium, and added sugars. Eliminating processed meats from menus

Irradiation of Food H-150.961
1. It is the policy of the AMA to: (1) affirm food irradiation as a safe and effective process that increases the safety of food when applied according to governing regulations; and
2. consider the value of food irradiation to be diminished unless it is incorporated into a comprehensive food safety program based on good manufacturing practices and proper food handling, processing, storage, and preparation techniques.

Addressing Adult and Pediatric Obesity D-440.954
1. Our American Medical Association will:
· Assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations.
· Encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations.
· Continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3. Our AMA will work with interested national medical specialty societies and state medical associations to increase public insurance coverage of and payment for the full spectrum of evidence-based adult and pediatric obesity treatment.
4. Our AMA will:
· work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment.
· work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.
4. Our AMA will leverage existing channels within AMA that could advance the following priorities:
Promotion of awareness amongst practicing physicians and trainees that obesity is a treatable chronic disease along with evidence-based treatment options.
Advocacy efforts at the state and federal level to impact the disease obesity.
Health disparities, stigma and bias affecting people with obesity.
Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
Increasing obesity rates in children, adolescents and adults.
Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods and food marketing practices.
5. Our AMA will conduct a landscape assessment that includes national level obesity prevention and

treatment initiatives, and medical education at all levels of training to identify gaps and opportunities where AMA could demonstrate increased impact.
6. Our AMA will convene an expert advisory panel once, and again if needed, to counsel AMA on how best to leverage its voice, influence and current resources to address the priorities listed in item 5 above.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(A-25)

Introduced by: American Thoracic Society

Subject: Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations

Referred to: Reference Committee F

Whereas, our American Medical Association Board of Trustees is reverently and uniquely positioned to uphold the principles and tenets of science and public health, and is entrusted to act on behalf of American physicians; and

Whereas, in existing policy and practice the Board of Trustees sets strategic direction and legislative priorities for report in the Interim Meeting, with the option to take action in between HOD Meetings in urgent situations; and

Whereas, current policy G-600.071 and current practice yield authority to BOT on AMA action in urgent situations, and further allow BOT to make a determination of what it deems best represent the interests of patients, physicians, and the AMA; however, current policy and practice do not require BOT take action in times of national or global crises to health or science; and

Whereas, the 2020 public health emergency of COVID-19 highlighted the need for AMA, particularly AMA leadership and the BOT, to reassess priorities and respond expediently to urgent needs; and

Whereas, in 2025 the first 100 days of the 2nd term for President Donald J. Trump has led to substantial and unprecedented challenges to the structures of science and American health, with many major national institutions and agencies voicing their positions on issues of importance to human health; and

Whereas, the actions of the current federal administration have caused affronts to the core of science and health system funding, policies, and institutions, and have caused disruptions to the healthcare workforce; and

Whereas, the actions of the current administration intend to continue toward cataclysm of fundamental health structures, including but not limited to

(1) disrupting the economic support for evidence-based medicine, which preserves the integrity of scientific inquiry and an open platform for discovery beyond corporate funded research;
(2) reducing the government's contributions to US health care expenditures, which are currently at approximately half (~$2.2 trillion) of total US health care expenditures[1], and upon which our US healthcare systems and hospitals are financially dependent;
(3) challenging the US health care workforce, of which 18.2% are foreign-born, including 26.5% of physicians being foreign-born[2], and its pipeline for creating healthcare workers that mirror the communities they serve, which research shows improves health care in minority populations[3];

(4) disrupting the pipeline of talent for scientific research, as 38.6% of US master's and postdoctoral students in science, engineering, and health are temporary visa holders[4], therefore creating vulnerability to the US scientific research industry, which as of 2023 has an estimated market impact of $320 billion in revenue, substantially due to a historic recognition of and reliance on foreign-born scientific labor and experts[5]; and
(5) discrediting the US as a global leader for using evidence-based findings to drive medical decisions, public policies, and research funding; and

Whereas, AMA advocacy is influential for the trajectory of American health care; and

Whereas, in conditions of transformational affronts to the policies and structures that enable our modern systems and foundational institutions for science and health, we require our AMA advocacy; and

Whereas, in such moments, the AMA HOD and physician members are reliant on the voice of our Board of Trustees to act - responsibly, clearly, and expediently; therefore be it

RESOLVED, that our American Medical Association amend G-600.071, "Actions and Decisions by the AMA House and Policy Implementation" to read

- 3. Except as noted herein and consistent with the AMA Bylaws, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates. ~~Further,~~
- 4. In urgent situations, the Board of Trustees has the will exercise its authority to take such action as it determines is appropriate in urgent situations to take those policy actions that the Board deems best represent the interests of patients, physicians, and the AMA. to advocate for science and public health**.** In representing AMA policy in critical situations, the Board will take into consideration existing AMA policy, recommendations from AMA policy staff, and input solicited or obtained from the House of Delegates or its Councils and Sections to inform its position on the interests of patients, physicians, and the AMA. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.

~~4.~~ 5. Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA considers transformational occurrences, including public health phenomena, sudden changes to national health policies, and sudden disruptions of health and science funding, to be urgent situations worthy of AMA Board of Trustee advocacy and action (New HOD Policy); and be it further

RESOLVED, that our AMA considers sudden federal funding cuts to foundational institutions of science research and public health to be urgent situations and requests the Board of Trustees take immediate action to respond responsibly, clearly, and expediently as an advocate for science, health care, and public health. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/22/25

REFERENCES
[1] Peter G. Peterson Foundation. "Healthcare Spending Will be One-Fifth of the Economy within a Decade." Updated Sept 16, 2024. Accessed 4/21/2025 at https://www.pgpf.org/article/healthcare-spending-will-be-one-fifth-of-the-economy-within-a-decade.
[2] Migration Policy Institute. "Immigrant Health-Care Workers in the United States." April 7, 2023. Accessed 4/21/2025 at https://www.migrationpolicy.org/article/immigrant-health-care-workers-united-states-2021.
[3] Silver JK, Bean AC, Slocum C, et al. Physician Workforce Disparities and Patient Care: A Narrative Review. Health Equity. 2019;3(1):360-377.
[4] National Science Foundation: National Center for Science and Engineering Studies. "Graduate Enrollment and Postdoctoral Appointments in Science, Engineering, and Health Rise, Driven Largely by Increases in the Number of Women and Temporary Visa Holders." January 21, 2025. Accessed 4/21/2025 at https://ncses.nsf.gov/pubs/nsf25316.
[5]Walsh B. "The self-inflicted death of American science has already begun." *Vox.* Apr 9 2025.

RELEVANT AMA POLICY

Annual Reporting Responsibilities of the AMA Board of Trustees G-605.050
Our American Medical Association Board provides the following four items to the AMA House:

1. At each Annual Meeting of the House, the Board submits a report to the House that provides highlights on the AMA's performance, activities, and status in the previous calendar year as well as a recommendation for the Association's dues levels for the next year. The report should include information on topics such as:
    a. AMA's performance relative to its strategic plan.
    b. Key indicators of the AMA's financial performance and, if not provided through other communication vehicles, information on the compensation of Board members, elected Officers, the Executive Vice President, and the expenses associated with the AMA Councils, Sections, Special Groups, and AMA's participation in the World Medical Association.
    c. An assessment of the performance, accomplishments, and activities of the Board, including the AMA appearance program and the results of the work of the Board's Audit Committee.
    d. AMA's membership situation, including an assessment of the membership communication and promotion activities;
    e. Highlights of the activities and accomplishments of the Association's major programs, including legislative and private sector advocacy.
    f. A description and assessment of efforts to address high priority issues.
    g. The AMA's relationships and work with other organizations, including Federation organizations, other health related organizations, non-health related organizations, and international organizations.

The Board may include any other topics in this report that it deems important to communicate to the House about the performance, activities, and status of the AMA and the health of the public.

2. As the principal planning agent for the AMA, the Board provides a report at each Interim Meeting of the House that recommends the AMA's strategic directions and plan for the next year and beyond. The report should include a discussion of the AMA's membership strategy.
3. At each Interim Meeting, the Board provides an informational report on the AMA's legislative and regulatory activities, including the Association's accomplishments in the previous 12 months and a forecast of the legislative and regulatory issues that are likely to occupy the Council on Legislation and other components of the AMA's for the next year.

In fulfilling its responsibilities to report to the House on topics and situations, the Board should provide succinct reports to the House. When detailed information on topics is warranted, the Board should

provide the information to interested members of the House through reports that can be downloaded from the AMA web site.
Nothing in this policy precludes the House from requesting that the Board report back to the House on any topic. Further, nothing in this policy should be construed as limiting the number or size of reports that the Board can send to the House.
Sub. Res. 52, A-74 Res. 57, A-81 Reaffirmed: CLRPD Rep. C, A-89 Sub. Res. 83 and 125, A-90 Reaffirmed: CLRPD Rep. F, I-91 Modified by Res. 609 Reaffirmed by 610 and 611, I-94 Res. 622, I-97 Appended by Rep. of the Ad Hoc Cmte. to Study the Sunbeam Matter and Res. 617, A-98 Res. 609, I-99 Reaffirmed: Sunset Report, I-00 Consolidated: CLRPD Rep. 3, I-01 Appended: Rep. of the Ad Hoc Cmte. on Governance and Res. 618, A-02 Modified: CLRPD Rep. 1, A-03 Modified: BOT Rep. 1, I-03 Modified: CCB/CLRPD Rep. 3, A-12 Reaffirmed: CCB/CLRPD Rep. 1, A-22

AMA Stance on the Interference of the Government in the Practice of Medicine H-270.959

1. Our American Medical Association opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.
2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:
    a. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
    b. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
    c. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.
    d. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter.
    Res. 523, A-06Appended: Res. 706, A-13Reaffirmed: Res. 250, A-22

Actions and Decisions by the AMA House and Policy Implementation G-600.071

1. AMA policy on House actions and decisions includes the following:
A. Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (i) correcting factual errors in AMA reports, (ii) rewording portions of a report that are objectionable, and (iii) rewriting portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible.
B. A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be amended by means of a positive action of the House specifically intended to change that policy.
C. Minor editorial changes to existing policies are allowed for accuracy, so long as such changes are reported to the House of Delegates so as to be transparent. Editorially amended policies, however, do not reset the sunset clock.
2. AMA policy on implementation of policy includes the following:
A. Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and report recommendations and specific actions that have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted.
B. Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions.
C. Any resolution which is adopted by our AMA House remains the policy of the Association until amended, rescinded or sunset by the House.

3. Except as noted herein and consistent with the AMA Bylaws, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates. Further, the Board of Trustees has the authority in urgent situations to take those policy actions that the Board deems best represent the interests of patients, physicians, and the AMA. In representing AMA policy in critical situations, the Board will take into consideration existing policy. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.
4. Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(A-25)

Introduced by: Minority Affairs Section

Subject: Renaming the Minority Affairs Section to the Underrepresented in Medicine Advocacy Section

Referred to: Reference Committee F

Whereas, the Minority Affairs Section (MAS) was officially established in 2010 to provide a dedicated voice within the AMA for learners, trainees, and physicians from historically marginalized and underrepresented communities, and has played a critical role in advancing health equity, workforce diversity, and inclusion in organized medicine; and

Whereas, the term “underrepresented in medicine” (UIM) is widely recognized by national medical organizations, including the AAMC, as a more precise and inclusive term that better reflects the systemic barriers faced by physicians and trainees from marginalized backgrounds[1]; and

Whereas, renaming MAS to the Underrepresented in Medicine Advocacy Section (UMAS) ensures that the section’s name accurately reflects its mission to advocate for physicians, trainees, and patients who experience systemic exclusion and health inequities; and

Whereas, this name change aligns with AMA’s ongoing efforts to promote equity, increase physician representation from underrepresented groups, and strengthen advocacy for minoritized communities[2,3]; therefore be it

RESOLVED, that our American Medical Association Minority Affairs Section (MAS) be renamed the Underrepresented in Medicine Advocacy Section (UMAS). (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

REFERENCES

1. Association of American Medical Colleges. Equity, Diversity, & Inclusion. https://www.aamc.org/about-us/equity-diversity-inclusion. Accessed March 23, 2025.
2. American Medical Association. The AMA’s commitment to workplace diversity, equity and inclusion. Published February 27, 2025. https://www.ama-assn.org/about/ama-career-opportunities/ama-s-commitment-workplace-diversity-equity-and-inclusion. Accessed March 23, 2025.
3. American Medical Association. Equity, diversity and belonging in medical education. Published January 14, 2025. https://www.ama-assn.org/education/changemeded-initiative/equity-diversity-and-belonging-medical-education. Accessed March 23, 2025.

RELEVANT AMA POLICY

Minority Affairs Section B-7.7
7.7 Minority Affairs Section. The Minority Affairs Section is a delineated Section.
7.7.1 Membership. All active members of the AMA, including residents and fellows and medical students, who express an interest in racial or ethnic minority issues shall be eligible for membership in

the Minority Affairs Section. Physicians or medical students who are not AMA members may join the Section for up to 2 years as provisional members without the right to vote.
7.7.2 Elections. Membership on the Governing Council shall be determined through election by members of the Minority Affairs Section. All members of the Minority Affairs Section, except provisional members, shall be entitled to vote in elections of Governing Council members. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.
7.7.2.1 Election of Officers. The Governing Council shall elect its Chair and Vice Chair from among the Governing Council members.
7.7.3 Cessation of Membership. If an officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.7.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant.
7.7.3.1 Section Representatives on the Governing Council. Section Representatives on the Governing Council. If a representative of the Resident and Fellow Section or Young Physicians Section ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of the respective section. If a representative of the Medical Student Section graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.
7.7.3.2 Section Representative as Immediate Past Chair. A Section representative who has been elected as chair of the Governing Council, but who ceases to meet the criteria for membership in the section from which elected during their term as Immediate Past Chair, shall be permitted to complete the term of office, as long as the officer remains an active physician member of the AMA.

H-350.978 Minorities in the Health Professions
The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.
(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.
(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.
(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.
(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.
(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.
(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.
(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18]

H-350.971 AMA Initiatives Regarding Minorities
The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the

development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components:
(1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine;
(2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities;
(3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities;
(4) Response to inquiries and concerns of minority physicians and medical students; and
(5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine. [CLRPD Rep. 3, I-98; CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(A-25)

Introduced by: Medical Student Section, American Association of Public Health Physicians, American College of Physicians, Minority Affairs Section

Subject: Advisory Committee on Tribal Affairs

Referred to: Reference Committee F

Whereas, there has been an exponential increase in the number of policies adopted or amended by the AMA House of Delegates, focused on improving the health of the American Indian and Alaska Native (AI/AN) population[1]; and

Whereas, American Medical Association staff has reported insufficient internal expertise to implement HOD-passed policies specific to AI/AN Tribes and Villages, and the Indian Health Service, due to a limited understanding of the federal trust responsibility[2]; and

Whereas, the 574 federally recognized AI/AN Tribes across the U.S. have distinct languages, traditions, and health needs, reflecting their sovereign status and a government-to-government relationship with the federal government rooted in the U.S. Constitution, treaties, laws, and executive orders[3-4]; and

Whereas, addressing the unique political, legal, and socioeconomic factors influencing AI/AN health outcomes requires specialized approaches beyond those applied to marginalized communities in general[5-6]; and

Whereas, establishing an AMA Advisory Committee on Tribal Affairs, composed of physicians, residents, and medical students with expertise in AI/AN health, would provide essential guidance to the Board of Trustees on implementing policies affecting AI/AN physicians, medical students, patients, and communities, while complementing—though not replacing—the direct involvement of the Association of American Indian Physicians and the Indian Health Service in the AMA House of Delegates; and

Whereas, tribal governments manage most Indian Health Service facilities, emphasizing the need for diverse perspectives to advise the AMA Board of Trustees[7]; therefore be it

RESOLVED, that our American Medical Association: (1) establish an Advisory Committee on Tribal Affairs composed of AMA members who themselves identify as American Indian and Alaska Native (AI/AN) or have direct experience or close professional relationships with AI/AN communities (e.g., members of Association of Native American Medical Students and Association of American Indian Physicians) or the Indian Health Service to advise the Board of Trustees on how to implement policy specific to AI/AN communities; and (2) promote and foster educational opportunities for AMA members and the medical community to better understand the contributions of AI/AN communities to medicine and public health, including cultivating a rich understanding and appreciation of AI/AN perspectives on health and wellness. (Directive to Take Action)

Fiscal Note: $74,321 Annual Cost

Date Received: 04/10/2025

REFERENCES

1. Business of the AMA House of Delegates Interim Meeting. American Medical Association. Published online November 15, 2023. https://www.ama-assn.org/house-delegates/interim-meeting/business-ama-house-delegates-interim-meeting
2. AMERICAN MEDICAL ASSOCIATION BOARD OF TRUSTEES MEETING SUMMARY AND HIGHLIGHTS. American Medical Association. Published online September 11, 2022. https://www.ama-assn.org/about/board-trustees/board-trustees-actions-official-record
3. IHS Profile. Indian Health Service. Published online August 2020. https://www.ihs.gov/newsroom/factsheets/ihsprofile/
4. Government-to-Government Relations with Native American Tribal Governments. Published online April 29, 1994. https://www.doi.gov/pmb/cadr/programs/native/Government-to-Government-Relations-with-Native-American-Tribal-Governments
5. General Principles of Federal Indian Law. University of Alaska Fairbanks. Published online 2016. https://www.uaf.edu/tribal/academics/112/unit-4/generalprinciplesoffederalindianlaw.php#:~:text=Government%2Dto%2DGovernment%20Relationship%3A,than%20one%20based%20on%20race
6. Warne D, Frizzell LB. American Indian health policy: historical trends and contemporary issues. Am J Public Health. 2014;104 Suppl 3(Suppl 3):S263-S267. doi:10.2105/AJPH.2013.301682
7. Agency Profile. Indian Health Service. Accessed March 31, 2024. https://www.ihs.gov/newsroom/factsheets/ihsprofile/

RELEVANT AMA POLICY

Advocacy for Physicians and Medical Students with Disabilities D-615.977
Our AMA will: (1) establish an advisory group composed of AMA members who themselves have a disability to ensure additional opportunities for including physicians and medical students with disabilities in all AMA activities; (2) promote and foster educational and training opportunities for AMA members and the medical community at large to better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which accommodations may not be immediately apparent; (3) develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians and medical students to manage their own disability-related needs in the workplace; and (4) communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws protections and reasonable accommodations for physicians and medical students with visible and invisible disabilities. [BOT Rep. 19, I-21]

AMA Support of American Indian Health Career Opportunities D-350.976

1. Our American Medical Association will work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, Association of American Indian Physicians, and Association of Native American Medical Students to increase representation of American Indian physicians in medicine by promoting effective practices in recruitment, matriculation, retention and graduation of American Indian medical students.
2. Our AMA will Convene key parties, including but not limited to the Association of American Indian Physicians (AAIP) and American Indian/Alaska Native (AI/AN) tribes/entities such as Indian Health Service and National Indian Health Board, to discuss the representation of AI/AN physicians in medicine and promotion of effective practices in recruitment, matriculation, retention, and graduation of medical students. [BOT Action in response to referred for decision: Res. 308, A-22; Modified: BOT Rep. 31, A-24; Reaffirmed: BOT Rep. 31, A-24]

Indian Health Service H-350.977
The policy of the American Medical Association 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. Our 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. Personnel:
   a. Compensation scales 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 specialty and primary care service in remote areas;
   c. In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers and other federal health agencies, thus increasing both the available staffing 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 without detracting from physician compensation;
   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 burnout; 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 supports 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.
8. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate, but incremental, loan forgiveness when they practice in an Indian Health Service, Tribal, or Urban Indian Health Program.
9. Our AMA supports reform of the Indian Health Service (IHS) Loan Repayment Program eligibility for repayment with either a part-time or full-time employment commitment to IHS and Tribal Health Programs. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Appended: Res. 305, A-23; Reaffirmed: BOT Rep. 09, A-23;

Reaffirmed: CMS Rep. 03, A-24; Reaffirmed: Res. 244, A-24; Reaffirmed: BOT Rep. 31, A-24; Modified: CMS Res. 305, A-24]

Reference Committee G

Report(s) of the Board of Trustees

06 Transparency and Accountability of Hospitals and Hospital Systems

19 Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout

Report(s) of the Council on Medical Service

01 Council on Medical Service Sunset Review of 2015 House Policies

03 Regulation of Corporate Investment in the Health Care Sector

04 Requiring Payment for Physician Signatures

07 Impact of Patient Non-adherence on Quality Scores

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713 Aiding Members of Medical Staffs

714 Root Cause Analysis of the Causes of the Decline of Private Medical Practice

715 Grace Period for Timely Filing Due to Technology Failures Regardless of Cause

716 Minimum Payer Communication Quality Standards

717 Promoting Medication Continuity and Reducing Prior Authorization Burdens

REPORT OF THE BOARD OF TRUSTEES

B of T Report 06-A-25

Subject: Transparency and Accountability of Hospitals and Hospital Systems

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee G

INTRODUCTION

At the 2024 Annual Meeting of the AMA HOD, Policy D-200.971, "Transparent Reporting of Physician Complaints Against Hospitals and Health Systems" was adopted as amended, and in the first directive asked that AMA "supports and facilitates transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as The Joint Commission Quality Check reports, to include periodic report back to the HOD with the first update to be given at A-25." This report specifically addresses the report-back requirements of the first directive of this policy. The second directive of the policy is not a topic of this report

BACKGROUND:

AMA's Position

The AMA has consistently opposed making the National Practitioner Data Bank publicly available (Policy H-355.975, "Opposition to the National Practitioner Data Bank") and upheld this position in BOT Report 29-A-24, citing concerns over incomplete and inaccurate information. The AMA also opposes requiring the AMA, FSMB, The Joint Commission, or any state or federal entity to publicly disclose disciplinary actions to avoid potential misinterpretation and misuse of the data. Instead, the AMA supports state medical boards in making general information about disciplinary actions public, and the FSMB Physician Data Center, which provides information to hospitals and health care organizations about licensure history and past regulatory actions for actively licensed physicians (Policy H-355.975, "Opposition to the National Practitioner Data Bank").

The AMA has also traditionally rejected efforts to amend the HCQIA and maintained this position in BOT Report 29-A-24 where no recommendation was made to add monetary penalties for organizations involved in bad-faith peer reviews. The position to not amend the HCQIA was taken to protect the peer review process and the safety of the physicians that participate in them and prevent entities whose interests are not aligned with organized medicine from reintroducing changes that have previously been proposed. It is also a costly and challenging endeavor to provide tangible evidence that a hospital or health care organization has engaged in a bad-faith peer review. Additionally, as it currently stands, the HCQIA already does not provide immunity to organizations found to have conducted a bad-faith peer review. Further, monetary penalties at the state level have not resulted in increased reporting or reduced incident rates.[1,2]

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DISCUSSION:

BOT Report 29-A-24

BOT Report 29-A-24 highlighted persistent barriers that prevent physicians from reporting patient care concerns or seeking recourse when subjected to a bad-faith peer review process. It identified interests that often prompt the initiation of bad-faith peer reviews, including retaliation for raising patient care concerns, efforts to limit competition, and racism. The report also outlined existing mechanisms for physicians to report concerns about their health system or hospital employer, as well as relevant AMA policies and resources. It recommended reaffirming these policies and urged the AMA to (1) support and facilitate transparent reporting of final physician complaints against hospitals through publicly accessible channels (e.g., the Joint Commission Quality Check reports), and (2) develop educational materials to help physicians recognize a bad-faith peer review and navigate the peer review process.

Status Update

To fulfill the AMA's responsibility to "support and facilitate transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as the Joint Commission Quality Check reports," the AMA sent a letter to the President and Chief Executive Officer of The Joint Commission, urging the Joint Commission to facilitate transparent reporting of patient care, safety concerns, or other inappropriate practices that physician employees observe within their hospital or health system.

The letter was sent to The Joint Commission in November 2024 wherein the AMA urged them to collect and publicly share final complaint determinations related to patient and staff safety violations to contribute to efforts to improve patient safety, care quality, and assist physicians in making informed decisions about where to work. The AMA recommended that one way The Joint Commission could achieve this was by developing a new reporting tool or enhancing its existing publicly available Joint Commission Quality Check reports.

The Joint Commission's President and Chief Executive Officer promptly replied, acknowledging receipt of the letter and its important subject matter. The letter was well-received and coincided with current efforts at The Joint Commission to improve transparency around safe practices in health care organizations and their Quality Checks program.

A meeting between the AMA and The Joint Commission occurred in March 2025 to further discuss this issue. Although The Joint Commission is appreciative of the AMA's efforts, they reported that publicly disclosing details about complaints—particularly at the level of disclosing individual organization information—would run counter to the agreements and accountabilities they hold with the organizations they accredit. They are also revising their Quality Check Reports to provide additional metrics by accredited organization, but their revisions will not include information about voluntary complaints. The Joint Commission recommended that the AMA look to the state medical societies and licensing boards to collect and report on such information relevant to health care organizations in their jurisdictions. Additional recommendations discussed include continuing the promotion of existing AMA initiatives (e.g., Joy in Medicine™ Health System Recognition Program) that provide guidance for physicians assessing potential employers and staying informed on emerging employee safety metrics. The AMA will continue exploring additional avenues to facilitate transparent public reporting of physician employees' concerns related to patient or staff safety, or other serious misconduct, by hospital and health system employers.

The AMA considered sending a similar letter to the EEOC; however, since the EEOC is required by law to keep charge information confidential and is prohibited from disclosing information about charges to the public[3], no communication was sent.

RECOMMENDATIONS

The Board of Trustees recommends:

1. That the first directive of Policy D 200.971 be amended by addition and deletion as follows: Our American Medical Association supports and facilitates transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as the Joint Commission Quality Check reports and will report back to the HOD every two (2) years through 2029 any AMA and/or industry efforts to advance this effort. ~~to include periodic report back to the HOD with the first update to be given at A-25.~~
2. That the remainder of this report be filed.

Fiscal Note: Minimal

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REPORT 19 OF THE BOARD OF TRUSTEES (A-25)
Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
Reference Committee G

EXECUTIVE SUMMARY

At the 2024 Annual Meeting of the House of Delegates (HOD), Policy D-460.962, "Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout," was adopted. This report addresses the first directive of this policy which asked that our American Medical Association (AMA) "monitor and report on the research regarding technology, measures, and effective use of personal and biological data to assess professional workforce wellbeing and inform organizational interventions to mitigates burnout" (Directive to Take Action). A separate report has been developed that addresses the second directive of this policy.

This report provides a literature review on the use of biometrics to study physician wellbeing. Relevant AMA policies are also detailed. Nine studies published between 2015 and 2025 were included in the review. The inclusion criteria were U.S.-based studies that used and reported biometric data to study professional wellbeing and included physicians as study participants. Various practice settings were studied including neurology, adult and pediatric emergency medicine, surgery, primary care, and academic medicine.

Most studies in the review used a wearable wrist-worn device to measure biometric data. Heart-related biometrics were the most common biometric data collected. Other biometric data included sleep-, respiratory-, exercise-, skin-, hormonal-, and ocular-related biometrics.

The review identified three major themes: (1) the use of biometric data to identify physiological biomarkers of physician stress and burnout; (2) the assessment of the feasibility of using wearable devices to study wellbeing and identify limitations; and (3) the importance of accounting for practice-specific factors as potential confounders when using wearables to study physician wellbeing.

Limitations identified in the studies reviewed were inconsistent wearing of the devices, technical challenges and inappropriate use of devices, short observation periods, and a lack of systematic use of validated burnout, depression, and anxiety measures.

This review has implications for research, clinical practice, and organizational leadership. Additionally, the studies reviewed shed light on short- and long-term impacts of work-related stressors on physician health. Included studies present the opportunity for efforts that facilitate early detection and mitigation of burnout. Future research using biometric data to measure physician wellbeing should incorporate organizational- and practice-specific variables to better understand factors that contribute to physician burnout.

As the literature review accomplishes the goal of monitoring and reporting on the research around the use of personal and biological data to examine physician wellbeing, the AMA Board of Trustees recommends that the first directive of Policy D-460.962 be rescinded (Rescind HOD Policy).

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 19-A-25

Subject:	Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee G

INTRODUCTION

At the 2024 Annual Meeting of the House of Delegates (HOD), Policy D-460.962, "Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout," introduced by the Integrated Physician Practice Section, was adopted. This report addresses the first directive of this policy which asked that our American Medical Association (AMA) "monitor and report on the research regarding technology, measures, and effective use of personal and biological data to assess professional workforce wellbeing and inform organizational interventions to mitigates burnout" (Directive to Take Action). A separate report has been developed that addresses the second directive of this policy.

BACKGROUND:

Physician burnout

Physician burnout is defined as "emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness" and impacts all physicians.[1] The dangers of physician burnout are significant and widespread, resulting in adverse outcomes not only for physicians—such as broken relationships, problematic alcohol use, and suicidal ideation[2]—but also for patients and the health care system at large. For instance, physician burnout has been shown to result in increased medical errors and malpractice suits[3–5], and physicians reducing their clinical hours or leaving the profession altogether.[6–12] Compared to other U.S. workers, physicians work longer hours and experience worse work-life integration.[2] Burnout is also associated with higher health care expenditures.[13–15]

Many factors, both at the system and practice level, can contribute to burnout, including high physician task load[16], poor work-life integration[17], administrative burdens related to electronic health records (EHRs)[15,18–24], and regulatory burden.[25–27] A lack of work control[28] and being unable to take vacation or having to work while on vacation also are associated with increased risk of burnout[29]. Additionally, the politicization of medical care[30] and childcare stress[31] during the COVID-19 pandemic have been associated with burnout.

Measuring burnout and wellbeing

Physician burnout is commonly measured using validated survey instruments. One of these surveys is the Maslach Burnout Inventory-Human Services Survey (MBI-HSS), a 22-question instrument

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released in 1981 that's considered the "gold standard" for assessing burnout.[32,33] The survey covers three areas—emotional exhaustion, depersonalization, and a low sense of personal accomplishment. Responses to questions covering these areas are rated by frequency: never, a few times a year or less, once a month or less, weekly, a few times a week, or daily. Researchers typically consider respondents to present at least one symptom of burnout if they have high scores on either the emotional exhaustion or depersonalization subscales.[33]

Developed for use in physicians and non-physician providers, the Mini-Z survey is a ten-question tool adapted from the Minimizing Error Maximizing Outcome clinician survey.[34,35] It was designed to assess workplace satisfaction, stress, and burnout. Additionally, it captures factors including work control, value alignment with organizational leadership, teamwork, documentation time pressure, and EHR use. The Mini-Z single item burnout measure has demonstrated good correlation with the MBI-HSS emotional exhaustion subscale[34] and thus, when researchers are solely interested in this subscale, they may use a single-item burnout measure like that from the Mini-Z to reduce survey length and increase response rates.[36] Since its development, it has been adapted for use in nurses, residents, medical students, and others.[35]

The Mini-Z tool is an essential part of the Organizational Biopsy®, an assessment tool offered by the AMA that measures the drivers of burnout and wellbeing at health systems and large practices.[37] The tool provides a comprehensive evaluation across four domains: organizational culture, practice efficiency, self-care, and retention.[38] It includes standardized questions on leadership, team culture, efficiency, and individual wellbeing. It also has demographic questions to aid health systems in identifying vulnerable populations in need of greater support, as well as customizable questions to gain insights into organization-specific concerns.[37]

As single-item burnout measures have been critiqued for providing an incomplete view of physician wellbeing, researchers from Stanford developed and validated the Stanford Professional Fulfillment Index—a comprehensive tool that captures key aspects of professional fulfillment, including satisfaction, engagement, happiness, and meaningfulness.[39] The instrument is a 16-question survey designed for physicians. It measures three areas: professional fulfillment, work exhaustion, and interpersonal disengagement using a five-point Likert scale. Higher professional fulfillment scores indicate greater wellbeing, while higher work exhaustion and interpersonal disengagement scores reflect greater burnout.[33]

The Patient-Reported Outcomes Measurement Information System (PROMIS) is a set of person-centered measures assessing physical, mental, and social health in both the general population and those with chronic conditions. It was designed to enhance clinician-patient communication across diverse research and clinical settings.[40] Although PROMIS has been widely used to measure patient outcomes, some studies have utilized PROMIS measures to evaluate aspects of physician health, including sleep-related impairment and mental health. For instance, one study used PROMIS to examine the relationship between sleep-related impairment and occupational wellness indicators such as work exhaustion, interpersonal disengagement, overall burnout, and professional fulfillment.[41]

In addition to surveys, factors that contribute to physician burnout have also been measured using EHR user audit log data[20,42,43], and through qualitative methods such as interviews[44–46] and focus groups[47,48]

Biometrics

"Biometrics" has emerged as another way of studying burnout and factors that contribute to it. It is the science of using measurable characteristics—often categorized into physiological or behavioral traits—to describe individuals.[49] It provides objective indicators of stress through sensors such as patient monitors or wearable devices that capture physiological changes associated with sympathetic nervous system activity (e.g., heart rate, respiratory rate, finger prints, retinal vessel patterns, and skin temperature).[49,50]

Until recently, studies aimed at measuring physiologic data to track and develop interventions designed to mitigate stress were conducted in a laboratory with participants attached to bulky cable monitor apparatuses to collect biometric data or via self-reported studies. Such methods made the study of live conditions challenging.[49,51] Wrist-worn wearable devices (e.g., the Fitbit) originally marketed to consumers to improve fitness[49] are beginning to be used in research to collect biometric data from study participants, determine associations with stress and burnout, and identify targeted interventions. Recent innovations in wearable technology enable unobtrusive, real-time monitoring of physiological metrics related to wellbeing.[50,51]

A substantial body of literature focuses on the use of biometric data to identify stress and wellbeing in the general population. This research highlights the potential of biometric feedback for promoting self-awareness and positive behavior change, as well as innovative solutions (e.g., smartwatches and machine learning algorithms) for continuous, real-time health monitoring. For example, Ortoleva et al. (2024) found that physical data representations enhanced self-reflection and mental health intentions in university students. Participants' heart rate (HR) data was collected via EEG Muse headbands and Fitbit watches.[52] Khayyat et al. (2024) analyzed streams of physiological and behavioral data to develop a highly accurate machine learning model for monitoring psycho-physiological stress among employees.[53] Matsumoto et al. (2022) also constructed a machine learning model that aimed to improve stress prediction in older adults by correlating daily activities with biometric data. The approach increased prediction accuracy by over ten percent compared to baseline data, highlighting the potential to improve health management, quality of life, and overall wellbeing for older adults through proactive and innovative solutions.[54]

The following literature review outlines research on the use of biometrics to study wellbeing among physicians specifically.

DISCUSSION

Literature review

Objective

The purpose of this review was to evaluate and understand the current state of research on biometric data to assess physician wellbeing and inform organizational interventions to mitigate burnout.

Methods

The literature review was conducted in the Google Scholar, PubMed, and Medline databases. Studies published between the years of 2015 and 2025 were included. The studies included consisted of U.S.-based studies that used and reported biometric data to study professional wellbeing and included physicians as study participants. In Google Scholar and PubMed,

"biometrics physician well-being" and then "biometrics physician stress" were first searched but did not yield studies aligned with inclusion criteria. Studies that met the inclusion criteria were identified in the three databases when the search terms were changed. The terms, "study of clinician burnout with biometrics", "biometrics physician well-being", and "biometrics physician stress", were searched in Google Scholar. The term, "biometrics physician stress", was searched in PubMed, and "physician stress AND biometrics" was searched in Medline. A total of 13 studies were originally identified and a duplicate included from both PubMed and Medline was removed. After the titles and abstracts of the remaining 12 studies were screened, one study was excluded since it was not U.S.-based. Next, the full text of the remaining 11 articles were screened and two were removed since they did not report biometric data. In the end, nine studies were eligible to be included in the review. Figure 1 summarizes this process and can be found in the appendix of this report.

Study Characteristics

Of the nine studies included in the review, the most common type of article was a prospective study, with six studies falling into this category. There were two mixed-methods studies, one of which was a live observational usability study and the other a simulation-based study. The remaining study was a scoping review. Eight of the papers were peer-reviewed journal articles, while one was a preprint. The year of publication ranged from 2018-2024, most of which were published within the last five years.

Regarding study samples, all but one study exclusively included physicians—attendings, trainees, residents, fellows, and faculty—while the remaining study also included nurses and medical students. Specialties and practice settings represented among the studies included neurology, emergency medicine (adult and pediatrics), surgery, primary care, and academic medicine.

Seven of the studies used a wearable device—either wrist-worn or a smart shirt—to measure biometric data, while the remaining two used a wearable eye tracking device and a patient monitor in which physicians were affixed to during surgery and had a blood pressure (BP) cuff, pulse oximeter probe, and nasal cannula placed onto them. The most common biometric data collected were heart-related, including heart rate variation (HRV), heart rate (HR), BP, and rate pressure product. Only one study in the review did not collect and/or report these biometrics. Sleep-related biometrics were also collected (e.g., sleep status level and total nightly sleep time), in addition to respiratory-related biometrics (e.g., oxygen saturation, end-tidal carbon dioxide, and respiratory rate). Physical activity and movement-related biometrics that were collected were strain, workout strain, total workouts per 24-hour period, and accelerometry. Other biometrics that were measured involved the skin (skin temperature and electrodermal activity), hormones (hair cortisol level), and eyes (gaze location/fixation and pupil dilation). Figure 2 in the appendix summarizes the characteristics of the nine studies included in this review.

Three major themes were identified in the studies. The first theme was the use of biometric data to identify physiological biomarkers of physician stress and burnout. The second theme was the assessment of the feasibility of using wearable devices to study wellbeing and identify limitations. The final theme to be addressed in this review is the importance of accounting for practice-specific factors as potential confounders when using wearables to study physician wellbeing.

Theme 1: Use of Biometric Data to Identify Physiological Biomarkers of Physician Stress & Burnout

Six studies, Barac et al. (2024), Kaczor et al. (2020), Ciraulo et al. (2022), Slamon et al. (2018), Wolfe et al. (2022), and Akbar et al. (2021), sought to identify physiological biomarkers of physician stress and/or burnout using biometric data. Barac et al. broadly focused on health care professionals (physicians, medical students, and nurses), while the other four studies were specialty-specific (emergency medicine and surgery). Barac et al., a scoping review, included ten papers and did not find any reliable associations between physiological measures derived from wearable wrist-worn devices and clinician burnout. However, the scoping review did identify associations between step count and time in bed with depression symptoms, and heart-related biometrics (HR and HRV) with acute stress.[55]

Kaczor et al. aimed to determine whether physiological biomarkers of stress among physicians during their clinical work could detect stress in the emergency medicine setting. All participants successfully wore a wearable sensor for nine clinical shifts over the course of six months. Findings showed that wearable sensors detected stress 20 minutes before individuals self-reported stress. This suggests the possibility of either delayed reporting or delayed stress awareness among physicians, and highlights an opportunity for interventions that support early detection of stress to improve wellbeing.[50]

Similarly, Slamon et al. measured HR and HRV of pediatric critical care physicians during live pediatric intensive care unit scenarios including patient rounds, tracheal intubation, and central line insertion. Compared to physicians' baseline biometric data, tracheal intubation and central line insertion activities resulted in higher levels of sympathetic activation.[49]

Wolfe et al. placed pediatric critical care fellows and faculty in simulated high and low stress roles to examine the relationship between subjective and objective stress measures. Subjective stress was measured via a self-reported anxiety assessment and objective stress was measured via HRV obtained from a wearable device. Significant differences in self-reported, subjective measurements and wearable-obtained, objective stress measurements were observed between low- and high-stress roles, as demonstrated by a strong correlation between HRV markers and anxiety levels.[56]

Additionally, Ciraulo et al. showed that surgeons experienced statistically significant increases in HR, BP, and cellular metabolism while performing operations, shedding light on the potential long-term risks resulting from continuous triggering of sympathetic activation (e.g., heart disease) by job-specific stress.[57]

Finally, Akbar et al. examined the relationship between EHR inbox work patterns and primary care physician physiologic stress. Physicians wore devices that measured HRV for seven days. On average, physicians spent 1.08 hours on inbox work of which patient messages consumed the most time. Findings revealed three periods in which physiological stress were shown to increase: in the first hour of work, early afternoon, and evening. Physicians tending to inbox work after hours experienced the longest average stress duration during work hours, as they were more likely to batch emails, spending more time per message, compared to those who managed their inbox during work hours (e.g., between patient appointments), thus spending less time per message.[51]

Theme 2: Assessing the Feasibility of the Use of Wearable Devices to Study Wellbeing & Identification of Limitations

The literature review also explored the feasibility and limitations of using wearable devices to study physician wellbeing. Niotis et al. (2021) and Kaczor et al. (2020) supported this high feasibility. In Kaczor et al., all emergency medicine physician participants successfully wore the wrist-worn sensors during their shifts. Only a five percent incidence of failure to fully capture data was experienced.[50] Niotis et al. used a wearable device to assess exercise and sleep among neurology residents and examine associations with validated survey measures. The majority of study participants (68.8 percent) were deemed "consecutive wearers" of the wrist-worn device. However, this study only found moderate-to-low correlations between physiological measures and survey responses. Additionally, barriers to wearing the device included participants forgetting and not being motivated.[58]

Barac et al., Akbar et al., and Slamon et al. detailed limitations in using wearable devices to study physician wellbeing. The scoping review by Barac et al. identified methodological issues including short durations of observing participants while wearing the devices which restrict the capture of real-world variations in workplace stressors. Additionally, a lack of systematic use of validated instruments to measure burnout, anxiety, and depression was noted.[55] In the Akbar et al. study, wearable device data for five primary care physicians was lost due to technical issues. Further, the study attempted to control for impacts on HRV measures by removing periods of physical activity recorded by the device. However, a carry-over effect of physical activity may have still been present in sedentary movements. Moreover, by removing periods of physical activity, the ability to capture stress may have been limited. For example, in the scenario of a stressed physician walking to a meeting, their stress would not have been captured due to it coinciding with physical activity, underscoring the need for innovative methods for biometric studies on burnout that account for factors such as exercise that elevate physiologic markers independently of burnout. Additionally, losing contact with the skin during physical activity was a barrier to the collection of biometric data in this study.[51] Slamon et al. also experienced technical difficulties in their use of a smart shirt device. Reliable readings were limited when the smart shirt wasn't worn tight enough to the skin or its elastic straps weren't worn. The study also had a small sample size.[49]

Theme 3: Accounting for Practice-Specific Factors as Confounders When Using Wearables to Study Physician Wellbeing

Many studies highlighted the need to account for practice-specific factors as potential confounders when using wearables to examine physician wellbeing. Cowart et al. (2022), Niotis et al., Ciraulo et al., and Akbar et al. focused on anesthesiology, neurology, surgery, and primary care settings, respectively, while Khairat et al. (2019), Kaczor et al., Slamon et al., and Wolfe et al. focused on the emergency medicine environment.

Barac et al. called attention to the multitude of factors—such as workplace stressors, job demand, patient acuity, shift length, and the availability of support staff—that vary by practice setting. As such, practice setting also impacts burnout biomarkers derived from wearable devices. The study suggested that future research "consider collecting organizational variables to better understand the systemic contributors of burnout".[55] Akbar et al. noted that inbox patterns vary between settings and organizations[51], and Slamon et al. identified plans to compare HRV data between different specialties.[49]

CONCLUSION

Current literature provides only a small amount of research focused on physicians and the health care workforce that uses biometric and personal data to measure wellbeing factors such as burnout. The reviewed literature on the use of personal and biological data to assess physician wellbeing focuses on three major themes: (1) the use of biometric data to identify physiological biomarkers of physician stress and burnout; (2) the assessment of the feasibility of using wearable devices to study wellbeing and identify limitations; and (3) the importance of accounting for practice-specific factors as potential confounders when using wearables to study physician wellbeing. The studies reviewed show variation in the utility of the tools studied and limitations that may restrict the feasibility of broad-scale or long-term use in measurement across larger populations.

Limitations of the studies included in the review included inconsistent wearing of the devices, technical challenges and inappropriate use regarding devices which restricted data collection, short observation periods, and a lack of systematic use of validated burnout, depression, and anxiety measures.

Future research should incorporate organization- and practice-specific variables to gain deeper insights into factors that contribute to physician burnout. Biometric data provides crucial knowledge for organizational leadership and clinical practice regarding the short- and long-term impacts of work-related stressors on physician health. For instance, Ciraulo et al. discussed that increased physiological demands over time could lead to future cardiovascular and cerebrovascular issues for physicians. Such research included in this review presents the opportunity for early detection of burnout and the identification of prevention strategies.

AMA POLICY

The AMA has several policies regarding the development and use of metrics to study physician wellbeing.

Our AMA will research and develop useful metrics that hospitals and hospital systems can use to improve physicians' experience, engagement, and work environment in a manner accessible to physicians, with report back to the House of Delegates no later than Annual 2026 (Policy D-215.979, "Published Metrics for Hospitals and Hospital Systems").

AMA policy also directs it to study current tools and develop metrics to measure physician professional satisfaction (Policy D-405.985, "Physician Satisfaction").

Additionally, the AMA recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician wellbeing, particularly for this population of physicians (Policy H-405.948, "Factors Causing Burnout").

RECOMMENDATIONS

The Board of Trustees recommends that the first directive of Policy D-460.962 be rescinded having been accomplished by this report and that the remainder of the report be filed.

Fiscal Note: Modest

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APPENDIX

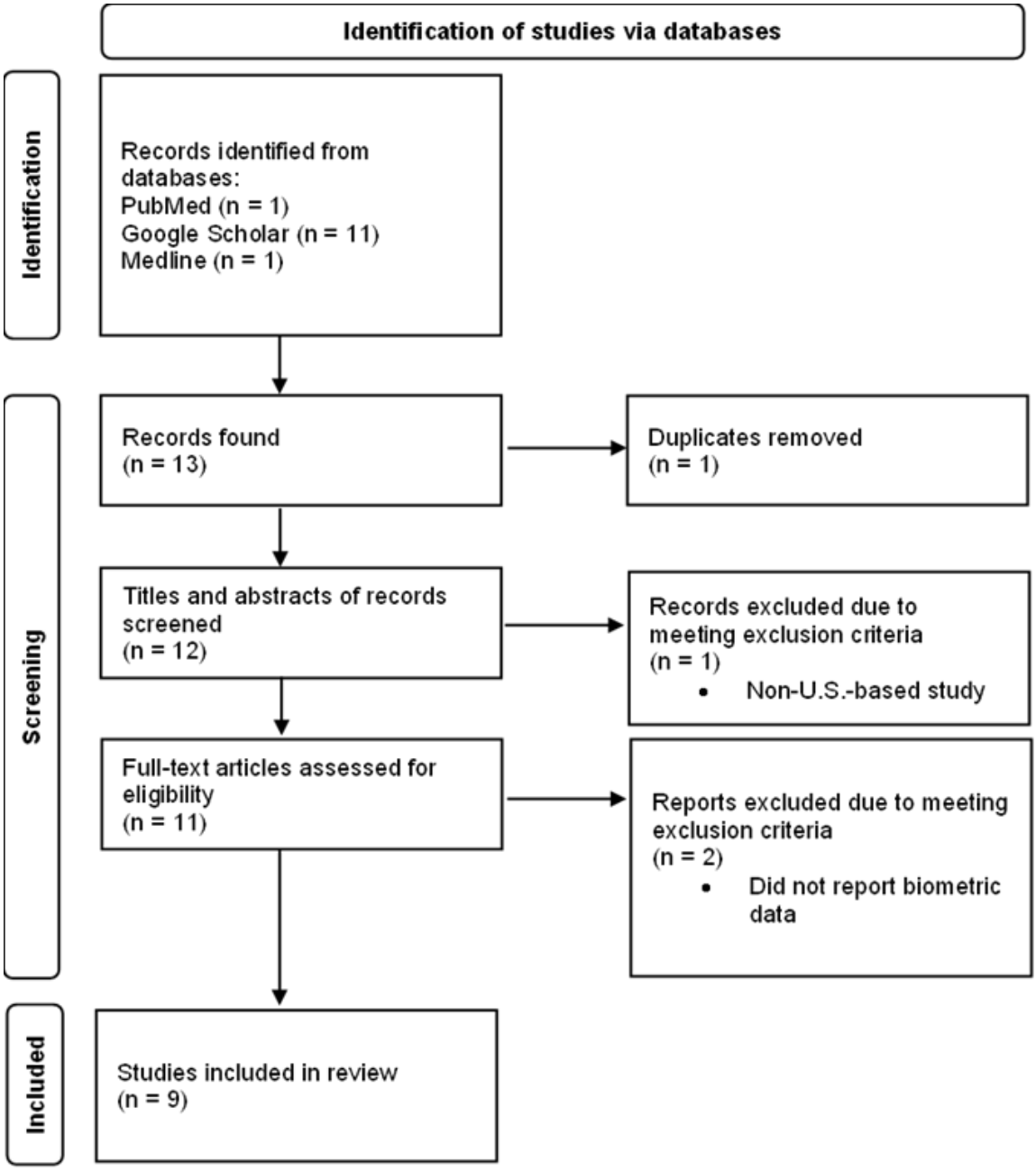


Figure 1: *PRISMA* flow diagram depicting literature review that yielded 9 studies.

Study	Slamon et al. (2018)	Khairat et al. (2019)	Niotis et al. (2020)	Kaczor et al. (2020)	Ciraulo et al. (2020)
Study Type	Prospective	Mixed-methods, live observational usability	Prospective	Prospective	Prospective
Objectives	To measure the biometrics of critical care physicians during clinical scenarios	To propose a framework for understanding EHR-related information overload by identifying areas of poor usability and clinician frustration	To evaluate a wearable biosensor's feasibility in characterizing exercise and sleep in neurology residents, its relationship to validated survey measures, its impact on well-being, and barriers to use	To characterize digital biomarkers of stress among emergency medicine physicians using a wearable sensor	To quantify the physiological impact of surgery on acute care surgeons
Sample	Pediatric critical care attendings/ fellows	Intensive care unit physicians	Neurology residents	Emergency medicine physicians	Surgeons
Biometric Data Collection Device	Hexoskin biometric smart shirt	Tobii Pro Glasses	WHOOP Strap	Empatica E4 wristband	Philips IntelliVue MP5 Patient Monitor
Biometrics Measured	HR, respiratory rate, and HRV	Pupil dilation and gaze location/fixation	Resting heart rate, HRV, strain, exercise frequency/ intensity, and total nightly sleep time	Accelerometry, electrodermal activity, skin temperature, and HR	BP, HR, rate pressure product, oxygen saturation, and end-tidal carbon dioxide
Primary Findings	Critical care activities requiring technical skills led to greater sympathetic activation, with significant increases in mean and maximum heart rate during central venous catheter or	Residents completed tasks more quickly than attending physicians; poor usability, complex interface screens, and navigation difficulties significantly correlated with high frustration levels; and more error messages were associated with longer completion times	Consecutive wearers had significantly higher baseline HRV, HR strain, and workout strain, while nonconsecutive wearers had longer total nightly sleep time. The data supported the feasibility of using these devices as a wellness	Wearable sensor data collected 20 minutes prior to a self-reported stress episode was indicative of stress, suggesting that wearable sensors can detect stress before it is reported or recognized by the individual.	Statistically significant differences were found between baseline data and maximum recordings during surgery for BP, HR, oxygen saturation, and end tidal carbon dioxide, suggesting potential long-term cardiovascular and

	breathing tube insertion in pediatric patients. Researchers found no statistically significant difference in stress levels between tracheal intubation and central line insertion.	due to increased temporal demand.	intervention for select resident groups.		cerebrovascular consequences due to increased physiological demand.

Study	**Akbar et al. (2021)**	**Cowart et al. (2021)**	**Wolfe et al. (2022)**	**Barac et al. (2024)**
Study Type	Prospective	Prospective	Mixed methods, simulation-based	Scoping review
Objectives	To collect EHR use and physiological stress data via unobtrusive means, identify EHR inbox work patterns, and evaluate their association with physicians' stress	To demonstrate the biophysical and psychological benefits of incorporating a mindfulness-based stress reduction program into an urban anesthesiology residency curriculum	To quantify stress differences between low- and high-stress roles and assess the impact of trainee preparedness and self-efficacy on stress levels	To identify physiological burnout biomarkers and highlight current gaps in using wearable technologies to predict burnout among health care professionals
Sample	Primary care physicians	Anesthesiology residents	Pediatric critical care fellows and faculty	Physicians, residents, medical students, and nurses
Biometric Data Collection Device	Garmin Vivosmart wrist-worn device	FitBit	Hexoskin biometric smart shirt	HealthPatch and FitBit
Biometrics Measured	HRV	Hair cortisol level, sleep status level, exercise, and HRV	HRV	HR, HRV, resting HR, respiratory rate, skin temperature, sleep, step count, and activity levels from a work shift
Primary Findings	Physiological stress patterns across the three groups increased during the first hour of work, early afternoon,	Depersonalization scores were significantly lower in the intervention group. Clinical anesthesia residents in PGY-3 had	Significant changes in subjective and objective stress measurements were observed between low- and	The studies found no relationship between wearable physiological data and burnout or anxiety, and a short observation

	and evening, with Group 1 physicians experiencing the longest stress duration during work hours. Factors such as inbox work duration, EHR window switching rate, and the proportion of inbox work done outside of work hours were independently associated with daily stress duration.	significantly higher emotional exhaustion and depersonalization scores than PGY-2 residents, with no significant differences in biophysical outcomes between cohorts.	high-stress roles. Two HRV markers were significantly correlated with State-Trait Anxiety Inventory levels. Participants who felt more confident discussing code status experienced a notable decrease in stress during both observer and hot seat roles.	duration was a major limitation.

Figure 2: Summary of nine studies included in literature review.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-25

Subject: Council on Medical Service Sunset Review of 2015 House Policies

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee G

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates adopts policies, a maximum 10-year time horizon shall exist. A policy will typically sunset after 10 years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

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RECOMMENDATION

The Council on Medical Service recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

APPENDIX – Recommended Actions

POLICY #	Title	Text	Recommendation
D-120.977	Medicare Patient Access to Implantable Morphine Pumps	Our AMA, in collaboration with appropriate medical societies, will continue to work to address the need for appropriate treatment of patients requiring long-term pain management.	Rescind. Numerous AMA policies address pain management, including H-185.931, D-120.976, and H-120.960. **Workforce and Coverage for Pain Management H-185.931** 1. Our AMA supports efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, including non-opioid options and interventional approaches when appropriate, with a focus on achieving improvement in function and activities of daily living. 2. Our AMA supports guidance on pain management for different clinical indications developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted, such as through medical journals, medical societies, and other appropriate outlets. 3. Our AMA will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain. 4. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits. 5. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, as well as an expanded behavioral health workforce to improve the availability of services to address the psychological, behavioral, and social aspects of pain and pain management within

POLICY #	Title	Text	Recommendation
			multidisciplinary pain clinics. Patients and their caregivers should be involved in the decision-making process. 6. Our AMA supports an expanded availability of comprehensive multidisciplinary pain medicine clinics for patients in both urban and rural areas, and an improvement in payment models for comprehensive multidisciplinary pain clinics services such that such services can become more financially viable. **Pain Management D-120.976** Our AMA will: (1) support more effective promotion and dissemination of educational materials for physicians on prescribing for pain management; (2) take a leadership role in resolving conflicting state and federal agencies' expectations in regard to physician responsibility in pain management; (3) coordinate its initiatives with those state medical associations and national medical specialty societies that already have already established pain management guidelines; and (4) disseminate Council on Science and Public Health Report 5 (A-06),"Neuropathic Pain," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain); and (5) disseminate Council on Science and Public Health Report 5 (A-10), "Maldynia: Pathophysiology and Nonpharmacologic Approaches," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain). **Protection for Physicians Who Prescribe Pain Medication H-120.960** Our AMA supports the following: (1) the position that physicians who appropriately prescribe and/or

POLICY #	Title	Text	Recommendation
			administer controlled substances to relieve intractable pain should not be subject to the burdens of excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution. It is the policy of the AMA that state medical societies and boards of medicine develop or adopt mutually acceptable guidelines protecting physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain before seeking the implementation of legislation to provide that protection; (2) education of medical students and physicians to recognize addictive disorders in patients, minimize diversion of opioid preparations, and appropriately treat or refer patients with such disorders; and (3) the prevention and treatment of pain disorders through aggressive and appropriate means, including the continued education of doctors in the use of opioid preparations. Our AMA opposes harassment of physicians by agents of the Drug Enforcement Administration in response to the appropriate prescribing of controlled substances for pain management.
D-160.933	Payment Mechanisms for Physician-Led Team-Based Health Care	Our AMA will develop educational programs to assist members wishing to develop and implement physician-led team based care payment methodologies at the individual team, practice, accountable care organization, hospital and health system levels.	Rescind. Accomplished by several *Advocacy Issue Briefs* and other resources on the AMA website: 1) Physician-Led Team-Based Care 2) AMA Advocacy Resource Center – Physician-Led Health Care Teams 3) Models of Physician-Led Team-Based Care 4) Summary of physician payment & delivery models 5) Ed Hub Module – Physician Payment Models Guide 6) Ed Hub Module – Physician-Led Models to Achieve the Quadruple Aim 7) AMA/AHIP/NAACOS Playbook of Voluntary Best Practices for VBC Payment Arrangements
D-165.954	Update on HSAs, HRAs, and Other Consumer-	Our AMA will: (1) educate physicians about health insurance plan practices that may impact physician billing and collection	Retain.

POLICY #	Title	Text	Recommendation
	Driven Health Care Plans	of payment from patients with health savings accounts (HSAs), health reimbursement arrangements (HRAs), and other forms of consumer-driven health care; and (2) monitor and support rigorous research on the impact of HSAs and HRAs on physician practices, and on levels and appropriateness of utilization, including preventive care, costs, and account savings.	
D-280.988	Observation Status and Medicare Part A Qualification	Our AMA will advocate for Medicare Part A coverage for a patient's direct admission to a skilled facility if directed by their physician and if the patient's condition meets skilled nursing criteria.	Rescind. Superseded by Policy H-280.947. **Three Day Stay Rule H-280.947** 1. Our American Medical Association will continue to advocate that Congress eliminate the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services, and educate Congress on the impact of this requirement on patients. 2. Our AMA will continue to advocate, as long as the three-day stay requirement remains in effect, that patient time spent in the hospital, observation care or in the emergency department count toward the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services. 3. Our AMA will actively work with the Centers for Medicare and Medicaid Services (CMS) to eliminate any regulations requiring inpatient hospitalization as a prerequisite before a Medicare beneficiary is eligible for skilled (SNF) or long-term care (LTC) placement. 4. Our AMA advocates that the Medicare three-day hospital inpatient requirement for skilled nursing facility admissions be immediately rescinded for uniformity and safety for all Medicare recipients.
D-290.987	Early and Periodic Screening, Diagnosis, and Treatment	Our AMA recognizes the importance of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and will advocate for EPSDT to remain intact as critical to the health and well-being of children.	Retain.

POLICY #	Title	Text	Recommendation
D-375.996	Peer Review Immunity	Our AMA: (1) recommends that medical staffs adopt bylaws that provide for a peer review process that is consistent with HCQIA criteria and AMA policy; (2) recommends medical staffs include bylaw provisions that provide an option or alternative for external and impartial review when there is an allegation by a reviewed physician; (3) recommends that if physicians believe that negligent or misdirected peer review is a problem, legislative action be considered at the state level to assure a fair due process proceeding for physicians subject to review; and (4) shall continue to monitor the legal and regulatory challenges to peer review immunity and non-discoverability of peer review records and proceedings, as well as consider legislative remedies, including the feasibility and impact of amending HCQIA to provide the option for external peer review for hospital medical staff physicians.	Rescind: Superseded by Policy D-375.997. **Peer Review Immunity D-375.997** 1. Our American Medical Association will recommend medical staffs adopt/implement staff by laws that are consistent with HCQIA and AMA policy by communicating the guidelines from AMA policy H-375.983 widely through appropriate media to the relevant organizations and institutions, including a direct mailing to all medical staff presidents in the United States, indicating that compliance is required to conform to HCQIA and related court decisions. 2. Our AMA will monitor legal and regulatory challenges to peer review immunity and non discoverability of peer review records/proceedings and continue to advocate for adherence to AMA policy, reporting challenges to peer review protections to the House of Delegates and produce an additional report with recommendations that will protect patients and physicians in the event of misdirected or negligent peer review at the local level while retaining peer review immunity for the process. 3. Our AMA will continue to work to provide peer review protection under federal law.
D-450.958	Pain Medicine	Our AMA: (1) continues to advocate that the Centers for Medicare & Medicaid Services (CMS) remove the pain survey questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); (2) continues to advocate that CMS not incorporate items linked to pain scores as part of the CAHPS Clinician and Group Surveys (CG-CAHPS) scores in future surveys; and (3) encourages hospitals, clinics, health plans, health systems, and academic medical centers not to link	Retain.

POLICY #	Title	Text	Recommendation
		physician compensation, employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain.	
D-450.962	Pain Management and the Hospital Value-Based Purchasing Program	1. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) to: (a) evaluate the relationship and apparent disparity between patient satisfaction, using the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) and Emergency Department Patient Experience of Care (ED-PEC) survey, and hospital performance on clinical process and outcome measures used in the hospital value based purchasing program; and (b) reexamine the validity of questions used on the HCAHPS and ED-PEC surveys related to pain management as reliable and accurate measures of the quality of care in this domain. 2. Our AMA urges CMS to suspend the use of HCAHPS and ED-PEC measures addressing pain management until their validity as reliable and accurate measures of quality of care in this domain has been determined.	Retain.
D-510.991	Requiring The Joint Commission to Conduct Root-Cause Analysis to Determine How its Surveys Allowed Veterans Administration Hospitals to Cause Delay in Treatment and Harm Veterans	Our AMA supports The Joint Commission making public its findings following its resurveying of Veterans Health Administration (VHA) facilities to ensure quality of care and patient safety.	Rescind: This has been completed.
D-70.945	ICD-10 Implementation	1. If a delay of ICD-10 implementation is not feasible, our American Medical	Rescind: ICD-10-CM was implemented on 10/1/15.

POLICY #	Title	Text	Recommendation
		Association will ask the Centers for Medicare & Medicaid Services (CMS) and other payers to allow a two-year grace period for ICD-10 transition, during which physicians will not be penalized for errors, mistakes, and/or malfunctions of the system. Physician payments will also not be withheld based on ICD-10 coding mistakes, providing for a true transition where physicians and their offices can work with ICD-10 over a period of time and not be penalized. 2. Our AMA will educate physicians of their contractual obligations under Medicare and insurance company contracts should they decide to not implement ICD-10 and opt to transition to cash-only practices which do not accept insurance. 3, Our AMA will aggressively promote this new implementation compromise to Congress and CMS since it will allow implementation of ICD-10 as planned, and at the same time protect patients' access to care and physicians' practices. 4. Our AMA will provide the needed resources to accomplish this new compromise ICD-10 implementation and make it a priority. 5. Our AMA will seek data on how ICD-10 implementation has affected patients and changed physician practice patterns, such as physician retirement, leaving private practice for academic settings, and moving to all-cash practices and that, if appropriate, our will AMA release this information to the public.	
D-70.946	Physician Participation as the 5th	1. Our American Medical Association will advocate for a group with strong physician	Retain; still relevant, as it references "future ICD systems" (e.g., ICD-11).

POLICY #	Title	Text	Recommendation
	Cooperating Party in the International Classification of Diseases System in the United States	participation to be the 5th Cooperating Party for ICD-9-CM and ICD-10-CM with equal power of the current four Cooperating Parties in the planning, interpretation and deployment of ICD-9-CM, ICD-10-CM and future ICD systems. 2. Our AMA will seek to be invited by the United States Department of Health and Human Services to submit nominee[s] for physician group[s] or a group with strong physician participation to be designated as the 5th Cooperating Party for ICD-9-CM, ICD-10-CM and future ICD systems.	
D-70.947	Uncoupling of CPT from ICD-10	Our American Medical Association recommends that the Comptroller General of the Government Accountability Office not address uncoupling the ICD diagnosis code from the CPT procedure code at the present time but this may be reconsidered in the future if new mechanisms are developed for payment of physician services.	Retain; still relevant, as it outlines reconsideration "if new mechanisms are developed for payment of physician services."
D-70.948	ICD-10 Transparency and Conversion	1. The provisions of the Protecting Access to Medicare Act of 2014 delaying the compliance date for the ICD-10 transition are consistent with and supported by existing AMA policy. 2. During the delay in implementation of the ICD-10 transition our AMA will seek and support efforts to ensure that any health plan (commercial, Medicare, Medicaid, or other) operating in the United States, shall provide to their provider network sufficient and timely information apprising providers of all planned changes, including coverage, guidelines, authorization, certifications, claims adjudications, pricing, payment, reporting, incentives and other rules, as well as	Rescind: ICD-10-CM was implemented on 10/1/15.

POLICY #	Title	Text	Recommendation
		resources such as crosswalks or maps, based on the conversion from ICD-9 to ICD-10.	
D-70.949	Stop the Implementation of ICD-10	1. Our AMA will continue to work diligently and actively with Congress to permanently remove the unnecessary administrative burden on physicians of ICD-10 implementation. 2. Our AMA will advocate that Congress ask the Comptroller General of the United States, in consultation with stakeholders in the medical community, to conduct a study to identify steps that can be taken to mitigate the disruption on health care providers resulting from a replacement of ICD-9 in the future; and that the Comptroller General shall submit to each House of Congress a report on such study no later than May 1, 2015 and such report shall include appropriate recommendations. 3. The Comptroller General's report should at least address these issues: 1) decreasing the massive number of codes down to a reasonable number such as Canada did; 2) putting the replacement of ICD-9 on hold until physicians fully implement the new Electronic Medical Record systems, the new government regulations and the Affordable Care Act regulations; and 3) consider adopting a policy for Medicare that provides a two year implementation period during which Medicare will not be allowed to deny payment based on the specificity of the ICD-10 code.	Rescind: ICD-10-CM was implemented on 10/1/15.
D-70.951	Alleviating the Financial Burdens Associated with ICD-10 Implementation	1. Our AMA will seek federal legislative and regulatory reform to require funding assistance be provided to physician practices to alleviate the financial burdens associated with the implementation costs, upgrades	Rescind: ICD-10-CM was implemented on 10/1/15.

POLICY #	Title	Text	Recommendation
		and staff training necessitated as part of the transition to ICD-10. 2. Our AMA will work toward the goal of having insurance companies and governmental entities reimburse physicians for the extra cost of increasingly complex and mandatory changes in coding.	
D-70.952	Stop the Implementation of ICD-10	1. Our AMA will: (A) vigorously work to stop the implementation of ICD-10 and to reduce its unnecessary and significant burdens on the practice of medicine; (B) do everything possible to let the physicians of America know that our AMA is fighting to repeal the onerous ICD-10 requirements on their behalf; (C) work with other national and state medical and informatics associations to assess an appropriate replacement for ICD-9; and (D) evaluate the feasibility of moving from ICD-9 to ICD-11 as an alternative to ICD-10 and report back to the House of Delegates. 2. In order to alleviate the increasing bureaucratic and financial burden on physicians, our AMA will vigorously advocate that the Centers for Medicare & Medicaid Services eliminate the implementation of ICD-10. 3. Our AMA will immediately reiterate to the Centers for Medicare & Medicaid Services that the burdens imposed by ICD-10 will force many physicians in small practices out of business. This communication will be sent to all in Congress and displayed prominently on our AMA website. 4. Our AMA: (A) will educate US physicians on the burdens of ICD-10 and how our AMA is fighting to repeal the onerous ICD-10 requirements on their	Rescind: ICD-10-CM was implemented on 10/1/15.

POLICY #	Title	Text	Recommendation
		behalf; (B) supports federal legislation to stop the implementation of ICD-10 and remain with ICD-9 until ICD-11 can be properly evaluated; and (C) supports federal legislation to mandate a two-year "implementation" period by all payers, including CMS, if ICD-10 or ICD-11 is implemented. During this time, payers will not be allowed to deny payment based on specificity of ICD-10/11 diagnosis. However, they will be required to provide feedback for incorrect diagnosis. In addition, no payer will be allowed to ask for "takebacks" due to lack of ICD-10/11 diagnosis code specificity for the aforementioned two-year implementation period.	
D-70.960	Implementation of ICD-10-CM	Our AMA will work for delayed implementation of a simplified, modified ICD-10-CM coding system which is less burdensome on practicing physicians, hospitals, and the health insurance industry.	Rescind: ICD-10-CM was implemented on 10/1/15.
D-90.994	Threats Against Physicians Based on Americans With Disabilities Act	Our American Medical Association encourages AMA members who are threatened with non-meritorious lawsuits, supposedly founded on the Americans with Disabilities Act, to contact the AMA's Private Sector Advocacy Group for assistance. The AMA will post a notice on its web site, informing physicians how to report such incidents.	Retain-in-part: Our American Medical Association encourages AMA members who are threatened with non-meritorious lawsuits, supposedly founded on the Americans with Disabilities Act, to contact the AMA. ~~'s Private Sector Advocacy Group for assistance. The AMA will post a notice on its web site, informing physicians how to report such incidents.~~
H-120.933	Emergency Prescription Drug Refills	Our AMA will advocate the following principles to guide the dispensing of emergency refills of prescription drugs: 1. Emergency refills should only be authorized if, in the pharmacist's professional judgment, failure to refill the prescription might result in an important interruption of a therapeutic regimen that could cause patient harm. 2. Emergency refills should only be dispensed if the pharmacy is	Retain.

POLICY #	Title	Text	Recommendation
		unable to readily obtain refill authorization from the prescriber; prior authorization cannot be obtained in a timely manner from the patient's health plan; or when an emergency order or a proclamation of a state of emergency is declared by a state's governor. 3. Schedule II controlled substances can be dispensed on an emergency basis as allowed under Drug Enforcement Administration protocol. 4. In general, the pharmacist may dispense a sufficient supply of the medication to maintain the prescribed treatment until prescriber authorization can be achieved. 5. If an emergency order or proclamation of a state of emergency is issued by a state's governor, an executive order may allow pharmacists to dispense up to a 30-day supply of a prescription drug, or other amount as provided for under existing state law. 6. The dispensing pharmacist should notify the prescriber of the emergency refill within 72 hours of dispensing. 7. Emergency refills should not be a regular occurrence. 8. The pharmacist should inform the patient or the patient's agent at the time of dispensing that the refill is being provided without the prescriber's authorization and that authorization of the prescriber is required for a future refill. 9. The pharmacist should notify the patient or the patient's agent of any cost-sharing responsibilities prior to dispensing. 10. A prescriber should not be subject to liability for any damages resulting from an emergency refill of a prescription drug by a pharmacist.	

POLICY #	Title	Text	Recommendation
H-120.935	Medication Administration in Assisted Living Facilities	Our AMA supports medication administration by appropriately trained facility staff for residents of assisted living and dementia care facilities who require assistance in taking their medications.	Retain.
H-155.956	Make Simplicity the Foremost Criteria for Any CMS Program	Our American Medical Association will: (1) continue to advocate for simplicity in any current or future programs initiated by the Centers for Medicare & Medicaid Services (CMS) that impact physicians; and (2) continue to advocate by all means necessary that any current or future programs initiated by the Centers for Medicare and Medicaid Services be summarized into an executive summary format or other format that is easily comprehensible to physicians, medical staff and administration in a medical office.	Retain.
H-155.965	Health Care Rationing	The AMA defines "health care rationing" as follows: "a process of allocating health care resources that results in limitations or denials of medical services."	Retain.
H-155.980	Patient and Public Education about Cost of Care	The AMA, as a part of its program to strengthen the US health care system, supports intensifying its efforts to better understand patient concerns regarding fees and other costs of health care in all settings, including the cost of medication, and supports attempts to relieve these concerns.	Retain.
H-155.994	Sharing of Diagnostic Findings	The AMA (1) urges all physicians, when admitting patients to hospitals, to send pertinent abstracts of the patients' medical records, including histories and diagnostic procedures, so that the hospital physicians sharing in the care of those patients can practice more cost-effective and better medical care; (2) urges the hospital to return all information on in-hospital care to the attending	Retain.

POLICY #	Title	Text	Recommendation
		physician upon patient discharge; and (3) encourages providers, working at the local level, to develop mechanisms for the sharing of diagnostic findings for a given patient in order to avoid duplication of expensive diagnostic tests and procedures.	
H-160.922	Physician and Health Plan Provision of Uncompensated Care	The AMA: (1) continues to urge physicians to share in the provision of uncompensated care to the uninsured indigent. (2) opposes any health plan-originated prohibition or discouragement of the provision of any uncompensated care by the plan's employed or participating physicians, in the absence of any external legislative or regulatory prohibition of such pro bono activities. (3) supports legislation prohibiting health plan-originated attempts to prohibit the provision of any uncompensated care by the plan's employed or participating physicians. (4) encourages physicians to contract wherever possible only with those health care delivery or financing plans that contribute in some way to care of the uninsured indigent and/or other community health needs, and that allow individual participating physicians to provide uncompensated care. (5) encourages all health care delivery or financing plans that control the source of covered services and the amount of payment for such services, including plans owned or sponsored by physicians, to contribute to the care of the uninsured indigent or to other community health needs through such means as: (a) Offering direct plan enrollment to individuals and families lacking group coverage and/or offering special coverages or premium subsidies for older, lower-income, and/or less healthy populations; (b)	Retain.

POLICY #	Title	Text	Recommendation
		Provision of preventive or basic care services to disadvantaged populations at reduced or no charge; (c) Health education programs for the community at large; and (d) Provision of professional staff services, training, equipment and/or other assistance to public health clinics, community health centers or other care resources serving the disadvantaged. (6) encourages organizations and entities that accredit or develop and apply performance measures for health plans to consider inclusion of recognition for such contributions in their evaluation criteria. (7) urges state medical societies to collect information on, recognize, and publicize the pro bono activities of health plans. (8) encourages state medical societies to support development of state assistance with malpractice premiums, caps on liability, or immunity from liability for services provided to uninsured indigent patients. (9) continues to support state legislation requiring diversion of assets to charitable causes by non-profit health plans converting to for-profit status.	
H-160.945	Subacute Care Standards for Physicians	AMA guidelines for physicians' responsibilities in subacute care include: (1) Physicians are responsible to their patients for delivery of care in all subacute care settings, 24 hours a day, 7 days a week. (2) Patients who might benefit from subacute care should be admitted to and discharged under the orders of the physician who is responsible for the continuous medical management needed to meet the patient's needs and safety and maintaining quality of care. (3) Physicians are responsible for coordinating care for their patients with other physicians	Retain.

POLICY #	Title	Text	Recommendation
		including medical directors, primary care physicians, and appropriate specialists, to optimize the quality of care in subacute settings. (4) Physicians are responsible for supervision and coordination of the medical care for their patients and providing leadership for all other health care providers in subacute care. (5) Physicians should guide procedures for their patients performed within integrated practices and direct other health care providers, consistent with federal and state regulations. (6) Physicians are responsible for: (a) Fulfilling their roles and identifying the medical skills needed to deliver care in subacute facilities and for creating and developing continuing medical education to meet the special needs of patients in subacute care. (b) Identifying and appropriately utilizing subacute care facilities in their communities. (c) Oversight of physician credentialing in subacute settings (d) Promoting medical staff organization and by-laws that may be needed to support peer evaluations. (e) Planning care of their patients with acute and chronic conditions in subacute care, as well as pursuing efforts to restore and maintain functions for quality of life. (7) Subacute units and/or programs need physician medical directors to assure quality of medical care, provide peer group liaisons, and coordinate and supervise patients and families input and needs. (8) Physicians provide a plan of care for medically necessary visits after completing an initial assessment within 24 hours of admission that identifies the medical services expected during subacute care.	

POLICY #	Title	Text	Recommendation
		(9) Attending physicians should: (a) make an on-site visit to review the interdisciplinary care plan within seventy two hours of admission. (b) Determine the number of medically necessary follow up visits; these may occur daily but never less often than weekly. (c) Document active involvement of physicians in interdisciplinary care and all major components of the patient care plan including completing a progress note for each patient visit. (10) Physicians should implement these guidelines through organized medical staff by-laws in subacute settings to assure quality patient care.	
H-160.971	Uncompensated Care	Our AMA supports (1) communicating to the public the problem of uncompensated care and the ever increasing regulations involving such care as well as the detrimental effect that uncompensated care has on the availability of necessary health care services to many citizens; and (2) publicizing the programs currently instituted to address uncompensated care and pursuing additional solutions for dealing with the problem of uncompensated care.	Retain.
H-165.854	Health Reimbursement Arrangements	It is the policy of the AMA: (1) to support Health Reimbursement Arrangements (HRAs) as one mechanism for empowering patients to have greater control over their health care decision-making; and (2) that employers offering HRAs be encouraged to consider: (a) making HRAs into real (rather than notional) accounts; (b) allowing rollover of all unspent HRA balances annually; and (c) making unspent HRA balances available to employees upon their retirement or departure from the company.	Retain.
H-165.863	Flexible Spending	1. Along with other efforts to liberalize the Health Savings Account rules, our AMA places a	Retain.

POLICY #	Title	Text	Recommendation
	Accounts (FSAs)	top priority on allowing employees to roll-over any unexpended funds in a Flexible Spending Account into a Health Savings Account. 2. Our AMA will advocate for a reasonable increase in Section 125 Flex Spending accounts.	
H-170.991	Information on Products and Services	The AMA strongly urges firms advising purchasers to seek medical advice regarding use of any product or service to include the name, address and telephone number of a responsible contact from whom information can be readily accessible to physicians on request (e.g., toll-free access or prompt delivery of printed matter about the product or service).	Retain.
H-180.956	Physician Privileges Application - Timely Review by Managed Care	Our AMA policy is that: (1) final acceptance of residents who otherwise are approved by a health plan should be contingent upon the receipt of a letter from their program director stating that their training has been satisfactorily completed; (2) health plans which require board certification should allow the completing resident to be included in their plan after showing evidence of having completed the required training and of working towards fulfilling the requirements in the time frame established by their respective Board for completion of certification; and (3) Medicare, Medicaid, and managed care organizations should (a) make final physician credentialing determinations within 45 calendar days of receipt of a completed application; (b) grant provisional credentialing pending a final credentialing decision if the credentialing process exceeds 45 calendar days; and (c) retroactively compensate physicians for services rendered from the date of their credentialing.	Retain.

POLICY #	Title	Text	Recommendation
H-185.928	Burdensome Paperwork for Breast Pumps	Our AMA will vigorously oppose unnecessary and burdensome paperwork which presents barriers to lactation support, such as prescriptions to support physiologic functions; and further, to ensure that The Joint Commission and Healthy People 2020 breastfeeding goals are met.	Retain-in-part: Our AMA will vigorously oppose unnecessary and burdensome paperwork which presents barriers to lactation support, such as prescriptions to support physiologic functions.~~; and further, to ensure that The Joint Commission and Healthy People 2020 breastfeeding goals are met.~~
H-185.930	Notification to Physicians Regarding COBRA Grace Period	Our American Medical Association will advocate for notification to physicians where patients are within the 45-day or 30-day COBRA grace periods in a manner similar to the ACA-required insurance marketplace 90-day notifications to physicians and, if possible, require such information to be provided in real-time.	Retain.
H-185.944	Subscriber Identification Cards	Our AMA: (1) urges any pertinent official or governmental agency to require health insurance plans to issue identification cards to its subscribers which prominently identify the full legal name of the insured; name of the policy holder; identification numbers needed for claim submission; and the primary insurance company name with its appropriate mailing address; and (2) will advocate for legislative and regulatory sanctions against insurance companies which present obstacles to the timely filing of claims which result in the denial of benefits.	Retain.
H-185.952	Elimination of Lifetime Maximums of Health Insurance Benefits	It is the policy of our AMA that employers and health insurers should eliminate the lifetime maximums of health insurance benefits.	Retain.
H-185.953	Health Insurance Coverage of Specialty Pharmaceuticals	Our AMA supports complete transparency of health care coverage policies related to specialty pharmaceuticals, including co-payment or co-insurance levels and how these levels are determined.	Retain.

POLICY #	Title	Text	Recommendation
H-185.955	Pap Smears as a Clinical Laboratory Test	The AMA: (1) advocates that it is imperative that Pap smear screening have sufficient payment levels to support the technology and personnel costs required to provide the service, and (2) seeks legislative and regulatory change in the Medicare payment policy for Pap smears so that payment for the technical component of the service is adequate to cover the cost of providing the service, and that pathologists are reimbursed for interpretation of abnormal Pap smears based on the RBRVS.	Retain.
H-185.956	Health Plan Coverage for Over-the-Counter Drugs	Our AMA: (1) opposes mandated health plan coverage for over-the-counter (OTC) pharmaceuticals, including those that had previously been available only with a prescription; (2) encourages health insurers and health plans to cover medically necessary OTC drugs for which no prescription alternative exists; and (3) continues to support efforts to study the effects of converting medically necessary drugs from prescription to over-the-counter status on the costs and access to such medications.	Retain.
H-185.957	Coverage for Strabismus Surgery	Our American Medical Association supports legislation that requires all third party payers that cover surgical benefits to cover all strabismus surgery where medically indicated.	Retain.
H-185.958	Equity in Health Care for Domestic Partnerships	Our AMA: (1) encourages the development of domestic partner health care benefits in the public and private sector; and (2) supports equity of pre-tax health care benefits for domestic partnerships.	Retain; Policy H-140.901 is identically titled; recommend amending title by addition as follows: "Equity in Health Care Benefits for Domestic Partnerships."
H-185.959	Health Care Benefit Discrepancies for Small Employers Under COBRA	Our AMA supports the principle that small employers who provide their employees with a group health insurance benefit, and who can afford to do so, should be encouraged to provide continuation coverage for their former employees, ideally	Retain.

POLICY #	Title	Text	Recommendation
		consistent with the 18 months of coverage under COBRA.	
H-210.978	Improving Home Health Care	Our American Medical Association: (1) supports the appropriate training of home health aides to ensure the quality of services they provide, guided by the standards of the Medicare Conditions of Participation, accreditation entities and the Institute of Medicine; (2) supports regulatory oversight of home health agencies that employ home health aides; and (3) will work with interested state medical associations to support state legislation that requires home health aides to obtain appropriate training before caring for patients.	Retain.
H-215.967	For-Profit Conversions of Health Care Organizations	The AMA adopts as policy the following principles regarding the for-profit conversion of not-for-profit health care organizations: (1) Representatives of state government (e.g. state attorney general, state insurance commissioner) should oversee all for-profit conversions of health care organizations; (2) Public notice and subsequent public hearings should be required prior to the approval of a for profit-conversion; (3) The health care organization converting to for-profit status should be required to obtain an independent appraisal of its assets prior to the conversion. This appraisal should be made available to the representatives of state government (e.g., state attorney general, state insurance commissioner) overseeing the for-profit conversion; (4) For-profit conversions should be structured to prohibit private inurement from officers, directors and key employees of the converting health care organization, as well as private benefit from other individuals; (5) If the establishment of a charitable foundation is required	Retain.

POLICY #	Title	Text	Recommendation
		as part of the for-profit conversion, the mission of the foundation, as well as its proposed program agenda, should be determined and offered for public comment prior to the completion of the conversion; (6) The mission of a charitable foundation resulting from a for-profit conversion should closely reflect the original mission of the not-for-profit health care organization; (7) A designated proportion of the members serving on the board of directors of a charitable foundation should be new, independent members not previously affiliated with the converting organization, who are selected based on their experience relative to the mission of the foundation; (8) The level of compensation received by members serving on the board of directors of a charitable foundation should be consistent with that received by board members of similar types and sizes of foundations; (9) Representatives of state government (e.g., state attorney general, state insurance commissioner) should approve the mission and governance of any charitable foundation established as a result of for-profit conversions; (10) Once a charitable foundation has been established as a result of a for-profit conversion, ongoing community liaison with the foundation should occur on a regular basis (e.g., community advisory committees, periodic public reports); and (11) There should be meaningful physician presence on the board of directors of a charitable foundation formed as a result of the conversion of a not-for-profit health care organization to a for-profit organization	

POLICY #	Title	Text	Recommendation
H-215.992	Hospital Security	Our AMA supports efforts by physicians and other hospital staff to encourage all hospitals to institute and/or maintain appropriate and adequate security measures, such as general identification, patrols, visual monitoring systems and metal detectors, in order to protect staff and patients.	Retain.
H-215.993	Medical Society-Governing Body (Trustee) Liaison Program	Our AMA (1) encourages state medical associations to maintain this activity to assure ongoing communication with hospital governing bodies; and (2) encourages state medical associations to draw upon all sources, including national level activities, to enhance their own direct communication with hospital governing bodies.	Retain.
H-220.980	Credentialing Procedure	The AMA encourages The Joint Commission to continue to monitor medical staff credentialing procedures to include clearly delineated authority to an elected physician of the medical staff for access, review and judgment over contents, to ensure that the individual medical staff member's credentials file contains only well documented and appropriate data and does not include information that is immaterial, misleading or of questionable value.	Retain.
H-220.989	Physician Credentialing	The AMA encourages The Joint Commission to develop standards that permit hospital medical staffs to establish educational needs as one of the criteria for medical staff privileges in teaching hospitals, to assure an appropriate number and variety of patients for educational purposes	Retain.
H-220.990	Principles for Revision of the Medical Staff Section of The Joint Commission "Accreditation	The AMA supports adherence to the following principles as the basis for any revision of the Medical Staff Section of the "Accreditation Manual for Hospitals": (1) continued use of the term "Medical Staff" in the title of the chapter and throughout	Retain.

POLICY #	Title	Text	Recommendation
	Manual for Hospitals"	the Manual; (2) deletion of any specific reference to limited licensed practitioners without precluding such practitioners from having hospital privileges consonant with their training, experience and current competence, if approved by the normal credentialing process; (3) consideration of qualified limited licensed practitioners in accordance with state law, and when approved by the executive committee of the medical staff, by the governing board, and when their services are appropriate to the goals and missions of that hospital, taking into account the training, experience and current clinical competence of the practitioners; (4) provision that the executive committee of the medical staff is composed of members selected by the medical staff, or appointed in accordance with the hospital bylaws. All members of the active medical staff, as defined in the Medical Staff Bylaws, are eligible for membership on the executive committee, and a majority of the executive committee members must be fully licensed physician members (Doctors of Medicine or Doctors of Osteopathy) of the active medical staff in the hospital; (5) assurance that the medical care of all patients remains under the supervision and direction of qualified, fully licensed physicians (Doctors of Medicine or Doctors of Osteopathy); and (6) assurance that the continued high quality of care, credentialing of physicians and other licensed practitioners, and effective quality assurance programs remain under the supervision and direction of fully licensed physicians.	
H-225.945	Temporary Medical Staff Privileges	Our AMA: (1) supports the use of temporary privileges in the following situations: (a) to fulfill	Retain.

POLICY #	Title	Text	Recommendation
		an important patient care, treatment, or service need, or (b) when an applicant for new privileges with a 'clean' application is awaiting review and approval by the medical staff executive committee and the governing body; and (2) will work with other stakeholders to preserve the use of temporary privileges in the following situations: (a) to fulfill an important patient care, treatment, or service need, or (b) when an applicant for new privileges with a 'clean' application is awaiting review and approval by the medical staff executive committee and the governing body.	
H-225.987	Reporting of Incidents	The AMA believes that (1) all hospital reports mandated by state agencies or outside authorities involving individual physician care of patients should be reviewed by an appropriate medical staff committee prior to reporting; (2) hospital medical staffs should be given a reasonable period of time to evaluate any reports pertaining to a physician's care of patients; and (3) the organized medical staff should seek the assurance of the state agency or outside authority that the report will remain strictly confidential.	Retain.
H-225.988	Hospital-Medical Staff Joint Ventures	The AMA believes it is vital for physicians to appraise responsibly the benefits and risks of specific hospital medical staff joint venture activities in light of their individual circumstances and the advice of knowledgeable and independent financial advisors and legal counsel.	Retain.
H-225.993	Medical Staff Policy Determination	The AMA believes that only fully licensed physicians on the medical staff should establish overall medical staff standards and policy for quality medical care, where consistent with local, state and federal laws.	Retain.

POLICY #	Title	Text	Recommendation
H-230.955	Clarification of Medical Staff Rights in Granting Clinical Staff Privileges	Our AMA: (1) policy is that medical staffs may establish any method of granting clinical privileges that complies with The Joint Commission standard MS.06.01.05; and (2) requests that its Commissioners to The Joint Commission ask The Joint Commission to notify all hospitals and medical staffs that there can be multiple ways to comply with The Joint Commission standards.	Retain.
H-230.957	Access to Hospital Records	Our AMA will support legislation guaranteeing that physicians engaged in staff privileges disputes have free and full access to all medical records related to those disputes so they can adequately defend themselves.	Retain.
H-230.958	Economic Loyalty Criteria for Medical Staff Privileges	Our AMA strongly opposes the implementation of economic loyalty criteria for medical staff privileges.	Retain.
H-230.971	Economic Credentialing	Our AMA will work with The Joint Commission to assure, through the survey process, that any criteria used in the credentialing process are directly related to the quality of patient care.	Retain.
H-230.985	Medical Staff Privileges	The AMA believes that if, under the principle of self-governance, a medical staff determines that productivity, as it has a direct relationship to quality of care, is a reasonable criterion to use in its consideration of reappointment, it should be permitted to do so. However, the AMA does not believe that economic productivity should be a factor in medical staff reappointment.	Retain.
H-230.987	Hospital Decisions to Grant Exclusive Contracts	Our American Medical Association supports the concept that individual medical staff members who have been granted clinical privileges are entitled to full due process in any attempt to abridge those privileges by granting of exclusive contracts by the hospital governing body.	Retain.

POLICY #	Title	Text	Recommendation
H-230.988	Guidelines for Maintenance and Exchange of Credentialing Information	The AMA supports the development of guidelines for the maintenance and exchange of credentialing information and encourages all health care facilities, including the military, the Veterans Administration and the Public Health Service, to comply with such guidelines.	Retain.
H-230.993	Physician Credentialing	The AMA recommends that hospital medical staffs adopt bylaws which enable them to retain the prerogative and responsibility, as granted by the hospital governing body, for credentialing all physicians and other licensees who apply for clinical privileges, including those who seek to enter into contractual arrangements with hospitals.	Retain.
H-235.980	Hospital Medical Staff Self-Governance	1. Our AMA: supports essentials of self-governance for hospital medical staffs which, at a minimum include the right to: (a) initiation, development and adoption of medical staff bylaws, rules and regulations; (b) approval or disapproval of amendments to the medical staff bylaws, rules and regulations; (c) selection and removal of medical staff officers; (d) establishment and enforcement of criteria and standards for medical staff membership; (e) establishment and maintenance of patient care standards; (f) accessibility to and use of independent legal counsel; (g) credentialing and delineation of clinical privileges; (h) medical staff control of its funds; and (i) successor-in-interest rights. 2. Our AMA opposes any attempts to reengineer or otherwise amend medical staff bylaws or split the bylaws into a variety of separate and unincorporated manuals or policies, thereby eliminating the control and approval rights of the medical staff as required by the	Retain.

POLICY #	Title	Text	Recommendation
		principles of medical staff self-governance. 3. Our AMA will ask its Commissioners to the Joint Commission on Accreditation of Healthcare Organizations to require that JCAHO medical staff standards require the following components to be an integral part of the medical staff bylaws, and not separate "governance documents," requiring approval by the entire medical staff. The medical staff is responsible for the following: (a) Application, reapplication, credentialing and privileging standards; (b) Fair hearing and appeal process; (c) Selection, election and removal of medical staff officers; (d) Clinical criteria and standards which manage quality assurance, utilization review; (e) Structure of the medical staff organization; (f) Rules and regulations that affect the entire medical staff. 4. Our AMA recognizes that hospital non-compliance with JCAHO Standard MS 1.20 will be treated in the same way as hospital non-compliance with any other standard.	
H-235.983	AMA Response to Hospital Governing Bodies in Challenging Medical Staff Self-Governance	The AMA (1) reaffirms its policy in support of medical staff self-governance, including the process of electing and seating officers of the staff in accordance with medical staff bylaws, and its policy in opposition to improper interference by the governing body in that process; and (2) supports working with state hospital medical staff sections, state medical societies, and individual medical staffs to support medical staff self-governance in appropriate situations.	Retain.

POLICY #	Title	Text	Recommendation
H-235.993	Representation of the Medical Staff on All Committees of the Governing Board and Administration of American Hospitals	The AMA supports (1) medical staff representation on all committees of the governing board and administration of American hospitals; and (2) hospital administration representation on administrative committees of the medical staff.	Retain.
H-235.996	Bylaws and Rules and Regulations - No Incorporation by Reference	The AMA encourages medical staffs to develop their own bylaws, rules and regulations and not to incorporate other documents by reference.	Retain.
H-240.979	Intrusion by Hospitals into the Private Practice of Medicine	The AMA urges private third party payers to implement coverage policies that do not unfairly discriminate between hospital-owned and independently-owned outpatient facilities with respect to payment of "facility" costs.	Retain.
H-240.995	Diagnostic Related Groups	The AMA (1) supports input by hospital medical staffs into the DRG process to insure that quality of care is not compromised; and (2) supports the concept that the individual hospital medical staff's responsibility is to ensure appropriate quality of care for patients.	Retain.
H-245.970	Early Hearing Detection and Intervention	Our AMA: 1) supports early hearing detection and intervention to ensure that every infant receives proper hearing screening, diagnostic evaluation, intervention, and follow-up in a timely manner; and 2) supports federal legislation that provides for the development and monitoring of statewide programs and systems for hearing screening of newborns and infants, prompt evaluation and diagnosis of children referred from screening programs, and appropriate medical, educational, and audiological interventions and follow-up for children identified with hearing loss.	Retain.
H-280.974	Medically Necessary	Our AMA (1) defines a "medically necessary" visit to a	Retain.

POLICY #	Title	Text	Recommendation
	Nursing Facility Visits	Medicare/Medicaid resident in a nursing facility as any physician visit necessary to complete comprehensive nursing facility assessments and other assessments that are required as a condition of Medicare or state statute, as well as those visits that respond to a patient's development of a significant complication or a significant new problem which requires the creation of a new medical plan of care or visits that respond to the reported possibility of a change in patient condition; (2) supports the concepts embodied in the CPT Evaluation and Management codes for Nursing Facility services, including the concept that counseling and/or coordination of care that are provided consistent with the patient and/or family's needs be recognized as medically appropriate and necessary; (3) will monitor the use of the CPT codes for Nursing Facility Services and Medicare's determination of medical necessity to determine if revisions to the definitions of medical necessity are necessary; (4) supports eliminating the Medicare established arbitrary visit frequency parameters (inclusive of multiple same day visits where quality of care and severity of condition necessitates such encounters); (5) supports eliminating required documentation for obtaining such payments which place a significant burden on physician endeavors to provide quality care; (6) urges carrier refrainment from references to bona fide multiple patient visits on the same day as "gang visits," which unjustly	

POLICY #	Title	Text	Recommendation
		impugn the quality of medical care provided; (7) supports establishment of a moratorium by CMS on any carrier collection of past "overpayments" for such multiple visits, and (8) will use whatever means necessary to achieve these objectives.	
H-280.995	Medicare Coverage of "Skilled Nursing Care"	The AMA encourages CMS to (1) clarify the Medicare definitions of "skilled nursing care" and "custodial care"; (2) identify and implement appropriate measures to assure greater consistency in the administrative interpretation of rules governing coverage of nursing home care; and (3) better explain to beneficiaries the exclusion for custodial care services.	Rescind: Accomplished by Centers for Medicare & Medicaid Services document that explains the definitions of "skilled nursing care" and "custodial care."
H-285.906	Protecting Against Forced Network Exclusivity of Specialist Physicians	Our AMA supports allowing specialty physicians to have primary contract status in more than one network.	Retain.
H-285.907	Out of Network Restrictions of Physicians	Our American Medical Association opposes the denial of payment for a medically necessary prescription of a drug or service covered by the policy based solely on the network participation of the duly licensed physician ordering it.	Retain.
H-285.969	Managed Care Education	The AMA will continue to emphasize professionalism, patient and physician autonomy, patient and physician rights, and practical assistance to physicians as key principles to guide AMA advocacy efforts related to managed care.	Retain.
H-285.970	Physician Office Review by Third Party Payers	The AMA supports development of standardized criteria to be used in managed care contracts for reviewing physicians' office and medical records in order to avoid multiple review.	Retain.

POLICY #	Title	Text	Recommendation
H-285.987	Guidelines for Qualifications of Managed Care Medical Directors	The AMA has adopted the following "Guidelines for Qualifications of Medical Directors of Managed Care Organizations": To the greatest extent possible, physicians who are employed as medical directors of managed care organizations shall: (1) hold an unlimited current license to practice medicine in one of the states served by the managed care organization, and where that Medical Director will be making clinical decisions or be involved in peer review that Medical Director should have a current license in each applicable state; (2) meet credentialing requirements equivalent to those met by plan providers; (3) be familiar with local medical practices and standards in the plan's service area; (4) be knowledgeable concerning the applicable accreditation or "program approval" standards for preferred provider organizations and health maintenance organizations; (5) possess good interpersonal and communications skills; (6) demonstrate knowledge of risk management standards; (7) be experienced in and capable of overseeing the commonly used processes and techniques of peer review, quality assurance, and utilization management; (8) demonstrate knowledge of due process procedures for resolving issues between the participating physicians and the health plan administration, including those related to medical decision-making and utilization review; (9) be able to establish fair and effective grievance resolution mechanisms for enrollees; (10) be able to review, advise, and take action on questionable hospital admissions, medically	Retain.

POLICY #	Title	Text	Recommendation
		unnecessary days, and all other medical care cost issues; and (11) be willing to interact with physicians on denied authorizations. The AMA strongly encourages managed care organizations and payer groups to utilize these guidelines in their recruitment and retention of medical directors.	
H-285.989	AMA Opposition to All Products Clauses	Our AMA will seek legislative action to prohibit tying a physician's membership in an insurance product (e.g., a PPO) to that physician's participation in any other insurance product (e.g., an HMO, workers' compensation, automobile personal injury protection insurance, Medicare and Medicaid).	Retain.
H-290.974	Status Report on the Medicaid Program	1. It is the policy of our AMA that in the absence of private sector reforms that would enable persons with low-incomes to purchase health insurance, our AMA supports eligibility expansions of public sector programs, such as Medicaid and the Children's Health Insurance Program, with the goal of improving access to health care coverage to otherwise uninsured groups. 2. Our AMA advocates that any tax treatment applied to health insurance for the purpose of encouraging individual ownership also apply to long-term care insurance. 3. Our AMA urges Congress and the Administration to develop proposals and enact solutions to address the pending growth of long-term care needs of the American population.	Retain.
H-290.995	Case Management System for Outpatient Clinics	The AMA has adopted the following policy: (1) That states be given the authority to establish primary care case management programs for populations whose medical care is provided through	Retain.

POLICY #	Title	Text	Recommendation
		Medicaid or other public welfare funding: (a) on a voluntary basis with incentives provided toward a prudent choice of care source; and (b) on a mandatory basis only for those recipients in a given area who have been identified as overutilizers or misutilizers of services; and (2) that comparative analyses of these programs be undertaken to determine their relative effectiveness regarding patient access, quality of and satisfaction with care, and cost reduction.	
H-320.955	Conflict of Interest in Care Review	AMA policy is that utilization review organizations make every effort to avoid potential conflicts of interest for physician reviewers by not assigning cases to a physician reviewer who (1) is an associate or competitor of the physician under review, (2) actively practices in the same hospital as the physician under review when feasible, (3) participated in the development or execution of the patient's treatment plan, or (4) is a member of the patient's family.	Retain.
H-320.969	Concurrent Review Procedures of Inpatient Care by HMO Representatives	The AMA encourages state regulation of third party reviewers who are on site in hospitals evaluating inpatient management so that these representatives: (1) must accrue clinical data in the hospital only under the control of hospital-based utilization review/quality assurance (UR/QA) personnel; (2) must not be enabled to have any direct inpatient contact; (3) must both communicate such suggestions directly to the attending physician and document all actions in the hospital's utilization office if they wish to provide input regarding patient management; (4) it is the role of the utilization review program or managed care plan to credential/certify that its reviewers are appropriately licensed and have the required	Retain.

POLICY #	Title	Text	Recommendation
		experience to perform review; (5) prior to the on-site review, the utilization review program or managed care plan should provide upon request the name(s), credentials and background of their reviewers to the medical staff credentials committee and/or quality assurance/utilization review committee; and (6) the medical staff should have: (a) established protocol for reviewers entry into the hospital and (b) a process for monitoring the reviewer's activities and the confidentiality of the records they review.	
H-320.993	Utilization Management	The AMA encourages physicians to take a leadership role in implementing and maintaining utilization management programs within their hospitals.	Retain.
H-330.881	Medicare Coverage for Evidence-Based Lymphedema Treatment	Our AMA supports Medicare coverage for appropriate and evidence-based treatment of lymphedema.	Retain.
H-330.882	Oppose Local Coverage Determination for Lower Limb Prostheses	Our AMA (1) opposes local coverage determinations on lower limb prostheses that undermine physician judgment and compromise patient access; and (2) will request that the Centers for Medicare and Medicaid Services expeditiously host a national meeting open to all interested parties to focus on appropriate standards for lower limb prostheses that optimize care for patients.	Retain.
H-330.883	Parity of Payment for Administering Biologic Medications	Our AMA supports and encourages interested national medical specialty societies and other stakeholders to submit a request to Medicare for a national coverage determination directing Medicare Administrative Contractors to consider all biologics as complex injections or infusions.	Retain.
H-373.994	Patient Navigation Programs	1. Our AMA recognizes the increasing use of patient navigator and patient advocacy services to help improve access to	Retain.

POLICY #	Title	Text	Recommendation
		care and help patients manage complex aspects of the health care system. In order to ensure that patient navigator services enhance the delivery of high-quality patient care, our AMA supports the following guidelines for patient navigator programs: a) The primary role of a patient navigator should be to foster patient empowerment, and to provide patients with information that enhances their ability to make appropriate health care choices and to receive medical care with an enhanced sense of confidence about risks, benefits, and responsibilities. b) Patient navigator programs should establish procedures to ensure direct communication between the navigator and the patient's medical team. c) Patient navigators should refrain from any activity that could be construed as clinical in nature, including interpreting test results or medical symptoms, offering second opinions, or making treatment recommendations. Patient navigators should provide a supportive role for patients and, when necessary, help them understand medical information provided by physicians and other members of their medical care team. d) Patient navigators should fully disclose relevant training, experience, and credentials, in order to help patients understand the scope of services the navigator is qualified to provide. e) Patient navigators should fully disclose potential conflicts of interest to those whom they serve, including employment arrangements.	

POLICY #	Title	Text	Recommendation
		2. Our AMA will work with the American College of Surgeons and other entities and organizations to ensure that patient navigators are free of bias, do not have any role in directing referrals, do not usurp the physician's role in and responsibility for patient education or treatment planning, and act under the direction of the physician or physicians primarily responsible for each patient's care. 3. Policy provisions for patient navigators are also relevant for community health workers and other non-clinical public health workers.	
H-375.994	Peer Review in All Health Care Facilities	The AMA supports the provision of comparable peer review systems of medical services offered in public, private and governmental hospitals.	Retain.
H-385.915	Integrating Physical and Behavioral Health Care	Our American Medical Association: (1) encourages private health insurers to recognize CPT codes that allow primary care physicians to bill and receive payment for physical and behavioral health care services provided on the same day; (2) encourages all state Medicaid programs to pay for physical and behavioral health care services provided on the same day; (3) encourages state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings; (4) encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care; and (5) promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating	Retain.

POLICY #	Title	Text	Recommendation
		behavioral health care services into primary care settings.	
H-385.955	Denial of Payment for Treatment of Immediate Family Members	The AMA calls upon CMS to amend its regulations denying payment for physician services and services incident to a physician's professional services for treatment of immediate family members by permitting an exception applicable to the services of any physician who is the single source of medical care in the community.	Retain.
H-385.989	Payment for Physicians Services	Our AMA: (1) supports a pluralistic approach to third party payment methodology under fee-for-service, and does not support a preference for "usual and customary or reasonable" (UCR) or any other specific payment methodology; (2) affirms the following four principles: (a) Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment. (b) Physicians should continue to volunteer fee information to patients, to discuss fees in advance of service where feasible, to expand the practice of accepting any third-party allowances as payment in full in cases of financial hardship, and to communicate voluntarily to their patients their willingness to make appropriate arrangements in cases of financial need. (c) Physicians should have the right to choose the basic mechanism of payment for their services, and specifically to choose whether or not to participate in a particular insurance plan or method of payment, and to accept or decline a third-party allowance as payment in full for a service. (d) All methods of physician payment should incorporate mechanisms to foster increased cost-awareness by both providers and recipients of service; and (3) supports modification of current	Retain.

POLICY #	Title	Text	Recommendation
		legal restrictions, so as to allow meaningful involvement by physician groups in: (a) negotiations on behalf of those physicians who do not choose to accept third party allowances as full payment, so that the amount of such allowances can be more equitably determined; (b) establishing additional limits on the amount or the rate of increase in charge-related payment levels when appropriate; and (c) professional fee review for the protection of the public.	
H-390.840	Update on Payment Mechanisms for Physician-Led Team-Based Health Care	1. Our AMA encourages public and private health insurers to develop and offer a variety of value-based contracting options so that physician practices can select payment models that best suit their delivery of care. 2. Our AMA encourages the Centers for Medicare & Medicaid Services (CMS) to ensure that Medicare Alternative Payment Models (APMs) do not require physicians to assume responsibility for costs they cannot control because such a requirement could potentially create an ethical conflict of interest. 3. Our AMA will continue to actively advocate to CMS that physicians in all specialties and modes of practice must have at least one Medicare APM in which they can feasibly participate. 4. Our AMA will advocate to CMS that any review process of alternative payment models proposed by stakeholders be completed in a timely manner, include an administratively simple appeals process and access to an ombudsman.	Retain.
H-390.841	Value Based Modifier and Flawed Drug Cost Attribution	Our American Medical Association will work with the Centers for Medicare & Medicaid Services to modify Value Based Modifier cost attribution with regard to all drug costs, to ensure	Retain.

POLICY #	Title	Text	Recommendation
		the cost calculation does not unfairly disadvantage certain providers.	
H-390.842	Include Physicians in CMS Rate Increases to Medicare Advantage Plans	Our American Medical Association (1) encourages Medicare Advantage plans to be transparent with respect to the allocation of their rate increases, and (2) encourages individual physicians to negotiate rate increases that parallel or improve upon the percentage increases received by the Medicare Advantage plans with which they contract.	Retain.
H-390.843	Physician-Led, Single and Multi-Specialty, Organized Group Practice Models	1. Our AMA recognizes that physician-led, single and multi-specialty group practices, integrated delivery systems, and other organized systems of care demonstrating the following attributes: (a) efficient provision of services, (b) organized system of care, (c) quality measurement and improvement activities, (d) care coordination, (e) use of IT and evidence-based medicine, (f) compensation practices that promote all aforementioned attributes, and (g) accountability, are credible models for providing coordinated, comprehensive, accountable, cost-effective, patient-centered care. 2. Our AMA will continue its involvement in activities that support physicians in all practice settings to implement solutions and strategies that can improve practice efficiency, helping them achieve improved quality at an affordable cost.	Retain.
H-390.872	Compensation for Physicians Who Accompany Seriously Ill or Injured Patients to Hospitals	The AMA: (1) urges CMS to allow payment for the services of physicians who accompany seriously ill or injured patients in the ambulance to hospitals and who report the appropriate level of evaluation and management service along with Prolonged Physician Service with Direct (Face-to-Face) Patient Contact (codes 99354 and 99355) or the	Retain.

POLICY #	Title	Text	Recommendation
		Critical Care Services codes (99291 and 99292); and (2) urges CMS to expand its guidelines to carriers to allow payment for a physician's return trip from accompanying an ambulance-borne patient, consistent with above, using code 99082, Unusual travel (e.g., transportation and escort of patient).	
H-390.880	Interest Rates Charged and Paid by CMS	1. (A) Our AMA will (1) determine if the recent interest rate changes implemented by CMS comply with current Medicare laws; (2) seek to ensure that CMS's interest charges do not exceed legal limits; and (3) work with CMS to ensure parity in interest rates assessed against physicians by CMS and interest rates paid to physicians by CMS. (B) If an agreement cannot be reached with CMS, the AMA will seek legislation to correct this situation. 2. Our AMA supports amending federal Medicare law to require that interest on both overpayments and underpayments to providers attaches upon notice of the error to the appropriate party in either instance.	Retain.
H-390.921	Uniformity of Operations of Medicare Administrative Contractors	It is the policy of the AMA (1) to use its influence and resources to bring about uniformity of business policies and procedures among the Medicare Administrative Contractors, and (2) to investigate and monitor the differing policies and procedures among the Medicare Administrative Contractors with respect to physician reimbursement.	Retain.
H-390.991	CMS Reimbursement Policy for Physicians in Solo Practice "Covering" Medicare	The AMA supports permitting physicians in solo practice, and those in different groups, to "cover" Medicare patients for each other, and making it possible for the personal physicians of Medicare patients	Retain.

POLICY #	Title	Text	Recommendation
	Patients for Each Other	to bill and to receive reimbursement for professional services rendered by their colleagues who "cover" for them.	
H-400.955	Establishing Capitation Rates	1. Our AMA believes Geographic variations in capitation rates from public programs (e.g., Medicare or Medicaid) should reflect only demonstrable variations in practice costs and correctly validated variations in utilization that reflect legitimate and demonstrable differences in health care need. In particular, areas that have relatively low utilization rates due to cost containment efforts should not be penalized with unrealistically low reimbursement rates. In addition, these payments should be adjusted at the individual level with improved risk adjustors that include demographic factors, health status, and other useful and cost-effective predictors of health care use. 2. Our AMA will work to assure that any current or proposed Medicare or Medicaid (including waivers) capitated payments should be set at levels that would establish and maintain access to quality care. 3. Our AMA seeks modifications as appropriate to the regulations and/or statues affecting Medicare HMOs and other Medicare managed care arrangements to incorporate the revised Patient Protection Act and to ensure equal access to Medicare managed care contracts for physician-sponsored managed care organizations. 4. Our AMA supports development of a Medicare risk payment methodology that would set payment levels that are fair and equitable across geographic regions; in particular, such methodology should allow for	Retain.

POLICY #	Title	Text	Recommendation
		equitable payment rates in those localities with relatively low utilization rates due to cost containment efforts.	
H-400.956	RBRVS Development	(1) That the AMA strongly advocate CMS adoption and implementation of all the RUC's recommendations for the five-year review; (2) That the AMA closely monitor all phases in the development of resource-based practice expense relative values to ensure that studies are methodologically sound and produce valid data, that practicing physicians and organized medicine have meaningful opportunities to participate, and that any implementation plans are consistent with AMA policies; (3) That the AMA work to ensure that the integrity of the physician work relative values is not compromised by annual budget neutrality or other adjustments that are unrelated to physician work; (4) That the AMA encourage payers using the relative work values of the Medicare RBRVS to also incorporate the key assumptions underlying these values, such as the Medicare global periods; and (5) That the AMA continue to pursue a favorable advisory opinion from the Federal Trade Commission regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and physicians.	Retain.
H-405.956	Transparency of Health Care Provider Profiles in Commercial and Federal Physician Comparison Databases	1. Our AMA encourages accurate and transparent listings of professional degree(s), post-graduate specialty education, and naming of the certifying agency with board certification data released to the public for comparison of healthcare providers or other healthcare services, in accordance with existing AMA policy.	Retain.

POLICY #	Title	Text	Recommendation
		2. Our AMA urges commercial entities and federal programs providing healthcare provider ratings, comparisons, referrals, direct appointments, telehealth, or other services to revise the search and reporting methodology used for profiling of all healthcare providers so as to increase transparency requirements, including the description of professional degree(s), post graduate specialty education, and naming of the certifying board(s), in accordance with existing AMA policy.	
H-405.995	Administration and Supervision of Rehabilitation Units	The AMA believes that (1) third party coverage for the administration and supervision of patient rehabilitation in the office, hospital, and free-standing units should continue to be determined by physician competence based on training and experience, and should not be denied on the basis of specialty certification; and (2) the determination of criteria for qualification in the administration and supervision of rehabilitation units should be based on competence gained by training and experience, and should not be arbitrarily restricted by specialty designation.	Retain.
H-406.993	Development and Use of Physician Profiles	The AMA: (1) urges state medical associations, national medical specialty societies, hospital medical staff, and individual physicians to seek active involvement in the development, implementation, and evaluation of physician profiling initiatives; (2) encourages research to develop improved data sources, methods, and feedback approaches to physician profiling initiatives; (3) opposes the use of profiling procedures that do not meet AMA principles for the credentialing or termination of physicians by managed care plans; (4) opposes physician profiling data being used for	Retain.

POLICY #	Title	Text	Recommendation
		economic credentialing purposes; (5) believes that any disclosure or release of physician profiles shall follow strict conformance to AMA policy on the use and release of physician-specific health care data (Policy 406.996); and (6) will monitor the use of profiling procedures related to physician profiling.	
H-406.994	Principles of Physician Profiling	Our AMA advocates that managed care organizations, third party payers, government entities, and others that develop physician profiles adhere to the following principles: (1) The active involvement of physician organizations and practicing physicians in all aspects of physician profiling shall be essential. (2) The methods for collecting and analyzing data and developing physician profiles shall be disclosed to relevant physician organizations and physicians under review. (3) Valid data collection and profiling methodologies, including establishment of a statistically significant sample size, shall be developed. (4) The limitations of the data sources used to develop physician profiles shall be clearly identified and acknowledged. (5) Physician profiles shall be based on valid, accurate, and objective data and used primarily for educational purposes. (6) To the greatest extent possible, physician profiling initiatives shall use standards-based norms derived from widely accepted, physician-developed practice parameters. (7) Physician profiles and any other information that have been	Retain.

POLICY #	Title	Text	Recommendation
		compiled related to physician performance shall be shared with physicians under review. (8) Comparisons among physician profiles shall adjust for patient case-mix, control for physician specialty, and distinguish between the ordering or referring physician and the physician providing the service or procedure. (9) Effective safeguards to protect against the unauthorized use or disclosure of physician profiles shall be developed. (10) The quality and accuracy of physician profiles, data sources, and methodologies shall be evaluated regularly.	
H-406.997	Collection and Analysis of Physician-Specific Health Care Data	1. Our AMA advocates that third party payers, government entities, and others that collect and analyze physician-specific health care data adhere to the following principles: (a) The methods for collecting and analyzing physician-specific health care data shall be disclosed to physicians under review and the public. (b) Physician-specific health care data shall be valid, accurate, objective and used primarily for the education of both consumers and physicians. (c) Data elements used in the collection of physician-specific health care data, including severity adjustment factors, shall be determined by advisory committees which include actively practicing, and where relevant, specialty-specific, physicians from the region where the data are being collected. (d) Statistically valid data collection, analysis, and reporting methodologies, including establishment of a statistically significant minimum number of cases, shall be developed and appropriately implemented prior	Retain.

POLICY #	Title	Text	Recommendation
		to the release of physician-specific health care data. (e) The quality and accuracy of the physician-specific health care data shall be evaluated by conducting periodic medical record audits. 2. Our AMA believes that health care coalitions which include physicians as full voting members are an appropriate forum for undertaking health care data collection and analysis activities; in consideration of the potential for misinterpretation, violation of privacy rights, and antitrust concerns, it is recommended that charge or utilization data provided to such entities by government, third party payers, and self-insureds companies be in the form of ranges or averages and not be physician-specific.	
H-406.998	Role of Physicians and Physician Organizations in Efforts to Collect Physician-Specific Health Care Data	Our AMA: (1) believes that physicians, as patient advocates and possessing unique qualifications in the review and analysis of health care data, must take the initiative in developing data collection systems at the local level which maintain high standards of confidentiality, accuracy and fairness; (2) urges state medical societies, national medical specialty societies, hospital medical staffs and individual physicians to: (a) participate in health care data collection programs designed to improve the quality of care; (b) be aware of the limitations of health care data; (c) encourage active involvement of physician organizations and practicing physicians in all aspects of health care data collection and interpretation; and (d) develop strategies to assist state agencies and others in improving the collection and interpretation of health data;	Retain.

POLICY #	Title	Text	Recommendation
		(3) urges health data commissions and other entities that collect, evaluate, and disseminate health care data to: (a) facilitate active involvement of physician organizations and practicing physicians in all aspects of the efforts to collect health care data; (b) provide adequate opportunity for physician organizations and practicing physicians to review and respond to proposed data interpretations and disclosures; (c) ensure accuracy of information in the data base; and (d) assure valid interpretation and use of health care data; (4) encourages relevant physician organizations to develop effective mechanisms to assist physicians in evaluating, using, and responding to physician-specific health care data; (5) encourages medical societies to use this information for educational purposes and for addressing such areas as utilization variation, quality assessment and appropriate cost containment activities; (6) encourages medical societies to play an active role in appropriate data collection and dissemination activities at the local level; and (7) urges state medical societies, hospital medical staffs and physicians to propose, monitor, and seek to influence quality of care and cost containment legislation to comply with AMA principles.	
H-435.955	Administrative and Liability Surcharges	Our AMA supports the ability of physicians to institute an "administrative surcharge" and/or a "liability surcharge."	Retain.
H-450.936	Physician Quality	Our AMA will continue to advocate for improvements in the	Rescind: The Physician Quality Reporting Initiative was replaced by

POLICY #	Title	Text	Recommendation
	Reporting Initiative Payment	Physician Quality Reporting Initiative (PQRI) including early education and outreach to physicians by the Centers for Medicare and Medicaid Services (CMS), the provision of confidential interim and final feedback reports from CMS to physicians on potential problems in their PQRI reporting, easier access to feedback reports, development of meaningful dispute resolution processes, and the provision to our AMA of the 2007 PQRI data set file.	the Merit-based Incentive Payment System (MIPS) in 2017.
H-465.986	Rural Health	1. The AMA urges CMS to disseminate widely information on the Rural Health Clinics Program, not only to states and health facilities but to state medical associations as well. 2. The AMA encourages state medical associations to evaluate the potential benefits and drawbacks to rural practices of seeking certification as rural health clinics, and transmit the result of such evaluation to their members. 3. The AMA encourages state medical associations to carefully evaluate the relevant practice acts in their jurisdictions to identify any modifications needed to allow the most effective use of mid-level practitioners in improving access to care, while assuring appropriate physician direction and supervision of such practitioners.	Retain; Policy H-465.989 is identically titled; recommend amending title by addition as follows: "Rural Health Clinics."
H-465.989	Rural Health	It is the policy of the AMA that: (1) the AMA closely monitor the impact of balance billing restrictions mandated by the Budget Reconciliation legislation on reimbursement levels and access to care in rural areas, and take action as needed to moderate that impact; (2) the AMA closely monitor implementation of the legislation establishing essential access community hospitals and	Retain.

POLICY #	Title	Text	Recommendation
		rural primary care hospitals, to ensure that this program is implemented in a manner conducive to high quality of patient care and consistent with Association policy concerning the functions and supervision of physician assistants and nurse practitioners; (3) state medical associations be encouraged to monitor similarly and to influence any legislation or regulations governing the development and operation of such limited service rural hospital facilities in their own jurisdictions; and (4) the AMA establish liaison with the American Hospital Association, Congress and the Centers for Medicare & Medicaid Services regarding any further development of essential access community hospitals and rural primary care hospitals grants.	
H-70.916	Delay or Canceling of ICD-10	Our AMA supports delaying or canceling the implementation of ICD-10.	Rescind: ICD-10-CM was implemented on 10/1/15.

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (A-25)
Regulation of Corporate Investment in the Health Care Sector

EXECUTIVE SUMMARY

Policy D-215.982, "The Corporate Practice of Medicine, Revisited" and Policy D-160.904, "The Regulation of Private Equity in the Health Care Sector" were adopted at the 2024 Annual Meeting. The former asks our American Medical Association (AMA) to revisit the concept of restrictions on the corporate practice of medicine including, but not limited to, private equities, hedge funds, and similar entities, review existing state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report that will study and report back by the 2025 Annual Meeting with recommendations on how to increase competition, increase transparency, support physicians and physician autonomy, protect patients, and control costs in already consolidated health care markets; and to inform advocacy to protect the autonomy of physician-directed care, patient protections, medical staff employment and contract conflicts, and access of the public to quality health care, while containing health care costs. The latter asks our AMA to propose appropriate guidelines for the use of private equity in health care, ensuring that physician autonomy and operational authority in clinical care is preserved and protected.

The corporate practice of medicine (CPOM) can take many forms. For example, private or public for-profit companies can purchase ownership stake in health care businesses, investment firms can partner with or acquire physician practices or hospitals, or health insurance companies can directly employ physicians.

There are risks and benefits associated with corporate investment and partnership. Corporate investment can offer a way for a practice to avoid selling to a hospital or health system, manage human resources, information technology, and other administrative tasks on behalf of the practice, offer lucrative deals for physician-owners wanting to retire or sell their practice, and help with medical liability costs. Risks include a loss of control of business decisions and/or clinical autonomy, drastic cost cutting measures, replacing physicians with non-physician practitioners, restrictive non-compete agreements, loss of liability tail coverage and retirement benefits, loss of employment, and the possibility of debt or bankruptcy for the physician-owner after the corporate investor has extracted profits and exited the partnership.

CPOM doctrine provides a legal basis for protecting the integrity of patient care in a health care environment complicated by corporate influence. Broadly, CPOM prohibitions forbid lay (i.e., non-physician) corporations from practicing medicine, owning physician practices, or otherwise employing physicians to provide medical services. While most states have CPOM restrictions in place, there is no single definition of what constitutes a valid CPOM exemption. Each state's CPOM doctrine has been shaped uniquely over the years by a combination of statutes, regulations, court decisions, attorney general opinions and actions by medical licensing boards. CPOM restrictions generally aim to avoid the commercialization of medical practice that might result when corporations own practices, to address misalignment between a corporation's obligation to its shareholders and a physician's obligation to their patients, and to ensure that a physician's exercise of independent medical judgment is not threatened because they are employed by a corporate entity.

The Council offers a series of recommendations to strengthen guidelines for physicians considering corporate partnerships, support capital reserve and leverage standards for firms looking to acquire health care facilities, and support the enforcement of regulations and legislation pertaining to the corporate control of practices in the health care sector. These recommendations aim to ensure physician clinical autonomy and operational authority are preserved and protected.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-25

Subject: Regulation of Corporate Investment in the Health Care Sector

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee G

Policy D-215.982, "The Corporate Practice of Medicine, Revisited' and Policy D-160.904, "The Regulation of Private Equity in the Health Care Sector" were adopted at the 2024 Annual Meeting. The former asks our American Medical Association (AMA) to revisit the concept of restrictions on the corporate practice of medicine including, but not limited to, private equities, hedge funds, and similar entities, review existing state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report that will study and report back by the 2025 Annual Meeting with recommendations on how to increase competition, increase transparency, support physicians and physician autonomy, protect patients, and control costs in already consolidated health care markets; and to inform advocacy to protect the autonomy of physician-directed care, patient protections, medical staff employment and contract conflicts, and access of the public to quality health care, while containing health care costs. The latter asks our AMA to propose appropriate guidelines for the use of private equity in health care, ensuring that physician autonomy and operational authority in clinical care is preserved and protected.

Of note, the Council on Ethical and Judicial Affairs (CEJA) has prepared a related report, CEJA Report 5-A-25, "Protecting Physicians Who Engage in Contracts to Deliver Health Care Services" which offers specific ethics analysis and guidance for physicians impacted by private equity's involvement in medicine.

BACKGROUND

The corporate practice of medicine (CPOM) can take many forms. For example, private or public for-profit or non-profit companies can purchase ownership stakes in health care businesses, investment firms can partner with or acquire physician practices or hospitals, or health insurance companies can directly employ physicians. Private equity firms apply several types of investment strategies. Traditional private equity firms utilize funds from leveraged buyouts to take a controlling stake in mature companies, venture capital firms invest in fledgling businesses, and growth equity firms partner with promising later-stage businesses to help them expand.

As stated in Board of Trustees Report 9-I-24, it is important for AMA policy to distinguish between corporate investment, corporate ownership, and corporate control in physician practices:

> The Board of Trustees believes that decisions made by a corporate investor on matters often characterized as operational or administrative may in some cases intrude on clinical decision-making and physician autonomy, as well as affect quality of care and patient outcomes. This is not simply in cases where the difference may be blurred, even matters that may be typically characterized as operations (coding, billing and collections, administrative, and non-clinical

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> management, risk management, etc.) may themselves be implemented in ways that interfere with clinical decision-making and physician autonomy and/or expose physicians to liability.

Private equity acquisitions of health care entities increased six-fold in a decade, growing from 75 deals in 2012 to 484 deals in 2021.[1] Since 2012, private equity firms have spent approximately $1 trillion on health care transactions and between 2018 and 2023, private equity firms spent $505 billion on health care acquisitions.[2,3] The shift toward private equity investment may have been exacerbated by the COVID-19 pandemic as a solution for practices struggling financially. According to the Private Equity Stakeholder Project, it is estimated that eight percent of all private hospitals in the United States and 22 percent of for-profit hospitals are owned by private equity firms.[4]

Private equity deals range from tens to hundreds of millions of dollars and are expected to deliver 20 to 30 percent returns to investors. Key tactics include increasing prices and volume.[5] Another common investment tactic for private equity firms following acquisition includes sale-leaseback arrangements, which sell acquired facilities' land and buildings to repay investors and then charge the facility rent on assets they once owned. On average, after a private equity firm acquires a hospital, the hospital's assets decrease by 24 percent relative to hospitals not purchased by private equity.[6] Private equity firms typically purchase an established practice and acquire smaller practices to create regional brands that can exercise greater bargaining power with insurers and medical supply companies. With these acquisitions, emphasis shifts to increasing profits, often by extracting higher contracted payment rates, lowering overhead, and increasing volume and ancillary revenue streams (i.e., imaging, procedures, over the counter products).[7]

The CPOM doctrine provides a legal basis for protecting the integrity of patient care in a health care environment complicated by corporate influence. Broadly, CPOM prohibitions forbid lay (i.e., non-physician) corporations from practicing medicine, owning physician practices, or otherwise employing physicians to provide medical services. While most states have CPOM restrictions in place, there is no single definition of what constitutes the CPOM, and exemptions – such as for-profit hospitals, nonprofits, or federally qualified health centers – vary broadly. Each state's CPOM doctrine has been shaped uniquely over the years by a combination of statutes, regulations, court decisions, attorney general opinions and actions by medical licensing boards. Consequently, it is difficult to succinctly summarize the CPOM doctrine of every individual state. However, CPOM restrictions generally aim to avoid the commercialization of medical practice that might result when corporations own practices, to address any lack of alignment between a corporation's obligation to its shareholders and a physician's obligation to their patients, and to ensure that a physician's exercise of independent medical judgment is not threatened because they are employed by a corporate entity.

Types of corporate arrangements

There are several types of corporate structuring and financing of medical practices that can occur. One of the most common is investment by private equity firms. A private equity firm pools investments and uses leveraged buyouts to purchase an ownership stake in a physician practice or hospital. The private equity firm then cuts costs and drives up profit with the goal of selling the business for a profit in three to seven years.

In a 2024 Stanford Law Review analysis, Fuse Brown and Hall point out that private equity poses three risks:

> First, private equity investment spurs health care consolidation, which increases prices and potentially reduces quality and access. Second, the pressure from private equity investors to increase revenue can lead to exploitation of billing loopholes, overutilization, upcoding,

aggressive risk-coding, harming patients through unnecessary care, excessive bills, and increasing overall health spending. Third, physicians acquired by private equity companies may be subject to onerous employment terms and lose autonomy over clinical decisions.[8]

While private equity investors are often viewed as exploitative, they may not be substantially different from other entities who invest in or acquire physician practices. Private equity investment is not inherently bad but likely includes both good and bad actors as does any other investor arrangement in the health care sector, or other markets more broadly. Professional risks are not unique to corporate investment alone. Notably, however, according to a study from the Private Equity Stakeholder Project, more than 20 percent of health care bankruptcies in 2023 were private equity-backed companies. Due to the nature of the leveraged buyout strategy employed by private equity firms, debt levels on these leveraged buyouts reached a 15 year high of 7.1 times earnings in 2022. Average debt to earnings before interest, taxes, depreciation, and amortization are around three times earnings.[9]

Hedge funds are also used to invest in and acquire health care entities. A hedge fund differs from private equity in that it is an investment strategy while private equity is a source of capital. Hedge funds pool money from wealthy entities to make investments in the stock market and use different market and trading strategies to insulate investments from market volatility. In another corporate arrangement seen in recent years, corporations such as Amazon (via One Medical) and Walmart have entered directly into the health care space. In addition, health insurers have entered the market by directly employing physicians. For example, Optum, a subsidiary of UnitedHealth Group, employs about 10,000 physicians and is affiliated with another approximately 80,000 physicians. In addition to physicians, Optum employs or is affiliated with approximately 40,000 non-physician practitioners (NPPs).[10,11]

Impact on Cost

Most studies done on the effects of private equity investment conclude that these transactions have led to higher prices for patients. Recently, private equity's role in contributing to the United States' medical debt crisis has been highlighted. According to the Private Equity Stakeholder Project, private equity firms are both "creating and profiting from medical debt" by expanding into billing services and collecting payments for the health care entities they acquire.[12] Private equity owned health care entities have been increasingly outsourcing financial work to the private equity firms themselves, who have consolidated debt collecting, claims processing, and billing into an "end-to-end" service. The result is higher costs for patients, either through upcoding, higher interest rates on outstanding balances, or more aggressive bill collection practices.[13]

Impact on Patients

Evidence on corporate investor impact on quality of care is mixed. According to a 2023 *JAMA* study, hospital-acquired adverse events increased by approximately 25 percent following private equity acquisition. The rise in adverse events was impacted by an increase in the number of falls and central line associated bloodstream infections, along with a larger, but less statistically precise increase in surgical site infections. Other studies have found that private equity acquisition may improve care quality, but only under certain market and regulatory conditions.[14,15] Greater transparency is needed over private equity investment in and ownership of physician practices to help patients make informed decisions about their care. While the onus should not be put on patients to know the ownership status of a hospital or practice before receiving care, and in many cases patients may not have a choice on where they seek care, greater transparency would be beneficial for patients and communities if and when it allows for more informed decision-making.

Impact on Physicians

Physicians may value investment from corporate partners because : 1) it can offer a way for the practice to avoid selling to a health system; 2) the corporate partner can manage administrative, technical, and human resources aspects of the business; 3) the corporate partner can offer financially attractive deals for physician-owners wanting to retire or exit ownership; and 4) these investors can help with medical liability costs. Some risks of partnering with corporate investors include losing control of business decisions and/or clinical autonomy; drastic cost cutting measures, including replacing physicians with NPPs; non-compete agreements which can prevent physicians from easily moving to another job; and the possibility of debt or bankruptcy for the physician-owner after the corporate investor has extracted profits from the practice and exited the partnership.[16] The use of non-compete agreements, or restrictive covenants, by larger corporations has the potential to hamper physicians' ability to leave a practice in search of another position. This is especially true of corporations that have a large geographical footprint or those that are in concentrated markets. With more limited ability to leave for another opportunity, the physician's ability to advocate for better working conditions is undermined. In these scenarios, a physician's only choice may be to move to another geographic area entirely, often uprooting themselves and their families. For employed physicians, risks could also include loss of liability tail coverage or loss of pension or retirement funds if their facility comes under private equity ownership or ultimately goes bankrupt. Physicians may also be pressured to see more patients each day or meet lofty financial targets to maximize profitability. Financial targets could include sales goals, using lower cost supplies, or encouraging patients to seek optional or cosmetic procedures that are often lucrative, but not always necessary. Additionally, high levels of debt from leveraged buyouts or sale-leaseback arrangements can burden health care practices and increase the risk of failure.[17]

While private equity and corporate investment in health care is rightfully scrutinized, it cannot be ignored that many physicians willingly choose to partner with or sell their practices to corporate investors. Owning and managing a private practice has become increasingly challenging and corporate investment offers an alternative to being employed by a hospital or health system, or leaving the practice of medicine entirely. Additionally, when physicians sell a practice to a corporate entity, the money from the sale is taxed at capital gains rates which are more favorable than income tax rates, adding to the list of incentives for pursuing these transactions. Physician-owners choosing to enter these partnerships should be aware of risks and do their best to ensure that physician autonomy in clinical and operational decision-making is sustained.

In all types of medical practice, physician autonomy is of the utmost importance. Many physicians are rightfully concerned about the loss of professional control that could arise from partnering with a corporate entity. Almost 61 percent of physicians have a negative view of private equity and less than 11 percent have a positive view, according to a 2024 study.[18] There is also emerging evidence that trainees are less likely to join a practice backed by private equity and that these practices have higher staff turnover rates. In one specific case, dermatologists drawn to private equity backed practices by high salaries quit after being pressured to significantly cut costs and meet high financial targets.[19] A February 2025 *JAMA Health Forum* article found that physician turnover also increased when private equity companies sold the practice or facility they were invested in. Physicians employed by exiting private equity firms were 16.5 percentage points less likely to continue working in that practice two years after the private equity firm exited and 10.1 percentage points more likely to go on to be employed by a facility with more than 120 practicing physicians.[20]

According to the AMA's 2022 Physician Practice Benchmark survey, 49.7 percent of physicians were employees, 44 percent were owners, and 6.4 percent were independent contractors. Between 2012 and 2022, the share of physicians who worked in practices wholly owned by physicians – private practices – dropped by 13 percentage points from 60.1 percent to 46.7 percent. In 2022, 4.5 percent of physicians

were participants in private equity ownership or investment arrangements.[21] Many physicians that have left private practice have become employed by a hospital or health system, where they feel as if they have less autonomy in clinical decision making. In 2023, 56 percent of employed physicians said what they like least about their job is decreasing autonomy, which was up from 48 percent the year prior. According to a survey from National Opinion Research Center at the University of Chicago, approximately 61 percent of employed physicians said they have moderate or no autonomy to make referrals outside of their practice or ownership system, and 47 percent said they adjust patient treatments to reduce costs based on practice policies or incentives.[22]

Another concern is changing workplace composition and replacing physicians with NPPs who can often be hired at a lower salary than physicians, resulting in savings for the practice owner. A January 2023 study examined workforce composition changes in private equity acquired practices and found that in aggregate, the clinician replacement ratio was higher for private equity acquired practices compared to those not acquired by private equity. When compared to non-private equity acquired practices, those acquired by private equity had a significant yearly increase in the number of NPPs after acquisition. While the study claimed to be preliminary in nature, it supported the hypothesis that physicians may be more frequently replaced at private equity acquired practices versus those not acquired by private equity. However, the study also conceded that regardless of ownership, there was a statistically significant increase in NPPs at all practices examined, which could be in response to physician supply shortages, payment reforms, a shift to team-based care, or other factors.[23]

Impact on Consolidation and Market Concentration

A March 2024 *Health Affairs* study looked at private equity acquired practices and market penetration between 2012-2021. This study found that private equity acquired physician sites increased from 816 across 119 metropolitan statistical areas (MSA) in 2012 to 5,779 across 307 MSAs in 2021. The result was single private equity firms having a significant market share, exceeding 30 percent in 108 MSA specialty markets and exceeding 50 percent in 50 of those markets.[24] As can be seen in Appendices A and B of this report, gastroenterology, dermatology, urology, obstetrics and gynecology, ophthalmology, and radiology have seen the highest increases in private equity investment in recent years.

When private equity firms acquire multiple providers in the same specialty within a local or regional market (also known as a "roll-up"), those firms can gain significant market power, which can lead to higher prices or lower quality, or both, due to reduced competitive pressure.[25] An example of a roll-up is U.S. Anesthesia Partners, Inc. (USAP) in Texas. USAP, backed by private equity firm Welsh Carson, systematically bought up many large anesthesiology practices in Texas to create one dominant provider with the power to increase prices. USAP and Welsh Carson further drove up prices by entering into price-setting agreements with the remaining independent anesthesiology practices as well as paying a competing anesthesiology practice to stay out of USAP market territory. The Federal Trade Commission (FTC) sued USAP and Welsh Carson and, at the time this report was written, the case was still ongoing, although Welsh Carson has been dismissed from the case.[26]

Strengthening CPOM bans to protect the independent professional judgment of physicians

States are exploring legislation to protect the independent judgment of physicians by strengthening CPOM bans, in part by setting clearer requirements that lay entities (expressly including private equity firms) may not interfere with a physician's medical decision-making or independent judgment and defining what activities constitute medical decision-making. For example, legislation proposed in Washington State in 2025 would codify that the following be included in the "professional judgment or clinical decision-making" of a physician:

> "(a) The period of time a provider may spend with a patient, including the time permitted for a health care provider to triage patients in the emergency department or evaluate admitted patients; (b) The period of time within which a health care provider must discharge a patient; (c) The clinical status of the patient, including whether the patient should be admitted to inpatient status, whether the patient should be kept in observation status, whether the patient should receive palliative care, and whether and where the patient should be referred upon discharge; (d) The diagnoses, diagnostic terminology, or codes that are entered into the medical record by the health care provider; (e) The range of clinical orders available to a health care provider, including by configuring the medical record to prohibit or significantly limit the options available to the provider; or (f) Any other action specified by rule to constitute impermissible interference or control over the clinical judgment and decision making of a health care provider related to the diagnosis and treatment of a patient."[27]

Similar legislation has been introduced in California and Vermont this year, and in 2024, California's legislature considered CA AB 3129, which would have strengthened California's already-strong corporate practice ban through similar provisions and by limiting private equity companies or hedge funds from controlling or directing a physician practice.[28,29]

Imposing limitations on the structure of Management Service Organizations (MSOs) to insulate corporate investors from clinical decisions

The structure of existing CPOM laws allow for broad workarounds that make room for corporate investors to influence the provision of health care. Every state allows for the creation of a special type of physician-owned legal entity, often known as a professional services corporation (PC), to provide medical services if the PC is entirely owned by physicians, with many states, such as Arizona, only requiring partial ownership of a PC by physicians.[30] When CPOM restrictions limiting practice ownership to physician-owned PCs ban corporate investors from employing physicians or practicing medicine, these lay entities may pursue ownership of a management services organization (MSO) to contract with the physician-owned PC. The MSO may operate the nonclinical aspects of a physician practice and conduct administrative functions, handle practice financials, or provide other clinical support services to the practice. Under these arrangements, the PC ostensibly maintains ownership.

However, existing state laws do not prevent corporate investors from exercising influence on patient care via "friendly PC" arrangements. Friendly PC or friendly physician models allow lay entities to invest in and control physician practices indirectly, generally through an MSO. Commonly, the corporate investor secures a physician(s) to work in the practice who is sympathetic ("friendly") to the investor, while the MSO is compensated to provide services necessary for practice operations. Often the "friendly physician(s)" will serve on the board of directors for or have an ownership stake in the PC, the MSO, or both. These types of arrangements may allow corporations to effectively assume control of physician practices. Major corporate investors in health care, including Oak Street Health and One Medical, leverage the friendly PC model.

Novel legislation first proposed in 2024 aims to address the friendly PC model and insulate corporate investors from clinical operations by imposing certain structural limitations on MSOs. These types of provisions, first seen in 2024 in Oregon (HB 4130), challenge the friendly PC model by prohibiting a physician from serving as a shareholder, director, officer, or employee of both a health care practice and an MSO with which the practice contracts. Essentially, they aim to prevent lay entities from circumventing CPOM bans and limit comingling between MSOs and PCs by ensuring that a physician associated with the MSO cannot also direct or own shares in the PC.[31] This year, legislation imposing structural requirements on MSOs has once again been proposed in Oregon and is being considered as a matter of first impression in both Washington and Vermont.[32] Notably, these provisions are controversial

among physicians, in part because they could disrupt existing arrangements that are ostensibly working well, and also because they might prevent physicians who have equity in an MSO from benefitting financially in the event of a sale (i.e., from receiving "roll-over equity").

Improving transparency and oversight

Legislation to increase transparency and state oversight of transactions involving corporate investors is also being considered at the state level. Corporate acquisitions of physician practices often fall under the radar because they do not meet the monetary threshold for reporting and review by federal governing agencies. This is concerning, because many strategies employed by private equity firms have anticompetitive effects that may impact cost, quality, and access to care. When implemented thoughtfully, legislation to increase oversight may allow state governing bodies to identify and mitigate transactions that may have anticompetitive effects or other harmful impacts on patient care.

A handful of state laws impose requirements that certain transactions – namely those involving corporate investors and falling under a specified threshold below the one required by the Hart-Scott-Rodino Act – be reported to the state attorneys general (AG). Indiana, for example, passed such a law in 2024, and Connecticut, Vermont, and New Mexico are among states considering such legislation in the 2025 session.[33,34] More aggressive proposals go beyond transparency and grant the state AG authority to block any transaction it deems anticompetitive or otherwise inappropriate under statute. To that end, legislation may enumerate specific characteristics that constitute "anticompetitive effects," or, importantly, may name other factors that might render a transaction unlawful, such as compromised quality of care or decreased access to care for patients. California and Massachusetts considered such legislation in 2024.[35] In 2025, a bill passed in Massachusetts that, among other things, broadened the definition of "material change transaction" to include transactions involving private equity, real estate investment trusts, and MSOs, thereby subjecting them to market impact review and potential referral to the AG for determination as to whether there is unfair competition or anti-competitive behavior.[36]

The business model employed by corporate investors in health care often allows a firm to control an acquired entity while paying only a small fraction of the total purchase price upfront. The acquired health care practice or hospital is then forced to take on debt to cover the remaining cost. When this debt load is combined with cost-cutting efforts to increase short-term profits – efforts that are often high-risk strategies given the relatively small amount of capital at stake for the private equity firm – the results can be unsustainable.[37] In recent years, this has been particularly evident in private equity's acquisition of hospitals, where private equity ownership has led to bankruptcies, service reductions, and closures that restrict patient access to care. Examples of such casualties include the 2019 bankruptcy of Hahnemann University Hospital in Pennsylvania, the bankruptcy and closure of several Steward hospitals and related physician practices over the past several years in Massachusetts, and the recent devastation of Prospect Medical hospitals in California, Connecticut, Pennsylvania, and Rhode Island.[38] These closures have also led to the loss of liability tail coverage and/or employment for many physicians.

As proposed in CA AB 3129, access to care was included as a factor that attorney general offices might consider in determining whether to approve a proposed transaction. Other proposed legislative solutions to protect patient access to care following the acquisition of a hospital or health system are multifaceted.[39] While there has not been significant activity in state legislatures, proposed federal legislation may serve as a guide for policy solutions implementable at the state level. Senator Edward Markey's (D-MA) 2024 Health Over Wealth Act is instructive: legislation could mandate an acquired system to establish escrow accounts that would cover operating and capital expenditures for a specified period of time in case of a threatened closure or service reduction; it may impose notice requirements for any service disruptions; and, in order to increase an acquiring firm's stake in the transaction and reduce the debt load taken on by the acquired system, it could require that a minimum financial investment be made by investors upfront.[40]

AMA POLICY

Board of Trustees Report 9-I-24, "Corporate Practice of Medicine Prohibition," took a strong stance on restricting CPOM arrangements. The report amended Policy H-215.981 by adding three new clauses that ask the AMA to vigorously oppose any effort to pass legislation or regulation that removes or weakens state laws prohibiting CPOM; oppose CPOM and support the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups; and create a state CPOM template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting CPOM in ways that are not detrimental to the sustainability of physician practices. In its report, the Board of Trustees recommended that AMA policy distinguish between corporate investment, corporate ownership, and corporate control in physician practices.

The Council has addressed this topic in three reports since 2013. In CMS 6-I-13 the Council discussed state CPOM doctrines and associated restrictions. Ultimately, the Council recommended the AMA maintain a balanced policy on CPOM and stated that the detrimental effects of CPOM can be mitigated by having strong policies in place to protect the independent medical judgment of physicians and patient-physician relationships. This report amended H-215.981 and reaffirmed other policies on physician employment. In CMS 11-A-19, the Council highlighted the risks and benefits of entering into corporate partnerships and noted that physician opinions vary regarding corporate investor involvement in physician practices. The report mentioned that although there has been a great deal of angst among physicians regarding private equity investment in practices, other physicians and physician groups have readily and successfully partnered with these firms. This report established Policy H-160.891, which created guidelines for physicians to consider when entering into corporate partnerships. In CMS 2-I-22, the Council provided a more detailed look at private equity investment in physician practices and shared emerging data on the impact these investments have had on physicians and patients. The report amended H-160.891 by adding two new clauses and established new Policy H-160.887.

The AMA has extensive policy on CPOM, consolidation, and related issues. Policy H-215.968 supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care. Policy H-160.960 states that when a private medical practice is purchased by corporate entities, patients going to that practice shall be informed of this ownership arrangement by the corporate entities and/or by the physician. Policy H-380.987 states that antitrust relief for physicians is a priority of the AMA.

Policy H-225.947 states that when physicians are seeking employment as their mode of practice they should strive for arrangements where physician clinical autonomy is preserved. Similarly, Policy D-225.977 states that the AMA will continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance.

Policy H-285.951 supports physicians' right to enter into whatever contractual arrangement with health care systems, plans, groups, or hospital departments they deem desirable and necessary, but they should be aware of the potential for some types of systems, plans, groups, and hospital departments to create conflicts of interest, due to the use of financial incentives in the management of medical care. Additionally, this policy states that physicians should disclose any financial incentives that may induce a limitation of the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options.

Policy H-275.937 highlights the sanctity of the patient-physician relationship by stating that the relationship between a physician and a patient is fundamental and is not to be constrained or adversely

affected by any considerations other than what is best for the patient. The existence of other considerations, including financial or contractual concerns, is and must be secondary to the fundamental relationship. The policy also states that some models of medical practice may result in an inappropriate restriction of the physician's ability to practice quality medicine and this may create negative consequences for the public. Physicians must take actions they consider necessary to assure that medical practice models do not adversely affect the care that they render to their patients. Furthermore, Policy H-225.950 states that in any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority. Additionally, this policy notes that divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address. Policy H-140.978 states that physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward, or the avoidance of financial penalties.

Related Policy H-385.926 states that the AMA supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.), as long as physicians are charging patients fair fees and provide adequate fee information prior to the provision of services. This policy ensures physician autonomy in business decisions, but affirms that decisions, especially around pricing and fees, should be done in good conscience and be fair and transparent for patients.

DISCUSSION

The Council has recently written several reports, and the AMA has extensive policy to guide physician relationships with CPOM. In this report, the Council aims to strengthen existing guidelines for physicians considering corporate partnerships, support capital reserve requirements for firms interested in investing in the health care sector, and support increased enforcement of existing regulations on CPOM. It is important to note that CPOM is not new, but the recent rise in corporate investment in the health care sector raises cause for concern, particularly as it relates to patient safety and physician autonomy in clinical and operational decision-making.

There are risks and benefits associated with corporate investment and partnership. Corporate investment can offer a way for a practice to avoid selling to a hospital or health system, manage human resources, information technology and other administrative tasks on behalf of the practice, offer lucrative deals for physician-owners wanting to retire or sell their practice, and help with medical liability costs. Risks to physicians include a loss of control of business decisions and/or clinical autonomy, drastic cost cutting measures, loss of employment or replacement by NPPs, restrictive non-compete agreements, loss of liability tail coverage, or increased pressure to meet lofty financial targets. For physician-owners, there is the possibility of debt or bankruptcy after the corporate investor has extracted profits and exited the partnership.

The corporate investor could also go bankrupt, as has happened most recently with Prospect Medical Holdings in January 2025, and with Steward Health and Hahnemann University Hospital in recent years. The Council discussed the importance of financial stability of private equity firms and other investors before investments are made. Because the nature of private equity investment relies heavily on investing with debt (leveraged buyouts), investments can be risky and can lead to bankruptcy if not managed properly. Anecdotally, this has led to several hospital and practice closures around the country. The *Kaiser Health News* collection "Patients for Profit: How Private Equity Hijacked Health Care" provides several examples of where this has happened in the United States and the detrimental effect it can have on patients, physicians, and communities. While an important consideration, the Council believes that it is outside the purview of the AMA to dictate specific financial requirements for corporate investors. Instead, the Council stresses the importance of due diligence on the part of physician-owners considering these partnerships to ensure that an interested corporate investor has the resources required to support a

successful business relationship. With the intent to avoid future hospital closures, the Council recommends that the AMA support capital reserve requirements and leverage standards that preserve access to care for patients by preventing the closure of health care facilities and the limiting of essential health services.

Another consideration for physicians is control over final billing and coding designations. When administrative tasks are outsourced, there is opportunity for errors or intentional upcoding by third-party companies outside of the physician's direct supervision. As it is the physician's ultimate responsibility to ensure that billing and coding are accurate for the services provided, Policy H-385.939 outlines how false claims attributed to them could result in reputational, financial, or even criminal consequences.

During deliberations on this report, the Council discussed the relationship between NPPs and private equity. Theoretically, if physicians are reluctant to enter into corporate partnerships, private equity and other corporate entities may seek to instead invest in health care practices affiliated with NPPs, such as nurse practitioners and/or physicians assistants. The Council recognizes that this could be a result of physician resistance to corporate partnerships but ultimately believes it would be out of scope for the Council to recommend policy on business models for NPPs since the AMA is an organization representing physicians and not NPPs. Informally, the Council believes that like physicians, all allied health professionals should exercise due diligence when considering partnerships with corporate entities.

It is important to enforce regulations on transparency of these transactions as well as the ownership of group practices, hospitals, and health systems, including corporate and private equity ownership and relationships. Additionally, corporate and private equity acquisitions should be reviewed for their potential to disrupt access to care and conditions should be placed to ensure physician independence, quality of care, minimization of conflicts of interest, and avoidance of excess market consolidation. It is also important to support regulations that prevent the closure of essential services, such as emergency departments or labor and delivery units, whenever possible. The importance of transparency is highlighted in Policy H-160.960, which states that patients must be informed when a corporate entity purchases a private medical facility.

Because of the intricacies involved in corporate entity transactions, the Council believes it would be difficult to unwind the mergers and acquisitions that have already taken place, both by corporate investors as well as by nonprofit entities or other types of firms (i.e., nonprofit hospitals, health systems, independent practices). However, to boost competition in already consolidated markets, current laws on CPOM need to be enforced and new businesses need to be able to enter the market. Where possible, mergers and acquisitions should be scrutinized by the appropriate parties (FTC, Department of Justice, state attorneys general, etc.) to ensure they are following antitrust laws and to determine the effect the transaction may have on the market. Pursuing transparency in ownership of health care practices, as well as transparency in pricing, could boost competition as well as allow patients to make an informed choice when it comes to the care they receive.

Given the breadth and depth of AMA policy on this topic, the Council recommends strengthening existing guidelines to promote physician due diligence and protection when considering a relationship with a corporate entity. Specifically, the Council recommends broadening policy to include other corporate structuring, not just corporate investors, including language about conflict resolution, more explicitly stating which clinical and operational decisions should remain under the direction of physicians, including considerations and protections for billing and coding responsibility, supporting physician engagement in organizational governance following a merger or acquisition, and supporting enforcement of CPOM doctrines. The Council recommends supporting capital reserve requirements for corporate entities considering investment in health care facilities in order to provide stable financing in order to preserve access to care for patients and fulfillment of contractual obligations to physicians. Finally, the

Council recommends reaffirming policy on the importance of preserving physician autonomy and clinical decision-making.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted and the remainder of the report be filed:

1) That our American Medical Association (AMA) amend Policy H-160.891, "Corporate Investors," by addition and deletion, including a change in title:

   CORPORATE INVESTORS AND OTHER CORPORATE ENTITIES, H-160.891

   1) Our American Medical Association encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under "friendly" physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:
      a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor/entity.
      b. Due diligence should be conducted that includes, at minimum, review of the corporate investor/entity's business model, strategic plan, leadership and governance, and culture.
      c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor/entity transactions.
      d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
      e. Physicians should consider whether and how corporate ~~investor~~ partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
      f. Physicians should consider the potential impact of corporate ~~investor~~ partnerships on physician and practice employee satisfaction and future physician recruitment.
      g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate ~~investor~~ relationships, and application of restrictive covenants, including any changes in the scope or implementation of any current or proposed restrictive covenants based on the corporate partnership.
      h. Physicians should consider corporate procedures ~~investor processes~~ for medical staff representation on the board of directors and medical staff leadership selection as well as processes for resolution of conflict between medical staff leadership and the corporate entity.
      i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate ~~investor~~ partnerships.

j. Prior to entering into a partnership with a corporate entity, physicians and the corporate entity should explicitly identify the types of clinical and business decisions that should remain in the ultimate control of the physician, including but not limited to:
   i. Determining which diagnostic tests are appropriate;
   ii. Determining the need for referrals to, or consultation with another physician or licensed health professional;
   iii. Being responsible for the ultimate overall care of the patient, including treatment options available to the patient;
   iv. Determining how many patients a physician shall see in a given period of time or how many hours a physician should work;
   v. Determining the content of patient medical records;
   vi. Selecting, hiring, or firing physicians, other licensed health care professionals, and/or other medical staff based on clinical competency or proficiency;
   vii. Setting the parameters under which a physician or physician practice shall enter into contractual relationships with third-party entities;
   viii. Making decisions regarding coding and billing procedures for patient care services; and
   ix. Approving the selection of medical equipment and medical supplies.

k. ~~j.~~ Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.

l. Clear protection and dispute resolution processes for physicians advocating on patient care and quality issues should be incorporated into an agreement between physicians and corporate entities.

m. ~~k.~~ Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.

2) Our AMA supports improved transparency regarding corporate investments in and/or relationships to physician practices, subsidiaries and/or related organizations that interact with the physician group and/or patients of the physicians, and subsequent changes in health care prices, quality, access, utilization, and physician payment.

3) Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.

4) Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors/entities on the practice of medicine.

5) Our AMA supports meaningful physician representation in any corporate governance structure (e.g., seats on the board of directors, and/or other relevant leadership bodies) of any entity with which a

physician practice, hospital, or other health care organization partners. (Modify HOD Policy)

2) That our AMA amend Policy H-215.981, "Corporate Practice of Medicine," by addition:

CORPORATE PRACTICE OF MEDICINE, H-215.981

1) Our American Medical Association vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.
2) Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine.
3) Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
4) Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
5) Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.
6) Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy and operational authority are preserved and protected.
7) Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.
8) Our AMA supports enforcement of existing regulations and legislation pertaining to corporate control of practices in the health care sector to ensure that physician clinical autonomy and operational authority is preserved and protected.
9) Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to physicians and trainees by providing stable financing for hospitals, clinics, and other health care facilities. (Modify HOD Policy)

3) That our AMA reaffirm Policy H-285.910, The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community, which provides a recommended clause to include in physician employment agreements and which states that in caring for patients physicians shall have the unfettered right to exercise independent and professional judgment and be guided by personal and professional beliefs as to what is in the best

interests of patients, the profession, and the community. Furthermore, nothing in the employment agreement shall prevent physicians from exercising their own medical judgment and employers may not retaliate against the physician in any way based on the physician's right to exercise their medical judgment. (Reaffirm HOD Policy)

4) That our AMA rescind Policy D-160.904, as it is accomplished by this report. (Rescind HOD Policy)

5) That our AMA rescind Policy D-215.982, as it is accomplished by this report. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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Appendix A

Characteristics of private equity (PE)-acquired and non-PE-acquired practice sites for 10 physician specialties and by specialty, 2021

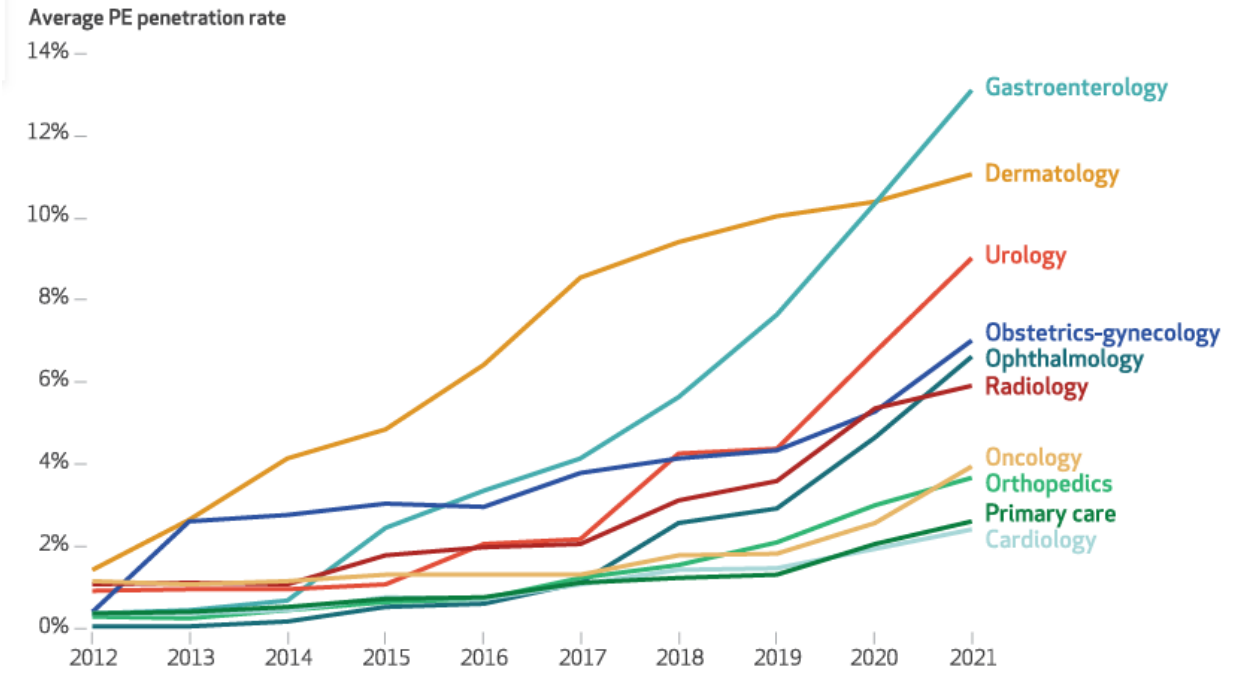
	PE-acquired practice sites (*N* = 5,779)		Non-PE-acquired practice sites (*N* = 131,552)	
Characteristics	**Number**	**Percent**	**Number**	**Percent**
No. of practice owners[a]	243	100.0	6,717	100.0
No. of physicians	14,656	100.0	328,335	100.0
No. of female physicians	5,372	36.7**	132,413	40.3
Age, years (SE)	53.3** (0.02)	—[b]	52.3 (0.09)	—[b]
Geographic region				
South	2,768	47.9	50,459	38.3
Northeast	1,157	20.0	29,212	22.2
Midwest	1,085	18.8	23,511	17.9
West	769	13.3	28,370	21.6
Specialty				
Primary care	1,440	24.9	72,412	55.1
Dermatology	827	14.3	5,818	4.4
Obstetrics-gynecology	798	13.8	10,944	8.3
Gastroenterology	697	12.1	4,468	3.4
Ophthalmology	648	11.2	8,966	6.8
Oncology	368	6.4	5,062	3.8
Urology	346	6.0	3,384	2.6
Radiology	257	4.4	4,991	3.8
Orthopedics	237	4.1	8,094	6.2
Cardiology	161	2.8	7,413	5.6

SOURCE Authors' analysis of data from the Irving Levin Associates Healthcare M&A Database, PitchBook private equity and merger and acquisition database, and OneKey Database provided by IQVIA. The PitchBook data presented here have not been reviewed by PitchBook analysts. The PitchBook database is dynamic; data for this exhibit are as of June 15, 2022. **NOTES** Specialties were identified at the physician level. Physicians who worked at multiple locations were counted as a fraction of physicians using full-time equivalents. If a practice included multiple specialties, counts were documented separately for each specialty, equivalent to each specialty being considered as a separate practice. We conducted a two-sample *t*-test on age and chi-square tests for the proportion of female physicians. [a]Practice owners are PE firms in the PE-acquired category and other corporate owners in the non-PE-acquired category. [b]Not applicable. **$p < 0.05$

Health Affairs. Private Equity-Acquired Physician Practices and Market Penetration Increased Substantially, 2012-21. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2023.00152

Appendix B

Trends in private equity (PE) penetration at the physician level in the US among 10 physician specialties, 2012–21



SOURCE Authors' analysis of data from the Irving Levin Associates Healthcare M&A Database, PitchBook private equity and merger and acquisition database, and OneKey Database provided by IQVIA (2020–21) and SK&A Office Based Physicians Database provided by IMS Health (now IQVIA) (2012–19). The PitchBook data presented here have not been reviewed by PitchBook analysts. The PitchBook database is dynamic; data for this figure are as of June 15, 2022. **NOTE** Average PE penetration rates at the physician level in each year by specialty were calculated by weighting each Metropolitan Statistical Area (MSA)-level market share by the number of full-time-equivalent physicians in that MSA by specialty, equivalent to the US penetration rate.

Health Affairs. Private Equity-Acquired Physician Practices and Market Penetration Increased Substantially, 2012-21. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2023.00152

Council on Medical Service Report 3-A-25
Regulation of Corporate Investment in the Health Care Sector
Policy Appendix

Corporate Investors, H-160.891

1. Our American Medical Association (AMA) encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:
    a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
    b. Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
    c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
    d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
    e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
    f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
    g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
    h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
    i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
    j. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.
    k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.
2. Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.

(CMS Rep. 11, A-19; Appended: CMS Rep. 2, I-22; Reaffirmed: BOT Rep. 14, A-23)

Corporate Practice of Medicine, H-215.981

1. Our American Medical Association (AMA) vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine.
2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine.

3. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
4. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
5. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.
6. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy and operational authority are preserved and protected.
7. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.
(Res. 247, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Modified: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 07, A-17; Modified: Res. 713, A-18; Reaffirmed: CMS Rep. 11, A-19; Reaffirmed: CME Rep. 01, I-22; Modified: Res. 710, A-24, Modified: BOT Rep. 09, I-24)

The Physician's Right to Engage in Independent Advocacy on Behalf of Patients, H-285.910
Our American Medical Association endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:

Physician's Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community

In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise independent professional judgment and be guided by personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician's right or ability to advocate on behalf of patients' interests or on behalf of good patient care, or to exercise their own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician's exercise of their rights under this paragraph.
(Res. 8, A-11; Reaffirmed: CEJA Rep.1, A-21; Modified: Speakers Rep. 02, I-24)

The Regulation of Private Equity in the Health Care Sector, D-160.904
Our American Medical Association will propose appropriate guidelines for the use of private equity in healthcare, ensuring that physician autonomy and operational authority in clinical care is preserved and protected.
(Res. 710, A-24)

The Corporate Practice of Medicine, Revisited, D-215.982
Our American Medical Association will revisit the concept of restrictions on the corporate practice of medicine, including, but not limited to, private equities, hedge funds and similar entities, review existing

state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report that will study and report back by Annual 2025 with recommendations on how to increase competition, increase transparency, support physicians and physician autonomy, protect patients, and control costs in already consolidated health care markets; and to inform advocacy to protect the autonomy of physician-directed care, patient protections, medical staff employment and contract conflicts, and access of the public to quality health care, while containing health care costs.
(Res. 702, A-24)

Corporate Practice of Medicine, H-160.887
Our American Medical Association acknowledges that the corporate practice of medicine:

1. has the potential to erode the patient-physician relationship.
2. may create a conflict of interest between profit and best practices in residency and fellowship training.

(CMS Rep. 2, I-22)

Corporate Ownership of Established Private Medical Practices, H-160.960
When a private medical practice is purchased by corporate entities, patients going to that practice shall be informed of this ownership arrangement by the corporate entities and/or by the physician.
(Res. 3, I-92; Modified by CMS Rep. 1, A-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15; Reaffirmed: CMS Rep. 11, A-19)

Antitrust Relief as a Priority of the AMA, H-380.987
Our American Medical Association will continue its aggressive efforts to achieve appropriate negotiations rights and opportunities and necessary antitrust relief for physicians, by whatever means. Achieving this important goal will remain a top priority for the Association.
(Sub. Res. 223, A-93; Reaffirmed by BOT Rep. 33, A-96; Reaffirmation A-97; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-04; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed in lieu of Res. 218, A-15; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: Res. 206, A-19)

Physician Employment Trends and Principles, H-225.947
1. Our American Medical Association (AMA) encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with the following principles: A. Physician clinical autonomy is preserved. B. Physicians are included and actively involved in integrated leadership opportunities. C. Physicians are encouraged and guaranteed the ability to organize under a formal self-governance and management structure. D. Physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care. E. A mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care. F A clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures.
2. Our AMA encourages continued research on the effects of integrated health care delivery models (that employ physicians) on patients and the medical profession.
(CMS Rep. 5, I-15; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19)

Physician Independence and Self-Governance, D-225.977

1. Our American Medical Association (AMA) will continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance.
2. Our AMA will promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care

systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care.
(Res. 801, I-11; Modified: BOT Rep. 6, I-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22)

Financial Incentives Utilized in the Management of Medical Care, H-285.951
Our American Medical Association believes that the use of financial incentives in the management of medical care should be guided by the following principles:

(1) Patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
(2) Physicians should have the right to enter into whatever contractual arrangements with health care systems, plans, groups or hospital departments they deem desirable and necessary, but they should be aware of the potential for some types of systems, plans, group and hospital departments to create conflicts of interest, due to the use of financial incentives in the management of medical care.
(3) Financial incentives should enhance the provision of high quality, cost-effective medical care.
(4) Financial incentives should not result in the withholding of appropriate medical services or in the denial of patient access to such services.
(5) Any financial incentives that may induce a limitation of the medical services offered to patients, as well as treatment or referral options, should be fully disclosed by health plans to enrollees and prospective enrollees, and by health care groups, systems or closed hospital departments to patients and prospective patients.
(6) Physicians should disclose any financial incentives that may induce a limitation of the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options. Physicians may satisfy their disclosure obligations by assuring that the health plans with which they contract provide such disclosure to enrollees and prospective enrollees. Physicians may also satisfy their disclosure obligations by assuring that the health care group, system or hospital department with which they are affiliated provide such disclosure to patients seeking treatment.
(7) Financial incentives should not be based on the performance of physicians over short periods of time, nor should they be linked with individual treatment decisions over periods of time insufficient to identify patterns of care.
(8) Financial incentives generally should be based on the performance of groups of physicians rather than individual physicians. However, within a physician group, individual physician financial incentives may be related to quality of care, productivity, utilization of services, and overall performance of the physician group.
(9) The appropriateness and structure of a specific financial incentive should take into account a variety of factors such as the use and level of "stop-loss" insurance, and the adequacy of the base payments (not at-risk payments) to physicians and physician groups. The purpose of assessing the appropriateness of financial incentives is to avoid placing a physician or physician group at excessive risk which may induce the rationing of care.
(10) Physicians should consult with legal counsel prior to agreeing to any health plan contract or agreeing to join a group, delivery system or hospital department that uses financial incentives in a manner that could inappropriately influence their clinical judgment.
(11) Physicians agreeing to health plan contracts that contain financial incentives should seek the inclusion of provisions allowing for an independent annual audit to assure that the distribution of incentive payments is in keeping with the terms of the contract.
(12) Physicians should consider obtaining their own accountants when financial incentives are included in health plan contracts, to assure proper auditing and distribution of incentive payments.
(13) Physicians, other health care professionals, third party payers and health care delivery settings through their payment policies, should continue to encourage use of the most cost-effective care setting in which medical services can be provided safely with no detriment to quality.

(CMS Rep. 3, I-96; Reaffirmed by CMS Rep. 15, A-98; Reaffirmation: A-99; Reaffirmed: CMS Rep. 12, I-99; Reaffirmation: A-00; Reaffirmation: A-01; Reaffirmed in lieu of Resolution 901, I-05; Modified: BOT Rep. 38, A-06; Reaffirmed: CMS Rep. 01, A-16; Reaffirmed: CMS Rep. 11, A-19)

American Medical Association Principles for Physician Employment, H-225.950

1. **Addressing Conflicts of Interest**
    a. Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
    b. In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
    c. Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
    d. A physician's paramount responsibility is to their patients. Additionally, given that an employed physician occupies a position of significant trust, they owe a duty of loyalty to their employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
        i. No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to their religious beliefs or moral convictions.
        ii. No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because they either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates their religious beliefs or moral convictions.
    e. Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. **Advocacy for Patients and the Profession**
    a. Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
    b. Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. **Contracting**
    a. Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance

plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

b. Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
c. When a physician's compensation is related to the revenue they generate, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
d. Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under their care. When a physician's employment status is unilaterally terminated by an employer, the physician and their employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in their new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of their patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
e. Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
f. Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
g. Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
h. Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. **Hospital Medical Staff Relations**
   a. Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
   b. Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
   c. Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
   d. Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. **Peer Review and Performance Evaluations**
   a. All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
   b. Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
   c. Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
   d. Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
   e. Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
   f. Upon termination of employment with or without cause, an employed physician generally should not be required to resign their hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the

medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:

i. The agreement is for the provision of services on an exclusive basis.
ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985.
iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a. Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
b. Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

(BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19; Reaffirmation: A-22; Reaffirmed: BOT Rep. 29, A-24; Modified: Speakers Rep. 02, I-24)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-25

Subject: Requiring Payment for Physician Signatures (Resolution 108-A-24)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee G

At the 2024 Annual Meeting, the House of Delegates referred Resolution 108, which was sponsored by the Mississippi State Medical Association, and asked the American Medical Association (AMA) to advocate that insurance companies be required to pay a physician for any required physician signature and/or peer-to-peer review which is requested or required outside of a patient visit.

BACKGROUND

Physician signatures are an integral part of health care delivered by a physician, as they serve as an identifier as to who provided services, verify care, assign legal responsibility, and demonstrate that services have been accurately documented to allow eligibility for payment.[1,2,3] Ensuring program integrity, signatures verify that the services provided were accurately and thoroughly documented and reviewed.[4] Physician signatures also assure patient safety by serving to identify which physician is responsible for the patient's care and attesting that they have carefully reviewed the patient's medical information.[5] Further, most health care regulations require signatures on medical records to verify the legitimacy of services provided and proper payment. The state of Illinois, for example, requires that, "all physician's orders and plans of treatment shall have the authentication of the physician…" as "authentication means an original written signature or an electronic signature system that allows for the verification of a signer's credentials."[6]

Physician signatures are required throughout the entire course of treatment for a patient, including prescriptions, medical orders, progress notes, discharge summaries, referrals, evaluations, re-evaluations, surgical reports, pathology reports, diagnosis/treatment plans, and claim forms.[7,8,9] For a prior authorization (PA), a physician's signature is typically required to authenticate the medical necessity of the requested treatment, meaning they must personally sign the document to indicate their approval and agreement with the information provided, usually including their full name and credentials.[10,11]

A peer-to-peer medical review is a dialogue between a treating physician, usually by telephone, and a medical director from a health insurance company, where the physician is required to explain the medical necessity of a treatment or procedure for a patient.[12] Typically, it is a discussion between medical peers to clarify a patient's case when coverage is disputed and occurs by request after a payer denies coverage for services. Denials are usually made for medical orders, services, and inpatient status but can occur for medications or medical devices.[13] While the process can be tedious and frustrating, in some circumstances, it can be expeditious when it gives the treating physician the opportunity to speak with another physician.[14] However, it can be less effective when

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the health plan reviewer is a physician from another specialty or subspecialty, knows little about the disease or treatment in determination, or may not be licensed in the same state.[15] Further, the process approaches futility when the assigned reviewer is not a physician.[16]

REPORTING PHYSICIAN SIGNATURES AND PEER-TO-PEER REVIEW

CPT Assistant, a digital monthly newsletter which serves as a companion to the *Current Procedural Terminology* (CPT®) code set, published an October 2024 article providing coding guidance for PA-related activities within evaluation and management (E/M) services.[17] The article describes how PA-related work of providing signatures can be reported with CPT code 99080 (*Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form*).[18] Code 99080 can be appropriately reported when a physician spends time solely on completing special reports or signing forms independent of PA-related work performed on the date of an E/M encounter, excluding time spent on the telephone or in other conversations.[19]

The article also describes how the PA-related work of peer-to-peer review can be captured in the CPT code set. When selecting a code based on total time, physicians or other qualified health care professionals may include both face-to-face and non-face-to-face time, including time spent on PA-related work, on the same date of the encounter.[20] Alternatively, if E/M reporting is based on medical decision making (MDM), the review can be accounted for in the MDM Risk Element by incorporating social drivers of health and elevating to moderate complexity. For peer-to-peer reviews that occur on a different day than the E/M encounter, a separate code for prolonged physician services can be reported.[21] A summary of the codes referenced in the article can be found in Appendix A.[22]

AMA POLICY

Policy D-320.978 advocates for the fair reimbursement of established and future CPT codes for administrative burdens. Policy D-320.993 supports the development of more stringent state laws and regulations that provide compensation to physicians for the administrative burden and costs of health plan documentation requirements. Policy D-330.919 tasks the AMA to re-engage with the Centers for Medicare & Medicaid Services to re-evaluate Medicare signature requirements. Policy H-155.976 directs the AMA to seek comprehensive reforms to reduce administrative inefficiencies, address the need to reduce administrative costs and burdens, and minimize the administrative burdens imposed on physicians Policy H-225.965 supports that, unless otherwise required by law or regulation, a single signature may document the validity of entries in the medical record. In addition, it is important to note that Policy H-70.919 delineates that the CPT Editorial Panel is the body charged with developing new and revised CPT codes, descriptors, guidelines, parenthetical statements and modifiers independent of the AMA. Therefore, the AMA cannot direct the activities of the CPT Editorial Panel, including the identification of potential gaps in the nomenclature surrounding the reporting of physician signatures and peer-to-peer review.

DISCUSSION

Resolution 108-A-24 asked the AMA to advocate for payment for physician signatures and/or peer-to-peer review requested or required outside of a patient visit. The Council understands the burden associated with required physician signatures and peer-to-peer reviews before, during, and after the treatment of a patient. However, we also believe that physician signatures are necessary to identify who provided services, ensure integrity, verify PA treatment necessity, assign legal responsibility, satisfy federal and state requirements, and demonstrate that services have been accurately

documented to allow eligibility for payment. Similarly, peer-to-peer reviews may allow a treating physician the chance to communicate the necessity of treatment as well as insight into new procedures or drugs not previously considered. Therefore, the Council recognizes that its recommendations must take each position into consideration.

Additionally, the Council's recommendations must not infringe on PA reform advocacy, which is a priority for the AMA. We are skeptical that the burden of physician signatures is confined to the PA process, as physician signatures are required throughout the entirety of a patient's treatment. Therefore, the Council recommends broadening policy to recognize this issue.

Recently, *CPT Assistant* provided coding guidance for PA-related activities, delineating how services such as signing forms may be appropriately reported with CPT codes. The Council believes that this guidance outlines infrastructure sufficient for the appropriate reporting of such services, thereby allowing eligibility for payment.

While Policy D-320.978 advocates for fair payment of established and future CPT codes for administrative burdens related to PA, the Council recommends underscoring this existing policy by creating a new, standalone policy, expanding it to include advocacy for fair payment of "all administrative tasks." The Council believes this fulfills the resolution's request, embeds seamlessly within existing policy, and provides an impactful solution.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-24 and the remainder of the report be filed:

1. That our American Medical Association (AMA) advocate for fair payment of CPT codes that accurately describe the myriad of administrative tasks performed by physicians, which can include the prior authorization process, appeals, or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials. (New HOD Policy)

2. That our AMA amend Policy D-320.978 by deletion as follows:

    1. Our American Medical Association will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices.
    2. Our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes.
    3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.
    ~~4. Our AMA will advocate for fair reimbursement of established and future CPT codes for administrative burdens related to:~~
        ~~a. the prior authorization process.~~
        ~~b. appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.~~ (Modify HOD Policy)

Fiscal Note: Minimal - less than $1,000.

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[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] Ibid.

Council on Medical Service Report 4-A-25
Requiring Payment for Physician Signatures
Policy Appendix

Fair Reimbursement for Administrative Burdens D-320.978

1. Our American Medical Association (AMA) will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices.
2. Our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes.
3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.
4. Our AMA will advocate for fair reimbursement of established and future CPT codes for administrative burdens related to:
    a. the prior authorization process.
    b. appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.

(Res. 701, A-22)

Insurance Coverage Appeals D-320.993

Our AMA will:
(1) continue to support the development of more stringent state laws and regulations that provide compensation to physicians for the administrative burden and costs of the health plan documentation requirements, such as the appeal process;
(2) continue to advocate to ensure that physicians receive prompt, fair payment from health plans through educational products, seminars and advocacy efforts;
(3) continue to encourage health plans to implement online appeal processes to reduce the administrative burden and cost to physicians and their patients when claims are denied inappropriately;
(4) continue to encourage health plans to streamline, provide transparency, and lessen the administrative burdens and costs that are incurred by physicians through the health plans appeals processes;
(5) remain an active participant in the standards development activities of several standards development organizations and data content committees; and
(6) continue in its leadership role in the National Uniform Claims Committee and its work with the standards development organizations.
(BOT Rep. 23, A-06 Modified: CMS Rep. 01, A-16 Reaffirmation: I-17)

Reduction of Burdensome CMS Signature Compliance Requirements D-330-919

Our AMA will re-engage the Centers for Medicare & Medicaid Services to re-evaluate Medicare signature requirements.
(Res. 813, I-10 Reaffirmed: Res. 708, A-18)

Administrative Costs and Access to Health Care H-155.976

Our American Medical Association supports accurate calculations of the administrative costs of government programs (Medicare, Medicaid, TRICARE, etc.) and private health insurance plans. It is the policy of the AMA:

(1) to begin immediately to seek comprehensive reforms to reduce the administrative inefficiencies, burdens and expenses involved in paying for health care services and to urge that proposals to increase access to health care also address the need to reduce administrative costs and burdens;
(2) that state and county medical societies and national medical specialty societies be urged to utilize the joint Guidelines for Health Benefits Administration in discussions with health care payers directed toward improving the efficiency of utilization management programs and minimizing the administrative burdens they impose on physicians and hospitals;
(3) that the AMA strongly encourage further study of the cost-effectiveness of all types of utilization management systems and programs and report further results of such study to the Federation as they become available;
(4) that state medical societies be urged to work for enactment of the AMA model state legislation governing: (a) clarity and readability of contract language and uniform policy provisions; (b) liability of review entities for injury to beneficiaries; (c) physician involvement in the review process; and (d) confidentiality of medical information requested by review entities; and
(5) that this information be conveyed to the American public through appropriate mechanisms.
(Res. 202, A-90 CMS Rep. A, A-90 Reaffirmed: BOT Rep. 40, I-93 CMS Rep. 12, A-95 Appended: Res. 715, I-02 Reaffirmation A-07 Reaffirmed in lieu of Res. 828, I-08 Reaffirmation I-11 Reaffirmation: A-17)

Activities of The Joint Commission and a Single Signature to Document the Validity of the Contents of the Medical Record H-225.965
The AMA supports the authentication of the following important entries in the medical record, history and physical examinations, operative procedures, consultations, and discharge summaries. Unless otherwise specified by the hospital or medical staff bylaws, or as required by law or regulation, a single signature may document the validity of other entries in the medical record.
(BOT Rep. 58, A-96 Reaffirmed: CLRPD Rep. 2, A-06 Modified: CMS Rep. 01, A-16 Reaffirmation: I-18)

Use of CPT Editorial Panel Process H-70.919
Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetic statements and modifiers.
(BOT Rep. 4, A-06 Reaffirmation A-07 Reaffirmation I-08 Reaffirmation A-09 Reaffirmation A-10 Reaffirmation A-11 Reaffirmation I-14 Reaffirmed: CMS Rep. 4, I-15 Reaffirmation A-16 Reaffirmed in lieu of: Res. 117, A-16 Reaffirmed in lieu of: Res. 121, A-17 Reaffirmation: A-18 Reaffirmation: I-18 Reaffirmed: Res. 816, I-19)

APPENDIX A

Reporting Prior Authorization Activities Provided as Part of Evaluation and Management Services

- 99203 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

- 99204 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

- 99205 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded. (For services 75 minutes or longer, use prolonged services code 99417)

- 99213 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

- 99214 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

- 99215 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded. (For services 55 minutes or longer, use prolonged services code 99417)

- 99358 - Prolonged evaluation and management service before and/or after direct patient care; first hour. Code 99359 can be used for each additional half hour.

- 99452 - Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional.

- 99080 - Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form.

REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-25)
Impact of Patient Non-adherence on Quality Scores
(Reference Committee G)

EXECUTIVE SUMMARY

Policy D-450.950 was adopted at the 2024 Annual Meeting and asks our American Medical Association (AMA) to study the issue of patients and parents not adhering to physicians' recommendations such as preventive screenings and vaccinations resulting in a deficiency of quality metrics by physicians for which the physicians are penalized and identify equitable and actionable solutions. This report discusses quality of care metrics, measuring patient adherence, the role of coding in value-based care (VBC), patient adherence models, and includes several policy recommendations.

As quality metrics assess the effectiveness of health care processes, outcomes, patient perceptions, and organizational structures or systems to meet assigned goals, they have increasingly been tied to payment in VBC. Poor patient adherence to physician recommendations obscures quality metrics and results in poor outcome measures. Many factors outside of the control of a physician impact the adherence of a patient to physician recommendations. Patient adherence can be measured in three ways: objective, subjective, and biomedical strategies.

In 2003, the World Health Organization (WHO) released a report which provided a critical review of potential solutions to improve adherence, including the WHO Multidimensional Adherence Model, which considers extrinsic factors impacting a patient. There are several additional adherence models that may provide a roadmap to improve patient adherence. While there is no "gold" standard to improve adherence, there may be opportunities based on a combination of methods enhancing patient self-regulation or self-management.

The Council on Medical Service recommends new policy supporting the removal of outcome scores that are unfairly tied to patient non-adherence and the development of models that provide guidance for physicians, medical practices, and health care teams to improve patient adherence in an individualized, continuous, and multidisciplinary way. The Council also recommends additional research on the intricacies of non-adherence and potential models to improve adherence.

Additionally, the Council recommends amending Policy D-450.958 to capture that patient non-adherence to physician recommendations should not be evaluated in the Hospital Consumer Assessment of Healthcare Providers and Systems and Clinician and Group Consumer Assessment of Healthcare Providers and Systems surveys nor should physician compensation, employment retention or promotion, faculty retention or promotion, or provider network participation be linked to patient non-adherence. Furthermore, the Council recommends reaffirming Policies H-450.947 and H-450.966 to illustrate the AMA's principles and guidelines for pay-for-performance payment systems as well as the principles to consider when assessing quality and performance measures. Lastly, the Council recommends reaffirming Policy H-390.837 to emphasize the AMA's position regarding the Medicare Access and CHIP Reauthorization Act system.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-A-25

Subject: Impact of Patient Non-adherence on Quality Scores

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee G

Policy D-450.950 was adopted at the 2024 Annual Meeting and asks our American Medical Association (AMA) to study the issue of patients and parents not adhering to physicians' recommendations such as preventive screenings and vaccinations resulting in a deficiency of quality metrics by physicians for which the physicians are penalized and identify equitable and actionable solutions. This report discusses quality of care metrics, measuring patient adherence, the role of coding in value-based care (VBC), patient adherence models, and includes several policy recommendations.

BACKGROUND

The National Academy of Medicine defines quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[1] Quality metrics assess the effectiveness of health care processes, outcomes, patient perceptions, and organizational structures or systems to meet assigned goals, such as safe, efficient, patient-centered, equitable, and timely care.[2] Increasingly, these quality measures are being linked to payment to ensure quality health care. For Medicare and Medicaid beneficiaries, the Centers for Medicare & Medicaid Services (CMS) uses measures in its various quality initiatives that include quality improvement, pay for reporting, and public reporting. Private payers are also increasingly measuring the performance of physicians, with the intent to provide financial incentives to improve health care delivery and establish transparency programs to allow comparison among physicians. While more than half of health care payments are still fee-for-service, CMS continues to expand its value-based payment and alternative payment model programs.[3] In 2022, CMS launched its National Quality Strategy which, "aims to promote the highest quality outcomes and safest care for all individuals" and instills a person-centered approach to the broader goal of quality by focusing on the overall care trajectory across the continuum of care. Further, the approach seeks to reduce provider burden, advance equity, aid in the transition from manual to digital reporting, and clarify comparison between quality and VBC programs.

Broadly speaking, quality can be measured in three ways: structure, process, and outcome.[4] Structural measures focus on the attributes of a setting in which the care is received. Some examples of structural measures include whether the health care organization uses electronic medical records, the number or proportion of board-certified physicians, or the ratio of providers to patients.[5] Process measures assess the interaction between the physician and patient and include the percentage of people receiving preventive services (such as mammograms or immunizations) or the percentage of people with diabetes who have their blood sugar evaluated and controlled.[6] Lastly, outcome measures address morbidity or quality of life. Examples of outcome measures include the percentage of patients who die because of surgery (surgical mortality rates) or the rate of surgical

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complications or hospital-acquired infections.[7] Some other examples of measurable care include: patients' reports on the care and service they receive from the hospital (process, structure, or outcome), provision of care instructions upon hospital discharge for certain conditions (process), percentage of patients receiving recommended hospital care for specific conditions such as heart attack (process), pneumonia care (process), and prevention of surgical infection (outcome), rates at which patients fall and incur injury during a hospital stay (outcome), and number of beds and the types of services available (structure).[8]

Unique challenges have arisen during the transition to VBC. For instance, the distinct values, perspectives, and self-interests of health care stakeholders have made it difficult to clarify what should be assessed. Beyond this, the considerable variety of quality measures has caused confusion as they do not share a common theme. Further, the increased requirement to report quality measures (quantity or complexity) leads to increased reporting burden. While the Medicare Merit-based Incentive Payment System (MIPS) is well intentioned, the reporting requirements are burdensome to physician practices and often appear to be irrelevant. MIPS is not unique in that the nature of having to report any quality measures creates a burden. It may be presumed that improving care is ancillary to "checking a box." Further, despite the current efforts to prioritize effective and relevant metrics to determine quality care, the problems within the current framework remain. According to the Commonwealth Fund, many primary care physicians have decided not to participate in value-based models based on "imperfect performance measures," as they believe that quality suffers because of these measures.[9] Indeed, commercial insurers often use the same, or similar, quality measures as CMS to adjust physician payment.

Beyond poor outcome scores, a physician can feel the negative impacts of VBC in a myriad of ways. For instance, there is financial risk associated with changing the payment structure. If the physician, or practice, does not meet targets or costs exceed what is expected, this can be a significant deterrent to VBC.[10] The financial risk can be especially pronounced if the practice does not have the infrastructure or resources to manage the consequences. Beyond this, data interoperability brought forth by fragmented health care data systems makes it difficult to obtain a complete understanding of the patient and their outcomes, which is critical for VBC.[11] Additionally, the administrative burden associated with VBC can be onerous, a transition to VBC may require a workflow redesign, and lack of technology and resources may impede the ability of the physician or practice to participate in VBC.[12]

Ideally, VBC would improve the quality of care and patient experience while decreasing health care costs. However, it is unclear whether that is the case. In some studies, there is evidence demonstrating its benefits.[13] Other studies contradict those sentiments.[14,15] Patient non-adherence to medication protocol, for instance, continues to be a significant issue.[16] One recent estimate revealed that morbidity and mortality associated with non-optimized prescription drug regimens, with non-adherence playing a significant role, cost $528.4 billion per year on average in the United States (U.S.).[17] Beyond this, health care costs have continued to rise during the transition to VBC. The cost of disease progression, readmissions, wasted resources, labor burden, and insurance costs represent three to ten percent of total health care costs in the U.S.[18] Indeed, one meta-analysis showed that all-cause non-adherence costs ranged from $5,271 to $52,341 per person.[19]

Poor patient adherence can obscure a prescribed treatment's effectiveness, or whether it results in avoidable hospitalization, increased mortality, and/or increased health care costs. Physicians may change the regimen with the belief that the health care provided is not improving the patient's outcome, thereby unintentionally negatively impacting a patient, and further complicating the cost or complexity of the health care provided. In addition, a physician may receive a poor-quality score despite providing evidence-based care.[20] However, if a physician provides care that focuses on the

patient's experience (e.g., choosing a lower cost alternative treatment at the patient's request) and the patient fails to improve, the physician is deemed to have provided poor quality care. For diabetes patients, for example, an individual may have a remarkably high blood sugar level when they begin seeing their physician. Over time, the blood sugar level may improve significantly due to the provision of evidence-based care, but the physician's care will be rated as poor quality if it does not meet a certain threshold.[21] Alternatively, if a patient cannot afford medication and the physician provides alternative mechanisms that are cost-effective but do not significantly improve blood sugar levels, the care is considered "poor quality."

Similarly, a physician may have a low MIPS score despite providing evidence-based care. One study suggests that MIPS score was inconsistently associated with performance on process and outcome measures as the MIPS program may be ineffective at measuring and incentivizing quality improvement among U.S. physicians.[22] Further, it was found that physicians caring for medically complex and socially vulnerable patients were more likely to receive low MIPS scores, even when they delivered relatively high-quality care.[23] In another study, it was proposed that safety-net hospitals are more likely to serve patients with higher risk factors and thus have worse performance measures, on average.[24] Hospital-based value-based payment programs may unintentionally increase financial penalties for social safety-net hospitals. Therefore, some VBC payment systems may be ineffective at evaluating and providing payment for quality of care in certain circumstances.

Furthermore, to understand the limitations of quality measures, it is important to consider disparities, structural racism, and discrimination. In 2003, the Institute of Medicine published the report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," which provided specific recommendations to reduce disparities by improving financing, allocation of care, communication, and community-based care.[25] The report outlined that racial and ethnic disparities are consistent across a range of illnesses and health care services. Racial and ethnic disparities remain even after adjustment for socioeconomic differences and other health care access related factors.[26] Moreover, while disparities based on race or ethnicity are pervasive, it is important to note that other forms of discrimination impact the health of a patient. For instance, sex, gender, sexual orientation, disability, and socioeconomic status can impede effective health care and create disparate outcomes. Further, while discrimination, bias, and disparities are prevalent in health care, they are also ubiquitous throughout society. Outcome measures evaluate physicians by the outcome of the patient, but many factors outside the physician's control, yet affect a patient's access. In some circumstances, a physician may help by creating alternative options for payment, testing, or treatment. However, many social drivers of health (SDOH) are beyond the control of a physician.

MEASURING PATIENT ADHERENCE

Patient adherence emphasizes the patient's active involvement and decision-making process in following treatment recommendations, suggesting that the patient understands, agrees with, and takes responsibility for their health behaviors. As VBC relies on outcome-based measures, patient adherence becomes a critical factor for tying physician payment to measurement since measures assume patient adherence with prescribed treatments. Unfortunately, patient adherence is contingent on many factors outside the control of a physician. Further, tying physician payment to measures that focus on patient adherence may improperly penalize physicians who are otherwise providing quality care.

The World Health Organization (WHO) defines adherence as "the extent to which a person's behavior – taking medication, following a diet, and/or executing lifestyle changes, corresponds

with agreed recommendations from a health care provider."[27] Measuring adherence involves objective, subjective, and biomedical strategies. Subjective strategies can include questionnaires, diaries, and interviews. Objective strategies can include counting remaining dosages, table counts, patterns of missed dosages, treatment attendance, or electronic monitoring devices which record the time and date when a medication container was opened. Biochemical measures usually involve the detection of a metabolite or marker in bodily fluids. There are drawbacks to each of the methods. For instance, subjective ratings may lead to overestimates of adherence and underestimates of non-adherence. Objective strategies, such as electronic monitoring devices or the use of pharmacy databases may be expensive and time consuming. Biochemical measures might not account for variability in areas such as drug-drug interactions, drug-food interactions, and individual pharmacokinetics of the drug. The most accurate approach may include a combination of all three.

Patient adherence research has focused on the determinants of non-adherence, extent of non-adherence, and strategies to improve adherence. Failure to address the patient's perspective in adherence research has led to a lack of progress in research as well as the lack of understanding physicians' prescribing practices. Furthermore, individual bias, or prejudice, is a key factor when understanding non-adherence. Physician bias, for instance, may impact care. A physician may unintentionally associate the patient's attributes with the care they receive because of ignorance of social or cultural norms.[28] Additionally, physicians, like others in our society, are affected by stereotypes.[29] These impediments to good health care outcomes, and effective care, may make it difficult for a patient to follow physician recommendations.

Furthermore, patient non-adherence to screening tests and vaccinations continues to be a significant impediment to quality metrics. Despite the importance of chronic disease screening, underutilization persists. Even though there is a preponderance of data explicating the usefulness of vaccines, there continues to be concern about their side effects. Parents may be hesitant to vaccinate their children due to concerns about long-term side effects, a lack of trust in medical authorities, and doubt about the benefits of vaccines.[30] Globally, while there was an improvement in vaccination rates in 2022 as compared to 2021, they still remain below 2019 rates.[31] In screening for lung cancer, patient adherence was found to be lower for high-risk individuals – people who smoke, those who are not white, or individuals older than 65.[32] Therefore, it was suggested that interventions to promote adherence should prioritize current smokers and smokers from minority populations.[33] While lung cancer screening is underutilized by minority populations, cancer screening, in general, continues to be underutilized for all populations despite its benefits to reduce morbidity and mortality.[34] Further, adherence to recommended blood-based screening is underutilized, which is troubling as it is an option for early detection and management of cancers or other chronic diseases.[35]

However, some key themes within studies give credence to ways to improve adherence. Physician recommendations significantly improve cancer screening rates among most populations.[36] While physician recommendations are necessary to improve adherence, they are not the only consideration, as the quality and content of the patient/parent-physician discussion also play key roles in the level of adherence since they foster shared decision making.[37] Limited success is also seen with vaccine counseling, as it continues to be the most significant way to improve vaccination rates, especially when coupled with technology such as sending text message reminders and allowing patients to make vaccine reservations.[38]

THE ROLE OF CODING IN VALUE-BASED CARE

As mentioned previously, SDOH factors outside of the control of a physician may impact health care outcomes. Some of these factors may be captured in the *Current Procedural Terminology* (CPT®) nomenclature, particularly with Category II codes.[39] Category II CPT codes are optional, supplemental codes used for performance measurement and intended to facilitate data collection about quality of care by reporting certain services and/or test results that support performance measures.[40] In addition to performance measure codes, performance measure modifiers are used to account for reporting measure exceptions due to the inability to meet the denominator action of the measure for medical, patient, or system reasons.[41]

Research has been compiled toward understanding how the CPT code set can help physicians adapt to VBC arrangements. Recently, the AMA developed an issue brief in conjunction with Manatt Health Strategies, "Accelerating the Adoption of Value-Based Care with the CPT Code Set," which outlines how the CPT code set supports current VBC arrangements and opportunities for continued evolution.[42] The issue brief synthesizes the feedback received from 34 organizations representing VBC provider organizations, health plans, integrated delivery systems, VBC enablement organizations, and health technology organizations, identifying three areas where codes are successfully enabling VBC adoption.[43] Interviewees suggested a variety of opportunities for the CPT code set to support accelerated adoption of VBC models, such as, "considering how CPT might address new types of health care services being delivered, such as how to best account for the delivery of services cognizant of patients' SDOH factors."[44] However, it is important to note that revision or expansion of the CPT code set must be done independent of the AMA HOD, as Policy H-70.919 attests that the CPT Editorial Panel maintains autonomy in the development of new and revised CPT codes, descriptors, guidelines, parenthetic statements, and modifiers.

There are limitations associated with Category II CPT codes, namely that CMS has replaced most Category II CPT codes with Healthcare Common Procedure Coding System (HCPCS) Level II codes. HCPCS Level II codes identify professional services and temporary procedures (G codes) as well as medical services (M codes) and can be used to report services such as the administration of a vaccine, ultrasound, or mammogram.[45] Furthermore, HCPCS Level II codes are used in the MIPS Value Pathways program to identify specific subsets of measures and activities to meet MIPS reporting requirements.[46] While HCPCS Level II codes were initially developed for Medicare claims, many private payers have adopted them. HCPCS Level II codes were selected as part of the Health Insurance Portability & Accountability Act (HIPAA) standard procedural code set for describing services, health care equipment, or supplies not represented in CPT.[47] One of the advantages of HCPCS Level II codes is that they allow for more specificity than CPT codes. For example, HCPCS Level II codes can identify durable medical equipment, prosthetic devices, prosthetics, orthotics, and supplies (like surgical bandaging or splints/casts).[48] While HCPCS Level II codes provide a standardized system for reporting across different payers, they have some drawbacks, as well. The complexity of the HCPCS Level II coding nomenclature necessitates specialized knowledge and can present obstacles for health care systems.[49] Additionally, selecting an incorrect code may lead to improper payment or a denial of claims which can result in recoupment or actions against the physician. Furthermore, the code set is updated throughout the year, which can make it difficult to stay up to date on the coding infrastructure.

WORLD HEALTH ORGANIZATION MULTIDIMENSIONAL ADHERENCE MODEL (WHO-MAM)

In 2003, the WHO released, "Adherence to Long Term Therapies: Evidence for Action," which provided a critical review of what is known about and potential solutions to improve adherence.[50]

The report was developed as a result of the WHO Adherence to Long-term Therapies Project, a global initiative launched in 2001 by the Noncommunicable Diseases and Mental Health Cluster of the WHO. The tenets include:[51]

- Poor adherence to treatment of chronic diseases is a worldwide problem of striking magnitude.
- The impact of poor adherence grows as the burden of chronic disease grows worldwide.
- The consequences of poor adherence to long-term therapies are poor health outcomes and increased health care costs.
- Improving adherence also enhances patients' safety.
- Adherence is an important modifier of health system effectiveness.
- Increasing the effectiveness of adherence interventions may have a far greater impact on the health of the population than any improvement in specific medical treatments.
- Health systems must evolve to meet new challenges.
- Patients need to be supported, not blamed.
- Adherence is simultaneously influenced by several factors.
- Patient-tailored interventions are required.
- Adherence is a dynamic process that needs to be followed up.
- Health professionals need to be trained in adherence.
- Family, community, and patients' organizations: a key factor for success in improving adherence.
- A multidisciplinary approach towards adherence is needed.

In addition, the report introduced five dimensions of adherence. The multidimensional interplay between these factors determines adherence to treatment. As the report mentions, "the common belief that patients are solely responsible for taking their treatment is misleading and most often reflects a misunderstanding of how other factors affect people's behavior and capacity to adhere to their treatment." However, the model may provide a solution to equitably promote adherence to physician recommendations. The dimensions of adherence include:[52]

A. Social and economic factors – negative impacts can include poor socioeconomic status, poverty, illiteracy, low level of education, unemployment, lack of effective social support networks, unstable living conditions, long distance from treatment center, high cost of transport, high cost of medication, changing environmental situations, culture and lay beliefs about illness and treatment, and family dysfunction.
B. Health care team and system-related factors – negative impacts can include poorly developed health services with inadequate or non-existent payment by health insurance plans, poor medication distribution systems, lack of knowledge and training for health care providers on managing chronic diseases, overworked health care providers, lack of incentives and feedback on performance, short consultations, weak capacity of the system to educate patients and provide follow-up, inability to establish community support and self-management capacity, lack of knowledge on adherence and of effective interventions for improving it.
C. Condition-related factors – condition-related factors represent illness-related demands faced by the patient.
D. Therapy-related factors – the most notable therapy-related factors are the complexity of the medical regimen, duration of treatment, previous treatment failures, frequent changes in treatment, the immediacy of beneficial effects, side-effects, and the availability of medical support to deal with them.
E. Patient-related factors – patient-related factors represent the resources, knowledge, attitudes, beliefs, perceptions, and expectations of the patient.

ADDITIONAL ADHERENCE MODELS

Besides WHO-MAM, there are other models to consider that could provide a roadmap to equitably improve adherence, such as:

- Medication Adherence Model (MAM):[53] This option was developed to address medication adherence in patients with hypertension. Its three core concepts are: a) purposeful action; b) patterned behavior; and c) feedback. Patients' initiating and sustaining medication adherence are dependent on the deliberate decision to take medications based on perceived need, effectiveness, and safety (Purposeful Action). Then they establish medication-taking patterns through access, routines, and remembering (Patterned Behavior). Individuals use information, prompts, or events (Feedback) during the appraisal process to evaluate health treatment that, in return, influences individuals' levels of Purposeful Action and Patterned Behavior.

- Hierarchical Model for Medication Adherence (HMMA):[54] The HMMA was developed in consideration of Maslow's hierarchy of needs. In this model, an individual acquires certain skills/beliefs/behaviors at lower levels to achieve the higher level of medication adherence behavior. At the base level, every individual should have adequate health literacy. Once the patient understands their disease and treatment, the beliefs component comes into play. The next phase in the model is an individual's belief in their medicines. The final stage of the hierarchical model is self-efficacy.

- Transtheoretical Model (TTM):[55] The TTM is a theory of change that a common set of change processes can be replicated across behaviors and situations. TTM posits that health behavior change involves progress through six stages of change: precontemplation, contemplation, preparation, action, maintenance, and termination. The stages are transtheoretical and integrate principles of change from across a variety of theories. Each stage brings an individual closer to behavioral changes.

- Three Factor Heuristic Model:[56] The model comprises three important clinical actions: (1) insuring that patients have the right information and know how to adhere – including listening to patients' concerns, encouraging their participation and partnership in decision-making, building trust and empathy, and enhancing recall; (2) helping patients believe in their treatment and become motivated to commit to it - that is, addressing the cognitive, social, cultural normative and contextual factors that affect patients' beliefs, attitudes and motivation; and (3) assisting patients to overcome practical barriers to treatment adherence and develop a workable strategy for long-term disease management - including assessing and enhancing patients' social support, identifying and treating their depression and helping patients overcome cost-related treatment barriers.

- Health Belief Model (HBM):[57] HBM allows physicians, and other health care professionals, access and assess the patient's behavior by breaking down their beliefs. Following the HBM, a health care provider should: verify the patient's understanding of the potential consequences of their disease; make sure the patient knows that they are susceptible to those consequences, and that they have a degree of control over the outcome; assess the patient's understanding of the benefits of the treatment to ensure they fully understand those benefits; and make sure that the patient has a realistic understanding of side effects to ensure that if side effects manifest, they do not undermine the perceived value of the behavior change.

- Theory of Planned Behavior (TPB):[58] TPB suggests that people will at least form the intention to conduct a given behavior if all three of the domains – beliefs about a behavior, the perception of a subjective norm, and the perception of control – come together. TPB adds an important social element because people are social and have strong reactions to behaviors that are perceived to affect social standing. To apply the TPB, health care providers should consider the following suggestions: ask the patient how difficult they think it will be to carry out suggestions and follow the prescription, ask the patient what they think might lead to failure, inquire about the degree to which the people close to the patient will either help or hinder behavior changes, and discuss the patient's perception of what other people or society in general might feel about the condition or treatment behaviors.

While there is an array of options to help assuage non-adherence, it is important to highlight that no one option is the "gold-standard." Indeed, none of the options boast a wide array of studies to verify legitimacy. Therefore, more research should be compiled to evaluate the most effective models.

IMPROVING PATIENT ADHERENCE

There may be opportunities to help improve patient adherence in an equitable way. According to the WHO report, some innovative interventions can target the patient, physician, and the health care system as outlined below. For example, the AMA Improving Health Outcomes (IHO) Group supports physicians, care teams and the patients they serve to prevent cardiovascular disease. IHO found that a lack of blood pressure measurement protocol contributes to variation and inaccurate measurements. As a result, patients with uncontrolled hypertension are sub-optimally treated, which frequently leads to non-adherence of medications and treatment plans. In response, IHO created the MAP (Measure Accurately, Act Rapidly, and Partner with Patients) Framework to address the systemwide problem.[59]

While the WHO report did not identify a single intervention as most effective, promising methods include a combination of the following strategies:[60]

- Patient Education
- Behavioral Skills
- Self-Rewards
- Social Support
- Telephone Follow-up

Further, it was found that the most effective interventions directed at patients aim to enhance self-regulation or self-management capabilities, such as:[61]

- Self-Monitoring
- Goal Setting
- Stimulus Control
- Behavioral Contracting
- Commitment Enhancement
- Creating Social Support
- Relapse Prevention
- Corrective Feedback

However, as the WHO's report outlines, "even the most efficacious patient-focused interventions have no substantial effects on adherence behavior over the long term." Therefore, further study is required to understand viable options to improve adherence behavior long-term.

AMA POLICY

Policy H-450.947 outlines Principles for Pay-for-Performance and Guidelines for Pay-for-Performance, which support the formation, implementation, and assessment of fair and ethical Pay-for-Performance programs. Further, the principles and guidelines reinforce the importance of a patient-centered approach and evidence-based performance measures.

Policy H-450.966 supports the need for the AMA, national medical specialty societies, state medical associations, and physicians to actively participate in the development, implementation, and assessment of quality and performance measures. Policy H-410.960 encourages physicians to support the development and usage of quality improvement standards and indicators for measurement of quality practice.

Policy H-390.837 encourages CMS to simplify MIPS, advocates for appropriate scoring adjustments for physicians treating high-risk beneficiaries in the Medicare Access and CHIP Reauthorization Act (MACRA) system, and urges CMS to study whether the MACRA system disincentives physicians to provide care to sicker Medicare patients. In addition, there are several policies that are more specific about the removal of measures or metrics within quality scores. Policy D-450.955 supports asking CMS to remove pain scores from quality metrics that impact payment from nursing facilities, while Policy D-450.958 advocates that CMS remove pain survey questions from the Hospital Consumer Assessment of Healthcare Providers and Systems and Clinician and Group Consumer Assessment of Healthcare Providers and Systems and encourages health care systems not to link physician compensation and attainment to patient pain scores.

DISCUSSION

While the Council recognizes the importance of performance measures and values their contribution to VBC, many require patient adherence which is not always controlled by the physician. In addition, the Council believes that physicians have a significant role to play in the development, assessment, and implementation of quality measures.

Quality metrics are specific, quantifiable measures used to evaluate the quality of care provided to patients. The metrics assess various aspects of health care delivery, including patient outcomes, safety, efficiency, and patient satisfaction. While these metrics are important in the evaluation of the care provided, unique challenges have been identified. For instance, quality metrics may not account for the progression of a patient. While a patient may get significantly better, they may not meet a certain threshold indicating so-called "good" care. Further, patient adherence may be a significant issue. A patient may not take medication because of social stigma or cultural differences. Beyond this, quality metrics do not consider the systemic issues that impede quality of care. Structural racism is a significant factor in the health care outcomes of patients, as is discrimination in other forms – such as disability, sex, gender, and socioeconomic status. Therefore, the Council supports the modification of quality measures and removal of outcome scores that are unfairly tied to patient non-adherence. Further, the Council recommends amending Policy D-450.958, to remove patient outcomes and patient non-adherence to treatment from the HCAHPS and to remove patient outcomes and adherence to treatment from the evaluation of physician compensation, retention, promotion, and provider network participation. The Council

recommends reaffirming Policy H-450.947, which outlines the Principles for Pay-for-Performance and Guidelines for Pay-for-Performance to highlight best practices when developing VBC.

Significant problems continue to exist with MIPS, leading the Council to believe that the unique challenges of MIPS are an organic extension of the issues related to VBC. As such, the Council recommends reaffirming Policy H-390.837, which encourages CMS to improve MIPS to a simplified quality and payment system. Furthermore, the Council believes that physicians must have a significant role in the assessment of quality and performance measures. Therefore, the Council recommends reaffirming Policy H-450.966, which provides the principles to consider while assessing quality and performance measures and the need for the AMA, national medical specialty societies, and state medical associations to be involved in the assessment, as well as the development and implementation of quality measures.

The importance of patient adherence in VBC cannot be overstated. VBC relies on outcome measures which are determined by the ability of the patient to adhere to prescribed treatments. However, patient adherence is contingent on many factors outside a physician's control. Research on patient adherence is lacking, specifically a patient's perspective, which has led to a lack of knowledge about how to address long-term adherence. Therefore, the Council recommends that additional research be conducted to understand patient non-adherence, and potential models or strategies to improve adherence. Furthermore, many models have been developed to address patient adherence and holistically improve health care outcomes. The most notable is the WHO-MAM, which was introduced in 2003, providing a critical review of what is known about and potential solutions to equitably improve adherence. Fourteen tenets captured the findings of the report, and five dimensions of adherence were outlined to diagram the multidimensional interplay that determines adherence. Therefore, the Council recommends support for these types of models to provide guidance to improve patient adherence.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the removal of physician outcome scores that are unfairly tied to patient non-adherence. (New HOD Policy)

2. That our AMA support the development of models that provide guidance for physicians, medical practices, and health care teams to improve patient adherence in an individualized, continuous, and multidisciplinary way. (New HOD Policy)

3. That our AMA support additional research to understand the intricacies of non-adherence and potential models/strategies to improve adherence. (New HOD Policy)

4. That our AMA amend Policy D-450.958, "Pain Medicine," by addition and deletion, including a change in title:

   PAIN MEDICINE AND PATIENT ADHERENCE IN QUALITY CARE ASSESSMENT, D-450.958
   Our AMA: (1) ~~continues to advocate that the Centers for Medicare & Medicaid Services (CMS) remove the pain survey questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); (2)~~ continues to advocate that the Centers for Medicare & Medicaid Services ~~CMS~~ not incorporate items linked to pain scores and adherence

to physician recommendations as part of the Consumer Assessment of Healthcare Providers and Systems ~~CAHPS~~ Clinician and Group Surveys and the Hospital Consumer Assessment of Healthcare Providers and Systems scores in future surveys; and (2) ~~(3)~~ encourages hospitals, clinics, health plans, health systems, and academic medical centers not to link physician compensation, employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain and better adherence to physician recommendations. (Revise HOD Policy)

5. That our AMA reaffirm Policy H-450.947, which outlines the Principles for Pay-for-Performance and Guidelines for Pay-for-Performance. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-450.966, which provides the principles to consider while assessing quality and performance measures and the need for the AMA and state medical societies to be involved in the assessment, as well as the development and implementation, of quality measures. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-390.837, which encourages the Centers for Medicare & Medicaid Services (CMS) to revise the Merit-Based Incentive Payment System to a simplified quality and payment system, asks the AMA to advocate for appropriate scoring adjustments for physicians treating high risk beneficiaries in the Medicare Access and CHIP Reauthorization Act (MACRA) program, and urges CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients. (Reaffirm HOD Policy)

8. Rescind Policy D-450.950, as having been completed with this report. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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Council on Medical Service Report 7-A-25
Impact of Patient Non-adherence on Quality Scores
Policy Appendix

Quality Management H-450.966

1. Our AMA continues to advocate for quality management provisions that are consistent with AMA policy.
2. Our AMA seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures.
3. Our AMA continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures.
4. Our AMA emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts.
5. Our AMA urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures.
6. Our AMA advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts:
    a. Standards and measures shall have demonstrated validity and reliability.
    b. Standards and measures shall reflect current professional knowledge and available medical technologies.
    c. Standards and measures shall be linked to health outcomes and/or access to care.
    d. Standards and measures shall be representative of the range of health care services commonly provided by those being measured.
    e. Standards and measures shall be representative of episodes of care, as well as team-based care.
    f. Standards and measures shall account for the range of settings and practitioners involved in health care delivery.
    g. Standards and measures shall recognize the informational needs of patients and physicians.
    h. Standards and measures shall recognize variations in the local and regional health care needs of different patient populations.
    i. Standards and measures shall recognize the importance and implications of patient choice and preference.
    j. Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured.
    k. Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured.

BOT Rep. 35, A-94 Reaffirmed: CMS Rep. 10, I-95 Reaffirmed: CMS Rep. 7, A-05 Modified: CMS Rep. 6, A-13 Reaffirmed in lieu of Res. 714, A-14 Reaffirmed in lieu of Res. 814, I-14 Reaffirmed in lieu of Res. 208, A-15 Reaffirmed in lieu of Res. 223, A-15 Reaffirmed in lieu of

Res. 203, I-15 Reaffirmed in lieu of Res. 216, I-15 Reaffirmed: BOT Rep. 20, A-16 Reaffirmed: CMS Rep. 02, I-17 Reaffirmation: A-22

Quality Patient Care Measures H-410.960
Our American Medical Association encourages all physicians to be open to the development and broader utilization of evidence-based quality improvement guidelines (pathways, parameters) and indicators for measurement of quality practice.
Res. 811, I-02 Reaffirmed: CSAPH Rep. 1, A-12 Reaffirmed: CSAPH Rep. 1, A-22

Pay-for-Performance Principles and Guidelines H-450-947
The following *Principles for Pay-for-Performance and Guidelines for Pay-for-Performance* are the official policy of our AMA.

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:
1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.
2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.
4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.
5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.
Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
- Evidence-based quality of care measures must be the primary measures used in any program.
1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
4. Performance measures should be scored against both absolute values and relative improvement in those values.
5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.
6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
7. Performance measures must be selected for clinical areas that have significant promise for improvement.
- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care.
1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
- Programs must neither directly nor indirectly encourage patient de-selection.
- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

Physician Participation

- Physician participation in any PFP program must be completely voluntary.

- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
1. Programs should provide physicians with tools to facilitate participation.
2. Programs should be designed to minimize financial and technological barriers to physician participation.
- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
1. Programs should use accurate administrative data and data abstracted from medical records.
2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.
- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.
1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.
- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards
- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds
- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not financially penalize physicians based on factors outside of the physician's control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance."

BOT Rep. 5, A-05 Reaffirmation A-06 Reaffirmed: Res. 210, A-06 Reaffirmed in lieu of Res. 215, A-06 Reaffirmed in lieu of Res. 226, A-06 Reaffirmation I-06 Reaffirmation A-07 Reaffirmation A-09 Reaffirmed: BOT Rep. 18, A-09 Reaffirmed in lieu of Res. 808, I-10 Modified: BOT Rep. 8, I-11 Reaffirmed: Sub. Res. 226, I-13 Appended: BOT Rep. 1, I-14 Reaffirmed in lieu of Res. 203, I-15 Reaffirmed in lieu of Res. 216, I-15 Reaffirmation I-15 Reaffirmed: BOT Rep. 20, A-16 Reaffirmed in lieu of: Res. 712, A-17 Reaffirmation: A-18 Reaffirmation: A-22

MACRA and the Independent Practice of Medicine H-390.837

1. Our AMA, in the interest of patients and physicians, encourages the Centers for Medicare and Medicaid Services and Congress to revise the Merit-Based Incentive Payment System to a simplified quality and payment system with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care.
2. Our AMA will advocate for appropriate scoring adjustments for physicians treating high-risk beneficiaries in the MACRA program.

3. Our AMA will urge CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients.

Alt. Res. 206, A-17 Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17

Remove Pain Scores from Quality Metrics D-450.955

Our AMA will work with the Centers for Medicare and Medicaid Services to remove uncontrolled pain scores from quality metrics that impact reimbursement for services rendered in the nursing facilities and from the five-star rating system for nursing facilities.

Res. 236, A-16

Pain Medicine D-450.958

Our AMA: (1) continues to advocate that the Centers for Medicare & Medicaid Services (CMS) remove the pain survey questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); (2) continues to advocate that CMS not incorporate items linked to pain scores as part of the CAHPS Clinician and Group Surveys (CG-CAHPS) scores in future surveys; and (3) encourages hospitals, clinics, health plans, health systems, and academic medical centers not to link physician compensation, employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain.

BOT Rep. 5, I-15

Use of CPT Editorial Panel Process H-70.919

Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetic statements and modifiers.

BOT Rep. 4, A-06 Reaffirmation A-07 Reaffirmation I-08 Reaffirmation A-09 Reaffirmation A-10 Reaffirmation A-11 Reaffirmation I-14 Reaffirmed: CMS Rep. 4, I-15 Reaffirmation A-16 Reaffirmed in lieu of: Res. 117, A-16 Reaffirmed in lieu of: Res. 121, A-17 Reaffirmation: A-18 Reaffirmation: I-18 Reaffirmed: Res. 816, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701
(A-25)

Introduced by: American Association of Clinical Urologists

Subject: Electronic Health Records Contract Termination

Referred to: Reference Committee G

Whereas, Electronic Health Records (EHR) are an integral part of medical practices; and

Whereas, implementation of an EHR requires significant time and analysis prior to purchase; and

Whereas, the financial burden of the investment for hardware, software, and training is substantial; and

Whereas, the ongoing maintenance costs for hardware, software and continuous training are also significant; and

Whereas, abruptly changing EHR vendors places the practice at risk of not meeting government mandates such as the Merit-Based Incentive Payment System (MIPS); and

Whereas, an EHR vendor recently provided 30-day notice of termination to a group of physician practices without cause; therefore be it

RESOLVED, that our American Medical Association adopt as policy that Electronic Health Record (EHR) vendors provide physician practices with a minimum180-day notification of contract termination without cause (New HOD Policy); and be it further

RESOLVED, that our AMA petition the Center for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) to mandate that EHR vendors provide a minimum 180-day notification of contract termination without cause to physician practices. (Directive To Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/15/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 702
(A-25)

Introduced by: The American Academy of Family Physicians

Subject: Strengthening Health Plan Accountability for Physician Satisfaction

Referred to: Reference Committee G

Whereas, there is no accrediting body that publicly reports metrics to quantify physician satisfaction with health insurance plans (e.g., comprehensive data exchange and feedback mechanisms, utilization management criteria, payment policies, claims denials, or customer service); and

Whereas, the current lack of standardized metrics for physician satisfaction with health insurance plans creates a gap in understanding and addressing the administrative burdens faced by physicians[1,2.]; and

Whereas, the integration of physician satisfaction metrics into health plan evaluations can provide valuable insights into the effectiveness of health insurance plans and their impact on healthcare delivery[2]; and

Whereas, the American Medical Association recognizes the importance of physician satisfaction as a critical component of healthcare quality and advocates for measures that enhance transparency and efficiency in health plan operations[1]; and

Whereas, the National Committee for Quality Assurance (NCQA) has the potential to play a pivotal role in advancing healthcare transparency by incorporating physician satisfaction metrics into its health plan measurement framework; therefore be it

RESOLVED, that our American Medical Association advocate for the NCQA to strengthen its health plan measurement framework by incorporating comprehensive physician satisfaction metrics (Directive to Take Action); and be it further

Fiscal Note: Minimal – less than $1,000

Received: 4/22/2025

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RELEVANT AMA POLICY

National Committee for Quality Assurance H-450.962
Our AMA promotes physician-developed guidelines for evaluating patient and physician satisfaction with plans, accreditation standards, utilization, quality, and cost policies.

Physician Satisfaction D-405.985
Our AMA will study current tools and develop metrics to measure physician professional satisfaction.

Health Plan "Report Cards" H-450.961
1. Our American Medical Association supports the development and appropriate use of health plan performance standards.

Insurance Coverage Appeals D-320.993
Our AMA... (4) continue to encourage health plans to streamline, provide transparency, and lessen the administrative burdens and costs that are incurred by physicians through the health plans appeals processes.

Prior Authorization and Utilization Management Reform H-320.939
1. Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

Prior Authorization Relief in Medicare Advantage Plans H-320.938
Our American Medical Association supports legislation and/or regulations that would apply the following processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans: c. Improve transparency by requiring plans to report on the scope of PA practices, including the list of services and prescription medications subject to PA and corresponding denial, delay, and approval rates.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 703
(A-25)

Introduced by: American Association of Gynecologic Laparoscopists, American College of Obstetricians and Gynecologists

Subject: Appropriate Use of Data from Surgical Practices

Referred to: Reference Committee G

Whereas, the advancement of technology in surgical practices, especially robotics, has significantly increased the amount of data that can be captured and analyzed, including metrics such as case duration, instrument usage, camera movement, and surgeon economy of motion[1]; and

Whereas, these data provide valuable insights and identifies areas for improvement that can help surgeons and trainees refine their surgical techniques, as well as offer opportunities for surgical innovation- thereby potentially improving patient safety and outcomes[2]; and

Whereas, no current guidelines exist that protect those same data, when accessed by hospital administrators, from being used to compare surgeons, construct productivity benchmarks, establish rigid surgical targets (e.g., goal case times, instrument cost limits), and create incentive/penalty systems based on these targets; and

Whereas, such practices can deter surgeons from involving trainees in surgical procedures, as trainees typically take more time and have less refined movements, potentially impacting their education and development[3-4]; and

Whereas, surgical procedures vary greatly in terms of complexity, and thus, the time taken, costs, and instruments used can differ significantly from one case to another[5]; and

Whereas, a surgeon's choices during a particular operation are influenced by innumerable factors, including the patient’s risk factors, history, and anatomy, as well as the surgeon’s prior experience, the types of equipment available, operating room availability, the quality and mix of operating room staff and assistants, and the operating room schedule[6]; and

Whereas, comparing individual surgeries or surgeons based on rigid metrics fails to account for the nuances and complexities inherent in different surgical cases[7]; and

Whereas, there is evidence that suggests the involvement of physicians in hospital decision-making is associated with lower-cost and higher-quality care, therefore hospitals benefit from the involvement of physicians in the decision-making process regarding the use of clinical data to ensure they are interpreted and used appropriately[6]; and

Whereas, surgical data have the potential to enhance patient safety and surgical education, but could also be used for punitive measures, emphasizing the importance of context in interpreting surgical metrics; and

Whereas, clear guidelines and robust studies are needed to ensure the appropriate and ethical use of surgical data; therefore be it

RESOLVED, that our American Medical Association advocate for policies that ensure data collected from surgical practices are used primarily to support surgical education, quality improvement, and patient safety, with appropriate protections to prevent misuse (New HOD Policy); and be it further

RESOLVED, that our AMA support physician leadership and involvement in the collection, interpretation, and application of surgical data to ensure that its use respects clinical complexity, preserves professional judgment, and accounts for patient-specific factors, surgical variability, and the nuances of individual operative decision-making (New HOD Policy); and be it further

RESOLVED, that our AMA oppose the use of surgical data by hospital administrators or other stakeholders to create rigid productivity benchmarks, comparative performance metrics, or incentive/penalty systems that fail to account for the educational value of training environments, differences in case complexity, or surgeon-specific clinical contexts. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/17/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 704
(A-25)

Introduced by: Florida, New York, Maryland, Mississippi, Tennessee, Pennsylvania, West Virginia

Subject: Mitigating the Impact of Excessive Prior Authorization Processes

Referred to: Reference Committee G

Whereas, excessive prior authorization requirements by insurance companies increasingly hinder timely patient access to necessary medical care; and

Whereas, these processes often lead to significant delays, outright denials, and increased administrative burdens on physicians without demonstrable benefit to patient care, quality, or outcomes; and

Whereas, the current prior-authorization structure imposes substantial financial and operational burden on physicians, undermines patient trust, and jeopardizes patient safety; and

Whereas, prior-authorization is performed by individuals who lack the skills, knowledge and training of the requesting residency-trained, specialist physician; and

Whereas, there is the need to comprehensively understand the impact of these practices on both patients and physicians to facilitate meaningful reform; therefore be it

RESOLVED, that our American Medical Association actively and urgently generate a prior authorization database collecting and analyzing data including metrics reflecting denial rates, care delays, impact on patient care, and associated cost adversely affecting patients and physicians across major healthcare insurers (Directive to Take Action); and be it further

RESOLVED, that our AMA working with legal experts, determine whether and to what extent it may be appropriate to initiate and/or support a class action lawsuit against insurance companies based on the identified prior authorization data, and, if so appropriate, collaborate with patient advocacy groups to support potential lawsuits (Directive to Take Action); and be it further

RESOLVED, that our AMA strengthen and expand the existing public awareness campaign including but not limited to social media, print media, and editorials to highlight the negative impacts of abusive and obstructive prior-authorization requirements on patient care, and educate physicians AND patients on their rights and available resources. (Directive to Take Action)

Fiscal Note: To Be Determined

Received: 4/21/25

RELEVANT AMA POLICY

Click D-320.974 Insurer Accountability When Prior Authorization Harms Patients
1. Our American Medical Association advocates for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts.
2. Our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization.
3. Our AMA supports that physicians be allowed to bill insurance companies for all full time employee hours required to obtain prior authorization.
4. Our AMA supports that patients be allowed to sue insurance carriers which preclude any and all clauses in signed contracts should there be an adverse outcome as a result of an inordinate delay in care. [Res. 711, A-24]

H-320.939 Prior Authorization and Utilization Management Reform
1. Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests. [CMS Rep. 08, A-17 Reaffirmation: I-17 Reaffirmed: Res. 711, A-18 Appended: Res. 812, I-18 Reaffirmed in lieu of: Res. 713, A-19 Reaffirmed: CMS Rep. 05, A-19 Reaffirmed: Res. 811, I-19 Reaffirmed: CMS Rep. 4, A-21 Appended: CMS Rep. 5, A-21 Reaffirmation: A-22]

D-478.958 Prior Authorization-Patient Autonomy
Our American Medical Association will advocate that patients and physicians should be given access to an electronic prior authorization system by their health plans with the ability to monitor the electronic prior authorization process in any model legislation and as a basis for advocacy for prior authorization reforms. [Res. 731, A-22]

D-320.978 Fair Reimbursement for Administrative Burdens
1. Our American Medical Association will continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices.
2. Our AMA will continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes.
3. Our AMA will oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services.
4. Our AMA will advocate for fair reimbursement of established and future CPT codes for administrative burdens related to:
a. the prior authorization process.
b. appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials. [Res. 701, A-22]

D-320.976 Prior Authorization Costs, AMA Update to CMS
Our American Medical Association will continue to conduct research on the costs associated with prior authorization by utilizing our AMA and other data sources. [Res. 720, A-23]

D-320.979 Processing Prior Authorization Decisions
Our American Medical Association will advocate that all insurance companies and benefit managers that require prior authorization have staff available to process approvals 24 hours a day, every day of the year, including holidays and weekends. [Res. 712, I-20 Reaffirmation: A-22] or tap here to enter text.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(A-25)

Introduced by: Georgia

Subject: Elimination of Transaction Fees for Electronic Healthcare Payments

Referred to: Reference Committee G

Whereas, fees associated with electronic transactions for healthcare services are a costly and unnecessary burden on patients and healthcare providers; and

Whereas, the Affordable Care Act requires that health plans give providers the option of being paid electronically to improve efficiency and save money; and

Whereas, in 2017, the Centers for Medicare & Medicaid Services (CMS) issued guidance that prohibited insurers and their payment processing vendors from "engaging in unfair business practices that do not support an efficient healthcare system," according to the Medical Group Management Association (MGMA)[1], though that guidance was later removed from the CMS website; and

Whereas, the Medical Group Management Association (MGMA) asserts that 75% of practices' annual revenue is paid electronically[2]; and

Whereas, addressing the burden of electronic transaction fees is especially crucial for the healthcare field as reimbursement rates continue to fall; and

Whereas, bipartisan legislation was introduced to the U.S. House of Representatives in 2023 to address the predatory electronic fund transfers (EFTs) fee process[3]; and

Whereas, our American Medical Association worked closely with the sponsors in drafting this legislation, the No Fees for EFTs Act (H.R. 6487 2023); and

Whereas, H.R. 6487 did not have any movement in the House of Representatives after its introduction; therefore be it

RESOLVED, that our American Medical Association continue to advocate to the United States Congress to eliminate transaction fees for electronic payments for healthcare. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 4/22/25

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2. https://www.ama-assn.org/practice-management/claims-processing/house-bill-makes-it-clear-no-fees-health-plan-efts
3. H.R. 6487—No Fees for EFTs Act (118th Congress, 2023-2024): https://www.congress.gov/bill/118th-congress/house-bill/6487

RELEVANT AMA POLICY

Amend Virtual Credit Card and Electronic Funds Transfer Fee Policy D-190.968

1. Our American Medical Association will advocate for legislation or regulation that would prohibit the use of virtual credit cards (VCCs) for electronic health care payments.
2. Our AMA will advocate on behalf of physicians and plainly state that it is not advisable or beneficial for medical practices to get paid by VCCs.
3. Our AMA will engage in legislative and regulatory advocacy efforts to address the growing and excessive electronic funds transfer (EFT) add-on service fees charged by payers when paying physicians, including advocacy efforts directed at:
    a. The issuance of Centers for Medicare & Medicaid Services (CMS) regulatory guidance affirming physicians' right to choose and receive timely basic EFT payments without paying for additional services.
    b. CMS enforcement activities related to this issue.
    c. Physician access to a timely no fee EFT option as an alternative to VCCs.

Res. 819, I-23

CMS Administrative Requirements D-190.970

1. Our American Medical Association will forcefully advocate that the Centers for Medicare and Medicaid Services (CMS) investigate all valid allegations of HIPAA Administrative simplification requirements thoroughly and offers transparency in its processes and decisions as required by the Administrative Procedure Act (APA).
2. Our AMA will forcefully advocate that the CMS resolve all complaints related to the non-compliant payment methods including opt-out virtual credit cards, charging processing fees for electronic claims and other illegal electronic funds transfer (EFT) fees.
3. Our AMA will communicate its strong disapproval of the failure by the CMS Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans.
4. Our AMA will through legislation, regulation or other appropriate means, advocate for the prohibition of health insurers charging physicians and other providers to process claims and make payment.

Res. 229, I-21Reaffirmation: A-22

Virtual Credit Card Payments H-190.955

1. Our American Medical Association will educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative of electronic funds transfer via the Automated Clearing House.

2. Our AMA will advocate for advance disclosure by third-party payers of transaction fees associated with virtual credit cards and any rebates or other incentives awarded to payers for utilizing virtual credit cards.

3. Our AMA supports transparency, fairness, and provider choice in payers' use of virtual credit card payments, including: advanced physician consent to acceptance of this form of payment; disclosure of transaction fees; clear information about how the provider can opt out of this payment method at any time; and prohibition of payer contracts requiring acceptance of virtual credit card payments for network inclusion.

Sub. Res. 704, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(A-25)

Introduced by: Illinois

Subject: Increasing Transparency Surrounding Medicare Advantage Plans

Referred to: Reference Committee G

Whereas, enrollment in Medicare Advantage (MA) plans has increased from 19% to 54% of all Medicare beneficiaries since 2007, with projections estimating this will increase to 64% by 2034 (1); and

Whereas, Medicare Advantage plans are able to negotiate provider networks, require referrals and prior authorizations, and impose out-of-pocket costs to constituents (2); and

Whereas, the lack of transparency surrounding Medicare Advantage plans recently led the National Association of Insurance Commissioners (NAIC) to submit a Request for Information to the Centers for Medicare & Medicaid Services (CMS) asking for increased reporting of various parameters including rates of prior authorization requirements, frequency of claim denials, network adequacy, and out-of-pocket costs to constituents of MA plans (3); and

Whereas, lack of transparency contributes to longstanding difficulties in holding CMS accountable for reclaiming overpayments made to those private insurance companies administering MA, leading to millions of lost tax dollars annually (4); and

Whereas, there is evidence to suggest that Medicare Advantage policies differ significantly from traditional Medicare in multiple areas including prior authorization, claims denials, network adequacy, and marketing practices; and

Whereas, traditional Medicare requires prior authorizations only in rare circumstances (5); and

Whereas, one cross-sectional study found that five major MA providers (encompassing 62% market share collectively) required prior authorizations for 17% to 33% of all healthcare spending, and that there was little agreement (less than 30%) between these five MA providers regarding which medical interventions warranted prior authorization, suggesting inconsistent criteria defining low-value care and suboptimal prior authorization policy (6); and

Whereas, prior authorization requirements place substantial administrative burdens on medical practices, disrupt workflow, and lead to costly delays and denials of necessary medical care, prompting the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) to report adverse impacts on beneficiary care due to delayed and denied prior authorization requests that nonetheless met Medicare coverage criteria (7); and

Whereas, CMS has identified the heightened prior authorization and administrative burden in MA plans compared to traditional Medicare as a significant source of provider burnout,

compelling providers to allocate resources to navigate varied authorization requirements across payers, which diverts time and resources from direct patient care (8); and

Whereas, Medicare Advantage plans deny more claims than traditional Medicare, with a 15% increasing rate of denials between 2014-2019, during which time one-third of MA beneficiaries experienced at least one denial each year among which 34% did not meet denial criteria under traditional Medicare guidelines (9); and

Whereas, Medicare Advantage plans restrict patient choice of hospitals and doctors through narrow networks that often do not meet network adequacy standards set by the CMS (10); and

Whereas, Medicare Advantage plans engage in deceptive marketing that appears as official correspondence from Medicare or government documents, as well as targeted marketing to individuals with cognitive impairment, prompting the Majority Staff of the U.S. Senate Committee on Finance to call for the CMS and Congress to regulate MA marketing materials (11); and

Whereas, Medicare Advantage plan marketing often leads seniors to believe they are receiving comprehensive benefits, only for them to later discover that certain services, providers, or coverage terms do not meet their initial expectations or needs (12); and

Whereas, professional societies including the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP) the American Academy of Neurology (AAN), the American College of Rheumatology (ACR), the American Optometric Association (AOA), the American Hospital Association (AHA), the American Psychiatric Association (APA), the American Dental Association (ADA), the American Speech-Language-Hearing Association (ASHA), the American Society of Nephrology (ASN), the American Academy of Audiology (AAA), and the American Association of Hip and Knee Surgeons (AAHKS) have raised concerns and/or supported increased transparency regarding MA plans (13-24); therefore be it

RESOLVED, that our American Medical Association support policy to increase financial transparency of Medicare Advantage plans, including mandated public reporting of prior authorization practices, claim denials, marketing expenses, supplemental benefits, provider contracts, and provider networks. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/21/25

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RELEVEANT AMA POLICY

Medicare Advantage Policies H-285.913

Our AMA will:

1. pursue legislation requiring that any Medicare Advantage policy sold to a Medicare patient must include a seven-day waiting period that allows for cancellation without penalty;

2. pursue legislation to require that Medicare Advantage policies carry a separate distinct page, which the patient must sign, including the statement, "THIS COVERAGE IS NOT TRADITIONAL MEDICARE. YOU HAVE CHOSEN TO CANCEL YOUR TRADITIONAL MEDICARE COVERAGE; NOT ALL PHYSICIANS, HOSPITALS AND LABORATORIES ACCEPT THIS NEW MEDICARE ADVANTAGE POLICY AND YOU MAY PERMANENTLY LOSE THE ABILITY TO PURCHASE MEDIGAP SECONDARY INSURANCE" (or equivalent statement) and specifying the time period before they can resume their traditional Medicare coverage; and

3. petition the Centers for Medicare and Medicaid Services to implement the patient's signature page in a Medicare Advantage policy.

Medicare Advantage Policies H-330.878
1. Our AMA supports that Medicare Advantage plans must provide enrollees with coverage for, at a minimum, all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts.
2. Our AMA will advocate: (a) for better enforcement of Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services (CMS) accountable for presenting transparency of minimum standards and to determine if those standards are being met for physicians and their patients; (b) that Medicare Advantage plans be required to post all components of Medicare covered and not covered in all plans across the US on their website along with the additional benefits provided; and (c) that CMS maintain a publicly available database of physicians in network under Medicare Advantage and the status of each of these physicians in regard to accepting new patients in a manner least burdensome to physicians.

Prevent Medicare Advantage Plans from Limiting Care D-285.959
Our AMA will: (1) ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization guidelines are followed for both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities; and (2) advocate that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions.

Medicare Advantage Plans H-330.867
1. Our American Medical Association encourages that Medicare Advantage risk adjustment formulas be revised so that claims data is based on the actual cost of providing care.
2. Our AMA will provide or create educational materials such as an infographic to compare Traditional Medicare and Medicare Advantage plans so that patients are able to make informed choices that best meet their health care needs.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(A-25)

Introduced by: Mississippi

Subject: Simplifying Correspondence from Health Insurers

Referred to: Reference Committee G

Whereas, multiple studies show the tremendous financial and human resource burden imposed upon physician practices by health insurance companies; and

Whereas, multiple polls and studies have shown that the unnecessary administrative burdens of medicine imposed upon physician practices by health insurance companies is a major factor in physician burnout; and

Whereas, there is a longstanding, widely-acknowledged physician shortage that is worsened by unreasonable and unnecessary administrative burdens imposed by health insurance companies upon physician practices; and

Whereas, the administrative burden of medicine is known to delay and deny necessary care to patients, often resulting in worsened outcomes; and

Whereas, non-standardized communication contributes to administrative burden by requiring physicians and their staff to read each correspondence to determine its purpose and reread it completely to find specific information each time the issue is dealt with; and

Whereas, standardized communication from health insurers will increase the efficiency of physician offices, and decrease administrative costs as well as physician burnout; therefore be it

RESOLVED, that the American Medical Association advocate for the regulation and standardization of correspondence from health insurers for the goal of simplifying the message, making it more readable, more quickly processed, and more efficiently reviewed. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(A-25)

Introduced by: Mississippi

Subject: Advocating Against Prior Authorization for In-Person Visits with Physicians

Referred to: Reference Committee G

Whereas, healthcare is a vital component of wellbeing; and

Whereas, the healthcare system is increasingly complicated, expensive, and difficult for the average adult to navigate in their favor; and

Whereas, health insurance is, for most Americans currently, necessary to access standard of care treatment and prevention for acute and chronic diseases; and

Whereas, some health insurers offer plans that require various processes of approval of an in-person healthcare visit with a physician; and

Whereas, many problems cannot be treated properly over the phone – even with visual capabilities; and

Whereas, in lieu of in-person visits with the patient's physician, some insurers require the patient to receive care by non-physician providers who do not know the patient prior to the patient's healthcare complaint and are not the patient's first choice to meet their healthcare needs; and

Whereas, this practice necessarily causes a delay in evaluation and treatment for the patient; and

Whereas, this practice increases the barriers and costs to care and unnecessarily complicates the healthcare system for patients who likely already have difficulty navigating the system effectively; and

Whereas, these cost-controlling measures by health insurers are unethical, unnecessary, and benefit only the health insurer; therefore be it

RESOLVED, that our American Medical Association advocate against health insurance plan policies that require prior authorization for in-person visits with a physician. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 709
(A-25)

Introduced by: New York

Subject: Allowing Timely Access to Pain Medications in Discharged Hospital and Ambulatory Surgery Patients

Referred to: Reference Committee G

Whereas, patients who are in pain are discharged from Hospitals and Ambulatory surgery centers deserve timely access to coverage for pain medication prescribed by their treating physician and/or other providers; and

Whereas, some Health Insurers create barriers to timely access to post discharge pain medications by requiring preauthorization or certain well established FDA approved medications even when cost effective generic versions exist, because of the perceived potential for addiction or abuse e.g. oxycodone or MS Contin or for financial reasons; and

Whereas, there is often little time to obtain preauthorization before the last dose of the prescribed medication given predischarge has worn off – resulting in patients who can't afford to pay cash for these medications suffering an unnecessary escalation in their pain – which may result in costly ER visits or readmission for pain control -further overburdening the strained ER /hospital systems in NY state; therefore be it

RESOLVED, that our American Medical Association shall advocate for legislation and/or regulation prohibiting ERISA and Medicare Advantage plans from requiring preauthorization for prescribed opioid pain medicine for post-surgery and post-hospital discharged patients for an initial 7-day supply. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 710
(A-25)

Introduced by: New York

Subject: Requiring Insurances to Apply Discounted Cost Medication to the Patient's Deductible

Referred to: Reference Committee G

Whereas, the insurance industry has created these outrageous entities called Pharmacy Benefit Managers (PBM) under the guise of prescription cost reduction; and

Whereas, many pharmacies have coupon codes and online websites that offer lower prices than the PBM; and

Whereas, these lower prices are then not applied to the patient's deductible and out of pocket maximum as it ultimately does not go through the patient's insurance, even though the PBM should have provided the lowest possible price; and

Whereas, many states have passed laws that prohibit so-called "co-pay" accumulators imposed by health plans and PBMs but these laws often do not apply to drug discount card program; therefore; therefore be it

RESOLVED, that our American Medical Association advocate for legislation or other appropriate mans to ensure that all payment made by patients for prescription medications outside of their insurance coverage (such as pharmaceutical discount programs) count towards that patient's annual deductible and out of pocket maximum. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 711
(A-25)

Introduced by: Oklahoma

Subject: Study of Practice Models for Physicians Working Across State Lines

Referred to: Reference Committee G

Whereas, physicians working with private procedure/surgical centers are increasingly entering the Oklahoma healthcare landscape, often performing procedures within the state without maintaining a local practice; and

Whereas, licensed physicians who primarily practice out of state may not provide continuity of care, potentially leaving patients without necessary follow-up, access to additional laboratory testing, or sufficient documentation when complications arise; and

Whereas, hospitals and their on-call healthcare providers may be left covering those complications without coverage agreements or appropriate access to records, increasing the risk of adverse outcomes; and

Whereas, there is growing national concern regarding the impact of licensed physicians who primarily practice out of state without appropriate backup agreements, including its effects on patient safety, physician autonomy, healthcare costs, and overall quality of care; and

Whereas, a comprehensive study of the effects of licensed physicians who primarily practice out of state without appropriate backup agreements, physicians practice requirements, rates, and other concerns, is necessary to assess the potential impact on Oklahoma patients and our medical community; therefore be it

RESOLVED, that our American Medical Association undertake a thorough review of the practice models for physicians relying on transfer agreements between corporate healthcare entities, rather than physician-to-physician backup agreements for back up coverage, their rates of expected and unexpected complications, the impact of this model on local patients and on local physician medical liability costs (Directive to Take Action); and be it further

RESOLVED, that our AMA should collect and analyze data regarding patient outcomes, complications, and continuity of care issues associated with licensed physicians who primarily practice out of state without appropriate backup agreements (Directive to Take Action); and be it further

RESOLVED, that our AMA's study should include an extensive review of the impact this practice model has on physicians thrust into cross coverage without adequate handoff or fore-knowledge of the patient, impact on physician malpractice costs, patient safety, and physician well-being in our country. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/17/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 712
(A-25)

Introduced by: Organized Medical Staff Section

Subject: Billings and Collections Transparency

Referred to: Reference Committee G

Whereas, most corporate-employed physicians are denied access to what is billed and collected in their name[1]; and

Whereas, a lack of transparency regarding what is billed and collected in a physician's name can lead to a feeling of being exploited and cause additional dissatisfaction for those practicing medicine[2]; and

Whereas, the physician is obligated to see this information to ensure honest billings and can be held individually liable for up-coding and fraud; and

Whereas, without this information the physician risks being a party to fee-splitting whereby a physician gives up a portion of their professional fee above fair market value in return for the right to see patients (received referrals) in their practice setting; and

Whereas, our American Medical Association policy H-190.971 states, "all physicians are entitled to receive detailed itemized billing and remittance information for medical services they provide, and that our AMA develop strategies to assist physicians who are denied such information" (reaffirmed 2019); and

Whereas, denial of this information can be detrimental to physicians in regards to unwitting participation in fee-splitting and up-coding as well as to the public if they are subject to excessive charges; and

Whereas, employed physicians routinely lack access to this information, and upon requesting it, are threatened with retaliation, termination or are "taken off the schedule"; and

Whereas, the billing entity is supposed to be answerable to the individual physician; and

Whereas, the reputation of a physician can be affected if inflated bills for services are sent to the patient; therefore be it

RESOLVED, that our American Medical Association amend policy H-225.950, Principles for Physician Employment, to include a new section to read as follows:

6. Payment Agreements

a. Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about

the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b. Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

c. The AMA will petition the appropriate legislative and/or regulatory bodies to establish the requirement that revenue cycle management entities, regardless of their ownership structure, and/or employers will directly provide each physician it bills or collects for with a detailed, itemized statement of billing and remittances for medical services they provide biannually and at any time upon request. Upon review of billing and remittance statements, physicians should reserve the right to override the initial decisions by revenue cycle management entities and submit billing that they believe to be best aligned and most reflective of the medical services that they have provided. Additionally, the physician shall not be asked to waive access to this information. Our AMA will seek federal legislation requiring this, if necessary. (Modify Current HOD Policy);

and be it further

RESOLVED, that our AMA will educate physicians as to the importance of billing transparency and advocate for employed physicians to have full access to itemized statements of billing and remittances for medical services they provide (Directive to Take Action).

Fiscal Note: Resolved 1 – Modest, between $1,000 - $5,000
Resolved 2 – Moderate, between $5,000 - $10,000

Received: 2/28/25

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2. Hudes, B. The core problem behind physician burnout: loss of independence. KevinMD.com 22 Jul 2023. https://www.kevinmd.com/2023/07/the-core-problem-behind-physician-burnout-loss-of-independence.html

RELEVANT AMA POLICY

AMA Principles for Physician Employment H-225.950

1. Addressing Conflicts of Interest
    a. Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
    b. In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
    c. Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their

employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.

d. A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
    i. No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions.
    ii. No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.
e. Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession
    a. Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
    b. Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.
3. Contracting
    a. Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
    b. Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
    c. When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
    d. Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the

care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

e. Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
f. Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
g. Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
h. Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations
    a. Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
    b. Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
    c. Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
    d. Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a. All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
b. Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
c. Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
d. Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
e. Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
f. Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
    i. The agreement is for the provision of services on an exclusive basis.
    ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985.
    iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements
    a. Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
    b. Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to

any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.
Citation: BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 5, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19; Reaffirmed: A-22; Reaffirmed: BOT Rep. 29, A-12

Physicians' Right to Receive Billing and Remittance Information H-190.971
AMA policy is that all physicians are entitled to receive detailed itemized billing and remittance information for medical services they provide, and that our AMA develop strategies to assist physicians who are denied such information.
Citation: Sub. Res. 711, I-97; Reaffirmed: I-04; Reaffirmed: A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 713
(A-25)

Introduced by: Organized Medical Staff Section

Subject: Aiding Members of Medical Staffs

Referred to: Reference Committee G

Whereas, a goal of our American Medical Association is to support the sustainability of medical practice; and

Whereas, for many years, the medical staff organization and bylaws were compacts honored by hospitals, but with the advent of corporate systems of healthcare there is more intrusion of hospital administration into the practice of medicine in the hospital, sometimes disregarding the boundaries between administration and the professional medical staff responsibilities; and

Whereas, where there is no legal protection of the status of the medical staff and its bylaws, individual physicians may be subject to adverse institutional actions without firm recourse; and

Whereas, some of the adverse actions have, in some instances:

- Taken the medical staff's bank account;
- Tried to oust duly elected medical staff officers and replace them with administration appointees;
- Unilaterally imposed a "code of conduct;"
- Adopted a conflict-of-interest policy without medical staff consent or input;
- Unilaterally amended medical staff bylaws;
- Bypassed the medical staff credentialing process;
- Refused to turn over charts for regular department peer review;
- A host of other violations of medical staff prerogatives[1]; and

Whereas, individual physicians may be at risk of administrative harm regardless of being a member of the medical staff[2]; and

Whereas, there are institutional as well as individual recourses that may apply to a physician threatened by administration with adverse action, which include having an independent lawyer who is an expert in medical staff and a physician advocate separate from hospital counsel, incorporation of the medical staff as a separate entity, and "engagement of state and national medical societies to lobby for stronger laws assuring medical staff independence"[3]; and

Whereas, our AMA has model legislation concerning legal definitions to protect the autonomy of the medical staff[4]; and

Whereas, "Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization… The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty. The right to full due process before the medical staff or health care

organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments"[5]; and

Whereas, in the last decade progress has been made in validating the independence of the medical staff, but the acceptance in law is not universal through the states nor universally defined[6-10]; and

Whereas, actions available to defend oneself against unfair actions may be a prohibitive barrier to success[11]; therefore be it

RESOLVED, that our American Medical Association establish and promote a well-defined procedure with access to resources to guide physicians on how to challenge adverse institutional actions or policies to practice medicine (Directive to Take Action).

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 2/28/2025

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RELEVANT AMA POLICY

Physician and Medical Staff Member Bill of Rights H-225.942

Our American Medical Association adopts and will distribute the following Medical Staff Rights and Responsibilities:

Preamble

The organized medical staff, hospital governing body, and administration are all integral to the provision of quality care, providing a safe environment for patients, staff, and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:

   a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body.

   b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

   c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.

   d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.

   e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.

   f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:

   a. The right to be self-governed, which includes but is not limited to

      i. initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations,

      ii. selecting and removing medical staff leaders,

      iii. controlling the use of medical staff funds,

      iv. being advised by independent legal counsel, and

      v. establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.

   b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.

d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts, close medical staff departments, or to transfer patients into, out of, or within the health care organization.

e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.

f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:

a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.

b. The responsibility to provide patient care that meets the professional standards established by the medical staff.

c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.

d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.

f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

g. The responsibility to utilize and advocate for clinically appropriate resources in a manner that reasonably includes the needs of the health care organization at large.

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.

b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.

c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care, medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization's administration or governing body, including advocacy both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.

e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.

f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.

g. The right of access to resources necessary to provide clinically appropriate patient care, including the right to participate in advocacy efforts for the purpose of procuring such resources both in collaboration with and independent of the organization's advocacy efforts, without fear of retaliation by the medical staff or the health care organization's administration or governing body.

Citation: BOT Rep. 09, A-17; Modified: BOT Rep. 05, I-17; Appended: BOT Rep. 13, A-19; Modified: BOT Rep. 13, A-21; Modified: CMS Rep. 5, A-21; Reaffirmed: A-22

Principles for Strengthening the Physician-Hospital Relationship H-225.957
The following twelve principles are our American Medical Association policy:

PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, protection from interruption of delivery of care, and working continuously to improve patient care and health outcomes—including but not limited to the development, selection, and implementation of augmented intelligence—with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.

2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.

3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.

4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.

5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.

6. The organized medical staff has inherent rights of self governance, which include but are not limited to:

a. Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.

b. Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.

c. Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.

d. Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.

e. Establishing within the medical staff bylaws:

    1. The qualifications for holding office.

    2. The procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee.

    3. The qualifications for election and/or appointment to committees, department and other leadership positions.

f. Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.

g. Retaining and being represented by legal counsel at the option and expense of the organized medical staff.

h. Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality of care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.

i. Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.

j. The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.

k. Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.

l. Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.

m. Enforcing the organized medical staff bylaws, regulations and policies and procedures.

n. Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.

7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.

8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.

9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.

10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.

11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.

12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body.
Citation: Res. 828, I-07; Rea ffirmed in lieu of: Res. 730, A-09; Modified: Res. 820, I-09; Reaffirmed: Res. 725, A-10; Reaffirmed: A-12; Reaffirmed: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 204, A-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 714
(A-25)

Introduced by: Private Practice Physicians Section

Subject: Root Cause Analysis of the Causes of the Decline of Private Medical Practice

Referred to: Reference Committee G

Whereas, the percent of physicians who are working in a private practice in the United States has dramatically declined in the past 50 years; and

Whereas, many physicians who were in private practice and ultimately went out of business and took an employed job did so against their wishes; and

Whereas, a greater ability to work independently would be critical for the ability of employed physicians to negotiate an acceptable contract for their services; and

Whereas, there are certain likely key factors to this decline in the ability of medical professionals to work independently and understanding such factors would be critical in any effort to reverse such processes; and

Whereas, such root causes likely include at least the following factors:

1) The declining inflation-adjusted Medicare rates
2) Stark laws, which allow hospitals, but not private physicians, to self-refer
3) The development of insurance plans that had no out-of-network benefits
4) The permitted consolidation of insurers and hospitals
5) Hospital-insurer agreements with minimal in-network fee requirement and other conditions such as the requirement for high hospital technical fees
6) Increased government influence by insurers and hospitals and decreased influence by doctors; and

Whereas, there may be other factors as well; therefore be it

RESOLVED, that our American Medical Association study and report back on the root cause of the decline in private practice to include consideration of at least the following factors:

1) The declining inflation-adjusted Medicare rates
2) Stark laws, which allow hospitals, but not private physicians, to self-refer
3) The development of insurance plans that had no out-of-network benefits
4) The permitted consolidation of insurers and hospitals
5) Hospital-insurer agreements with minimal in-network fee requirement and other conditions such as the requirement for high hospital technical fees
6) Increased government influence by insurers and hospitals and decreased influence by doctors

(Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 4/21/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 715
(A-25)

Introduced by: Private Practice Physician Section

Subject: Grace Period for Timely Filing Due to Technology Failures Regardless of Cause

Referred to: Reference Committee G

Whereas, there is a lag period between when a claim is submitted and when it is acted upon for many payers despite timely filing laws in many states; and

Whereas, for months after the Change Healthcare cyber-event, claims were not being acted upon by payers using this clearinghouse; and

Whereas, some insurers, even those that are subsidiaries of United Healthcare, did not create a grace period for timely filing despite the Change Healthcare cyber-event; and

Whereas, having an all-payer extended grace period would assist practices destabilized by the Change Healthcare cyber-event and would strengthen the healthcare economy by aiding medical practices still weakened by the Covid pandemic to recover financially from the cyber-event; therefore be it

RESOLVED, that our American Medical Association advocate for a two-year grace period from the date of a claims processing failure, allowing payers to resolve claims before denying them based on a “timely filing limit”. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/25

RELEVANT AMA POLICY

Ransomware and Electronic Health Records D-478.960

1. Our American Medical Association acknowledges that healthcare data interruptions are especially harmful due to potential physical harm to patients and calls for prosecution to the fullest extent of the law for perpetrators of ransomware and any other malware on independent physicians and their practices, healthcare organizations, or other medical entities involved in providing direct and indirect care to patients.
2. Our AMA will:
    a. advocate for federal legislation which provides for the prosecution of perpetrators of ransomware and any other malware on any and all healthcare entities, involved in direct and indirect patient care, to the fullest extent of the law;
    b. encourage health care facilities and integrated networks that are under threat of ransomware attacks to upgrade their cybersecurity and to back up data in a robust and timely fashion;
    c. advocate that the security of protected healthcare information be considered as an integral part of national cybersecurity protection; and
    d. seek inclusion of federal cybersecurity resources allocated to physician practices, hospitals, and health care entities sufficient to protect the security of the patients they serve, as part of infrastructure legislation.

Citation: Res. 210, A-21; Reaffirmed: Res. 241, A-24

Assessing the Intersection Between AI and Health Care H-480.931
Augmented Intelligence Development, Deployment, and Use in Health Care

1. General Governance
    a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
    b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
    c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
    d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
    e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduc [See also Augmented Intelligence in Health Care H-480.939 at (1)]
    f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
    g. Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
    h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.
    i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]
2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
    a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
        i. AI disclosure should align and meet ethical standards or norms.
        ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
        iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.

iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.

b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.

c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.

d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.

3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies

a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:

i. Regulatory approval status.

ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.

iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.

iv. Intended population and intended practice setting.

v. Clear description of any limitations or risks for use, including possible disparate impact.

vi. Description of how impacted populations were engaged during the AI lifecycle.

vii. Detailed information regarding data used to train the model:

1. Data provenance.
2. Data size and completeness.
3. Data timeframes.
4. Data diversity.
5. Data labeling accuracy.

viii. Validation Data/Information and evidence of:

1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
2. Constraint to evidence-based outcomes and mitigation of "hallucination"/"confabulation" or other output error.
3. Algorithmic validation.
4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.

ix. Data Use Policy:

1. Privacy.
2. Security.
3. Special considerations for protected populations or groups put at increased risk.

x. Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.

xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.

b. Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

4. Generative Augmented Intelligence
    a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
    b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
        i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
        ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
        iii. Lack of regulatory or clinical oversight to ensure performance of the tool.
        iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
        v. Data privacy.
        vi. Cybersecurity.
        vii. Physician liability associated with the use of generative AI tools.
    c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
    d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
    e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies
    a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
        i. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
        ii. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
        iii. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
    b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.
    c. Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.

6. Data Privacy and Augmented Intelligence
    a. Entity Responsibility:
        i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.
        ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
        iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.
    b. User Education:
        i. Users should be provided with training specifically on generative AI. Education should address:
            1. Legal, ethical, and equity considerations.
            2. Risks such as data breaches and re-identification.
            3. Potential pitfalls of inputting sensitive and personal data.
            4. The importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

7. Augmented Intelligence Cybersecurity
    a. AI systems must have strong protections against input manipulation and malicious attacks.
    b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
    c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
    d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.
8. Mitigating Misinformation in AI-Enabled Technologies
    a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training dat Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
    b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
    c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
    d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
    f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.
9. Payor Use of Augmented Intelligence and Automated Decision-Making Systems

a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

Citation: BOT Rep. 1, I-24

Indemnity for Breaches in Electronic Health Record Cybersecurity D-315.977
Our AMA will advocate for indemnity or other liability protections for physicians whose electronic health record data and other electronic medical systems become the victim of security compromises.
Citation: Res. 221, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 716
(A-25)

Introduced by: Private Practice Physicians Section

Subject: Minimum Payer Communication Quality Standards

Referred to: Reference Committee G

Whereas, the entire healthcare community is affected by insurance company business structures that shield them from complaints, requests, questions or directly addressing client and contractor needs; and

Whereas, some government payer websites do not have a telephone number or email address published. Many would consider these to be the most basic of customer service standards. Some physicians are only able to resolve payer issues by working through their congressional office; and

Whereas, even if a telephone number is published, some phone tree messaging never leads to a human being able to comprehend and address the clinician's problem; and

Whereas, even if a telephone number is published, some payer hold times are beyond any industry standard; therefore be it

RESOLVED, that our American Medical Association advocate for payer minimum quality standards to include immediate access to a live representative during business hours. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 4/21/25

RELEVANT AMA POLICY

Augmented Intelligence in Health Care H-480.939
Our American Medical Association supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on

   a. clinical validation.
   b. alignment with clinical decision-making that is familiar to physicians.
   c. high-quality clinical evidence.
4. Payment and coverage for health care AI systems must
   a. be informed by real world workflow and human-centered design principles.
   b. enable physicians to prepare for and transition to new care delivery models.
   c. support effective communication and engagement between patients, physicians, and the health care team.
   d. seamlessly integrate clinical, administrative, and population health management functions into workflow.
   e. seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
   a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
   b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
   a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
   b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
   c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations:
   a. Identify areas of medical practice where AI systems would advance the quadruple aim.
   b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts.
   c. Outline new professional roles and capacities required to aid and guide health care AI systems.
   d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

Citation: BOT Rep. 21, A-19; Reaffirmed: A-22

Assessing the Intersection Between AI and Health Care H-480.931
Augmented Intelligence Development, Deployment, and Use in Health Care

1. General Governance
   a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.

b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduc [See also Augmented Intelligence in Health Care H-480.939 at (1)]
f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
g. Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.
i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
    a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
        i. AI disclosure should align and meet ethical standards or norms.
        ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
        iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
        iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
    b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician’s consent and final review.

c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.

3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies
    a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
        i. Regulatory approval status.
        ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.
        iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.
        iv. Intended population and intended practice setting.
        v. Clear description of any limitations or risks for use, including possible disparate impact.
        vi. Description of how impacted populations were engaged during the AI lifecycle.
        vii. Detailed information regarding data used to train the model:
            1. Data provenance.
            2. Data size and completeness.
            3. Data timeframes.
            4. Data diversity.
            5. Data labeling accuracy.
        viii. Validation Data/Information and evidence of:
            1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
            2. Constraint to evidence-based outcomes and mitigation of “hallucination”/“confabulation” or other output error.
            3. Algorithmic validation.
            4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
            5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
            6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
            7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.
        ix. Data Use Policy:
            1. Privacy.
            2. Security.
            3. Special considerations for protected populations or groups put at increased risk.
        x. Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.
        xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.
    b. Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this

information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

4. Generative Augmented Intelligence
    a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
    b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
        i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
        ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
        iii. Lack of regulatory or clinical oversight to ensure performance of the tool.
        iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
        v. Data privacy.
        vi. Cybersecurity.
        vii. Physician liability associated with the use of generative AI tools.
    c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
    d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
    e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies
    a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
        i. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
        ii. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
        iii. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
    b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.
    c. Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.
6. Data Privacy and Augmented Intelligence
    a. Entity Responsibility:
        i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use.

Individuals should know how their data will be used or reused, and the potential risks and benefits.

ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.

iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.

b. User Education:

i. Users should be provided with training specifically on generative AI. Education should address:

1. Legal, ethical, and equity considerations.
2. Risks such as data breaches and re-identification.
3. Potential pitfalls of inputting sensitive and personal data.
4. The importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

7. Augmented Intelligence Cybersecurity
    a. AI systems must have strong protections against input manipulation and malicious attacks.
    b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
    c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
    d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.
8. Mitigating Misinformation in AI-Enabled Technologies
    a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training dat Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
    b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
    c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
    d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
    f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.
9. Payor Use of Augmented Intelligence and Automated Decision-Making Systems
    a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor

criteria), and disclosed to both patients and their physician in a way that is easy to understand.

b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

Citation: BOT Rep. 1, I-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 717
(A-25)

Introduced by:	Young Physicians Section
Subject:	Promoting Medication Continuity and Reducing Prior Authorization Burdens
Referred to:	Reference Committee G

Whereas, patients who have lost their primary care physician or experienced gaps in health insurance coverage face increased prior authorization burdens, often leading to disruptions in their medication regimens, which can result in adverse health outcomes and increased healthcare costs[1,2]; and

Whereas, research shows that patients who experience disruptions in health insurance coverage are significantly less likely to receive preventive services, more likely to forgo needed care due to cost, and have higher rates of medication non-adherence, with those experiencing longer coverage disruptions facing even worse outcomes in care access, receipt, and affordability[3]; and

Whereas, uninsured individuals with limited access to affordable care and medications often resort to emergency departments and urgent care facilities for manageable conditions, leading to preventable utilization of these high-cost services and straining healthcare resources[1]; and

Whereas, the process of re-obtaining prior authorizations for previously approved medications can be time-consuming and burdensome for both patients and physicians, potentially delaying necessary treatment; and

Whereas, early career physicians, who typically change employers within two years[4] of completing their training, are at higher risk of experiencing personal gaps in health insurance coverage and medication access and

Whereas, prior authorization requirements impose substantial administrative burdens on physicians, diverting time away from direct patient care, increasing practice costs, significantly contributing to physician burnout, and undermining the financial stability of physician practices already struggling with declining Medicare reimbursements[5]; and

Whereas, research shows that disruptions in health insurance coverage continue to negatively impact access to care for more than a year after coverage is regained, suggesting that improving healthcare access requires not only helping uninsured individuals gain coverage, but also strengthening coverage continuity for those who are already insured[6]; and

Whereas, streamlining the prior authorization process for previously approved medications could significantly reduce administrative burdens on physicians, strengthen coverage continuity for those re-insured, and improve patient care; therefore be it

RESOLVED, that our American Medical Association advocates for federal and state legislation that minimizes the impact of prior authorization requirements and payer-specific formulary tiering policies for medications during transitions or lapses in insurance coverage (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborates with relevant stakeholders to develop and promote best practices for implementing medication continuity policies across different insurance plans and healthcare systems. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 04/21/2025

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5. American Medical Association. 2021 AMA prior authorization (PA) physician survey. Accessed 9/23/24. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
6. Yabroff KR, Zhao J, Halpern MT, et al. Health insurance disruptions and care access and affordability in the u. S. *Am J Prev Med*. 2021;61(1):3-12.

RELEVANT AMA POLICY

Economics of Prescription Medication Prior Authorization H-120.916
Our American Medical Association supports working with payers and interested parties to ensure that prior authorization denial letters include at a minimum:

a. a detailed explanation of the denial reasoning;
b. a copy of or publicly accessible link to any plan policy or coverage rules cited or used as part of the denial; and
c. what rationale or additional documentation would need to be provided to approve the original prescription and alternative options to the denied medication.
[CMS Rep. 06, A-24]

Insurer Accountability When Prior Authorization Harms Patients D-320.974
1. Our American Medical Association advocates for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts.

2. Our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization.
3. Our AMA supports that physicians be allowed to bill insurance companies for all full time employee hours required to obtain prior authorization.
4. Our AMA supports that patients be allowed to sue insurance carriers which preclude any and all clauses in signed contracts should there be an adverse outcome as a result of an inordinate delay in care.
[Res. 711, A-24]

Prior Authorization and Utilization Management Reform H-320.939

1. Our American Medical Association will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

[CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22]

Opposition to Prescription Prior Approval D-125.992

Our American Medical Association will urge public and private payers who use prior authorization programs for prescription drugs to minimize administrative burdens on prescribing physicians.
[Sub. Res. 529, A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed: CMS Rep. 1, A-21; Reaffirmation: A-22]

Informational Reports (A-25)

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03 2024 Grants and Donations

05 Update on Corporate Relationships

07 AMA Performance, Activities and Status in 2024

08 Annual Update on Activities and Progress in Tobacco Control: March 2024 through February 2025

10 American Medical Association Health Equity Annual Report

11 AMA Efforts on Medicare Payment Reform

12 Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted

15 Physician Assistants and Nurse Practitioner Movement Between Specialties

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27 AMA Reimbursement of Necessary HOD Business Expenses for Delegates and Alternates

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03 Reconsidering Terminology to Describe Physician Assisted Suicide

04 Reconsideration of Physician Assisted Suicide

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01 Palliative Care

Report(s) of the Council on Long Range Planning and Development

03 Demographic Characteristics of the House of Delegates and AMA Leadership

Report(s) of the Council on Medical Service

08 Prescription Drug Affordability Boards

REPORT OF THE BOARD OF TRUSTEES

B of T Report 03-A-25

Subject: 2024 Grants and Donations

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

This informational financial report details all grants or donations received by the American Medical Association during 2024.

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American Medical Association
Grants & Donations Received by the AMA
For the Year Ended December 31, 2024
Amounts in thousands

Funding Institution	Project	Amount Received
Centers for Disease Control and Prevention (subcontracted to AMA through American College of Preventive Medicine)	Building Healthcare Provider Capacity to Screen, Test, and Refer Disparate Populations with Prediabetes	$ 50
Centers for Disease Control and Prevention	Engaging Physicians to Strengthen the Public Health System and Improve the Nation's Public Health	488
Centers for Disease Control and Prevention	Improving Health Outcomes through Partnerships with Physicians to Prevent and Control Emerging and Re-Emerging Infectious Disease Threats	23
Centers for Disease Control and Prevention (subcontracted to AMA through American College of Preventive Medicine)	Improving Minority Physician Capacity to Address COVID-19 Disparities	112
Centers for Disease Control and Prevention	National Healthcare Workforce Infection Prevention and Control Training Initiative Healthcare Facilities	81
Centers for Disease Control and Prevention	Physicians and Medical Students: Prevention Rx: Engaging Physicians to Enhance Public Health	20
Centers for Disease Control and Prevention	Protecting and Improving Health Globally: Building and Strengthening Public Health Impact, Systems, Capacity and Security	1,774
Substance Abuse and Mental Health Services Administration (subcontracted to AMA through American Academy of Addiction Psychiatry)	Providers Clinical Support System Medications for Opioid Use Disorders	11
Government Funding		**2,559**
American Chemical Society	International Congress On Peer Review and Scientific Publication	20
American College of Physicians, Inc.	International Congress On Peer Review and Scientific Publication	10
American Medical Association Foundation	Health Equity Acceleration Fund	341
American Medical Association Foundation (supported by Robert Wood Johnson Foundation funding)	The Truth, Reconciliation, Healing, and Transformation Project	520
Nonprofit Contributors		**891**
John Wiley & Sons, Inc.	International Congress On Peer Review and Scientific Publication	30
Contributors less than $5,000	International Medical Graduates Section Reception	5
Other Contributors		**35**
Total Grants and Donations		**$ 3,485**

REPORT OF THE BOARD OF TRUSTEES

B of T Report 05-A-25

Subject: Update on Corporate Relationships

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2024. Corporate activities that associate the American Medical Association (AMA) name or logo with a company, non-Federation association or foundation, or include commercial support, currently undergo review and recommendations by the Corporate Review Team (CRT) (Appendix A).

BACKGROUND

At the 2002 Annual Meeting, the HOD approved revised principles to govern the AMA's corporate relationships, HOD Policy G-630.040 "Principles on Corporate Relationships." These guidelines for American Medical Association corporate relationships were incorporated into the corporate review process, are reviewed regularly, and were reaffirmed at the 2012 and 2022 Annual Meetings. AMA management is responsible for reviewing AMA projects to ensure they fit within these guidelines.

YEAR 2024 RESULTS

In 2024, 102 activities were considered and approved through the Corporate Review process. Of the 102 activities recommended for approval, 52 were conferences or events, 11 were educational content or grants, 33 were collaborations or affiliations, four were member programs and two were business arrangements/licensing programs. See Appendix B for details.

CONCLUSION

The Board of Trustees (BOT) continues to evaluate the CRT review process to balance risk assessment with the need for external collaborations that advance the AMA's strategic focus.

Appendix A

CORPORATE REVIEW PROCESS OVERVIEW

The Corporate Review Team (CRT) includes senior managers from the following areas: Strategy, Finance, Health Solutions (HS), Advocacy, Office of the General Counsel, Medical Education, Publishing, Enterprise Communications (EC), Marketing and Member Experience (MMX), Center for Health Equity (CHE), and Health, Science and Ethics.

The CRT evaluates each project submitted to determine fit or conflict with AMA Corporate Guidelines, covering:

- Type, purpose, and duration of the activity;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);
- Source of external funding;
- Use of the AMA name and logo;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement;
- Status of single and multiple supporters; and
- Risk assessment for AMA.

The CRT reviews and makes recommendations regarding the following types of activities that utilize AMA name and logo:

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.
- AMA sponsorship of external events.
- Independent and company-sponsored foundation supported projects.
- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks. This does not include database or Current Procedural Terminology (CPT ®) licensing.
- Member programs such as new affinity or insurance programs and member benefits.
- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members.
- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.
- Collaboration with academic institutions in cases where there is corporate sponsorship.

For the above specified activities, if the CRT recommends approval, the project proceeds. In addition to CRT review, the Executive Committee of the Board must review and approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.

- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Activities involving risk of substantial financial penalties for cancellation.
- Upon request of a dissenting member of the CRT.
- Any other activity upon request of the CRT.

All Corporate Review recommendations are summarized annually for information to the Board of Trustees (BOT). The BOT informs the HOD of all corporate arrangements at the Annual Meeting.

Appendix B

SUMMARY OF CORPORATE REVIEW
RECOMMENDATIONS FOR 2024

CONFERENCES/EVENTS

Project Number	Project Description	Corporations	Approval Date
48882	**Bryce Harlow Foundation 42nd Annual Awards Dinner** - Sponsorship with AMA name and logo.	Bryce Harlow Foundation	01/17/24
48561	**Anarcha, Lucy, Betsey Annual Conference** – Sponsorships with AMA name and logo.	The More Up Campus Faith Crusade Montgomery Rescue Mission	01/19/24
48398	**National Rx & Illicit Drug Summit** - Repeat sponsorship with AMA name and logo.	Healthcare Made Practical (HMP) Global	01/22/24
48956	**Becker's Collaborations** - CEO & CFO Roundtables, Annual Hospital Review, White paper and Webinar with AMA name and logo.	Becker's Hospital Review ASC Communications	01/24/24
49031	**National Independent Laboratory Association Annual Meeting** - Repeat sponsorship with AMA name and logo.	American Association of Bioanalysts AIMA Business and Medical Support LLC BacterioScan Lighthouse Lab Services BioPathogenix Credence Global Solutions	01/29/24

49012	**NAMSS 48th Annual Educational Virtual Conference and Exhibition** - Repeat sponsorship with AMA name and logo.	National Association of Medical Staff Services ABMS Solutions Medallion Qgenda HealthStream MD-Staff National Committee for Quality Assurance RLDatix Symplr Axuall Medicred PreCheck Santech Acorn Credentialing AOA Profiles Federation of State Medical Boards The Hardenbergh Group Verifiable Credentialing	01/31/24
49056	**March of Dimes Gourmet Gala -** Repeat sponsorship with AMA name and logo.	March of Dimes Blue Cross Blue Shield Association Pampers Comcast WalMart Abbott AdvaMed	02/01/24
48932	**South by Southwest Conference** - Sponsorship with AMA name and logo.	South by Southwest Johnson & Johnson	02/01/24
48908	**Machine Learning for Healthcare Conference** - Sponsorship with AMA name and logo.	Columbia University Johns Hopkins University Duke University Apple Microsoft	02/06/24
48795	**Ottawa Conference 2026** - Sponsorship of continuing medical education conference with AMA name and logo.	Association for Medical Education in Europe (AMEE)	02/06/24
48850	**ViVE Sponsorships** – Repeat sponsorships with AMA name and logo.	College of Healthcare Information Management Executives HLTH Inc.	02/06/24

48463	**AZARA User Conference** – Sponsorship with AMA name and logo.	Azara Healthcare	02/08/24
48958	**Art Institute of Chicago Exhibition –** Art exhibit featuring Journal of Ethics artwork and name and logo.	School of the Art Institute of Chicago	02/14/24
49206	**Chicago Cares Leadership Breakfast** – Repeat sponsorship with AMA name and logo.	Chicago Cares	02/19/24
49411	**International Association of Industrial Accident Boards and Commissions Convention -** Repeat sponsorship with AMA name and logo.	International Association of Industrial Accident Boards and Commissions National Council on Compensation Insurance Optum Aerie EDI Group The Black Car Fund Sedgwick Claims Management Service Concentra SFM Mutual Insurance Official Disability Guidelines by Milliman Care Guidelines Health Safety National Verisk	02/21/24
49259	**Medical Library Association Annual Meeting** – Sponsorship with JAMA Network name and logo.	Medical Library Association	02/23/24
49297	**ROCS Foundation Summit** – Repeat sponsorship with AMA name and logo.	ROCS Foundation John A. Hartford Foundation The Commonwealth Fund	02/26/24

49462	**Credentialing State Shows –** Repeat sponsorship with AMA name and logo.	Arizona Association of Medical Staff Services California Association of Medical Staff Services Illinois Association of Medical Staff Services Texas Society of Medical Services Specialists Florida Association of Medical Staff Services Massachusetts Association for Medical Staff Services New York State Association of Medical Staff Services Ohio Association Medical Staff Services Medical Staff Services Association of Pennsylvania Washington Association Medical Staff Services ABMS Solutions AMN Healthcare/Silversheet Barton Associates CIMRO Edge-U-Cate The Hardenbergh Group Hooper, Lundy & Bookman PC Lash & Goldberg MD Review MD Staff NAMSS PASS Polsinelli PreCheck Procopio PRS Credentialing Services Qgenda SkillSurvey Symplr VerityStream YS Credentialing	02/28/24

49453	**The Association of LGBTQ Journalists Annual Conference –** Repeat sponsorship with AMA name and logo.	The Association of LGBTQ Journalists Axios CBS News Fox News Hearst Corporation McClatchy Media Company DotDash Meredith Publishing Nexstar SAG-AFTRA Scripps Tegna The Athletic CNN TNT Sports	03/01/24
49458	**Asian American Journalists Association's Annual Convention** – Repeat sponsorship with AMA name and logo.	The Guardian Sinclair Broadcast Group IW Group Johnson & Johnson Pew Research Center	03/04/24
49483	**Healthcare Information Management Systems Society (HIMSS) Middle East Forum -** Sponsorship with AMA name and logo.	Healthcare Information Management Systems MWAN Events Gulf Cooperation Council eHealth ZIMAM Elsevier Dedalus	03/04/24
65938	**HIMSS Global Health Conference & Exhibition –** Sponsorship with AMA name and logo.	Healthcare Information Management Systems MWAN Events Gulf Cooperation Council eHealth ZIMAM Elsevier Dedalus	11/22/24
48811	**"Reckoning with Race and Racism in Academic Medicine" Conference –** Sponsorship with AMA name and logo.	Johns Hopkins School of Medicine American Association of Medical Colleges (AAMC) Molina Foundation Robert Wood Johnson Foundation National Institutes of Health	03/06/24

49096	**Bernard Lown Awards Dinner** – Sponsorship with AMA name and logo.	Lown Institute The Commonwealth Fund Robert Wood Johnson Foundation John A. Hartford Foundation Kaiser Permanente California Healthcare Foundation Gordon and Betty Moore Foundation Well-Being Trust Foundation Arnold. P. Gold Foundation	03/19/24
49253	**National Association of Black Journalists Convention** – Repeat sponsorship with AMA name and logo.	Bloomberg CBS Sports Climate Central Gannett Media Lumina National Association of Realtors	03/25/24
49214	**AMA International Medical Graduates Section Annual Meeting Desserts Reception –** Repeat sponsorship with AMA name and logo.	Association of Physicians of Pakistani Descent of North America Association of Haitian Physicians Abroad	03/29/24
50702	**Rock Health Summit –** Repeat sponsorship with AMA name and logo.	Rock Health Foundation California Health Care Foundation Google Tulsa Innovation Labs 1501 Health BioReference Laboratories Amazon Web Services Morgan Stanley Myovant Russell Reynolds	04/05/24
50519	**TruBridge National Client Conference** – Sponsorship with AMA name and logo.	TruBridge i2i Population Health Blockit SureScripts Wolters Kluwer	04/12/24

50589	**Southern Association of Workers' Compensation Administrators Convention and Luncheon** – Repeat sponsorship with AMA name and logo.	AKERA Claims Solutions American International Group Ametros CompTrust Mutual Insurance Company Concentra Enlyte FAIR Health Healthesystems Meridian Wealth Management National Council on Compensation Insurance Official Disability Guidelines by Milliman Care Guidelines Health Occupational Managed Care Alliance Optum Safety National Casualty Company Sedgwick Trean Corporation Verisk Workers' Compensation Institute	04/15/24
50575	**Essence Festival of Culture "Release the Pressure" Health Innovators Hub** – Repeat sponsorship with AMA and RTP name and logo.	Essence Festival New Voices Foundation	04/19/24
50586	**Greenway reENGAGE Client Summit** – Sponsorship with AMA name and logo.	Greenway Health Clearwave Phreesia Surescripts 3M Solventum HealthAsyst Relatient Instamed Vaytiv Updox	04/22/24

62721	**Project IMG (International Medical Graduate) Annual Conference** – Sponsorship with AMA name and logo.	Project IMG Palm Beach Atlantic University Brown University Intealth OET (Occupational English Test) mQ Mental Health Research Essen Healthcare UWorld Boards & Beyond American Medical Women's Association	06/06/24
62849	**Graphic Medicine Annual Conference** – Sponsorship with AMA Journal of Ethics name and logo.	Graphic Medicine International Collective Fáilte Ireland (National Tourism Authority) Meet in Ireland	06/21/24
62841	**American Society of Bioethics and Humanities Conference –** Sponsorship with AMA Journal of Ethics name and logo.	American Society of Bioethics and Humanities Hastings Center American Journal of Bioethics The Journal of Medicine and Philosophy Case Western Reserve University School of Medicine UCLA Health Ethics Center Sutter Health Belmont University Northwell Health Loyola University Bioethics Graduate Programs	06/26/24
62989	**Chief Medical Officer Exchange** – Repeat sponsorship with AMA name and logo.	Healthcare Compliance Professionals HealthLeaders Xtend Healthcare ShiftMed Solutions Vizient Inc. Optum R1 RCM Inc. Microsoft	07/05/24

63282	**Annual Convention and Scientific Assembly of the National Medical Association –** Repeat sponsorship with AMA name and logo.	National Medical Association Gilead Pfizer Hitachi Merck American College of Obstetricians and Gynecologists (ACOG) Glaxo Smith Kline Sutter Health ViiV Healthcare Regeneron Pharmaceuticals National Institutes of Health Centers for Disease Control and Prevention Morehouse School of Medicine Meharry Medical College Howard University College of Medicine University of Michigan University of Virginia The Ohio State University Harvard Medical School	07/10/24
63437	**Latino Medical Student Association National Conference** – Sponsorship with AMA Journal of Ethics name and logo.	Latino Medical Student Association	07/25/24
63241	**Facing Race: A National Conference** – Sponsorship with AMA, Rise to Health Coalition and Grand Rounds logos	Race Forward Accreditation Council for Graduate Medical Education RespectAbility National Center for Interprofessional Practice and Education Institute for Healthcare Improvement	07/26/24

63372	**Annual Princeton Conference** – Repeat sponsorship with AMA name and logo.	The Council on Health Care Economics and Policy at Brandeis University American Hospital Association Arnold Ventures Blue Cross Blue Shield of Massachusetts Foundation Blue Shield of California Foundation Booz Allen Hamilton California Health Benefits Review California Health Care Foundation Jewish Healthcare Foundation MAXIMUS Peterson Center on Healthcare The Health Industry Forum The John A. Hartford Foundation	07/29/24
64332	**Genetic Health Information Network Summit** - Repeat sponsorship with AMA name and logo.	Concert Genetics Illumina	08/07/24
64508	**Collaborative Family Healthcare Association Integrated Care Conference** – Repeat sponsorship with AMA name and logo.	Collaborative Family Healthcare Association The University of Texas Health Center of San Antonio American Psychological Association University of Nebraska Medical Center Munroe-Meyer Institute Area Health Education Centers EvolvedMD Health Federation of Philadelphia Merakey Mental Health Services National Register of Health Service Psychologists University of Houston Integrated Primary Care, Inc. The Foundation for Burnout Solutions Iris Telehealth	08/16/24
64665	**Southern College of Occupational and Environmental Medicine Conference** – Sponsorship with AMA name and logo.	Southern College of Occupational and Environmental Medicine Medlock Pfizer Psychemedics	09/03/24

65064	**MD-Staff Educational Conference -** Sponsorship with AMA name and logo.	MD-Staff PreCheck ABMS Solutions	09/20/24
65074	**Politico's Exchange Dinner** – Sponsorship with AMA name and logo.	Politico	09/26/24
65264	**HLTH Conference** - Repeat sponsorship with AMA name and logo.	HLTH Inc. HLTH Foundation	10/03/24
64748	**Association of American Medical Colleges Annual Meeting** – Repeat sponsorship with Journal of Ethics name and logo.	Association of American Medical Colleges	10/09/24
65537	**Women Business Leaders Annual Summit -** Repeat sponsorship with AMA name and logo.	Elevance Health Inc. Johnson & Johnson McKesson Corporation Tivity Health Amazon Web Services Epstein Becker & Green United Health Group Mintz Law Firm Newport Healthcare ProgenyHealth PYA Accounting Korn Ferry AArete Global Consulting Hello Heart Trustmark Medecision Morgan Health	10/18/24
65562	**College Art Association Annual Conference** – Sponsorship with AMA Journal of Ethics name and logo.	College Art Association JSTOR Digital Library Blick Art Materials University of California Press	10/29/24

66081	**Alliance for Continuing Education in the Health Professions Annual Conference** – Sponsorship with AMA EdHub name and logo.	Alliance for Continuing Education in the Health Professions Medlive/PlatformQ Conexiant PACE freeCME Medscape Partnership in International Management AcademicCME DKBmed Continuing Medical Education ReachMD Haymarket Media Talem Health NOVA Takeda Pharmaceuticals InfographEd CloudCME Med-IQ	11/18/24
66144	**AIDS Foundation of Chicago 40th Anniversary Gala –** Sponsorship with AMA name and logo.	BMO Harris Illinois Tool Works Kehoe Designs Morgan Stanley J&L Catering University of Illinois Health	11/25/24
66672	**Digital Health Innovation Ecosystems Forum** – Sponsorship with AMA name and logo.	MWAN Events OneSource Solutions International CHIME International HLTH Europe Scottish Developmental International MECOMED Invest Northern Ireland	12/27/24
66659	**Healthcare Burnout Symposium –** Sponsorship with AMA name and logo.	International Conference Development Events	01/02/25

EDUCATIONAL CONTENT OR GRANT

Project Number	Project Description	Corporations	Approval Date
50525	**OutCare Health Education** - AMA EdHub hosted content with AMA name and logo.	OutCare Health	04/24/24
49258	**Collaboration with National Association of County and City Health Officials** - AMA EdHub hosted content with AMA name and logo.	National Association of County and City Health Officials	03/12/24
49611	**Brain Health and Dementia Risk Reduction Collaboration** - AMA EdHub hosted continuing medical education with AMA name and logo.	Centers for Disease Control (CDC) Alzheimer's Association	03/19/24
62759	**Project Firstline Webinar - Building Blocks of Infection Prevention and Control -** AMA EdHub hosted continuing medical education with AMA name and logo.	CDC Project Firstline American Society of Nephrology	06/03/24
62924	**Measles: Stories from the Frontline** - AMA EdHub hosted content with AMA name and logo.	CDC Project Firstline Pediatric Pandemic Network American Academy of Pediatrics American Nurses Association	06/17/24
62981	**Language Equity Toolkit** – AMA EdHub hosted content with AMA name and logo.	Accreditation Council for Graduate Medical Education Association of American Medical Colleges National Council on Interpreting Health Care	07/05/24

64452	**American Health Information Management Association Workshop -** Training on clinical documentation coding with AMA name and logo.	American Health Information Management Association	08/14/24
64324	**MedCerts Collaboration** – MedCerts-hosted AMA content on improving BP measurements, with AMA name and logo.	MedCerts	08/16/24
64210	**Permanente Medical Group Collaboration** - AMA EdHub hosted content with AMA name and logo.	The Permanente Medical Group	08/29/24
64669	**Healthcare Webinar Series** - AMA sponsored segment on Medicare payment reform, with AMA name and logo.	WTOP Radio Federal News Network	09/03/24
65773	**Credentialing School Sponsorship** - Repeat sponsorship with AMA name and logo.	Edge-U-Cate Symplr The Hardenbergh Group	11/01/24

COLLABORATIONS/AFFILIATIONS

Project Number	**Project Description**	**Corporations**	**Approval Date**
48378	**Atlanta Hypertension Initiative –** Sponsorship of initiative improving hypertension in Atlanta area, with AMA name and logo.	Atlanta Hypertension Initiative Atlanta Regional Collaboration for Healthcare Improvement CDC Million Hearts American Heart Association National Association of Chronic Disease Directors	01/04/24

48723	**The Million Hearts Hypertension in Pregnancy Change Package** – Collaboration on resource to improve hypertension in pregnancy, with AMA name and logo.	Center for Disease Control and Prevention Million Hearts The Society for Maternal-Fetal Medicine The American College of Osteopathic Obstetricians and Gynecologists College of Nurse-Midwives The National Association of Nurse Practitioners in Women's Health	01/05/24
48617	**Chicago Area Public Affairs Group** – Repeat sponsorship with AMA name and logo.	Chicago Area Public Affairs Group Chicago Title Insurance Company BMO Bank JP Morgan Chase APCO Worldwide Boyce Possley The Clover Group	01/10/24
48870	**MAP Dashboards for Healthcare Organizations (HCOs)** – AMA co-branding with healthcare organizations for MAP blood pressure dashboard project.	Michigan Primary Care Association Hamilton Community Health Network Western Wayne Family Health Centers Grace Health Asian Human Services Family Health Center Concord Hospital Medical Group	01/16/24
49094	**Peterson Healthcare Technology Institute Digital Health Collaborative** – Collaboration researching benefits of digital health technology, with AMA name and logo.	Peterson Foundation AHIP National Alliance of HC Purchasers National Health Council National Partnership for Women and Families	02/02/24
49065	**Prevention Strategy Collaboration with Health Care Organizations –** Update to diabetes prevention program with AMA name and logo.	DePaul Community Health Centers Erie Family Health Centers Bedford-Stuyvesant Health Center Health Federation of Philadelphia AllianceChicago Hines VA Hospital Sparta Community Hospital University of Colorado Medicine Alabama Primary Health Care Association Hawaii Island Community Health Center East Central Mississippi Health Care Greater Philadelphia Health Action Health Partners of Western Ohio	02/07/24

		Colorado Community Managed Care Network Louisiana Primary Care Association Emplify Health Star Community Health Prosano Health Mass General Brigham Southwest Virginia Community Health Center	
49063	**American Telehealth Association Membership –** Repeat sponsorship with AMA name and logo.	American Telehealth Association	02/07/24
48981	**Access to Care Report** – Co-branded report on increasing access to care for pregnant patients with substance use disorder.	Manatt Health - Manatt, Phelps & Phillips, LLP	02/09/24
49541	**Physician Innovation Network (PIN) –** AMA PIN collaboration agreement with AMA name and logo.	RedCrow Healthcare Technology	03/08/24
49532	**AMA MAP Hypertension Quality Improvement Pilot** - Evaluation of AMA MAP program in a virtual care setting, with AMA name and logo.	KeyCare	03/14/24
49099	**Equitable Professional Societies Network Leadership Roundtables** – Health equity collaboration with healthcare leaders, with AMA name and logo.	Council of Medical Specialty Societies HealthBegins Race Forward	03/15/24
49432	**Digital Medicine Society Integrated Evidence Plans** – Toolkit collaboration with AMA name and logo.	Peterson Health Technology Institute Alliance of Community Health Plans American College of Cardiology Genentech Food & Drug Administration U.S. Department of Veterans Affairs	03/15/24

49097	**AMA Grand Rounds** – Health equity event and content collaboration with AMA and Grand Rounds name and logo.	Accreditation Council for Graduate Medical Education National Center for Interprofessional Practice and Education RespectAbility	03/18/24
49257	**Practice Transformation Survey Assessment** – AMA co-branding with healthcare organizations for physician burnout survey.	Advocate Health Care Allied Physician's Group of Riverhead Ballad Health Medical Associates Baystate Health Boulder Medical Center Carilion Clinic Cayuga Health Children's Hospital of The King's Daughters Medical Group Christus Health Cook Children's Hospital Dayton Children's Hospital Guthrie Health System Health Partners & Park Nicollet HealthONE Holland Hospital Huntington Health Jefferson Health Lahey Hospital & Medical Center Luminis Health MaineHealth Medical Group Memorial Health Ohio Methodist Mansfield Medical Center Methodist Medical Group MyMichigan Health Newark Beth Israel Medical Center Denver Health Northern Ohio Medical Specialists Northern Arizona Regional Behavioral Health Authority NYU Langone Family Health Centers Olive View, UCLA Medical Center ONCare Alliance OneHealth Saint Peter's University Hospital Schumacher Clinical Partners Health Sky Ridge Medical Center Sound Physicians South Shore Health St. Louis University SUNY Upstate Medical University Tapestry 360 Health The Guidance Center Trinity Health	03/25/24

		University of Michigan Health University of Missouri Healthcare Valley Children's Healthcare Virginia Center for Health Information Trusted Doctors Washington University School of Medicine West Virginia University Medicine Witham Hospital	
50700	**AI in Health – Navigating New Frontiers** – Working group collaboration and report on AI in Health, with AMA name and logo.	Alliance for Health Policy Kaiser Permanente Elevance Health Inc. MITRE Crowell & Moring Law The Patient-Centered Outcomes Research Institute Ostuka Pharmaceuticals Amazon Shields Health Solutions Association for Community Affiliated Plans	04/03/24
50609	**All In Campaign** – Repeat healthcare workforce wellbeing campaign with AMA name and logo.	Harvard TH Chan School of Public Health National Medical Association American Nurses Foundation AHIP Medicine Forward Institute for Healthcare Improvement American Foundation for Suicide Prevention American Society of Hospital Pharmacists	04/12/24
48927	**Validated Device Listing** – Update validatebp.org with language “a public health service supported by AMA."	National Opinion Research Center	04/13/24
62084	**Drug Shortage Task Force** - Coalition for policy recommendations to reduce drug shortage issues, with AMA name and logo.	United States Pharmacopeia Cancer Support Community Generics Access Project Association for Clinical Oncology Alliance for Aging Research Hemophilia Federation of American Friends of Cancer Research Howard University College of Pharmacy	05/28/24

		Arthritis Foundation National Consumers League National Psoriasis Foundation American Pharmacists Association Association of Health System Pharmacists Angels for Change Susan G. Komen Foundation American Cancer Society	
62184	**Release the Pressure Coalition** – Updated coalition for collaboration on reducing hypertension in minority women, with RTP name and logo.	AMA Foundation American Heart Association National Medical Association Association of Black Cardiologists Minority Health Institute	06/04/24
62977	**Joy in Medicine** – Repeat AMA recognition program on AMA website for outstanding healthcare organizations.	Catholic Health Columbus Regional Health Common Spirit CommonSpirit Mountain Region Community Health Network Veterans Integrated Service Network Intermountain Health Memorial Healthcare System MemorialCare Medical Group Novant Health Inc NYC Health + Hospitals TMCOne VA Illiana Health Care System Children's Healthcare of Atlanta Dana-Farber Cancer Institute Bellin and Gundersen Health System HealthPartners Kansas City VA Medical Center Naples Comprehensive Health Nuvance Health Trinity Health Hospital-Ann Arbor/Trinity Health IHA Medical Group UMass Chan Medical School Baystate and Baystate Health The University of Chicago Medicine University of Kentucky College of Medicine The University of Texas Health Science Center at San Antonio Bryan Medical Center Dayton Children's Hospital Denver Health	06/25/24

Endeavor Health Edward Hospital
Endeavor Health Elmhurst Hospital
El Rio Health
Medical College of Wisconsin
Froedtert Hospital
Children's Wisconsin Hospital
Hartford HealthCare
Jefferson Health
Johns Hopkins Medicine
Mercy Health
Moffitt Cancer Center
MultiCare Health System
MyMichigan Health
Nemours Children's Health
Northwell Health
Oak Street Health
Olive View-UCLA Medical Center
Owensboro Health
Pediatric Physicians' Organization
Penn Medicine Lancaster General Health
Roper St. Francis Healthcare
Roswell Park Comprehensive Cancer Center
Samaritan Health Services
St. Luke's Health System
Stamford Health
Sutter Health
Sutter Independent Physicians
The Christ Hospital Health Network
UMass Memorial Health
University of California Irvine Health
University of Mississippi Medical Center
Atlantic Health System
Bayhealth
Hattiesburg Clinic
Henry Ford Health
Lehigh Valley Health Network
Mid-Atlantic Permanente Medical Group
Northwest Permanente
The Southeast Permanente Medical Group
Texas Children's Pediatrics

63251	**Rise to Health Coalition** – Updated health equity coalition focused resources for healthcare professionals, with AMA name and logo.	Encoding Equity Alliance National League for Nursing National Council of Asian Pacific Islander Physicians Student National Medical Association US Professional Association for Transgender Health	07/12/24
64628	**National Latino Physician Day** – Awareness Campaign with AMA name and logo.	National Latino Physician Day	08/29/24
64431	**Cardiovascular Disease Prevention Collaboration** – Heart disease prevention materials and training, with AMA name and logo.	Aledade Inc.	09/03/24
64783	**CPT & Value-Based Care Collaboration** - Co-branded issue brief, with AMA name and logo.	Manatt Health, Manatt, Phelps & Phillips, LLP	09/16/24
64838	**AMA Annual Research Challenge** – Repeat annual AMA branded competition with Laurel Road sponsored prize.	Laurel Road Bank	09/18/24
65068	**AMA STEPS Forward and Value-Based Care Collaboration** – Value-based care case studies and AI governance toolkit, with AMA name and logo.	Manatt Health, Manatt, Phelps & Phillips, LLP Geisinger Health System Hattiesburg Clinic	09/24/24
64957	**Athenahealth Co-Branded Collaboration** – "Fix Medicare Now" sponsorship with AMA name and logo.	Athenahealth	09/25/24
65073	**Keep Americans Covered Program** – Coalition to extend Affordable Care Act tax subsidies, with AMA name and logo.	AHIP American Cancer Society Cancer Action Network Blue Cross Blue Shield Association Leukemia & Lymphoma Society	09/27/24

		Federation of American Hospitals American Association of Retired Persons Alliance of Community Health Plans American Academy of Family Physicians The American College of Physicians American Heart Association American Lung Association Association for Community Affiliated Plans National Association of Pediatric Nurse Practitioners National Association of Community Health Centers Families USA National Rural Health Association Small Business for America's Future Susan G. Komen Foundation Unidos US United States of Care	
65613	**Mental Health Parity Collaboration –** Pilot for online tool comparing insurance mental health coverage, with AMA name and logo.	The Kennedy Forum Third Horizon Strategies	11/01/24
65577	**Physician Data Initiative** – Working group to establish data collection and categorization standards, with AMA name and logo.	MedBiquitous Association of American Medical Colleges Accreditation Council of Graduate Medical Education	11/04/24
66040	**Collaboration supporting CDC Million Hearts Project** – with AMA name and logo.	AllianceChicago CDC Million Hearts	11/103/24
66085	**Sponsorship supporting Physician Health Programs** – with AMA name and logo.	Federation Of State Physician Health Programs Coverys Insurance MedPro Group Medical Liability Mutual Insurance Company Physicians Insurance State Volunteer Mutual Insurance Company The Doctors Company	11/206/24

		Medical Professional Liability Association	
66163	***Academic Medicine:* Disability Supplement Collaboration** – with AMA name and logo.	Academic Medicine Association of American Medical Colleges Docs With Disabilities Initiative Robert Wood Johnson Foundation	12/18/24

MEMBER PROGRAMS

Project Number	Project Description	Corporations	Approval Date
65576	**Avid Traveling Update** - Travel affinity program with AMA name and logo.	AHI Travel Avid Traveling	10/24/24
49605	**Boards & Beyond Member Benefit** – Discount on medical student test prep materials, with AMA name and logo.	Boards & Beyond	03/12/24
66466	**AMBOSS Member Benefit** – Discount on medical student test prep materials, with AMA name and logo.	AMBOSS	12/12/24
66498	**UWorld Member Benefit** – Discount on medical student test prep materials, with AMA name and logo.	UWorld	12/16/24

BUSINESS ARRANGEMENTS/LICENSING PROGRAMS

Project Number	Project Description	Corporations	Approval Date
64865	**AMA MAP Hypertension Quality Improvement Program** - Business agreement with AMA name and logo.	Forward Health Group	10/09/24
64952	**Cadence Software Group** – AMA Guides content licensing agreement, with AMA Guides name and logo.	Cadence Software Group	12/12/24

REPORT OF THE BOARD OF TRUSTEES

B of T Report 07-A-25

Subject: AMA Performance, Activities and Status in 2024

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Policy G-605.050, "Annual Reporting Responsibilities of the AMA Board of Trustees," calls for the Board of Trustees to submit a report at the American Medical Association (AMA) Annual Meeting each year summarizing AMA performance, activities, and status for the prior year.

INTRODUCTION

The AMA's mission is to promote the art and science of medicine and the betterment of public health. As the physician organization whose reach and depth extend across all physicians, as well as policymakers, medical schools, and health care leaders, the AMA uniquely can deliver results and initiatives that enable physicians to improve the health of the nation.

Grounding our work in the Principles of Medical Ethics and the policies and wisdom of AMA House of Delegates, in 2024 the AMA was resolute in its fight to repair a broken health care system—one that is threatening the viability of physician practices and patient access to care, contributing to alarming rates of burnout and dissatisfaction, and placing enormous pressure on an already strained public health infrastructure.

Representing physicians with a unified voice

The AMA remained strongly focused on advocacy priorities critical to supporting and strengthening our nation's physician workforce and improving the lives of patients.

Thanks to the AMA's year-long push to reform an unsustainable Medicare reimbursement model that has cut physician payment by 33 percent since 2001, policymakers in Washington, D.C., now understand and acknowledge the crisis and are working in a bipartisan fashion on permanent solutions aligned with AMA recommendations.

The AMA's "Fix Medicare Now" grassroots campaign, which received widespread media attention, generated more than half-million contacts to members of Congress and helped secure introduction of two important pieces of federal legislation to reform the Medicare payment system.

- H.R. 2474, which would enact an annual, permanent inflationary payment update in Medicare that is tied to the Medicare Economic Index
- H.R. 6371, which would reform the budget neutrality policies that have been producing across-the-board payment cuts

Similarly, the AMA's advocacy campaign to reform the onerous prior authorization process, including its "Fix Prior Auth" grassroots campaign, resulted in important reforms both at the federal level and in more than a dozen states.

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- The Centers for Medicare & Medicaid Services released final regulations to cut patient care delays and electronically streamline the prior authorization process for physicians—saving physicians an estimated $15 billion dollars.
- At the state level, over a dozen states enacted prior authorization reform laws—supported by the AMA and state medical associations.

In the courts, the AMA was a critical voice for physicians and organized medicine on a broad range of public health issues, including restricting access to e-cigarettes, tougher regulation of unlicensed and untraceable "ghost" guns, and expanding access to care. In addition to defending physicians from criminal and civil penalties for providing necessary care, the AMA was a plaintiff in a major antitrust case against MultiPlan, a data analytics company accused of creating a price-fixing conspiracy with the largest commercial health insurance companies in the country.

The AMA worked alongside state medical associations from across the country to oppose inappropriate scope expansions in more than 40 states. Much of the success was bolstered by the "AMA Scope of Practice Partnership" initiative that has provided more than $4 million in grants since its inception.

The AMA's efforts helped deliver concrete results in protecting patients from inappropriate scope of practice expansions, including the defeat of over 80 bills that would have allowed:

- Physician assistants and nurse practitioners to independently practice medicine
- Pharmacists to independently diagnose and prescribe medications to patients
- Naturopaths to prescribe legend drugs or perform surgical procedures
- Optometrists to perform surgery
- Nurse anesthetists to provide anesthesia services without physician supervision
- Psychologists to independently prescribe medications

Through proactive strategies and reactive opportunities, the AMA elevated the voice of physician leadership on critical issues of public health and our priority topics with media clips exceeding our three-year average. This includes the work to avert the Medicare payment cuts, as well as media and speech visibility throughout the year, leading to more than 3.8 billion media impressions (up from two billion in 2023 and a 10X increase from 2021). Meanwhile, our prior authorization legislation is on the precipice of passing, due to this sustained topic of visibility over the past decade, including 4.7 billion media impressions in 2024 (up from 2.3 billion in 2023)

Removing obstacles that interfere with patient care

Support for physician mental health and well-being expanded in 2024 as the AMA led, funded, or contributed to 38 research projects either to address burnout, promote digital health solutions or aid the long-term sustainability of physician practices. The AMA also recognized 62 health systems for implementing evidence-based strategies to improve physician and health provider well-being through the AMA's Joy in Medicine™ Health System Recognition Program.

Guided by the AMA and in support of physician well-being, a total of 34 licensure boards as of 2024—including 29 medical boards, and more than 425 hospitals and health systems—have revised their licensing or credentialing applications to remove intrusive mental health questions and stigmatizing language. This result is due to an ongoing advocacy effort by the AMA and our close partnerships with organizations like the Dr. Lorna Breen Heroes' Foundation.

AMA STEPS Forward® developed over 90 new or updated resources focused on preventing physician burnout, creating the organizational foundation for joy in medicine, and improving practice efficiency. The resources include toolkits, webinars, podcast episodes, and the new "Reducing Regulatory Burden and Value of Feeling Valued" playbooks.

To expand insight into burdensome electronic health record (EHR) systems, the AMA awarded grants to five organizations through the AMA Electronic Health Record Use Research Grant Program to study EHR usage and improve workflow and resource allocation at the practice and system-level.

The AMA conducted research to explore the role of Current Procedural Terminology (CPT®) in value-based care. Among other vital information, the research identified crucial ways that help ensure the CPT code set remains relevant as value-based care continues to evolve in health care delivery.

To help eliminate obstacles to patient care, the AMA launched VeriCre™, which streamlines the credentialing process, improves efficiency and reduces redundancy for physicians, hospitals, and health plans allowing patients to receive care sooner. VeriCre™ allows physicians to easily manage their credentials, career information and forms for efficient distribution and secure integration with third-party credentialing software.

Driving the future of medicine

To help physicians assess the risks and opportunities of augmented intelligence (AI) in medicine, the AMA continued to develop tools, resources, and support for AI study and implementation, and elevated the most pressing concerns of physicians to those shaping our digital health future.

Underscoring our commitment to ensure the physician voice is integrated into all aspects of health care technology, the AMA released an AI landscape report that provides an overview of current and future use cases, potential applications, and opportunities and risks of AI. The AMA also presented three webinars on future health topics including digital empathy, the human factor in solving problems, and navigating AI in health care.

JAMA® hosted the second annual *JAMA* Summit™, which convenes leaders from across sectors and around the world to discuss and debate critical issues in medicine, health, and health care. This year's event focused on the integration of AI in clinical medicine. *JAMA*® created and launched JAMA+ AI, a channel devoted as the first stop for authors and readers seeking the best science and commentary on AI and its application to medicine and public health.

The AMA, in partnership with the University of Michigan, developed a new seven-part online activity series "AI in Health Care**,**" which introduces learners to foundational principles of AI and machine-learning.

As a leader in the advancement of precision education, the AMA concluded the 2024 AMA ChangeMedEd® Innovation Grant Program that awarded 13 grants and focused on the application

of precision education across the medical education continuum—from medical school and residency to continuing medical education. The AMA continued to further define precision education as a critical way to develop an effective model of lifelong learning in medical education, one which produces a physician workforce capable of caring for our patients, families, and communities.

AMA Ed Hub™ partners with more than 60 organizations as a vital source of professional education for physicians by providing trusted, high-quality education to enable lifelong professional development. In 2024, AMA Ed Hub™ continued to experience high engagement.

- 8000+ education activities available
- 475,000+ registered users
- 4 million visitor sessions
- 600,000 courses completed

Leading the charge to confront public health crises

To address systemic inequities that have contributed to poorer health outcomes for historically marginalized communities, the AMA reaffirmed its commitment to health equity by extending our multi-faceted health equity strategic plan through 2025. This work spans state and federal advocacy, education and training for physicians, and community investments that target the root causes of inequities in medicine and help all people achieve their optimal health.

In collaboration with more than 20 organizations, the AMA hosted two National Health Equity Grand Rounds, which featured 14 national experts and reached over 24,000 viewers.

Building on its long legacy of advancing public health, 2024 saw the AMA develop a new strategic approach for promoting greater blood pressure control in targeting the number one cause of premature death in the U.S.: heart disease. By engaging more than 280 health care organizations the AMA helped reach more than 2.5 million hypertensive patients with solutions that assisted physicians and care teams in lowering their patients' blood pressure risks.

Amid the rising rates of sexually transmitted infections and viral hepatitis across the U.S., the AMA, in collaboration with the Centers for Disease Control and Prevention (CDC), launched a new online toolkit to help physicians and other health care professionals increase routine screenings for human immunodeficiency virus, sexually transmitted infections, viral hepatitis, and latent tuberculosis. We also hosted a series of educational webinars about best practices and strategies for routine screening.

The CDC's National Partners Cooperative Agreement awarded the AMA $2.45 million to support our efforts in advancing hypertension and cholesterol care in communities across the U.S.

The AMA's Enterprise Social Responsibility (ESR) program celebrated its fifth year of working to reduce health inequities in partnership with communities. AMA's ESR program aligns with the needs of the organizations through active partnerships, where AMA's activities are recognized as collaborative and add value to the community. In 2024, the ESR program recorded the most impactful year to date hosting over 40 events, supporting 85 organizations.

Membership

The AMA's advocacy and mission activities were again fueled by another year of strong financial performance and continued membership growth. AMA membership has increased more than 40 percent in the last 15 years with a 3.1 percent increase in dues paying members in 2024 alone as more physicians, medical students, and residents recognize our efforts and want to join the AMA in fighting on their behalf.

EVP Compensation

During 2024, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was $1,400,311 in salary and $1,262,299 in incentive compensation, reduced by $2,902 in pre-tax deductions. Other taxable amounts per the contract are as follows: $168,999 distribution from a deferred compensation plan; $23,484 imputed costs for life insurance, $24,720 imputed costs for executive life insurance, $22,865 for legal fee reimbursement, $2,820 paid for parking and $2,500 paid for a fitness facility.

For additional information about AMA activities and accomplishments, please see the "AMA 2024 Annual Report."

REPORT OF THE BOARD OF TRUSTEES

B of T Report 08-A-25

Subject: Annual Update on Activities and Progress in Tobacco Control: March 2024 through February 2025

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

This report summarizes trends and news on tobacco usage, policies, and tobacco control advocacy activities from March 2024 through February 2025. The report is written pursuant to American Medical Association (AMA) Policy D-490.983, "Annual Tobacco Report."

TOBACCO USE AT A GLANCE*

Adult smoking rates are at an all-time low of 11 percent and yet it is still the leading cause of preventable death in the United States. According to U.S. Surgeon General, one in five of all deaths are caused by smoking.[1] According to the Centers for Disease Control and Prevention (CDC) cigarette smoking accounts for more than 480,000 deaths every year, or about one in five deaths. Chronic diseases associated with cigarette smoking include respiratory and cardiovascular diseases, cancers, and diabetes. More than 16 million Americans live with a smoking-related disease.[2]

Despite large absolute differences in the numbers of smoking-attributable deaths by race and ethnicity, smoking accounts for a similar proportion of deaths among non-Hispanic Black (18 percent) and non-Hispanic White (20 percent) people and for approximately 10 percent of deaths among Hispanic people. In January 2025, Health and Human Services released the 35th United States Surgeon General's report on tobacco, Eliminating Tobacco-Related Disease and Death: Addressing Disparities. The report documents the persistence of disparities in tobacco product use and exposure to secondhand tobacco smoke and outlines recommendations that include marketing and manufacturing restrictions, funding for evidence-based programs and cessation inventions and eliminating menthol and flavorings in all tobacco products.[1]

Cigarettes remain the most commonly used type of tobacco product followed by e-cigarettes. Although cigarette smoking rates decreased, e-cigarette use increased from 3.7 percent in 2020 to 6.5 percent in 2023 according to National Health Interview Survey.[3] Men were more likely than women to use e-cigarettes. In 2019 3.5 percent of women and 5.5 percent of men reported using e-cigarettes. This increased to 5.5 percent and 7.6 percent in 2023. Examining usage by different age groups in 2023, e-cigarette usage was highest in adults ages 21-24 (15.5 percent), with usage decreasing with increased age among those 25 and older.

Current use of any tobacco product among middle and high school declined overall according to an analysis of the 2024 National Youth Tobacco Survey (NYTS) from 10 percent in 2023 to 8.1 percent in 2024. The analysis was published in the October 17, 2024, Morbidity and Mortality Weekly Report (MMWR).[4] The overall declines were largely driven by the decline in high school e-cigarette use that went from 1.56 million in 2023 to 1.2 million in 2024. But despite the declines one in 10 high school students and one in 20 middle school students reported current tobacco use of any product in 2024.

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E-cigarette products were the most used tobacco product of middle and high school students with 5.9 percent reporting current e-cigarette use followed by nicotine pouches (1.8 percent), and cigarettes (1.4 percent). Among students who had ever used an e-cigarette, 43.6 percent reported current use. Tobacco use declined for Hispanic students and remained stable for other racial and ethnic groups but increased for non-Hispanic American Indian or Alaska Native. The continued disparities among youth tobacco users reported in the analysis highlights the need to continue to develop targeted prevention and control interventions.

NYTS is a cross-sectional, voluntary, school-based, self-administered, Internet survey of U.S. middle school (grades 6–8) and high school (grades 9–12) students. A stratified, three-stage cluster sampling procedure was used to generate a nationally representative sample of U.S. students attending private or public middle and high schools. Data were collected during January 22–May 22, 2024; 29,861 students from 283 schools participated, with an overall response rate of 33.4 percent.

EFFORTS TO ADDRESS TOBACCO CONTROL

Medicaid coverage improves for tobacco cessation, but barriers still exist

More than one in five adults enrolled in Medicaid smoke cigarettes which is higher than adults with private insurance. In 2021, prevalence in adults enrolled in Medicaid was 21.5 percent compared to 8.6 percent enrolled in private insurance. According to a report, State Medicaid Coverage for Tobacco Cessation Treatments and Barriers to Accessing Treatments — United States, 2018–2022, the number of states with comprehensive Medicaid coverage of tobacco cessation treatment increased from 15 to 20 states.[5]

The American Lung Association (ALA) authored the report that analyzed state-level information looking at coverage for nine tobacco cessation treatments and access barriers which include co-payments, prior authorization, treatment duration, annual and lifetime limits, and two others. The biggest improvement in removing barriers was for co-payments with nearly a third of the states without this requirement. The authors credit the enactment of the Families First Coronavirus Response Act which increased the federal share of Medicaid spending and required states to limit new cost-sharing for Medicaid enrollees.

Low-income populations are disproportionately affected by smoking-related diseases. Smoking cessation is one of the most effective interventions to prevent the health risks associated with chronic diseases.[6] Removing barriers to cessation services would improve quality of life as well as reduce the direct and indirect costs of tobacco-related diseases.

AMA Litigation Center joins with public health groups to protect tobacco regulation

In the courts, the AMA has continued to be very active in supporting efforts to further regulate and limit tobacco products and electronic nicotine delivery systems (ENDS). The AMA has joined numerous amicus briefs around the country in cases involving the federal government’s efforts to regulate and remove flavored ENDS from the market, which have contributed to favorable outcomes in several federal circuit courts. In addition, the AMA has supported state and local governments with amicus briefs after their laws banning flavored tobacco products and ENDS have been challenged by the tobacco and vaping industry.

Notably, the AMA Litigation Center joined two amicus briefs in the United States Supreme Court involving marketing denial orders of flavored products under the Tobacco Control Act. The two

cases, Federal and Drug Administration (FDA) v. Wages and Lion Investments and FDA v. R.J. Reynolds Vapor, have been briefed and argued and the Court is expected to rule before the end of June 2025.

In 2020, the AMA joined the African American Tobacco Control Leadership Council (AATCLC) as a plaintiff in its lawsuit against the Department of Health and Human Services and the FDA on account of the FDA's failure to prohibit the sale of menthol-flavored cigarettes. An FDA report found menthol cigarette use is associated with increased smoking initiation among youth and young adults, greater signs of nicotine dependence, and less success in smoking cessation. As of June 2024, the FDA had still not released rules for prohibiting the sale of menthol-flavored cigarettes. In January 2025, the Trump Administration withdrew the proposed federal rule banning menthol flavoring. This AMA/AATCLC lawsuit continues with Action on Smoking and Health and National Medical Association joining the suit.

California rolls back secondhand smoke protections

Public health and medical organizations were stunned when California Governor Gavin Newsom signed Assembly Bill 1775 (AB 1775) into law in September 2024. This law expands what is permitted at cannabis/marijuana retailers. Existing law gives California cities and counties the authority to decide if cannabis retailers are permitted in the jurisdiction, and to decide whether those cannabis retailers may allow onsite use, such as indoor cannabis smoking and/or vaping.

According to the Americans for Nonsmokers Rights the new law, which went into effect January 1, 2025, goes a step further by allowing jurisdictions to permit an additional element at cannabis retailers: the sale of food and non-alcoholic beverages and the sale of tickets to performances. This law, one of the first in the country, rolls back California's leadership in protecting workers from the health risks associated with secondhand smoke exposure which includes cannabis smoke. In fact, Governor Newsom had vetoed a similar law the previous year but succumbed to pressure from the rising influence of the cannabis lobby. [7,8,9]

Tobacco control advocates will continue to work at the local level to call for restrictions on cannabis retailers while working at the state level to overturn AB 1775.

American Lung Association Releases its 2025 State of Tobacco Report

The ALA released its 2025 "State of Tobacco Control" (https://www.lung.org/research/sotc) which reviews tobacco control activities at the state and federal levels and assigns grades based on laws and regulations designed to prevent and reduce tobacco use including e-cigarettes.[10] This is the 23rd edition of the ALA's State of Tobacco report which has served as a blueprint to public health organizations, and local, state and federal governments for enacting proven tobacco control policies. The 2025 report reveals the continued impact of tobacco use, including menthol cigarettes, on individuals and families across the country, and underscores the continued influence of the tobacco industry. These include tobacco industry efforts to stop former President Biden from ending the sale of menthol cigarettes and flavored cigars as well as industry efforts at the state level to stop proven-effective policies to prevent and reduce tobacco use.

Four states, Alabama, Georgia, Mississippi and Texas, received the worst grades in the nation. These states either did not advance any policies or weakened existing tobacco control efforts. Every state received an F for failing to pass any legislation or regulation prohibiting the sales of flavored tobacco products. The variety of flavors available for use in e-cigarettes has grown exponentially, especially among youth and young adults, according to a Tobacco Free Kids issue

brief.[11] The city of Denver passed a comprehensive flavored tobacco law, again demonstrating the leadership of local communities on this issue.

Maryland was lauded for increasing its cigarette tax by $1.25 per pack, making it the second highest state cigarette tax in the country at $5.00 per pack. Tobacco taxation, passed on to consumers in the form of higher cigarette prices, is one of the most effective population-based strategies for decreasing smoking and its adverse health consequences.[12]

Effective September 2024, 21 is the national tobacco sales age

After almost four years of delay, stricter requirements for tobacco retailers were finalized by the FDA in August 2024. In accordance with the 2019 passage of the Tobacco 21 legislation, the FDA issued final rules that became effective September 30, 2024, requiring retailers to use a photo ID to verify the age of anyone under the age of 30 trying to purchase any tobacco product including smokeless. In addition, the rules prohibit tobacco product vending machines in facilities where individuals under 21 are present or are permitted to enter. In 2019 Senators Tim Kaine (D-VA) and Mitch McConnell (R-KY) worked together to pass the Tobacco 21 law which also called for the FDA to issue guidance on implementation and enforcement. In 2022 they called on then FDA Commissioner Dr. Robert Califf to provide greater transparency on delays.[13] It is estimated that raising the minimum legal age to 21 years would reduce the smoking initiation rate among 15- to 17-year-olds by 25 percent, lead to 50 000 fewer cases of lung cancer and prevent 223 000 early deaths in the US.[14, 15]

*Note – at the time this report was prepared updated tobacco/smoking related data and reports were unavailable from trusted government sources. Due to the Trump Administration Executive Orders, CDC and other agencies were required to remove sources of public health surveillance data and reports.

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REPORT 10 OF THE BOARD OF TRUSTEES (A-25)
American Medical Association Health Equity Annual Report
(Informational)

EXECUTIVE SUMMARY

Background: At the 2018 Annual Meeting, the House of Delegates (HOD) adopted the recommendations of Policy D-180.981 directing our American Medical Association (AMA) to "develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities" and instructing the "Board to provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements." The HOD provided additional guidance via Policy H-180.944: "Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity." HOD policy was followed by creation of the AMA Center for Health Equity ("Center") in April 2019, the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 ("Plan") in May 2021, and the successor 2024-2025 AMA Organizational Strategic Plan to Advance Health Equity in June 2024. In 2022, updated Policy H-65.946 specified that this report will also include "updates on [the AMA's] comprehensive diversity and inclusion strategy." This report marks the sixth AMA Health Equity Report.

Discussion: The AMA has continued its efforts over recent years to further embed equity in our work. The 2024-2025 iteration of the Plan continues to serve as a guide for this work. This report outlines the activities conducted by our AMA during calendar year 2024, divided into the five strategic approaches detailed in the Plan: (1) Embed Equity; (2) Build Alliances and Share Power; (3) Ensure Equity in Innovation; (4) Push Upstream; and (5) Foster Truth, Reconciliation, and Racial Healing. The updates on diversity and inclusion strategy updates are located within the Embed Equity section.

Conclusion: This report highlights only a portion of the work accomplished and lessons learned in 2024. AMA staff have devoted countless hours to learning how they can collaborate in advancing health equity and applying those insights within and beyond the organization. The AMA remains committed to driving progress toward health equity and embedding racial and social justice, making meaningful progress toward fulfilling the commitments outlined in both iterations of the Strategic Plan.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-A-25

Subject: American Medical Association Health Equity Annual Report

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

BACKGROUND

At the 2018 Annual Meeting, the House of Delegates (HOD) adopted Policy D-180.981, directing our American Medical Association (AMA) to "develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities" and instructing the "Board to provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements." The HOD provided additional guidance via Policy H-180.944: "Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity." HOD policy was followed by creation of the AMA Center for Health Equity ("Center") in April 2019, the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 ("Plan") in May 2021, and the successor 2024-2025 Plan in June 2024. In 2022, updated Policy H-65.946 specified that this report will also include "updates on [the AMA's] comprehensive diversity and inclusion strategy." This report marks the sixth AMA Health Equity report.

DISCUSSION

Our AMA has committed to advancing health equity, advocating for racial and social justice, and embedding equity across the organization and beyond. In 2024, the Center continued to collect enterprise-wide equity related work and track progress toward the five strategic approaches detailed in the AMA's Plan. This report outlines the activities conducted by our AMA during calendar year 2024, divided into five strategic approaches detailed in the Plan: (1) Embed Equity; (2) Build Alliances and Share Power; (3) Ensure Equity in Innovation; (4) Push Upstream; and (5) Foster Truth, Reconciliation, and Racial Healing. Updates on diversity and inclusion strategy updates are included within the Embed Equity section.

Embed Equity

Ensuring a lasting commitment to health by our AMA involves embedding equity using anti-racism, structural competency, and trauma-informed lenses as a foundation for transforming the AMA's staff and broader culture, systems, policies, and practices, including training, tools, recruitment and retention, contracts, budgeting, communications, publishing, and regular assessment of organizational change. The following are some of the relevant accomplishments during 2024:

- At the 2024 Annual and Interim House of Delegates Meetings, equity-focused reports, resolutions, and education sessions were presented, including Council on Ethical and Judicial Affairs reports: "Short Term Global Health Clinical Encounters" and "Expanding Access to Palliative Care." The Council on Science and Public Health presented 18 reports on topics such as: Sex and Gender Differences in Medical Research, Universal Screening for Substance Use and

Substance Use Disorders during Pregnancy, Stand Your Ground Laws, and Reducing Sodium Intake to Improve Public Health.

- The AMA Journal of Ethics published five equity-related issues such as Critical Pedagogies in Health Professions Education (Jan 2024); Global Medical Supply Chain Security (April 2024); Antimicrobial Stewardship (June 2024); Harm Reduction and Opioid Use Disorder (July 2024); and Sleep Stewardship (October 2024). The AMA released a podcast series, "Equity in our DNA: The Past and Promise of Genetics" in which experts discuss advances in modern medicine and provide insights into historical harms creating public mistrust. It provides an opportunity for viewers to understand how changes in precision medicine can reduce health equity gaps. Furthermore, the AMA, in collaboration with the U.S. Centers for Disease Control & Prevention (CDC), published seven episodes of the "Stories of Care" podcast series, resulting in 3,299 downloads and 1,405 continuing medical education completions. The AMA continued its campaign with the CDC and the Ad Council to promote flu vaccinations, focusing on Black and Hispanic/Latinx populations, reaching 1.6 million broadcast impressions and 404 million digital impressions.
- Diverse representation among AMA publications remained a goal. The AMA updated 29 images in the 2025 CPT Professional book to reflect diverse populations. Input was gathered from internal and external reviewers. This progress is contributing to AMA's four-year plan to update 75-100 CPT Professional book illustrations to depict authentic and diverse individuals.
- AMA content on health equity saw increased engagement in 2024, with 2.2 million website users, 23,200 referrals to the AMA Ed Hub, and 45 news articles. AMA expanded communication of equity initiatives through social media, newsletters including the Advocacy Update, Advocacy Insights webinar series, Center for Health Equity, CPT news email, and webinars. AMA social media had 343,000 views of health equity content with an average of one to two health equity related posts per week.
- On the AMA Ed Hub site, the AMA published 169 new equity-related activities and renewed 101, with engagements reaching 311,429 (vs. 189,721 in 2023) and completions increased to 68,700 (vs. 34,782 in 2023). The AMA partnered with medical schools to assign AMA health equity trainings, driving over 900 completions of health equity courses from medical student members. All four of the health equity foundational courses offered are in the top 15 percent of courses most utilized by medical students. Additionally, the AMA partnered with graduate medical education institutions to assign health equity courses to residents, resulting in more than 18,900 completions across more than 240 institutions. In 2024, there was an all-time high of foundations of health equity module completions seen in a year. Notably, in 2024, there were four newly uploaded quality improvement and patient safety (QIPS) courses and a new curriculum that centered on health equity focused patient scenarios. More than 4,000 resident members have enrolled in the curriculum since its launch in July 2024. Additionally, seven episodes of Prioritizing Equity were produced in 2024: Black Maternal Health; Voter Protections for During and After Incarceration; The Importance of Highlighting Historically Marginalized Physician's Journey Through Medicine; International Medical Graduates Experience in Medicine; Equitable Climate Action for Health; Culturally Responsive Communication Strategies for Equity; and Embedding Equity in Crisis Preparedness and Response in Health Systems Guide.
- The JAMA Network held quarterly diversity, equity, and inclusion (DEI) editor meetings to support DEI related concerns and share best practices. The JAMA fellowship welcomed eight early-career health equity scholars in the fully remote fellowship program, intended to foster accessibility and inclusivity of the program.
- In 2023-2024, the AMA evaluated external perceptions of its equity and social justice work and opportunities for strategic partnerships and allyships. There was a two-part analysis in support of these aims: a series of interviews with leaders within national equity and social justice organizations, and an analysis of social media conversations being had by the general public.

- Our AMA published playbooks and other educational resources for physicians, practices, and health systems, such as the health coaching toolkit to include the importance of community health workers, updated the Private Practice Playbook to include social determinants of health and health equity content, and developed virtual coaching options to help reach patients in traditionally remote and underserved communities. STEPS Forward® has continued to hold events, reaching a wider audience of attendees, while maintaining discounted attendance for federally qualified health centers (FQHCs) and safety-net providers. The bootcamps offer evidence-based time management and team-based care strategies to provide quality patient care. The Private Practice Simple Solutions learning collaboratives were created in support of practices in communities that may lack financial resources to engage with consultants or other external partners and continued to run through 2024, expanding to timely and relevant topics that are often complex in nature and that these practices may need support on, such as the implementation of virtual assistants or value-based care.

The AMA's employee life cycle and internal DEI framework helped to operationalize DEI initiatives across the enterprise. Within the embedding equity strategic approach, updates on the AMA's diversity and inclusion strategy included a number of efforts and initiatives:

- Our AMA supports DEI initiatives through nine Employee Resource Groups (ERGs), fostering inclusion and belonging across the organization. In 2024, the ERGs collectively had 640 staff who were members of their groups and hosted over 90 events designed to advance equity learning, cultivate community, and support the personal and professional development of their members.
- Staff are strongly encouraged to seek equity-focused learning opportunities, with minimum hours set in the organization's first year of internal enterprise-wide equity goals, and staff averaging over 16 hours in 2024. Among business units (BUs), staff have organized educational activities and events to strengthen community engagement and learning. As an example, AMA Insurance (AMAI) organically produced and presented a six-hour long Lunch and Learn training focused on equity and inclusion. Each AMAI staff is responsible for logging their required minimum of 7.5 hours of equity training/related programming participation.
- In addition, the Center for Health Equity and Human Resources have offered equity focused workshops to support staff completion of their equity learning goal. Staff participated in the Racial Equity Trainings offered by the Racial Equity Institute, the Diversity, Equity, Inclusion, and Belonging Foundation Course through Be More with Anu, and skill-based inclusion modules on Psychological Safety, Inclusive Communication, Identifying and Responding to Microaggressions, and Inclusive Facilitation. For the skills-based modules, 246 staff members completed 362 workshops, reflecting both a 36 percent increase in staff participation and a 41 percent increase in the number of completed workshops when compared to 2023. These trainings provided and/or helped refine actionable skills to promote inclusion across the employee lifecycle at the AMA.
- The AMA offered the staff management team, in partnership with Equity & Results, an in-person and virtual live workshop series on Antiracist Results-Based Accountability. Participants learned root cause analysis for inequities, strategy development to address "hot roots" and "pain points" that drive inequity, and operational plan and performance measurement development to enhance equitable impact internally and externally. A seven-session series (final four sessions in 2024) included 47 unique equity leads (including current and former business unit equity action team members) across all 18 BUs and one affiliate with 82 percent of the final session's survey respondents agreeing or strongly agreeing to knowledge gained. A three-session series, in support of enterprise-wide equity goals, included 57 directors and vice presidents from all business units,

with more than half agreeing or strongly agreeing they were confident about applying what they learned.

- Our AMA continues to work toward identifying and replacing offensive terminology across the enterprise. The AMA conducted a comprehensive search for outdated terms in our information technology (IT) systems and has embarked on instituting these updates starting in 2025 to replace harmful language.

Build Alliances and Share Power

Building strategic alliances and partnerships and sharing power with historically marginalized and minoritized physicians and other stakeholders is essential to advancing health equity. This work centers previously excluded people, expertise and knowledge, builds advocacy coalitions, participates in national networks, and establishes the foundation for true accountability and collaboration. The following are some of the relevant accomplishments during 2024:

- Our AMA launched the second iteration of the AMA's Strategic Plan to Embed Racial Justice and Advance Health Equity to advance health equity, with a viewpoint summarizing AMA's renewed commitment to the work and lessons learned from the original strategic plan.
- The AMA continued the Summer Health Law Internship and will continue in 2025, expanding from an eight-week to a ten-week paid summer internship for a rising third-year law student, with a focus on health disparities and the law.
- The AMA's Release the Pressure campaign, alongside the Henry Schein Cares Foundation, American Dental Association, National Medical Association, Care Quest Institute for Oral Health, and the Arnold Gold Foundation created the Prevention is Power Coalition. Educational materials including fact sheets, posters, and patient cards on hypertension for Federally Qualified Health Centers were created and reached over 800 organizational members and 65,000 health-focused followers through the National Association of Community Health Center's network.
- The AMA conducted a survey to understand physician perceptions of their health center-built environments and assess impact on their well-being. Of the 12,277 contacted, 526 responded and 281 agreed to follow-up interviews. The surveyed physicians included American Indian or Alaskan Native/Native Hawaiian or Pacific Islander, Hispanic or Latino, Black or African American, Middle Eastern or North African. The surveyed physicians are in the process of being connected with diverse learning communities such as Rise to Health and In Full Health resources.
- Seven new partners joined the AMA's Ed Hub in 2024, including Institute for Healthcare Improvement, Johns Hopkins University, National Association of County and City Health Officials, National Resources Defense Council, Oregon Health & Science University, OutCare Health, and The Permanente Medical Group. These organizations will be contributing to equity-related content on AMA Ed Hub site.
- Out AMA continued to follow the Enterprise Social Responsibility (ESR) team's health equity framework to build meaningful relationships with community organizations. In 2024, the ESR team hosted over 40 community engagement events with organizations including Erie Neighborhood House, Gardeneers, Nourishing Hope, Pilsen Food Pantry, and Project Linus. To highlight, AMA's ESR team partnered with MyBlock MyHood MyCity to co-design a weeklong service event. The weeklong service event celebrated the AMA ESR program's fifth year anniversary and provided volunteers with deeper engagement to build upon health equity work that is already happening in the community. The weeklong event impacted 423 residential homes and 12 neighborhood blocks.
- Additionally, there are increased efforts to contract with minority- and/or women-owned or led businesses for AMA projects, including local West Side vendors, which has led to successful

agreements. The AMA continues to participate in monthly West Side United (WSU) Anchor Partner meetings and attended a vendor summit event, meeting several WSU vendors in person.

- Our AMA's 2024 media sponsorships focused on reaching diverse audiences, supporting events with the National LGBTQ+ Journalists Association, the Asian American Journalists Association, and the National Association of Black Journalists, to name a few.
- In collaboration with the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, the AMA released recommended standards for collecting, reporting, and sharing race, ethnicity, and language data in health care. The standards represent a multi-year initiative around sociodemographic physician workforce data. Organizations, such as MedBiquitous, have agreed to adopt and promote these standards to the health care community.
- In 2024, our AMA continued collaborative research that leverages critical data from the AMA's Physician Professional Data aimed to study and evaluate the most pressing issues impacting equitable care.
- AMA has a goal to scale solutions to improve blood pressure control for five million patients diagnosed with hypertension (HTN) with a specific goal to impact one million patients identified as Black, Latina/e/o/x/Hispanic, Asian, Indigenous, and other historically marginalized groups. At the end of Q4 2024, approximately 2,589,155 patients were reached, and have impacted 774,261 patients with hypertension towards the goal of five million, with 38 percent from historically marginalized populations. AMA is embedding and advancing equity within its AMA MAP HTN™ program by evaluating program data, developing tools for health care professionals to identify inequities in blood pressure control rates, and creating inclusive patient education materials related to cardiovascular disease prevention that have been translated into over 15 languages.
- Across the enterprise, individual BUs sought out ways to embed equity within their departments. As an example, the AMA continued hosting students from historically marginalized backgrounds with the opportunity to visit the AMA, engage with AMA IT professionals, and learn about the organization's history and its role in promoting national health and wellbeing. Similarly, JAMA partnered with the Urban Alliance on a summer internship program to provide opportunities for Chicago students to explore Medical Editing and Publishing as a career path.
- The AMA contributed to revising the Declaration of Helsinki, supporting the creation of the new version that more effectively addresses health determinants and inequity. For example, the revision has a stronger emphasis on environmental considerations, for the first time requires post-clinical trial provisions (such as providing any intervention identified as beneficial and reasonably safe in the trial for participants who still need it) and discusses vulnerability in a more nuanced way.
- The AMA continued to partner with March of Dimes and Sinai Urban Health Institute to examine the impact of facility closures and loss of services on the South and West Sides of Chicago, publishing a final report in August 2024, titled "From Facilities to Outcomes: A Neighborhood-Level Examination of Maternal and Infant Care Access in Chicago."
- Our AMA conducted 32 burnout assessments at FQHCs and/or community health centers, all organizations serving patients from predominantly historically marginalized communities, including 23 organizations in the Arizona Alliance, a consortium of FQHCs. Several virtual workshops and reporting sessions to provide insight into interventions to reduce medical staff burnout were held.
- Several participating FQHCs were recognized through the AMA's Joy in Medicine™ Health System Recognition Program. AMA continued to work with FQHCs, and staff traveled to an FQHC located in Chicago's South Side, Alivio, and met with their leadership team to learn more about their needs and challenges.

- AMA staff continue to be present at minoritized and marginalized physician convenings to grow and foster relationships, as well as learn about health care priorities of these groups. Staff participated in various conferences to support building alliances, learning about the context necessary for restorative practice, and incorporating context into the AMA's own work. These conferences included: 8th Annual Urban Native Education Conference, National Hispanic Medical Association 30th Anniversary Celebration and Leadership Summit, Unidos US Annual Conference, Access in Medicine Summit, National Medical Association National Colloquium on African American Health and Annual Convention and Scientific Assembly, The Latino Medical Student Association National Conference, American Association of American Indian Physicians 52nd Annual Meeting and Health Conference, GLMA's 42nd Annual Conference on LGBTQ+ Health, and AAMC Annual Meeting. Staff gained insights into incorporating restorative practices and equity into AMA's work.

Push Upstream

Pushing upstream requires looking beyond cultural, behavioral, or genetic reasons to understand structural and social drivers of health and inequities, dismantle systems of oppression, and build health equity into health care and broader society. The following are some of the relevant accomplishments during 2024:

- Equity-related policy priorities can be seen throughout the AMA's engagement with Congress, the Administration, state legislatures and other policymakers, in the form of advocacy letters, presentations and testimony to state legislatures, national and medical organizations, and countless additional opportunities that engaged organized medicine and policymakers. In 2024, the AMA continued to actively voice support for:
    - International medical graduates;
    - Deferred Action for Childhood Arrivals recipients;
    - Migration and refugee population health and safety;
    - Nutrition programs expansion and culturally respectful dietary guidelines;
    - Medicaid coverage expansion;
    - Medicaid and Children's Health Insurance Program coverage extension;
    - Maternal and child health programs;
    - Protecting reproductive health;
    - Advancing data privacy principles and protecting the abuse/misuse of sensitive health data;
    - Enhanced revisions to the federal race and ethnicity data standards;
    - Mental health and substance use disorder parity laws;
    - Protections for physicians who seek care for wellness and burnout;
    - Evidence-based gender affirming care;
    - Prohibition of the so-called conversion therapy;
    - Fair student loan efforts;
    - Increased funding for graduate medical education;
    - Elimination of harmful race-based clinical algorithms;
    - Telehealth flexibilities in Medicare;
    - Reducing the prior authorization burden on patients; and
    - Addressing quality and administrative barriers in Medicare Advantage and other insurance plans.
- The AMA amplifies voices of historically marginalized individuals through its litigation efforts. Examples from this past year:
    - Reproductive health and gender-affirming care: The AMA has filed and joined dozens of amicus briefs across the country on these critical issues in state and federal courts,

including several briefs at the U.S. Supreme Court. The briefs have consistently emphasized the harm that government interference in the patient-physician relationship has on marginalized communities. The litigation team has also provided support to the AMA's Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted.
    - Anti-smoking: The AMA has continued to be a central voice in litigation on anti-smoking efforts, including serving as a named plaintiff in a case to ban the sale of menthol cigarettes. The AMA has also joined several amicus briefs supporting state and local restrictions on flavored tobacco and briefs supporting restrictions on flavored electronic nicotine delivery systems, including in the U.S. Supreme Court.
    - Affordable Care Act (ACA) Preventive Care: The AMA has been a leader in organizing amicus briefs supporting the ACA and opposing efforts to dismantle the preventive care provisions of the law. These briefs have included dozens of Federation members and have been filed at all levels of the case.
    - Medicare: The AMA has supported the federal government's efforts to support health equity in Medicare through the use of anti-racism plans under the MIPS program.
    - Internal and External Communication: The litigation team routinely communicates with state and specialty societies about possible collaboration efforts in order to support health equity in the courts.
- The AMA proposed revisions adopted into World Medical Association policy, advocating against anti-LGBTQ+ legislation worldwide. AMA also supported and facilitated World Medical Association policies addressing humanitarian issues in Gaza and Turkey. Additionally, the AMA facilitated an opportunity for Jesse Ehrenfeld, MD, MPH, to speak and participate in a panel at the World Medical Association General Assembly on the opportunities and risks of innovation in health equity.
- The AMA hosted the first two hybrid National Health Equity Grand Rounds: Advancing Health Equity Through Resistance: A State of the Union on Threats and Opportunities in New York City, with 990 live attendees, and Rewrite the Script: Narrative Transformation for Equity in Health at the Facing Race conference in St. Louis, Missouri, with 1,044 live attendees. Overall, 90 percent of Grand Rounds viewers reported that they were satisfied or very satisfied with the 2024 events.
- In its second year, the Health Equity in Organized Medicine (HEIOM) survey was distributed to the AMA Federation of Medicine in January 2024. The survey seeks to understand the current state of organized medicine’s efforts in advancing health equity and developing a shared understanding of equity initiatives across states and specialties. Despite an increasingly complex political landscape and efforts to discredit diversity, equity, and inclusion initiatives, the 2024 HEIOM survey found continued engagement around equity and inclusion efforts across various sectors. Notably, 74.1 percent of organizations reported taking at least one action to make equity a strategic priority. Among organizations that completed both 2023 to 2024 surveys, 51.9 percent reported completing or sustaining the majority of their actions, and no organization reported stopping or canceling the effort they had underway in 2023.
- In response to AMA HOD policy D-405.970: Racism – A Threat to Public Health, the AMA submitted new ICD-10 codes focused on the conditions related to the experience of racism to the National Center for Health Statistics in 2024. The AMA supported the successful implementation of Gravity Project’s social determinants of health terminology and Fast Healthcare Interoperability Resources exchange standards across the state of New York (NY) to provide the data standards necessary to more effectively identify and address the health-related social needs of 6.9 million Medicaid beneficiaries. The use of these standards in NY, and across the country, also enables the stories of marginalized populations to be more accurately told in a way that was not possible before the Gravity Project. When aggregated, this data will help local, state, and

federal officials to make more informed decisions about the needs of these marginalized populations and the impact of addressing these needs on health care outcomes and spending.

- The AMA has worked to close coverage gaps in Medicaid programs so that beneficiaries have coverage for a blood pressure (BP) monitoring device and cuff. AMA has also worked to increase Medicaid coverage for clinical services related to self-measured blood pressure.
- In Atlanta, the AMA collaborated with the CDC, local American Heart Association (AHA) representatives, and a local collaborative on health improvement to convene more than 75 organizations and align solutions to social drivers of health to improve blood pressure for Black adults. Notably in Atlanta, the Medical Association of Georgia and Medical Association of Atlanta are engaging their membership locally. The AMA has deployed AMA MAP™ resources, tools, and educational content to health care organizations in the Atlanta area.
- New STEPS Forward® content helped address determinants of health and inequities. For example, 2024 STEPS Forward® podcast content included episodes focused on (1) Integrating a Community Health Worker into Team-based Care, (2) Connecting the Dots Between Social Determinants of Health and Climate Change, (3) Frontline Connect: Eliminating Barriers to Mental Health Services for the Health Care Workforce, and (4) I felt such a shame to be me: How One Medical Educator is Working to End Mental Health Stigma in Medicine.
- As part of The AMA Foundation's Health Equity Accelerator fund, the AMA was awarded a two-year $2.3 million collaborative grant to focus on promoting equitable practices and diversity in the admissions process after the 2023 U.S. Supreme Court (SCOTUS) decision on affirmative action. The proposal was written to supplement ongoing efforts, including a separate set of roundtable discussions, the completion of the book *Remaining Medical Education: The Future of Health Equity and Racial Justice*, and broader Medical Education strategies. The grant-funded initiative, referred to as Equity and Justice in Medical Education, is convening key stakeholders most affected by the SCOTUS decision to collect their reflections on the challenges and opportunities of the changing landscape. The participating organizations include the National Medical Association, National Hispanic Medical Association, Association of American Indian Physicians, National Council of Asian Pacific Islander Physicians, Asian Pacific American Medical Student Association, Latino Medical Student Association, Association of Native American Medical Students, Student National Medical Association, American Association of College of Osteopathic Medicine, and the Association of American Medical Colleges. A total of six convenings will be held during the grant period. These convenings aim to foster collaboration between participants with the hope of developing common approaches that will leverage collective influence while not countermanding efforts of any one organization over another.

Ensure Equity in Innovation

The AMA is committed to ensuring equitable health innovation by embedding equity in innovation, centering historically marginalized and minoritized people and communities in development and investment, and collaborating across sectors. The following are some of the relevant accomplishments during 2024:

- The new Health Solutions Innovation Framework now includes Equity Impact as a mandated quadrant of the Product Lean Canvas (a one-page business plan to help determine if a product is worth moving forward) and continues to propagate across the additional stages through product development and delivery.
- The AMA hosted an expert convening on postpartum HTN to identify best practices for postpartum blood pressure monitoring and management. Specifically, convening participants highlighted that policy change, further research, and practice tools and resources are needed to support broad improvements in postpartum HTN care.

- The AMA worked with external organizations, health innovation and technology companies to encourage organizations that support health care delivery, such as health technology, payers, and others, to use an equity lens to understand population representation within their studies and programs, investment and removal of barriers for those who have been historically marginalized, and transparency for specific populations. Additionally, the US Validated Blood Pressure Device Listing has continued to grow in number and variety of devices, including broader cuff sizes and lower price points to reach a broader population in need.
- The AMA continued to strive toward the adoption, optimization, and sustainability of responsible, impactful and equitable digitally enabled innovations. This included highlighting organizations that are championing and implementing health equity via the Physician Innovation Network (PIN) and providing a place through PIN to engage in important conversations centering the Principles of Equitable Innovation. The AMA connected stakeholders and fostered collaboration to improve the development, evidence base, and quality of digital health solutions.
- The AMA provided Innovation Grants to twelve organizations and developed a community of practice where grantees meet monthly. As part of the AMA "Innovation in Medical Education Series" with Elsevier, the recently published *Reimagining Medical Education: The Future of Health Equity and Social Justice* illuminates multiple aspects and points of view connected to this important and evolving topic. This externally commissioned publication was written in response to a 2021 report by the AMA Council on Medical Education. The AMA Council on Medical Education report included a directive 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. The book was published in November 2024 after an extensive process of selecting an editorial panel and facilitating dialogs on developing a common vision for the book. The book envisions medical education's many concrete and potential contributions to social justice and racial equity. The AMA contracted with the Social Mission Alliance to review the book and identify their recommendations of which parts of the book may be most important and feasible to enact quickly. A report with those recommendations was submitted in October 2024 and it will be used with other analyses to help build a strategy on enacting recommendations from the book.

Foster Truth, Racial Healing, Reconciliation, and Transformation

The AMA recognizes the importance of acknowledging and rectifying past injustices in advancing health equity for the health and well-being of both physicians and patients. Truth, racial healing, reconciliation, and transformation is a process and an outcome, documenting past harms, amplifying and integrating narratives previously made invisible, and creating collaborative spaces, pathways, and plans. The following are some of the relevant accomplishments during 2024:

- Presented the restorative justice framework and community engagement plan for conversation at the Association of American Indian Physician's 52nd Annual Meeting and Health Conference, entitled "A Pathway and Journey Toward Truth and Reconciliation;" at the GLMA Health Professionals Advancing LGBTQ+ Equity (GLMA) 42nd Annual Conference on LGBTQ+ Health in a Lunch Plenary and Discussion on Restorative Justice and Representation; and at the GLMA Workshop, "Restorative Justice in Medicine Workshop."

- A cross-enterprise, cross-functional staff team has been supporting the Truth, Reconciliation, Healing and Transformation (TRHT) Task Force that was established by HOD policy.
    - Facilitated, supported and worked closely with two TRHT Task Force sub-groups (Writing and Narrative), including creation of recommendations and guidance to plan collection of testimonies from physicians, advocates and patient populations on historical harms in medicine, and implementation of the plan to collect physician narratives for the report to the Board.
    - Planned and implemented educational opportunities for TRHT task force members, staff, and minoritized physician groups including three asynchronous learnings in October on the History of Medical Harms in the Asian and Pacific Islander American community (Winston Wong, MD, MS), The AMA and Harms Arising from Exclusionary Training (Harriet Washington, MA) and Research on Race and Health in the US: Some Historical Background (David R. Williams, PhD, MPH, MA).
    - Planned and supported the TRHT Task Force Meeting with two panel presentations: (1) The Legacy of Medical Experimentation and Maternal Health featuring Michelle Browder and Lee Sharma, MD and (2) Developing Responsive Policies and Practices to Maternal and Reproductive Health Inequities in the Region featuring Tom Ellison, MD, PhD; Natalie Hernandez, PhD, MPH; and Yolanda Lawson, MD.
- The AMA partnered with the Institutional Antiracism and Accountability (IARA) Project, funded by a Robert Wood Johnson Foundation grant, subgranted by the AMA Foundation. IARA's Truth, Reconciliation, Healing, and Transformation Archival Research Project is using their specially granted access to AMA archival materials to examine the historical roots of health inequities in the U.S. and will use this work to inform actionable strategies for advancing health equity.
- The AMA continues its work of revising the AMA Guides to the Evaluation of Permanent Impairment, in accordance with existing AMA policy on race as a social construct and national standards of care, to modify recommendations that perpetuate racial essentialism or race-based medicine. Specifically, a race-neutral approach to pulmonary function test interpretation algorithms is being implemented by reporting and interpreting results using average reference equations rather than using race-based calculations.
- The AMA and Association of American Medical Colleges (AAMC) were invited by one of the partners of The REParations and Anti-Institutional Racism (REPAIR) Project to co-sponsor an event for May 2024 on their campus. The REPAIR Project is a three-year initiative designed to address anti-racism and better incorporate structural competency in science and medicine. The project recognizes that long-standing racial inequities in health, health care institutions and scholarship are a result of systemic race-based violence and racism in society as a whole and seeks to open conversation and promote efforts to rectify and eliminate these problems. It also recognizes the need to support a strategy of maximizing the effect of the Liaison Committee on Medical Education standard on structural competency to accelerate health equity.

Challenges & Opportunities

Across the AMA, several challenges have been identified in advancing health equity goals. Time constraints and the lack of prioritization for equity-focused projects amid competing demands remain significant hurdles. Smaller teams struggle to allocate time for participation in events and for equity action team meetings. Additionally, some BUs report limited access to subject matter experts, further complicating efforts to develop equitable internal strategies.

A recurring challenge is ensuring leadership elevates marginalized perspectives, staff, collaborators, contractors, and patients and communities most impacted by inequities. The same individuals have often

been driving equity initiatives for years, leading to fatigue within equity action teams. Equity-related work often takes a backseat to other organizational priorities, leaving staff feeling overwhelmed by the magnitude of inequities and the limited time to address them. There is difficulty in embedding equity into team practices in places where direct leadership support and involvement is less robust.

The cross-enterprise antiracist results-based accountability training course has provided an opportunity for equity champions and leadership to identify opportunities and strategies to embed equitable principles throughout AMA systems and structures. However, there remain varying levels of understanding of root causes of inequities and confidence in applying equity strategies among staff and varying degrees of commitment to integrating equitable approaches (e.g., data transparency, inclusive decision-making) among leadership.

CONCLUSION

This report highlights only a portion of the work accomplished and lessons learned in 2024. AMA staff have devoted countless hours to learning how they can collaborate in advancing health equity and applying those insights within and beyond the organization. The AMA remains committed to driving progress toward health equity and embedding racial and social justice, making meaningful progress toward fulfilling the commitments outlined in both iterations of the Strategic Plan.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-A-25

Subject: AMA Efforts on Medicare Payment Reform

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

BACKGROUND

At the 2023 American Medical Association (AMA) Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-385.945, "Advocacy and Action for a Sustainable Medical Care System" and amended Policy D-390.922, "Physician Payment Reform and Equity." Together, they declare Medicare physician payment reform as an urgent advocacy and legislative priority, call on the AMA to implement a comprehensive advocacy campaign, and for the Board of Trustees (the Board) to report back to the HOD at each Annual and Interim meeting highlighting the progress of our AMA in achieving Medicare payment reform until a predictable, sustainable, fair physician payment system is achieved. The Board has prepared the following report to provide an update on AMA activities for the year to date. (Note: This report was prepared in March based on approval deadlines, so more recent developments may not be reflected in it.)

AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM

The AMA's Medicare physician payment reform efforts were initiated early in 2022, following the development of a set of principles outlining the "Characteristics of a Rational Medicare Payment System" that was endorsed by 124 state medical associations and national medical specialty societies. These principles identified strategies and goals to: (1) ensure financial stability and predictability for physician practices; (2) promote value-based care; and (3) safeguard access to high quality care.

Subsequently, the AMA worked with Federation organizations to identify four general strategies to reform the Medicare payment system, including:

- Automatic annual payment updates based on the Medicare Economic Index (MEI);
- Updated policies governing when and how budget neutrality adjustments are made;
- Simplified and clinically relevant policies under the Merit-based Incentive Payment System; and
- Greater opportunities for physician practices wanting to transition to advanced alternative payment models (APMs).

At the heart of the AMA's unwavering commitment to reforming the Medicare physician payment system lie four central pillars that underscore our strategic approach: legislative advocacy; regulatory advocacy; federation engagement; and grassroots, media, and outreach initiatives. Grounded in principles endorsed by a unified medical community, our legislative efforts drive the advancement of policies that foster payment stability and promote value-based care. We actively champion reform through regulatory channels, tirelessly engaging with crucial agencies such as the Centers for Medicare & Medicaid Services (CMS) and the White House to address impending challenges and ensure fair payment policies. Our federation engagement fosters unity and consensus

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within the broader medical community, pooling resources and strategies to amplify our collective voice. Lastly, our continued grassroots, media, and outreach efforts bridge the gap between policymakers and the public, ensuring our mission is well-understood and supported from all quarters. Together, these pillars fortify our endeavors to achieve a more rational Medicare physician payment system that truly benefits all.

Legislative Advocacy

The AMA shares its members' deep frustration over the persistent cuts to Medicare payments. While Congress mitigated approximately half of the 2024 Medicare physician payment cuts that were initially implemented in January 2024, physicians continue to sound the alarm about how two decades of annual cuts are jeopardizing practice viability and limiting patient access to care. Unfortunately, the final 2025 Physician Payment Rule imposed an additional 2.83 percent cut.

An early draft of a year-end legislative package in December included a proposal to address 2.5 percent of the scheduled cut. However, this proposal collapsed under political pressure, and the scaled-down spending package that ultimately passed failed to address the payment cuts. As a result, physicians are now facing Medicare cuts for the fifth consecutive year, which went into effect on January 1, 2025. Meanwhile, CMS projects that the MEI will increase by 3.5 percent in 2025, further widening the gap between what Medicare pays physicians and the actual cost of delivering quality patient care.

The financial stability of physician practices and the long-term sustainability of the nation's entire health care system are at serious risk. Medicare physician payment rates have effectively plummeted 33 percent from 2001 to 2025 when adjusted for inflation in practice costs. Addressing this widening gap is essential to ensure physicians can continue providing high-quality care to Medicare patients.

Fixing our unsustainable Medicare payment system will remain an urgent advocacy and legislative priority for our AMA until meaningful reform is achieved. The need to stop the annual cycle of pay cuts and patches and enact permanent Medicare payment reforms could not be clearer. Because of Congress' failure to reverse these cuts, millions of seniors will find it more difficult to access high quality care and physicians will find it more difficult to accept new Medicare patients. The impact of sustained, year-over-year Medicare payment cuts will become noticeable first in rural and underserved areas and with small, independent physician practices which will be highly detrimental for some of our nation's most vulnerable patients.

As a result of the continued advocacy efforts of the AMA and larger physician community and direct engagement with Congress, a collection of influential Dear Colleague letters were circulated and commonsense legislation introduced to address the broken Medicare physician payment system and build upon "Characteristics of a Rational Medicare Physician Payment System" including:

Medicare Reform: Automatic Annual Inflation-based Updates

- The AMA and our Federation partners continue to advocate for an inflation update to Medicare payments, on top of reversing the new round of 2.83 percent cuts that began on January 1.
- The 118th Congress took an important first step toward Medicare reform with the introduction of H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," a bill that would provide automatic, annual payment updates to account for practice cost inflation as reflected in the MEI. We will advocate for the introduction of similar legislation in 2025.

- Tying annual payment updates to the MEI has long been supported by the AMA to promote the financial viability of physician practices and place physicians on equal ground with other health care providers. Federation groups have joined forces in seeking bipartisan cosponsors for this legislation and to educate Congress on why it is needed.

Medicare Payment Reform: Budget Neutrality

- A bill that was strongly supported by the AMA was introduced in the House last year by the co-chairs of the GOP Doctors Caucus (H.R. 6371), based on AMA recommendations, that would reform the budget neutrality policies that have been producing across-the-board payment cuts. The bill would have:
  - Required CMS to review actual claims data and correct flawed utilization projections that cause inappropriate conversation factor cuts or increases; and
  - Raised the spending threshold that triggers a budget neutrality adjustment from $20 million to $53 million.
- The AMA is advocating for the introduction of similar legislation in 2025.

Medicare Payment Reform: Revising the Medicare Merit-based Incentive Payment System (MIPS)

- Together with Federation groups, the AMA has developed legislative language to improve the MIPS program. The AMA draft would:
  - Address steep penalties that are distributed unevenly and disproportionately impact small, rural, and independent practices;
  - Hold CMS accountable for providing physicians with timely and actionable data; and
  - Reform MIPS so that it is more clinically relevant and less burdensome.
- We will work to advance these MIPS reforms with the new Administration and Congress.

Summary of Recent AMA Advocacy Efforts at the end of the 118th Congress and beginning of the 119th

- On September 10, the AMA joined more than 120 organizations representing more than one million health care providers and their patients in a sign-on letter calling on Congress to take action to address the unsustainable Medicare physician payment system. The letter specifically mentioned three pieces of bipartisan legislation that were introduced in the 118th Congress to address systemic flaws to the Medicare physician payment system, all of which the AMA has advocated in support of:
  - The Strengthening Medicare for Patients and Providers Act (H.R. 2474) which would enact an annual, permanent inflationary payment update in Medicare that is tied to the MEI;
  - The Physician Fee Stabilization Act (S. 4935), which would increase the budget neutrality threshold under the Medicare physician Fee Schedule and provide regular indexing to the MEI; and
  - The Provider Reimbursement Stability Act (H.R. 6371), which would build upon the provisions in S. 4935 through its inclusion of additional key components to reform budget neutrality laws.

- In October, Representatives Mariannette Miller-Meeks, MD (R-IA) and Jimmy Panetta (D-CA), along with 233 bipartisan members of Congress sent a “Dear Colleague” letter urging House leadership to take immediate action to not only stop the 2.8 percent cut, but also provide

physicians with a much-needed payment update that reflects the inflationary pressure they are facing running a medical practice.

- As a direct result of AMA advocacy efforts, Reps. Greg Murphy (R-NC), and Jimmy Panetta, (D-CA) introduced in October, H.R. 10073, the "Medicare Patient Access and Practice Stabilization Act of 2024" to eliminate the 2.83 percent Medicare cuts and provide physicians with a 1.8 percent payment increase.

- On November 15, an AMA-led letter co-signed by 128 national medical societies and state medical associations was sent in support of Congress expeditiously passing H.R. 10073 before January 1, 2025.

- On November 21, a bipartisan, Senate "Dear Colleague" letter led by Sens. John Boozman, (R-AR) and Peter Welch, (D-VT) with 41 signors was sent to Senate leadership warning the cuts would interfere with the ability of physicians to provide high-quality care supporting efforts to prevent a pending 2.8 percent cut in Medicare physician payments that went into effect on January 1.

- As a result of AMA advocacy efforts, Reps. Greg Murphy, MD (R-NC) and Jimmy Panetta (D-CA), along with a bipartisan group of legislators, introduced in January the Medicare Patient Access and Practice Stabilization Act of 2025 (H.R. 879). This legislation, with more than 120 co-sponsors, would prospectively cancel the 2.83 percent payment cut that went into effect on January 1, while also providing a 2.0 percent payment update, helping to stabilize physician practices and protect patients' access to care.

- In February, an AMA-led sign-on letter was sent to Congressional leadership with 80 medical specialty societies and all 50 state medical societies urging Congress to reverse the 2.83 percent Medicare payment cuts and provide physicians with a meaningful payment increase that reflects ongoing inflationary pressures and to pass H.R. 879, the Medicare Patient Access and Practice Stabilization Act.

- In March, the AMA signed onto a letter with several other physician groups to Congressional leadership calling on Congress to include H.R. 879 in the March continuing resolution appropriations legislation. Unfortunately, H.R. 879 or provisions reversing the 2.83 Medicare cuts were not included in the March appropriations legislation.

Physician Call to Take Action

The AMA will continue to work with Congress to build bipartisan support for a proposal that will put an end to the annual cycle of Medicare cuts that threaten seniors' access to care. Bipartisan support for the aforementioned legislative proposals continues to grow among rank-and-file Members of Congress. However, the need for further advocacy remains to push the relevant Committees and Congressional leadership to make Medicare physician payment reform a top priority.

AMA National Advocacy Conference - February 2025, Washington, DC

The Advocacy team successfully hosted several members of Congress during the AMA National Advocacy Conference (NAC) at the "Fix Medicare Now" Kick Off event, held at the Cannon House Office Building. Notable attendees included Reps. Greg Murphy, MD (R-NC), Jimmy Panetta,

(D-CA), Kimberly Schrier, MD (D-WA), Mariannette Miller-Meeks, MD (R-IA), John Joyce, MD (R-PA), Raul Ruiz, MD (D-CA), Ami Bera, MD (D-CA), and Mike Kennedy, MD (R-UT). These legislators addressed the physician attendees and voiced their support for H.R. 879, emphasizing the urgent need to reverse Medicare payment cuts to protect patient access to care and stabilize physician practices.

The "Fix Medicare Now" Kick Off event was a powerful visual statement of physician unity against the payment cuts, with hundreds of physicians dressed in white coats rallying together. Physicians participated in over 350 visits with House members and senators, urging them to support H.R. 879 and introduce companion legislation in the Senate.

Additionally, physicians at the NAC were equipped with an AMA action kit that focused solely on Medicare physician payment, including compelling facts and figures demonstrating the adverse effects of the Medicare payment cuts, including the statistic that physicians are now being paid 33 percent less for Medicare services (adjusted for inflation) than they were in 2001.

The AMA also took out a full-page advertisement in The Hill, advocating for passage of H.R. 879. The ad included a QR code directing viewers to more information about the legislation.

The AMA NAC further featured presentations by several congressional members at the Grand Hyatt, including Herb Conaway, MD (D-NJ), Robert Onder, MD (R-MO), Raja Krishnamoorthi, (D-IL), Maxine Dexter, MD (D-OR), Kelly Morrison, MD (D-MN), Diana DeGette, (D-CO), and Rich McCormick, MD (R-GA). All these Members expressed the need to stop the Medicare cuts and to reform the payment system.

Our AMA President opened the conference by highlighting the unsustainable financial pressures physicians face and the urgent need to fix the broken Medicare payment system.

Grassroots, Media, and Outreach

The AMA has maintained a continuous drumbeat of grassroots contacts through its Physicians Grassroots Network, Patients Advocacy Network, and its Very Influential Physicians program. Op-eds have been placed in various publications from AMA leaders, as well as from "grasstops" contacts in local newspapers. Digital advertisements are running, targeted specifically to publications read on Capitol Hill, and media releases have been issued to highlight significant developments.

The AMA has a dedicated Medicare payment reform web site, www.FixMedicareNow.org, which includes a range of AMA-developed advocacy resource material, updated payment graphics and a new "Medicare basics" series of papers describing in plain language specific challenges presented by current Medicare payment policies and recommendations for reform.

To support the Medicare legislation cited above, the AMA has been engaged in a major grassroots campaign to engage patients and physicians in our lobbying efforts. The following 2025 statistics result from the Fix Medicare Now campaign and engagement with the Physician Grassroots Network and Patients Action Network.

- 50+ million in earned media and ad impressions,
- 2 million+ media and ad engagements,
- 292,000+ pageviews,

- 276,000+ site users,
- 52,000+ contacts to Congress, and
- A combined 150+ third-party media placements and grass top contacts made in key Congressional districts.

Continuing Advocacy Amidst Legislative Challenges

We do not expect quick action in Congress in the near term to advance legislation to reform the Medicare physician payment system and include permanent MEI payment updates given its potential to cost more than $300 billion over a 10-year period. The Republican majority in the House and Senate is currently focused primarily on adopting a final budget resolution that would allow for "reconciliation" legislation to extend expiring tax cuts and significantly reduce federal spending while bypassing Senate filibuster rules. Achieving consensus on tax, spending, and budgetary matters has always been very challenging in Congress.

Despite these hurdles, the AMA advocacy team has made substantial progress in laying the groundwork for Medicare physician payment reform. This report has highlighted the team's efforts, including:

- Aggressively advocating to replace the 2.83 percent Medicare physician payment cut that took effect on January 1, 2025, with a payment update that better reflects practice costs;
- Pushing for reforms to the budget neutrality process, the MIPS program, and modifications to APMs;
- Strengthening coalitions by partnering with allied professions and the patient community, both of whom are negatively impacted by the broken Medicare payment system;
- Organizing grassroots efforts and ensuring continuous physician engagement through initiatives like the Physicians Grassroots Network; and
- Equipping physicians with advocacy tools and resources to effectively communicate their concerns and solutions to lawmakers.

The journey toward comprehensive Medicare physician payment reform will not be easy, but the AMA remains unwavering in its commitment to this cause. By building on each incremental reform, the AMA is establishing a strong foundation for eventual success.

As physicians across the country continue to share their stories and advocate for reform, there is hope that our united efforts will eventually break through the political and financial barriers that have hindered progress. The AMA will continue to fight tirelessly until a sustainable, fair, and effective Medicare physician payment system is achieved.

CONCLUSION

The AMA will continue to engage the federation and press Congress to develop long-term solutions to the systematic problems with the Medicare physician payment system and preserve patient access to quality care. Despite the aforementioned challenges, the continued engagement of the physician community is crucial. It is vital to continue advocating for reform, engaging with legislators, and highlighting the real-world impacts of the current, broken system on patient care and physician practices. Please follow Advocacy Update, join the Physicians Grassroots Network, visit www.FixMedicareNow often for updated material and alerts, and follow other AMA communications vehicles to stay up to date and engaged on this topic.

REPORT 12 OF THE BOARD OF TRUSTEES (A-25)
Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted

EXECUTIVE SUMMARY

American Medical Association (AMA) Policy G-605.009 entitled, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted," instructs the AMA to establish a task force to, "help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources." AMA Policy D-605.982 entitled, "Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance," requires the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted (Task Force) provide an annual report to the House of Delegates (HOD) at each Annual Meeting. Accordingly, this report highlights the Task Force's activities to date.

In 2024, the Task Force was formed by the AMA Board of Trustees and began work to carry out the directives adopted by the HOD. There are 29 physician members serving on the Task Force, 11 representing national medical specialty societies, 10 representing AMA Councils, seven representing state medical associations, and one representing the AMA Board of Trustees. Staff from the respective medical associations are also invited to support their assigned physician members in Task Force activities.

To date (the date of this writing), the Task Force held virtual meetings in May 2024, December 2024, and January 2025; in-person meetings in July 2024 and February 2025; and an informational session at the 2024 AMA Interim Meeting. The discussions at these meetings have generated ideas for numerous projects, including a web-based resource hub, research and resources on workforce impact, messaging and strategy research, and the development of state law guides.

The July in-person meeting examined legal issues related to abortion care, including abortion-related litigation activity across the country, legal resources for physicians, the Emergency Medical Treatment and Active Labor Act, and shield law protections for abortion care providers. Task Force members discussed each issue and raised items for further action. In accordance with policy and in preparation for a new website that will serve as a resource hub for physicians and others navigating abortion restrictions, the Task Force also reviewed implementation-focused practice and advocacy resources on a range of issues, such as, health disparities, practice management, medical education, privacy, and legal issues, as well as identified resource gaps and options to fill the gaps.

In accordance with the amendment to Policy G-605.009 adopted at the 2023 Interim Meeting, the Task Force formed a subcommittee to focus on payment issues in gender-affirming care for adults and held an in-person meeting in February 2025 focused on these issues. Presentations and discussions covered the legislative and litigation landscape, coding issues, Medicaid, and insurance regulations all pertaining to gender-affirming care for adults and raised solutions to address barriers to care.

The Task Force will host informational sessions at the 2025 Annual and Interim Meetings of the HOD, and in-person meetings in July 2025 and February 2026 to discuss the impact of abortion restrictions on education, training, and workforce and the intersection of abortion care, health equity, and public health, respectively. Virtual calls will be scheduled as needed.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-A-25

Subject: Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

This report provides an update on the activities of the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted (Task Force) in accordance with Policies G-605.009, D-5.998, and D-605.982. (Note: Because of approval deadlines, this report was prepared in February and may not include more recent developments.)

BACKGROUND

American Medical Association (AMA) Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted," was adopted at the 2022 Annual Meeting of the AMA House of Delegates (HOD). Policy G-605.009 instructs that:

1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
    a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
    b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
    c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
    d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
    e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;

f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

Adopted during the AMA 2022 Interim Meeting, Policy D-5.998, "Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era," added a requirement for an annual report of the Task Force. Policy D-5.998(1) instructs that:

1. Our AMA Task Force developed under HOD Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted," will publish a report with annual updates with recommendations including policies, strategies, and resources for physicians who are required by medical judgment and ethical standards of care to act against state and federal laws.

At the AMA 2023 Interim Meeting, the HOD amended Policy G-605.009, adding the creation of an ad hoc committee on payment and reimbursement issues in gender affirming care to the Task Force's directives. Specifically, the amendment instructs that:

1. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care.

At the AMA 2024 Interim Meeting, the HOD amended Policy G-605.009, adding that the Task Force:

h. Work with interested parties to encourage the development of institution-level guidance and protection for physicians practicing in states with restrictions potentially interfering with the patient-physician relationship.

Also at the AMA 2024 Interim Meeting, the HOD adopted Policy D-605.982, "Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance," which states:

1. Our American Medical Association's Task Force, to Preserve the Patient-Physician Relationship, will present annual updates on their findings at AMA Annual Meetings until the objectives have been completed.

DISCUSSION OF TASK FORCE ACTIVITIES

Task Force Formation

As directed by the HOD and in response to the U.S. Supreme Court's landmark 2022 decision in *Dobbs v. Jackson Women's Health Organization*, which held that the U.S. Constitution does not

confer a constitutional right to abortion and returned the authority to regulate abortion to the states and the subsequent enactment of abortion bans in half the states, the AMA Board of Trustees' (Board) formed the Task Force in June of 2023. With the formation of the Task Force and consistent with AMA Policies G-605.009 and D-5.998, as noted above, the Board envisioned that the Task Force would advise the Board of new and emerging threats to the provision of evidenced-based medical care and appropriate and innovative responses to protect access to care and to preserve the role of the patient-physician relationship as a central element in medical decision-making.

In accordance with the specific language of AMA Policies G-605.009 and D-5.998, in September 2023, the Chairs of the Councils on Legislation, Medical Service, Medical Education, Science and Public Health, and Ethics and Judicial Affairs each appointed two Council members to serve on the Task Force. As a result, 10 Council representatives serve on the Task Force. The Immediate Past Chair of the Board, Willie Underwood III, MD, MSc, MPH, appointed Madelyn E. Butler, MD, AMA Trustee, and Maryanne C. Bombaugh, MD, MBA, MSc, member of the Executive Committee for the AMA Council on Legislation, to serve as Co-Chairs of the Task Force.

In addition, and in accordance with the underlying policy, in the spring of 2024, AMA invited 10 state medical associations and 13 national medical specialty societies to appoint a physician representative to serve on the Task Force. The organizations were selected based on their expertise, experience, and response to an AMA survey fielded in November 2022 (which was described in detail in the 2023 report of the Task Force) that asked about priorities and capacity to engage on the issues identified in AMA Policy G-605.009.

Seven state medical associations and 11 national medical specialty societies nominated a physician representative to serve on the Task Force. The participating national medical specialty societies include:

- American Academy of Child and Adolescent Psychiatry
- American Academy of Dermatology
- American Academy of Family Physicians
- American Academy of Pediatrics
- American College of Emergency Physicians
- American College of Obstetricians & Gynecologists
- American College of Physicians
- American Psychiatric Association
- American Society for Reproductive Medicine
- American Society of Clinical Oncology
- The Endocrine Society

The participating state medical associations include:

- California Medical Association
- Idaho Medical Association
- The Maryland State Medical Society (MedChi)
- Massachusetts Medical Society
- Pennsylvania Medical Society
- Texas Medical Association
- Medical Society of Virginia

In total, there are 29 physician members on the Task Force.

Task Force Meetings

As the Task Force formed, staff across the AMA conducted environmental scans and gaps analyses of the issues identified in Policy G-605.009. These landscape analyses identify implementation-focused practice and advocacy resources on issues including health equity, practice management, medical education, privacy, and legal issues and identify potential resource gaps. The landscape analyses were presented to Council representatives monthly, beginning in January of 2024 and concluding in May of 2024. The landscape analyses were used (and will continue to be used) to identify key topics of discussion for meetings of the Task Force and were distributed to all Task Force members prior to the first in-person meeting of the Task Force.

Since its inception in spring of 2024, the Task Force has held three virtual meetings, two in-person meetings, and one informational session. The virtual meetings were held in May 2024, December 2024, and January 2025. In-person meetings were held in July 2024 and February 2025. The informational session was held at the AMA 2024 Interim Meeting of the HOD in November 2024.

The Task Force held a virtual kick-off meeting on May 2024, in which the Task Force Co-Chairs laid out the Task Force's scope, deliverables, and calendar for upcoming meetings. In December 2024, the Task Force held a meeting to discuss the remarks given at the informational session at the 2024 Interim Meeting of the HOD and discuss ongoing Task Force projects. Then in January 2025, the Task Force met to review research conducted into strategy and messaging. (Note: Additional details about the research discussed in the January meeting is provided later in this report.) The Task Force will continue to schedule virtual meetings as necessary.

The Task Force held its first in-person meeting in July 2024 in Chicago. The in-person meeting focused on legal issues in abortion care and featured a range of speakers and presenters on topics all relating to legal issues in abortion care including, abortion-related litigation activity across the country, legal resources for physicians, the Emergency Medical Treatment and Active Labor Act (EMTALA), and shield law protections for abortion care providers. Following each presentation, Task Force members asked questions and discussed issues and concerns. During a working lunch, Task Force members were asked to strategize and identify resource gaps and potential deliverables for the Task Force regarding advocacy, health equity, medical education and workforce, legal issues, practice issues, and public health. The exercise generated numerous ideas for action. At the conclusion of the day, as directed by the Board and in accordance with Policies G-605.009 and D-5.998, which instruct the Task Force to identify and create implementation-focused practice and advocacy resources, the Task Force discussed existing resources and limitations of those resources, and identified gaps where resources need to be developed.

Following its July meeting, the Task Force hosted an informational session at the AMA's 2024 Interim Meeting to engage with AMA Delegates, Alternate Delegates, and representatives from the AMA Sections. This session was an opportunity to elevate important voices that are not members of the Task Force. At the session, the Task Force co-chairs presented on the Task Force's directives, scope, and activities in 2024. Following the presentation, selected representatives from the AMA's Sections were invited to provide remarks about their experience with laws restricting or banning reproductive health care. The representatives' remarks focused on state laws' impacts on patient care, career and family decisions, educational opportunities, fears for patient outcomes, and, overall, increased physician stress and anxiety. The selected speakers from the AMA Sections represented:

- Women Physicians Section
- Medical Student Section

- Resident and Fellow Section
- Young Physicians Section
- Minority Affairs Section
- LGBTQ+ Section
- Private Practice Physician Section
- Organized Medicine Staff Section
- Academic Physicians Section
- International Medical Graduates Section
- Senior Physician Section

After the representatives from AMA's Sections spoke, other interested parties were invited to ask questions or provide remarks on issues being considered by the Task Force that had not been addressed by previous speakers. These speakers focused their remarks on requests for more communication about the Task Force's work and opportunities for future engagement with the Task Force. To foster continued communication with AMA Delegates, Alternate Delegates, representatives from AMA Sections, and other interested parties, the Task Force plans to host informational sessions at the 2025 Annual and Interim Meetings of the HOD. The Board encourages all interested members to participate in the informational sessions in June and November. In addition to the informational sessions, AMA staff expect to conduct outreach with Sections and specialty groups in the lead up to the HOD meetings and will meet with them at their request.

In accordance with the amendment to Policy G-605.009 adopted at the AMA 2023 Interim Meeting, in summer of 2024 the Task Force formed a subcommittee to focus on payment and reimbursement issues in gender-affirming care for adults. Members of the subcommittee represent the following nine organizations:

- AMA Board of Trustees
- AMA Council on Legislation
- AMA Council on Ethical and Judicial Affairs
- American Academy of Child and Adolescent Psychiatry
- American Academy of Dermatology
- American Psychiatric Association
- American Society for Reproductive Medicine
- The Endocrine Society
- Idaho Medical Association

AMA staff conducted a landscape analysis on payment and reimbursement issues that hinder access to gender-affirming care in adults, which, like the landscape analyses on abortion, identified existing resources and gaps in those resources and helped inform discussion during in-person meetings. The subcommittee met in August 2024 to identify issues in payment and reimbursement for gender-affirming care in adults and plan the topics, structure, and agenda for the Task Force's meeting in February 2025 dedicated to these issues.

One of the issues identified by the subcommittee was challenges arising from CPT® coding for gender-affirming care in adults. As such, the subcommittee collaborated with the LGBTQ+ Section to field a survey to better understand these coding challenges. The input from this survey aided the Task Force's discussion of coding issues during its February 2025 meeting.

As directed by AMA Policy, the Task Force met in February of 2025 in Chicago to "identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to

address these barriers to care." The meeting featured a range of speakers on topics all involving payment and reimbursement limitations and administrative challenges that impede access to gender-affirming care for adults, including challenges stemming from outdated or inadequate billing codes, inadequate provider networks, low reimbursement rates, discriminatory laws and policies, and state and federal efforts restrict or criminalize access to gender-affirming care. Speakers included physicians who provide gender-affirming care to adult patients, attorneys, coding experts, a state insurance regulator, and a Medicaid expert. The meeting was structured to allow ample time after each presentation for Task Force members to ask questions of the presenters and discuss barriers to care with one another. These discussions focused on the current landscape and highlighted potential pain points for physicians and patients. Much of the discussion also centered around recent federal executive orders to prohibit federal funding of services for minors and the impact those policies could have on care for other populations. In the last session of the meeting, as directed by the Board and consistent with Policy G-605.009, which instructs the Task Force to recommend solutions to these barriers to care, the Task Force members discussed opportunities and strategies for improving access to care and alleviating administrative burden, including working towards updating CPT® codes, continuing to advocate against criminalization, and supporting physicians who care for transgender and gender diverse patients. This discussion was informed by Task Force member's perspectives as clinicians, the speaker's presentations, and discussions throughout the meeting. Work related to the payment and coding issues raised in this meeting and by the Task Force subcommittee, as it relates to the adult patient population, is ongoing.

Ongoing Projects of the Task Force

As a result of reproductive care resource gaps identified by the Task Force during its July 2024 meeting, AMA, at the direction of the Board, has undertaken a series of projects to fill those gaps, including the development of a resource hub, strategy and message development, research and resources on workforce impact, and development of state law guides.

First, AMA is developing a website to serve as a resource hub for physicians navigating abortion restrictions. The website will exist separately from the AMA's website and will be available to the public. The website will house resources created and developed by the Task Force, as well as resources created and provided by Federation partners and other external organizations. At this time, AMA staff has secured the funding for the website's creation and contracted with a vendor, and creation of the website is in process. The Task Force will inform the HOD when the website is available later this year.

Second, to further refine AMA's advocacy strategy and messaging around abortion restrictions, AMA staff collaborated with a research consulting firm to conduct qualitative research using surveys, in-depth interviews, and focus groups. The research helped explain how different messages, language, and tone resonate across key constituent audiences and build a more compelling narrative for reproductive health advocacy grounded in a strategic messaging foundation. The research provided insight for Task Force members and their organizations on physicians' and the public's perception of the current reproductive health care landscape and will inform strategy for the Task Force going forward. The Task Force met in January 2025 to review the research findings and discuss their implication for Task Force messaging strategy.

To better understand how abortion bans and restrictions impact the physician workforce, AMA staff has initiated a research project examining the impact of abortion restrictions on the physician workforce and where physicians choose to practice. The research and mapping project is scheduled to be completed in spring 2025.

Because of the Task Force's discussions surrounding the need for legal resources for physicians, the AMA has supported the Abortion Defense Network (ADN) and their network of attorneys and law firms that provide legal advice and representation to physicians navigating the post-*Roe* legal landscape. Their resources include 16 in-depth "Know Your State's Abortion Laws" guides for medical professionals, which aim to provide clarification on what conduct is permitted and what the law requires in states with abortion restrictions. The guides cover state laws and professional guidelines on numerous facets of reproductive health care, including medication abortion, contraception, and obligations under EMTALA. In addition to their written legal resources, ADN provides physicians with personalized legal advice and assistance through their hotline. All of these resources are available to physicians and other health care providers at www.abortiondefensenetwork.org, and the AMA is exploring opportunities to support creation of additional ADN resources and further publicize existing resources.

Prompted by the discussions at the Task Force's February meeting, AMA staff is exploring potential next steps related to payment and reimbursement in gender-affirming care in adults, including reviewing and updating existing resources, following up on coding issues, continuing collaboration with state medical associations where appropriate, and supporting physician wellness for physicians navigating challenges in providing gender-affirming care. (Note: Because of approval deadlines, this report was prepared in February 2025 and may not include more recent developments about the Task Force's activities. The Board urges all interested members to participate in the informational session at the 2025 Annual Meeting.)

In addition to these activities, due to the timeliness and prioritization of the issues, the AMA State Advocacy Summit held in January 2025 included a panel of leading staff from state attorneys general offices across the country to highlight ongoing work to protect and promote reproductive health care. The panelists discussed shield laws, programs to link physicians with legal support, and ways state attorneys general can work directly with health care professionals to resolve complaints and mitigate barriers to care. The AMA State Advocacy Summit is held annually to elevate state legislative and regulatory issues and strategies in advance of the upcoming state legislative sessions. Attendees include physician leadership from the AMA, national, state, and specialty medical associations, including the members of the Board, Council members, delegates, and alternate delegates to the HOD, as well executive, health policy, and government affairs staff from organized medicine.

The Task Force continues to consider additional deliverables to support physicians navigating state laws restricting or banning abortion and experiencing challenges related to payment and reimbursement for gender-affirming care. In particular, in accordance with AMA policy passed at the 2024 Interim Meeting, AMA is continuing to meet and collaborate with American College of Obstetricians and Gynecologists on a project to facilitate institutional guidance in states with abortion restrictions. The Task Force is also receiving quarterly updates on litigation activity from the AMA Office of the General Counsel. Additionally, throughout the Spring of 2025, the co-chairs of the Task Force have reached out to and are meeting with various AMA Sections in an effort to continue dialogue, hear concerns, and take back recommendations to the larger Task Force.

Upcoming Meetings of the Task Force

The Task Force will host an informational session at the AMA 2025 Annual Meeting to continue to engage AMA Delegates, Alternate Delegates, and representatives from AMA Sections. This session is an opportunity to elevate important voices that are not members of the Task Force. Attendees of the informational session will hear about the activities of the Task Force and are

invited to share their perspective on the issues being considered by the Task Force. The Board encourages all interested members to participate in this informational session.

The Task Force will also host an in-person meeting in July 2025 to discuss the impact of abortion restrictions on education, training, and workforce; an informational session at the 2025 Interim Meeting of the HOD; and an in-person meeting in February 2026 to discuss the intersection of abortion care, health equity, and public health.

CONCLUSION

The Board, through the Task Force, will continue to implement Policies G-605.009 and D-5.998, monitor and prepare for new and emerging threats to the provision of evidenced-based medical care, and work to protect access to care and preserve the role of the patient-physician relationship as a central element in medical decision-making.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-A-25

Subject: Physician Assistants and Nurse Practitioner Movement Between Specialties

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

INTRODUCTION

At the 2024 Annual Meeting, Board of Trustees Report 14 was adopted as amended creating Policy H-35.960, "Physician Assistant and Nurse Practitioner Movement Between Specialties" and the remainder of the report was filed.

1. Our American Medical Association encourages hospitals and other health care entities employing nurse practitioners and physician assistants to ensure that the practitioner's certification aligns with the specialty in which they will practice.
2. Our AMA will continue educating policymakers and lawmakers on the education, training, and certification of nurse practitioners and physician assistants, including the concept of specialty switching.
3. Our AMA will continue to support research into the cost and quality of primary care delivered by nurse practitioners and physician assistants.
4. Our AMA will continue to support research into the distribution and impact of nurse practitioners and physician assistants on primary care in underserved areas.
5. Our AMA will continue to support the expansion of access to physicians in under-resourced areas.

Two additional recommendations from this report were referred for further study:

1. That the American Medical Association (AMA) support workforce research, including surveys by state medical and nursing boards, that specifically focus on gathering information on nurse practitioners and physician assistants practicing in specialty care, their certification(s), alignment of their certification to their specialty, and whether they have switched specialties during their career. (New HOD Policy)
2. That the AMA support research that evaluates the impact of specialty switching by nurse practitioners and physician assistants on the cost and quality of patient care. (New HOD Policy)

This Board of Trustees Informational Report summarizes data on this topic to date and discusses our AMA's ongoing research to fill the remaining gaps in the data. This research will inform our AMA's next steps and will also address the referred items as more information is obtained.

BACKGROUND

Existing data from the American Association of Nurse Practitioners (AANP), American Association of Physician Assistants (AAPA), and National Commission on Certification of

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Physician Assistants (NCCPA) provide insight into which specialties nurse practitioners and physician assistants are practicing, as well as nurse practitioner and physician assistant certifications, including optional specialty certifications. The AAPA and NCCPA data also provide details on specialty switching by physician assistants.

Nurse Practitioners

The AANP, the largest professional organization and leading advocate for nurse practitioners, conducts an annual workforce survey of nurse practitioners practicing in the United States. Per AANP, 385,000 nurse practitioners are currently licensed in the United States. The AANP nurse practitioner workforce survey was sent to all AANP members and nonmembers in the AANP National NP database, excluding individuals without a valid email address, individuals not currently practicing in the United States, and individuals who opted out of receiving AANP surveys. The final sampling group for the information published in the *2024 Nurse Practitioner Practice Report (Practice Report)* and included in this report represents a sample of 10,275 nurse practitioners. The *Practice Report* includes relevant information on the top clinical areas of focus in which nurse practitioners practice, nurse practitioner certification, and optional specialty certifications that are held by nurse practitioners.

The *Practice Report* shares the top 10 clinical areas in which nurse practitioners practice. These clinical focus areas presumably align with the specialty in which the individual is practicing; however, the type of setting in which the nurse practitioner practices may vary. Based on this information, 36.8 percent of nurse practitioners are practicing in a primary care specialty, which the *Practice Report* defines as family practice, primary care, internal medicine, geriatrics, and OBGYN women's health.

Table 1. Top 10 clinical focus areas[1]	(percent)
Family practice	16.9
Primary care	9.4
Psychiatry/mental health	5.9
Urgent care	5.8
Cardiology	4.2
Internal medicine	4.2
Geriatrics	3.3
OBGYN women's health	3.0
Oncology/hematology	2.7
Pediatrics/general	2.6

The *Practice Report* also provides information on nurse practitioners by population certification area; the certification obtained following graduation and typically required for state licensure as a nurse practitioner. Population certifications may be obtained from a variety of certifying bodies, such as the American Academy of Nurse Practitioner Certification Board or the American Nurses Credentialing Center. Each certifying body offers their own certification and administers their own examination which are generally aligned with the population foci of the nurse practitioner's training. Certification is typically required for state licensure as a nurse practitioner. Most nurse practitioners are certified as Family Nurse Practitioners (FNP-C or FNP-BC). As some nurse practitioners hold multiple certifications the sum of all percentages in the table below is greater than 100 percent.

Table 2. Nurse Practitioners by population certification area[2]	(percent)
Family	68.7
Adult-gerontology primary care	7.9
Psychiatric/mental health	7.1
Adult	7.0
Adult-gerontology acute care	6.1
Acute care	3.9
Pediatric-primary care	2.9
Women's health	2.0
Gerontology	0.9
Neonatal	0.9
Pediatric-Acute Care	0.7
No certification	0.6

Finally, the *Practice Report* shares the percentage of nurse practitioners with additional specialty practice certifications. Nurse practitioners may pursue optional certification(s) in various specialties/subspecialties after initial certification in their role and population focus, as shown in the previous table. An array of certifying boards issue "specialty" certifications for nurse practitioners—typically these certifications are based on hours of practice experience in a specialty and passage of an exam. Customarily, the certifying boards are specific to nursing and specific to a single specialty. Of note, 92.8 percent of nurse practitioners obtain no optional specialty certification.

Table 3. Nurse practitioners with additional specialty practice certifications[3]	(percent)
Wound care	1.3
Hospice and palliative care	1.3
Emergency	1.1
Oncology	0.9
Diabetes management-advanced	0.7
Addictions advanced practice	0.7
Pediatric-primary care mental health	0.4
Occupational health	0.3
Dermatology	0.3
Orthopaedics	0.3
Nephrology	0.2
Genetics advanced nurse	0.1
School health	0.1
No advanced certifications	92.8

Physician Assistants

The NCCPA, which is the only certifying organization for physician assistants in the United States, conducts similar workforce surveys of physician assistants, including the *Statistical Profile of Board Certified Physician Assistants (General Report)*, and *Statistical Profile of Board Certified Physician Assistants by Specialty (Specialty Report)*.[4,5] The latest NCCPA reports are based on data collected from all physician assistants who are board certified as of December 31, 2023 and have made updates to their profile maintained by NCCPA. Of these physician assistants, 149,909 provided responses for at least a portion of their profile which informed the reports. These reports

provide data on physician assistants by their principal clinical specialty, relevant specialty certifications, as well as specialty switching.

The *Specialty Report* includes detailed data on the number of physician assistants practicing in 68 specialties. According to the *General Report*, 75.3 percent of physician assistants practice in one of the top 10 specialties, as follows:

Table 4. Physician Assistants by specialty[6]	Number (percent)
Family medicine/general practice	20,940 (16.5)
Other	14,208 (11.2)
Emergency medicine	13,727 (10.8)
Surgery – orthopaedic	13,534 (10.7)
Dermatology	5,449 (4.3)
Internal medicine/general practice	5,073 (4)
Hospital medicine (hospitalist)	4,548 (3.6)
Surgery – general	3,895 (3.1)
Internal medicine – cardiology	3,705 (2.9)
Surgery - cardiothoracic	3,056 (2.4)

The *General Report* analyzes changes in physician assistants' primary practice areas between 2019 and 2023. For example, the *General Report* shows that 18.7 percent of physician assistants practiced in a surgical specialty (e.g., orthopaedic surgery, cardiovascular surgery, and neurosurgery) in 2023.[7] This is the largest practice area for physician assistants and has remained the same since 2019. By contrast, the number of physician assistants practicing in family medicine/general practice has declined from 18.6 percent in 2019 to 16.5 percent in 2023. The number of physician assistants in emergency medicine has also declined slightly from 12.8 percent in 2019 to 10.8 percent in 2023.

The *Specialty Report* includes information on the percentage of board-certified physician assistants who completed a postgraduate program (fellowship or residency) in a specialty, including primary care. The five highest specialties in which physician assistants completed a postgraduate program are: critical care medicine (16.1 percent), emergency medicine (10.4 percent), dermatology (9.0 percent), cardiothoracic and vascular surgery (8.4 percent), and psychiatry (8.1 percent).[8] The *Specialty Report* also highlights the relationship between the postgraduate program and the specialty in which the physician assistant is currently practicing, as shown in the table below. The likelihood of physician assistants practicing in the same specialty in which they completed a postgraduate program varies considerably. For example, of the physician assistants who completed a postgraduate program in emergency medicine, 85.7 percent are currently practicing in emergency medicine, while only 11.1 percent of physician assistants who completed a post graduate program in gerontology are currently practicing in gerontology.[9]

Table 5[10]		
Physician Assistants postgraduate program by specialty practice area	Complete postgraduate program (residency or fellowship) (percent)	Practice area of postgraduate program same as current principal practice area (percent)
Primary care	3.3	47.6
Cardiology	2.9	27.4
Cardiothoracic and vascular surgery	8.4	33.7
Critical care medicine	16.1	69.9
Dermatology	9.0	84.1

Emergency medicine	10.4	85.7
Family medicine/general practice	3.4	44.7
Gastroenterology	2.8	33.3
General surgery	6.7	72.3
Geriatrics	2.9	11.1
Hospital medicine	5.0	65.9
Internal medicine-general practice	2.9	27.6
Neurology	3.7	54.0
Neurosurgery	4.3	27.0
Obstetrics and gynecology	4.1	73.0
Occupational medicine	5.9	21.3
Oncology	3.9	53.1
Orthopaedic surgery	5.0	68.5
Otolaryngology	4.3	40.7
Pain medicine	3.5	15.4
Pediatrics-general	2.9	47.7
Physical medicine/rehabilitation	1.8	23.1
Plastic surgery	6.6	13.0
Psychiatry	8.1	74.4
Urology	3.8	31.4

The *Specialty Report* also elucidates on specialty switching. As part of the data gathering by NCCPA, physician assistants were asked "how many times they changed specialties throughout their career thus far."[11] The rate of those who have not changed specialties varied from a high of 60.3 percent for physician assistants practicing in orthopaedic surgery to a low of 19.2 percent for those practicing in occupational medicine.[12] A separate report by AAPA, *PAs and Specialty Change*, provides some additional data on the preparation, motivation, and timing of specialty switching by physician assistants.[13] Per this report, 20 percent of physician assistants have changed their specialty at some point in their career.[14] Overall physician assistants with less than five years of experience were most likely to change specialties.[15] The report also found that physician assistants who switched specialties once were more likely to switch multiple times. In terms of preparation by physician assistants prior to switching specialties, 79.9 percent stated they prepared through on-the-job training while 77.3 percent identified self-study.[16] Finally, the report examined the type of support physician assistants receive after they have switched specialties, finding that 88 percent of physician assistants who have switched specialties in 2021 received onboarding support for six months or less.[17]

Table 6. Physician Assistants Specialty Switching[18]

Specialty	Have not changed specialties (percent)	1 time (percent)	2 to 3 times (percent)	4 to 5 times (percent)	6 to 10 times (percent)	Over 10 times (percent)
Primary care	54.0	19.4	20.0	5.1	1.4	0.1
Cardiology	46.3	26.4	22.2	4.0	1.1	<0.1
Cardiothoracic and vascular surgery	52.1	23.4	19.8	3.9	0.8	0.1
Critical care medicine	47.1	24.3	22.6	4.9	1.0	0.1
Dermatology	50.2	26.1	19.2	3.7	0.9	<0.1
Emergency medicine	52.9	22.6	19.6	3.9	1.0	0.1

Family medicine/general practice	56.3	18.4	19.2	4.8	1.3	0.1
Gastroenterology	41.9	27.4	23.8	5.2	1.7	0.1
General surgery	45.8	23.1	23.4	6.0	1.7	0.1
Geriatrics	32.0	22.7	30.2	11.4	3.4	0.4
Hospital medicine	52.2	19.2	21.5	5.7	1.3	<0.1
Internal medicine-general practice	45.3	22.2	23.6	6.9	2.0	0.1
Neurology	42.2	25.5	23.4	7.3	1.4	0.2
Neurosurgery	50.5	20.7	23.4	4.2	1.2	0.0
Obstetrics and gynecology	50.0	23.9	20.0	5.2	0.9	0.1
Occupational medicine	19.2	22.1	36.6	17.0	4.8	0.2
Oncology	44.8	25.6	21.8	6.7	1.1	0.0
Orthopaedic surgery	60.3	19.7	16.2	3.2	0.6	<0.1
Otolaryngology	42.4	27.4	24.0	4.5	1.8	0.0
Pain medicine	29.8	26.9	29.7	10.9	2.7	0.1
Pediatrics-general	52.5	22.6	20.4	3.8	0.6	0.1
Physical medicine/rehabilitation	31.6	23.1	32.9	9.5	2.9	0.0
Plastic surgery	33.9	29.5	27.9	7.4	1.4	0.0
Psychiatry	45.6	23.8	21.1	7.2	2.2	0.1
Urology	46.0	22.0	22.8	7.4	1.7	0.0

DISCUSSION

The AANP, NCCPA, and AAPA reports provide some useful data on nurse practitioner and physician assistant certifications and the specialties in which they practice. For example, the data show that while 68.7 percent of nurse practitioners are certified in primary care, only 36.8 percent practice in primary care. Additionally, a shockingly low number of nurse practitioners receive any optional advanced certifications in specialties, suggesting that most nurse practitioners practicing in specialties have no training in that specialty. Similarly, the NCCPA data shows that only a small percentage of physician assistants receive any specialty specific postgraduate training, yet the majority of physician assistants practice in specialties and over half switch specialties at least once during their career. This also suggests that physician assistants practicing in specialties often have no formal training in that specialty.

CONCLUSION

While the AANP, NCCPA, and AAPA reports provide some useful data, gaps in data remain necessitating additional research to provide a full response to the first two resolves of BOT 14-A-24. To fill these gaps, our AMA has engaged with a trusted vendor to conduct additional research. This research is currently underway and will be shared with the HOD in a subsequent Report at I-25.

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[13] American Academy of Physician Assistants. *PAs and Specialty Change: Preparation, Motivation, and Scope*. 2024.
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REPORT 25 OF THE BOARD OF TRUSTEES (A-25)
AMA Public Health Strategy Update

EXECUTIVE SUMMARY

BACKGROUND: Policy D-440.922, "Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems," adopted by House of Delegates at I-21 directed our American Medical Association (AMA) to develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress. Policy D-145.992, "Further Action to Respond to the Gun Violence Public Health Crisis" has called for the AMA to report annually to the House of Delegates on our AMA's efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence. This informational report is an effort to provide regular updates on the status of the AMA's mission critical public health work to the HOD.

DISCUSSION

In recent months there have been a number of proposed policies that threaten to weaken our public health infrastructure, undermine science and evidence-based practice, and weaken protections for underserved and marginalized communities, which will result in increasing health inequities. The intent of this report is not to outline those proposed policies and their potential impacts, but rather to share the work that the AMA has done to advance our current public health priorities, which are as follows:

1. Promote evidence-based clinical and community preventive services.
2. Respond to public health crises impacting physicians, patients, and the public. This includes addressing the threat of climate change, preventing firearm injuries and deaths, being prepared for emerging and remerging infectious disease threats, and ending the nation's drug overdose epidemic.
3. Strengthen the health system through improved collaboration between medicine and public health.
4. Combat the spread of misinformation and disinformation.

CONCLUSION

The AMA continues to advance its mission, to promote the art and science of medicine and the betterment of public health. The highlighted accomplishments in this report capture the work accomplished from March of 2024 – March of 2025 related to the AMA's current public health priorities. In the current environment, AMA may need to increase efforts in these areas to maintain the organization as a trusted source of information for physicians and the public and to help protect the nation's public health infrastructure.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 25-A-25

Subject: AMA Public Health Strategy Update

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

BACKGROUND

Policy D-440.922, "Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems" adopted by House of Delegates (HOD) at I-21 directed our American Medical Association (AMA) to:

> develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress.

Policy D-145.992, "Further Action to Respond to the Gun Violence Public Health Crisis" has also called for the AMA to report annually to the House of Delegates on our AMA's efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence.

In recent months there have been a number of concerning policies that threaten to weaken our public health infrastructure, undermine science and evidence-based practice, and weaken protections for underserved and marginalized communities, which will result in increasing health inequities. This informational report is an effort to provide regular updates on the status of the AMA's mission critical public health work to the HOD.

DISCUSSION

What is Public Health?

Since its founding in 1847, the AMA's mission has been "to promote the art and science of medicine and the betterment of public health." According to the Centers for Disease Control and Prevention (CDC), public health is "the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals."[1] Public health promotes and protects the health of people and the communities where they live, learn, work and play.[2] Public health practice is a different field than clinical medicine with different motivating values, responsibilities, and goals.[3] While a doctor treats people who are sick, those working in public health try to prevent people from getting sick or injured in the first place. A public health professional's duty is to the community rather than an individual patient.

Connection with Health Equity

It is important to acknowledge that health equity is a central concept in public health and is essential to improving the health of populations. The AMA's health equity strategy recognizes that

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structural and social drivers of health inequities shape a person's and community's capacity to make healthy choices, noting that downstream opportunities provided by the health care system and individual-level factors are estimated to only contribute 20 percent to an individual's overall health and well-being, while upstream opportunities of public health and its structural and social drivers account for 80 percent of impact on health outcomes.[4] The AMA develops an annual report on health equity activities. Progress towards the health equity strategy is reported in the Board of Trustees (BOT) annual health equity report. (See BOT Report 10, "Center for Health Equity Annual Report.")

AMA PUBLIC HEALTH AND PREVENTION ACTIVITIES

1. Promote evidence-based clinical and community preventive services.

A. Serve as a liaison to the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Community Preventive Services Task Force (CPSTF) and support the dissemination of recommendations to physicians.

In addition to representing the AMA at meetings of these committees and task forces over the last year, the AMA continues to disseminate information on evidence-based preventive services. Examples include:

USPSTF

- The Journal of the American Medical Association (JAMA) continues to publish the recommendations of the USPSTF. These recommendations are also featured in the AMA *Morning Rounds* newsletter.
- The AMA submitted comments on the USPSTF recommendation related to food insecurity.
- The AMA has submitted amicus briefs in the case of *Braidwood Management v. Becerra*, a case that challenges the Affordable Care Act's requirement for private health plans to provide people with access to preventive services. The U.S. Supreme Court is scheduled to hear oral arguments in April of 2025, on whether the structure of the USPSTF violates the Constitution's appointments clause and in declining to sever the statutory provision that it found to unduly insulate the task force from the Health & Human Services (HHS) secretary's supervision.

ACIP

- The AMA's ACIP Liaison joined the AMA Update podcast throughout the year to provide updates to physicians.
    - The March 8, 2024, episode covered the latest ACIP COVID vaccine recommendations, which include an additional dose of the updated vaccine for those 65 and reviewed CDC's new isolation guidelines after testing positive for COVID.
    - The July 8, 2024, episode covered recommendations for RSV, COVID-19, and pneumococcal vaccines as well as updated information on flu vaccines.
    - The September 4, 2024, episode covered the new COVID vaccine coming out in Fall 2024.
    - The November 6, 2024, episode covered what physicians need to know about the new recommendations from CDC's ACIP for COVID vaccine frequency for seniors as well as updates on the RSV vaccine.

- The February 26-28, 2025, ACIP meeting was postponed. The AMA joined a letter to the Secretary of HHS, the Interim Director of the Centers for Disease Control and Prevention (CDC), and U.S. Senator Bill Cassidy calling for the rescheduling of this critical meeting and the reconciling of the absent portal for public remarks to ensure Americans receive the information needed to protect themselves against vaccine-preventable illnesses, confirming immunization's importance in the mission to make America healthier.

B. Help prevent cardiovascular disease (CVD) by addressing major risk factors (AMA Strategic Priority led by the Improving Health Outcomes team)

The AMA is committed to improving the health of the nation and reducing the burden of chronic diseases. Our primary focus is preventing cardiovascular disease (CVD), the leading cause of death in the U.S., accounting for one in four deaths among adults.[5] Two major risk factors for CVD are hypertension and type 2 diabetes.

- To prevent CVD and address related health inequities, the AMA is developing and disseminating CVD prevention solutions in collaboration with health care and public health leaders. These solutions educate clinical care teams and patients, guide health care organizations (HCOs) in clinical quality improvement and promote policy changes to remove barriers to care. The AMA disseminates these solutions through strategic alliances with various organizations including the CDC, the American Heart Association (AHA), and West Side United in Chicago.
- The AMA MAP ™ Hypertension clinical quality improvement program was designed to improve hypertension management and control. The free program has demonstrated effectiveness in a variety of health care settings from large health care organizations (HCO) to community health centers. Participating HCOs are provided with clinical based practice facilitation and a personalized dashboard with performance metrics.[6] The AMA MAP ™ set of solutions is expanding to include management for other cardiovascular disease risk factors, including cholesterol, prediabetes, and post-partum hypertension.
- In 2024, the AMA was awarded a multi-year CDC grant to implement three projects aimed at improving the quality of cardiovascular disease-related preventive care in Community Health Centers/Federally Qualified Health Centers. The funding will allow AMA to scale its existing quality improvement program. The goal is to help 500,000 patients achieve blood pressure control.
- AMA MAP™ houses a suite of tools and resources designed to help organizations build and integrate diabetes prevention strategies into their organizations. AMA has worked with more than 80 health care organizations across the country to increase identification and management of patients with prediabetes. In 2024, the AMA submitted one of its prediabetes quality measures to the Centers for Medicare & Medicaid Services (CMS) for consideration for inclusion in the Merit-based Incentive Payment System (MIPS) Program. In January 2025, the measure, Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes, was recommended for adoption and the approval vote was unanimous.
- Additionally, the AMA, in collaboration with the AHA, developed Target: BP™, which recognizes organizations that have achieved milestones in their commitments to improving blood pressure control. In 2024, Target: BP ™ Achievement Awards recognized 1,812 HCOs for efforts to prioritize control of their patients' blood pressure (BP) through attested evidence-based blood pressure measurement practices, like using the US Validated Blood Pressure Device Listing (VDL™). Participants came from 47 states or U.S. territories and served about 34 million patients, including 9 million with hypertension. Nearly half of

participating organizations are nonprofit health centers that receive federal funding to reach medically underserved populations, known as federally qualified health centers, reflecting the associations' shared commitment to improving health equity.

- One in three adults enrolled in Medicaid have hypertension and since 2022, the AMA has worked to increase Medicaid coverage to ensure that beneficiaries receive home blood pressure devices and have their condition monitored by physician-led care teams. As of October 2024, 22 states have coverage for self-measured blood pressure clinical services and home BP devices.
- Another cardiovascular disease risk factor is obesity, which is linked to cardiovascular disease mortality, independent of other risk factors. The AMA is collaborating with Federation members, including the American College of Physicians and the Obesity Medicine Association, to explore opportunities for improving access to evidence-based obesity treatments.

C. Screening and Reducing Risk for Dementia

Under the Navigating Brain Health and Dementia Project, the AMA reviewed available materials on the AMA Ed Hub addressing Brain Health and Dementia to determine potential gaps, developed three CME webinars, seven short videos, and one podcast, and continued collaboration and relationship building with the Alzheimer's Association and other partners. The webinars were developed in collaboration with CDC and the Alzheimer's Association, and focused on (1) the Screening and Diagnosis of Alzheimer's Disease and Related Dementias (ADRD), (2) Reducing Risk of ADRD, and (3) Treatment of ADRD. The seven YouTube short videos addressed the growing impact of the disease, key considerations around screening, addressing risk factors, as well as addressing cardiovascular risk factors, blood pressure control, and loneliness. For the webinars, there have been a total of 4,541 views; for the short videos, there have been a total of 7,962 views on YouTube.

With recently awarded funding from the CDC, this important work will continue through the convening of a workgroup comprised of clinicians and/or researchers with expertise in ADRD research, clinical care, and/or education. The workgroup will inform the design of a needs assessment to better understand the current knowledge, daily practices, challenges, and training needs of physicians and other health care professionals in the prevention, screening, diagnosis, and treatment of ADRD. The workgroup and needs assessment findings will inform the development of education opportunities, training, communication strategies, and resources for health care professionals involved in the assessment and management of ADRD.

D. Collaborate with CDC to improve the implementation of routine screening for HIV, STI, Viral Hepatitis and latent tuberculosis (LTBI).

Through funding from the CDC, the AMA has been engaged in a project entitled, "Promoting HIV, Viral Hepatitis, STDs and LTBI Screening in Hospitals, Health Systems and Other Healthcare Settings." The scope of this project includes developing, piloting and launching a toolkit that outlines ways to increase routine screening for HIV, STIs, viral hepatitis and LTBI. The toolkit contains two different sets of strategies – one targeted to community health centers (CHCs) and a second to emergency departments (EDs). The toolkit was launched to the public with a press release on March 6, 2024.[7]

- In conjunction with the launch of the toolkit, we hosted a three-part webinar series that highlights key strategies to improve routine screening including opt-out testing, care team training and forming a strong referral network.[8] Since its launch, the toolkit has had over

22,000 pageviews, over 18,000 views of the launch series webinars and over 220 downloads of the PDF toolkit (as of January 31, 2025).

- In April 2024, we concluded a pilot of the routine screening toolkit with four EDs. The ED pilot cohort included: Harris Health Ben Taub Hospital (staffed by Baylor College of Medicine physicians and residents), Mayo Clinic, University of Colorado and Valleywise Health. Each pilot site selected 2-3 of the quality improvement strategies outlined in the toolkit to implement in their emergency department to provide tangible feedback to the AMA on the effectiveness of these strategies and ease of implementation in addition to providing input overall on the toolkit itself.
- The pilot activities with the EDs, as well as our pilot in 2023 with CHCs, demonstrated that implementing programs to screen, diagnose, and connect patients to care for multiple infections is possible in EDs and CHCs. The AMA toolkit can help organizations implement screening programs successfully. Sites with leadership support, strong community ties, and efficient workflows succeeded in implementing the AMA toolkit, while technical and resource limitations posed implementation challenges.
- In September 2024, the AMA was awarded additional funding from the CDC to continue to increase awareness of and engagement with the HIV, STIs, Viral Hepatitis and LTBI Routine Screening Toolkit by hosting a Community of Practice to convene CHC and ED facilities interested in implementing strategies outlined in the toolkit to increase screening.
- The AMA has identified a group of approximately 20 CHCs and EDs from across the country to participate in this 6-month Community of Practice which is planned to take place in 2025. The AMA has also identified a group of national organizations who serve CHCs and EDs who are committed to helping promote the routine screening toolkit to their members during 2025.
- In addition to the work on the routine screening toolkit, the AMA has also received funding from the CDC to explore barriers in accessing preventive medications including pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for HIV and doxycycline post-exposure prophylaxis (doxy PEP) for STIs. The findings will inform the development of targeted education and resources to help improve access to these interventions.

E. Promote evidence-based preventive services to the public in collaboration with the Ad Council and other health partners.

While the AMA's primary audience is physicians, there are limited instances where the AMA has partnered on public information campaigns on select priority issues. This work has been made possible through partnerships with other health-related organizations and the Ad Council. The AMA will explore opportunities for future campaigns on an ongoing basis, while recognizing that we must prioritize our efforts and that engagement in these campaigns alone is not feasible due to cost.

Get My Flu Shot. The Ad Council, AMA, CDC and the CDC Foundation have partnered since the 2020-2021 flu season through an annual campaign to motivate more people to get vaccinated against seasonal influenza (flu) to protect themselves and their loved ones. During a severe season, flu has resulted in as many as 41 million illnesses and 710,000 hospitalizations among the U.S. population. This year's campaign features a new PSA titled "Play Defense Against Flu" that leverages comedy to highlight how antibodies that develop after getting a flu vaccination work hard to protect oneself, loved ones and the community at large from the flu. Audiences are encouraged to gear up with a flu shot. The Get My Flu Shot campaign PSAs were launched nationwide to reach people with the message that a flu shot can help you stay healthy, reduce risk

of severe outcomes, such as hospitalization and death, and avoid missing work, school, or special moments with family and friends. PSAs are available to run in English and Spanish across all platforms, in donated time and space throughout flu season. The campaign ads direct audiences to GetMyFluShot.org for more information, including where to get a flu vaccine in their area. Some highlights from the 2024-25 flu campaign are as follows:

- The donated media value for the current Flu season reached $2.4 million. The most support has come from out of home (OOH – $1,103,913), closely followed by TV support ($1,017,100).
- A media tour was held on October 10, 2024, in English and Spanish, featuring spokespeople from the AMA and representatives from the CDC. Over 40 placements were secured across TV, radio, and digital, with a reach of 404 million digital impressions and 1.6 million broadcast impressions.
- A second media tour was held on December 9, 2024, in English and Spanish, with spokespeople from the AMA and representatives from the CDC. Over 90 placements across TV, radio, and digital were secured with a reach of 206.9 million digital impressions and 6.5 million broadcast impressions.
- We partnered with Influential for our trusted messenger activation on social media. The concepts include athletes showing how they keep themselves in top shape by prepping for flu. Data is incoming for the total impressions and estimated reach.
- PSA awareness is now 57 percent in Black and Hispanic respondents based off our most recent December 2024 tracking study.

2. Responding to public health crises impacting physicians, patients, and the public.

The AMA's public health work has also been focused on responding to public health crises. These crises are often associated with significant health risk for patients, raising concerns among physicians. However, these crises are unlikely to be solved in a clinical setting alone. The AMA's response to public health crises is typically focused on (1) ensuring physicians and trainees have the data and resources needed; (2) identifying evidence-based policies and interventions; (3) elevating the voices of physician leaders through AMA channels and platforms; and (4) convening and collaborating with stakeholders to advance priority policies and interventions.

A. Address the public health crisis of climate change.

At the 2022 Annual Meeting of the House of Delegates, policy was adopted declaring "climate change a public health crisis that threatens the health and well-being of all individuals." Since the A-24 meeting, AMA has accomplished the following activities and developed a strategy to address climate change and health which was adopted at the I-24 HOD meeting:[9]

- The AMA has made climate change and sustainability education available via the Ed Hub™ from a variety of sources including the UC Center for Climate, Health, and Equity, Stanford Medicine, AMA Journal of Ethics, the Journal of the American Medical Association (JAMA), and the American Public Health Association (APHA). For example:
    - In July 2024, the JAMA Network developed a short film on how operating rooms can be cleaner, featuring physician experts working to make operating rooms more sustainable.
    - On October 29, 2024, Clinically Significant™, an AMA Continuing Medical Education (CME) podcast covered the climate impacts of metered-dose inhalers.[10]

    - In February 2025, the AMA STEPS Forward® podcast released an episode presented the benefits of going green and effective strategies to implement sustainability throughout medical practices.
- AMA's Center for Health Equity released an episode as part of the Prioritizing Equity series featuring physicians and scholarly leaders advocating for equitable climate action to remedy the disproportionate burden of health harms climate crisis puts on historically marginalized communities (summer 2024).[11]
- The AMA is in the process of developing a new CME module for physicians and trainees on climate change and health which is anticipated to be available in early summer 2025. The focus of the module is to bring awareness to physicians about the impact of climate change on the nation's health and to empower physicians to begin conversations with their patients about how climate change is affecting their health and what they can do about it.
- The *AMA Update* podcast featured topics related to climate change impacts throughout the year to provide updates to physicians, including:
    - May 1, 2024, covered the recently released CDC heat risk initiative.
    - June 19, 2024, delved into the symptoms of heat stroke versus heat exhaustion that physicians should watch out for during 2024 heat waves.
    - June 26, 2024, focused on heat-related illnesses as many states across the country were experiencing record breaking heatwaves.
    - July 26, 2024, covered how the Earth was experiencing its hottest day (and year) on record.
    - January 15, 2025, discussed California wildfire smoke and how to improve air quality during wildfires.
- AMA developed and distributed a survey to physicians to assess perceptions on climate change and health, including the level of importance and relevance of climate change to physicians, understanding day-to-day effects of climate change that physicians may be experiencing or anticipating experiencing in the future, and exploring what the AMA's role should be in supporting physicians on climate change. Data analysis of survey results is ongoing.
- The AMA submitted an abstract to the APHA annual conference to be held in November 2025 to present findings from the survey distributed to physicians in December 2024 and will identify other avenues of dissemination for this information.
- The AMA continues to engage in the Medical Society Consortium on Climate and Health (MCSSH), which brings together associations representing over 600,000 clinical practitioners.[12] The AMA sits on the executive committee of this group. Additionally, the AMA was a sponsor of the MSCCH Annual Convention, held in March 2025 in Washington, DC.
- The AMA is a member and sponsor of the National Academy of Medicine Action Collaborative on Decarbonizing the Health Sector as a member of the Steering Committee and co-lead of the Health Care Delivery Workgroup. The Health Care Delivery Workgroup has been focused on three deliverables:
    - The *Building Momentum to Act on Health Care Decarbonization* webinar Series;
    - The *Clinical Environmental Sustainability Journey Map* to provide health care leaders and clinicians with actions they can implement to enable sustainable health care transformation of their organizations and practices.
    - A *Clinicians Key Actions Shortlist* on decarbonization that will pull key actions clinicians in the U.S. can take modeled after Choosing Wisely Canada's Climate-Conscious Recommendations designed to mobilize clinicians to stop or reduce low-value practices that harm the environment without compromising patient care.

- The AMA is represented on the APHA Center for Climate, Health, and Equity Advisory Board, which meets regularly to guide the overall strategic direction of APHA's Center for Climate, Health and Equity.
- Additionally, the AMA participates in the American Lung Association's Healthy Air Partners campaign, which is a coalition of 40 national public health, medical, nursing and health care organizations engaged in healthy air advocacy efforts.[13] The Coalition is united in its calling for strong federal laws and policies to slash air pollution and address climate change, recognizing climate change can affect air quality, and certain air pollutants can affect climate change.
- In terms of advocacy efforts, the AMA joined with partners or submitted comments separately on the following:
    - AMA joined 85 other medical and public health organizations on January 25, 2025 in a letter to the Occupational Health and Safety Administration in support of their proposed standard on heat injury and illness prevention in outdoor and indoor work settings.[14]
    - AMA submitted a comment letter to CMS on June 10, 2024, in support of the Transforming Episode Accountability Model Decarbonization and Resilience Initiative, a voluntary effort designed to address threats posed by climate change to the nation's health and health care system by collecting, monitoring, and assessing, hospital carbon emissions and their effects on health outcomes, costs, and quality.

B. Prevent firearm injuries and deaths.

In the 1980's the AMA recognized firearms as a serious threat to the public's health as weapons are one of the main causes of intentional and unintentional injuries and deaths. At the 2016 Annual Meeting, following the Pulse nightclub shooting, policy was adopted declaring that "gun violence represents a public health crisis which requires a comprehensive public health response and solution." Since that time firearm injuries and deaths have increased, and disparities have widened.[15]

- The AMA continues to convene its Firearm Injury Prevention task force, which is charged with advising the AMA Board of Trustees on the role of organized medicine in firearm injury prevention and developing resources for physicians and trainees on firearm injury prevention to increase counseling of high-risk patients and awareness of available interventions.
- On June 10, 2024, the Firearm Injury Prevention task force hosted an educational session on *Health Care Strategies for Firearm Injury Prevention* at the House of Delegates meeting. Representatives from the Health Alliance for Violence Intervention, American Geriatric Society, Society of Critical Care Medicine, and American Pediatric Surgical Association. The session was recorded and shared on the AMA Ed Hub and YouTube channel.
- Task force members have participated in *AMA Update* video and podcast episodes on safe and secure firearm storage (featuring the American Academy of Pediatrics representative); the health system role in firearm injury prevention (featuring the American Pediatric Surgical Association representative), and Extreme Risk Protection Orders (featuring the Society of Critical Care Medicine representative and the Johns Hopkins Center for Gun Violence Solutions).
- The task force will be working to inform the development of resources for health care professionals to be featured on an expanded digital resource hub being developed with the Ad Council.

- On June 25, 2024, the AMA released a statement applauding the Surgeon General advisory on firearm violence as a public health crisis.
- On February 27, 2025, the Ad Council launched a new youth gun violence prevention initiative in collaboration with a coalition of health care and business leaders, including the AMA. This new effort is the first national cross-sector youth gun violence prevention campaign that aims to address the fact that firearm injuries have been the leading cause of death for children ages 1 to 17 for three consecutive years in the United States. The new public service announcement (PSA) is focused on parents and those with youth in their lives and encourages them to take action by visiting AgreeToAgree.org, where individuals can learn about gun violence and how to have conversations with their communities supported by conversations guides and resources.
- In conjunction with the Ad Council campaign launch on February 27th, 2025, Children's Hospital Association President and CEO Matthew Cook and American Medical Association CEO and EVP James L. Madara, MD authored an opinion piece published in Becker's Hospital Review titled, "*Hospitals and healthcare professionals must lead on firearm injury prevention to keep children and communities safe*."
- The AMA also partnered with the Ad Council on a video content series, featuring health care professionals speaking directly to other health care professionals on the responsibility and unique role they hold to help prevent firearm injuries through supportive conversations with their patients. The video series directs audiences to AgreeToAgree.org/HealthCare to learn more.
- On Thursday, March 6, 2025, AMA participated in a Washington Post Live conversation about how gun violence has impacted communities around the country, initiatives to find common ground, and efforts to bolster public safety and health.
- The AMA is also participating in the Health Professional Education and Advocacy/Policy committees of the Healthcare Coalition for Firearm Injury Prevention, which is being led by American Academy of Pediatrics, American College of Emergency Physicians , American College of Physicians, American College of Surgeons, and the Council of Medical Specialty Societies.[16]
- In terms of advocacy, the AMA wrote a letter to the leadership of the Maine Judiciary Committee on April 4, 2024, expressing our support for LD 2283, legislation to establish crisis intervention orders to temporarily remove firearms from individuals deemed at high risk to themselves or others.

C. Respond to emerging and remerging infectious disease threats and prepare for future pandemics.

Infectious diseases continue to evolve and advance throughout the U.S. Pathogens that were once geographically limited are now advancing beyond traditional borders. Blastomycosis, Histoplasmosis and Coccidioidomycosis are all fungal infections that have pushed through expected boundaries. In addition to organisms known to be found in the U.S., tropical diseases like malaria, dengue and Leishmaniasis have all been found in the U.S. in nontravelers. Re-emerging pathogens like measles continue to find footholds across the country. Currently, H5N1 (avian influenza) is spreading through poultry and dairy farms with sporadic human cases and one death.[17] In addition, Clade I mpox (a more severe strain than was seen here in 2022) is spreading in part of Africa with a few cases occurring in the U.S. so far.[18] As the AMA is relied upon as a source of information by physicians and patients, the AMA must maintain the ability to respond and share information and advocate for physicians, patients, and the public in line with AMA policies.

- The AMA is currently maintaining resources pages on mpox, H5N1, and COVID-19. We are working to create additional infectious disease related resources for physicians to be available on the AMA website to help ensure the continued availability of information should other sources not remain available.
- The AMA continues to release weekly *AMA Update* video and podcast episodes focused on public health topics, including the latest outbreak information. AMA YouTube subscribers have increased from 42,000 to 255,000 since the beginning of 2025.
- The AMA is a collaborator in Project Firstline, the CDC's National Training Collaborative for Healthcare Infection Control. Project Firstline offers educational resources in a variety of formats to meet the diverse learning needs and preferences of the health care workforce.[19]
- Over the last year, AMA has developed 7 *Stories of Care* podcast episodes exploring inequalities in infection prevention and control (IPC). The podcast series has featured episodes on improving hand hygiene compliance, IPC challenges within long-term acute care hospitals, how nurse-driven protocols can reduce HAIs, challenges with burnout in IPC teams, pediatrics and IPC challenges, how fostering resiliency improves retention in medical teams, and the importance of IPC research in medical training.
- The AMA funded seven state and specialty medical societies to develop training and IPC content for its membership and disseminate Project Firstline content with over 69,000 impressions in the first 6 months.
- In 2024, the AMA partnered with the CDC on two webinars addressing the measles resurgence and lower vaccine rates. The first, *Be on Alert for Travel-Related Measles*, featured a discussion on current measles epidemiology trends, measles recognition, travel-associated risks, core health care infection prevention measures and the importance of vaccination. The second webinar, *Measles: Stories From the Frontlines* featured speakers from the CDC, the Pediatric Pandemic Network, American Nurses Association, and American Academy of Pediatrics to bring their experiences caring for patients with measles.
- On August 6, 2024, AMA hosted a webinar to provide information on preparing for viral respiratory season including vaccination updates. Participants included CDC Director Mandy Cohen, MD, MPH and Demetre Daskalakis, MD, MPH.
- A six-part, ECHO-style tele-mentoring series ran from April through June of 2024 that explored the nuances of infection prevention in facility types outside of the acute care hospital. Settings included acute rehabilitation hospitals, ambulatory surgery centers, behavioral health units, post-acute long-term care facilities, dialysis facilities, and pediatric units.
- A CME module was published in 2024 that presents patient cases in a choose-your-own-adventure format outlining transmission-based precautions so that physicians and other health care professionals can recognize how to protect themselves in any situation.
- AMA is working with the American Society of Nephrology (ASN) to reach clinicians working in dialysis facilities. ASN is producing three hour-long webinars looking at preventing dialysis-related infections and how health care professionals can use social determinants of health to meet patients where they are. The first webinar was hosted in February 2025.
- On November 21, 2024, the AMA participated in a webinar with the CDC on *Leading the Way to a Healthier Winter: A Conversation for Clinicians on Flu, COVID-19, & RSV Vaccine.* The briefing covered new updates to vaccine recommendations for common respiratory viruses, the latest trends in respiratory illness, what to know about vaccination among health care professionals.

D. End the nation's drug overdose epidemic.

Ending the nation's drug overdose epidemic will require increased physician leadership, a greater emphasis on overdose prevention and treatment, and better coordination and amplification of the efforts and best practices already occurring across the country.

The AMA makes education available to physicians on this topic via the AMA Ed Hub™ to help physicians gain critical knowledge around acute and chronic pain management, substance use treatment, overdose prevention, and pain treatment to meet regulatory requirements. Courses are developed by AMA as well as by other partners. The AMA is also a member of the Providers Clinical Support System (PCSS), which is made up of a coalition of major health care organizations all dedicated to addressing this health care crisis and is led by the American Academy of Addiction Psychiatry. PCSS provides evidence-based training and resources to give health care providers the skills and knowledge they need to treat patients with opioid use disorders and chronic pain.[20] The following summarizes the numerous resources created and work done on this topic:

- In 2024 the AMA completed the content and resource update for the physician education series module *Practical Guidance for Pain Management*. This content was made available to help physicians meet the DEA's MATE Act requirements, effective as of June 27, 2023.
- The AMA continues to convene the Substance Use and Pain Care Task Force, which supports and guides the development of the annual Overdose Epidemic Report on the overdose epidemic outlining current data, policy, updates, clinical accomplishments and what still needs to be done.[21]
- In 2024, the AMA developed additional episodes of the physician education podcast series on *The Opioid Overdose Epidemic*. Podcast episodes feature experts who shared relevant research, insights, and experience to help physicians of all specialties in addressing the opioid overdose epidemic. The four additional episodes include: *Opioid Use Disorder and Pregnancy, Opioid Utilization in Hospice and Palliative Care, Disparities in Access to Medication for Opioid Use Disorder, and Opioid Use a Prevention Approach.* As of December 2024, podcast engagement has risen annually from 7,930 downloads to 27,133 downloads, with a high interest in the following topics: *Opioid Prescribing and Appropriate Pain Management, Opioid Overdose Prevention, and Opioid Use Disorder Treatment.*
- In 2024, the AMA was awarded funding from the CDC to develop and implement a clinician toolkit focused on the recommendations and guiding principles of the 2022 Clinical Practice Guideline for Prescribing Opioids for Pain that is specifically tailored to community health centers (CHCs). During the two-year project period the AMA will partner with the National Association of Community Health Centers to develop an actionable toolkit resource for clinicians and will implement the toolkit resource in CHCs. The toolkit will provide an extensive, multidisciplinary, evidence-based educational experience for clinicians working in CHCs that is unique and sensitive to the needs of CHCs while also preparing them to serve as content experts and agents of change for their local healthcare communities regarding pain care.
- In November of 2024, the AMA released its 2024 Overdose Epidemic Report, showing progress in harm reduction services and policy promoting evidence-based care, but underscoring ongoing challenges as the nation's drug overdose epidemic continues.
- The AMA continues to participate as a member of the National Academy of Medicine Action Collaborative on Countering the U.S. Opioid Epidemic. The Action Collaborative uses a systems approach to convene and catalyze public, private, and non-profit

stakeholders to develop, curate, and disseminate multi-sector solutions designed to reduce opioid misuse, and improve outcomes for individuals, families, and communities affected by the opioid crisis.

- The AMA's Cannabis task force was established to inform and develop evidence-based education on cannabis. In 2024, the AMA developed and disseminated a podcast series on *Cannabis Education.* Episodes feature expert discussions and insights that can help physicians of all specialties understand cannabis and the health effects of cannabis use. Initial podcast episode course completions demonstrate a high interest in the topic *Cannabis and Pain Management.* Additional episodes with substantial engagement include *Cannabis Use and Psychiatric Disorders, Cannabis Pharmacology, How Addictive in Cannabis, Cannabis Use among Pregnant Persons, Preventing Cannabis Use among Minors, and What to Know about FDA-approved Cannabis-derived Products.*

3. Strengthen the health system through improved collaboration between medicine and public health.

The AMA is collaborating with leading health care organizations to strengthen the interface between public health and health care. In November 2023, AMA and health care partners announced the Common Health Coalition: Together for Public Health, a partnership between AMA and four other leading healthcare organizations, including: AHIP (formerly America's Health Insurance Plans), Alliance of Community Health Plans, American Hospital Association , and Kaiser Permanente.[22] The Common Health Coalition is focused on translating the hard-won lessons and successes of the COVID-19 pandemic response into actionable strategies that will strengthen the partnership between our health care and public health systems.

- The Coalition's founding members have called on health care and public health organizations across the country to consider joining this effort. Interested organizations can learn more and take steps to join us by visiting the website, https://commonhealthcoalition.org/.
- On December 9, 2024, the Coalition announced its launch of the Inaugural Common Health Challenge to Champion Catalysts for Change, which will focus on Community Health Workers. As part of this initiative, the Common Health Coalition aims to advance meaningful Community Health Worker initiatives across the U.S. through partnership between health care and public health.[23]

In addition, the AMA took the following actions:

- In April of 2024, the AMA joined a letter to Congress urging the Labor, Health and Human Services, Education and Related Agencies appropriations bill for Fiscal Year (FY) 2025 to include funding to modernize and sustain our public health data infrastructure. The letter specifically requested at least $340 million annually for Public Health Data Modernization at the CDC.
- AMA released a leadership viewpoint in November of 2024, titled, *Building a robust public health system will benefit us all*.
- In March of 2025, the AMA joined a letter to the National Institutes of Health (NIH) expressing our appreciation for their longstanding commitment to funding scientific research that advances medical breakthroughs but noting that we are deeply concerned about the recently announced policy imposing a 15 percent cap on indirect cost recovery for NIH grants. The letter urges NIH to rescind this directive and instead work collaboratively to develop a solution that balances transparency, efficiency, and sustainability.

4. Combat the spread of misinformation and disinformation.

The AMA remains engaged in external collaborations to address mis- and disinformation, such as the Coalition for Trust in Health & Science and the recently rebranded physician-focused coalition, Mitigating Medical Misinformation Workgroup.

- The Coalition for Trust in Health and Science's vision is for all people to have equitable access to accurate, understandable, and relevant information to make personally appropriate health choices and decisions. The AMA is an active member, engaging with leadership and participating in programming. The AMA also made a financial contribution in 2024 to support the Coalition's work.
- The AMA is also an active participant in the Mitigating Medical Misinformation Workgroup and supported its recent research that found primary care physicians were viewed as the most trusted source for medical information. The AMA will work with this group to disseminate these findings to a broader audience and will continue to coordinate efforts internally to ensure alignment.
- The AMA filed an amicus brief with the U.S. Supreme Court in the case of *Murthy v. Missouri.* The brief focuses on how disinformation diminished uptake of COVID-19 vaccines, which then limited the vaccines' ability to save lives by controlling the spread of disease—thereby creating a compelling interest for the government to act. The court ruled that the plaintiffs did not have standing to bring the lawsuit as they could not show a substantial risk that, in the near future, at least one platform will restrict their speech in response to the actions of a government defendant.

CONCLUSION

The current environment has elevated the critical importance of AMA's role of promoting and disseminating evidence-based public health policy and content. The AMA continues to advance its mission, to promote the art and science of medicine and the betterment of public health. The highlighted accomplishments in this report capture a fraction of the work accomplished from March of 2024 – March of 2025 related to the AMA's public health strategy. The AMA will likely need to increase efforts in these areas to maintain the organization as a trusted source of information for physicians and the public and to help protect the nation's public health infrastructure.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 27-A-25

Subject: AMA Reimbursement of Necessary HOD Business Expenses for Delegates and Alternates

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

At the 2024 Interim Meeting, the House of Delegates adopted the following recommendations in Board of Trustees Report 16, AMA Reimbursement of Necessary Business Meeting Expenses for Delegates and Alternates (Policy D-600.951):

1. Our American Medical Association will issue a report at the 2025 Annual Meeting, and each meeting thereafter, identifying the number of delegates and alternate delegates supported by the grants and the total amount provided under our AMA House of Delegates Emergency Assistance Program.
2. Our AMA will provide the House of Delegates with reports on a regular cadence detailing ongoing work regarding House of Delegates meetings to mitigate costs, explore solutions, and maintain participation while reducing the financial burden on all parties over the long term.
3. Our AMA will not reduce by one day the 2025 Annual and Interim Meetings and will issue a report for consideration at the 2025 Annual Meeting outlining details for potential changes to the length and format of future House of Delegates meetings.

This report is presented as information to the House of Delegates.

In November 2024, the Board of Trustees established an Emergency Assistance Pilot Program (EAP) to support state medical associations and national medical specialty societies experiencing financial hardship. The program, limited to meetings of the House of Delegates (HOD), will be in effect for the Annual and Interim meetings in 2025 and 2026. Information on applying and qualifying for the program, including data about delegate apportionment was sent to the Chief Executive Officer/Executive Director of each organization seated in the House of Delegates. Societies must apply annually; if approved, the emergency assistance grant will apply to both the Annual and Interim meetings for that calendar year.

In its initial cycle, twenty-four societies inquired about the program, and twenty-one submitted applications. Two societies did not meet the two percent of revenue threshold for delegate and alternate delegate expenses, and one was unable to provide the necessary tax documentation. Ultimately, 18 societies qualified for assistance, covering approximately 300 delegates and alternates -- including some regional medical student delegates and sectional resident and fellow delegates. The AMA will disburse 50 percent of the emergency grant assistance in advance of the meetings with the remainder paid after attendance has been confirmed.

While the AMA has restored the original meeting schedule for the HOD and opted not to shorten the 2025 Annual and Interim Meetings by one day, the Board has tasked the Council on Long Range Planning and Development with preparing a comprehensive report. This report will explore potential changes to the length, format, and structure of future HOD meetings and will be submitted to the Board for review and further consideration.

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The Board of Trustees will provide the House of Delegates with a future report summarizing these ongoing efforts to mitigate meeting-related expenses, ensure broad participation, and responsibly steward AMA resources over the long term.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 03-A-25

Subject: Reconsidering Terminology to Describe Physician Assisted Suicide

Presented by: Jeremy A. Lazarus, MD, Chair

At the 2023 Interim meeting, Resolution 004-Reconsideration of Medical Aid in Dying (MAID) was referred and asked, "that our AMA study changing our existing position on medical aid in dying, including reviewing government data, health services research, and clinical practices in domestic and international jurisdictions where it is legal." This informational report provides supplemental background and analysis to support Board of Trustees Report 18-A-25, which responds to the referred resolution.

BACKGROUND

The AMA *Code of Medical Ethics* defines physician assisted suicide (PAS) (Opinion 5.7 "Physician-Assisted Suicide") as the practice of a physician facilitating "a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act". In companion 1997 cases, the US Supreme Court held that there is no Constitutional right to PAS, and, therefore, permissibility should rest with the states [1]. Over the nearly three decades since, 10 states and the District of Columbia have legalized the practice [2].

ETHICAL ISSUE

Resolution 004 directed the Council on Ethical and Judicial Affairs (CEJA) to study whether current research, practice, or policy changes warrant reconsideration of CEJA's ethical analysis and/or position on PAS.

ETHICAL ANALYSIS

At the 2019 Annual meeting, the AMA House of Delegates adopted CEJA Report 02-A-19 entitled "Physician-Assisted Suicide" and upheld AMA *Code of Medical Ethics* Opinion 5.7 which opposes PAS as a practice that is "fundamentally incompatible with the physician's role as a healer." CEJA Report 02-A-19 also recognized, in an Appendix, that "morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician-assisted suicide." This Appendix noted that the AMA *Code* preserves the opportunity as articulated in Opinion 1.1.7, "Physician Exercise of Conscience," for individual physicians "to act (or refrain from acting) in accordance with the dictates of conscience in their professional practice." AMA's position on physician assisted suicide is not a position of neutrality, establishing that the profession of medicine should not support the practice of physician assisted suicide or see it as part of a physician's role. The aim of the Appendix to CEJA Report 02-A-19, however, is to reassure individual physicians that those who, after due moral consideration, decide to participate in the practice, will be judged to have acted conscientiously, consistent with the AMA *Code*.
In developing CEJA Report 02-A-19, the Council's analyses and deliberations were informed by available data and research. However, its decision was not an empirically dictated one, but rather, it was driven by the core values of medicine preserved within the *Code of Medical Ethics*. The

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Council has reviewed legislative developments since 2019 and has also reviewed recent government data, health services research and clinical practices in US and international jurisdictions where PAS and/or euthanasia are legal. The Council noted that these empirical data are subject to varied interpretations and concluded that, as a matter of ethical reasoning, the data do not settle the ethical issue. The relevant core ethical values at stake have not changed since the adoption of CEJA Report 02-A-19. As such, the AMA's position on physician assisted suicide remains unchanged.

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 04-A-25

Subject: Reconsideration of Physician Assisted Suicide

Presented by: Jeremy A. Lazarus, MD, Chair

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ETHICAL ANALYSIS

At the 2019 Annual meeting, the AMA House of Delegates adopted CEJA Report 02-I-19 entitled "Physician-Assisted Suicide" and upheld AMA *Code of Medical Ethics* Opinion 5.7 which opposes PAS as a practice that is "fundamentally incompatible with the physician's role as a healer." CEJA Report 02-A-19 also recognized, in an Appendix, that "morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician-assisted suicide." This Appendix noted that the AMA *Code* preserves the opportunity as articulated in Opinion 1.1.7 for individual physicians "to act (or refrain from acting) in accordance with the dictates of conscience in their professional practice."

AMA's position on physician assisted suicide is not a position of neutrality, establishing that the profession of medicine should not support the practice of physician assisted suicide or see it as part of a physician's role. The aim of the Appendix to CEJA Report 02-A-19, however, is to reassure individual physicians that those who, after due moral consideration, decide to participate in the practice, that they will be judged to have acted conscientiously, consistent with the AMA *Code*. In developing CEJA Report 02-A-19, the Council's analyses and deliberations were informed by available data and research. However, its decision was not an empirically dictated one, but rather, it was driven by the core values of medicine preserved within the *Code of Medical Ethics*. The

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Council has reviewed legislative developments since 2019 and has also reviewed recent government data, health services research and clinical practices in US and international jurisdictions where PAS and/or euthanasia are legal. The Council noted that these empirical data are subject to varied interpretations and concluded that, as a matter of ethical reasoning, the data do not settle the ethical issue. The relevant core ethical values at stake have not changed since the adoption of CEJA Report 02-A-19. As such, the AMA's position on physician assisted suicide remains unchanged.

Fiscal Note: Less than $500

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 12-A-25

Subject: Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

Presented by: Jeremy A. Lazarus, MD, Chair

At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a detailed explanation of its judicial function. This undertaking was motivated in part by the considerable attention professionalism has received in many areas of medicine, including the concept of professional self-regulation.

CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove a membership application or to take action against a member. The disciplinary process begins when a possible violation of the Principles of Medical Ethics or illegal or other unethical conduct by an applicant or member is reported to the AMA. This information most often comes from statements made in the membership application form, a report of disciplinary action taken by state licensing authorities or other membership organizations, or a report of action taken by a government tribunal.

The Council rarely re-examines determinations of liability or sanctions imposed by other entities. However, it also does not impose its own sanctions without first offering a hearing to the physician. CEJA can impose the following sanctions: applicants can be accepted into membership without any condition, placed under monitoring, or placed on probation. They also may be accepted, but be the object of an admonishment, a reprimand, or censure. In some cases, their application can be rejected. Existing members similarly may be placed under monitoring or on probation, and can be admonished, reprimanded or censured. Additionally, their membership may be suspended or they may be expelled. Updated rules for review of membership can be found at https://www.ama-assn.org/governing-rules.

Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA's activities during the most recent reporting period is presented.

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APPENDIX

CEJA
Judicial Function
Statistics

APRIL 1, 2024 – MARCH 31, 2025

Physicians Reviewed	SUMMARY OF CEJA ACTIVITIES
6	Determinations of no probable cause
11	Determinations following a plenary hearing
9	Determinations after a finding of probable cause, based only on the written record, after the physician waived the plenary hearing

Physicians Reviewed	FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS
13	No sanction or other type of action
0	Monitoring
5	Probation
0	Revocation
5	Suspension
0	Denied
0	Suspension lifted
10	Censure
1	Reprimand[1]

Physicians Reviewed	PROBATION/MONITORING STATUS
8	Members placed on Probation/Monitoring during reporting interval
3	Members placed on Probation without reporting to Data Bank
14	Probation/Monitoring concluded satisfactorily during reporting interval
1	Memberships suspended due to non-compliance with the terms of probation
14	Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues
11	Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues

[1] Sanction no longer in use.

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 01-A-25

Subject: Palliative Care

Presented by: Jeremy A. Lazarus, MD, Chair

INTRODUCTION

At the 2024 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 1-I-24, "Expanding Access to Palliative Care." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the online edition of the *Code of Medical Ethics*.

E-5.10 – Palliative Care

Physicians have clinical ethical responsibilities to address the pain and suffering occasioned by illness and injury and to respect their patients as whole persons. These duties require physicians to assure the provision of effective palliative care whenever a patient is experiencing serious, chronic, complex, or critical illness, regardless of prognosis. Palliative care is sound medical treatment that includes the comprehensive management and coordination of care for pain and other distressing symptoms including physical, psychological, intellectual, social, spiritual, and existential distress from serious illness. Evaluation and treatment are patient-centered but with an additional focus on the needs, values, beliefs, and culture of patients and those who love and care for them in decision-making accordingly.

Palliative care is widely acknowledged to be appropriate for patients who are close to death, but persons who have chronic, progressive, and/or eventually fatal illnesses often have symptoms and experience suffering early in the disease course. The clinical ethical responsibilities to address symptoms and suffering may therefore sometimes entail a need for palliative care before the terminal phase of disease. Moreover, the duty to respect patients as whole persons should lead physicians to encourage patients with chronic, progressive, and/or eventually fatal conditions to identify surrogate medical decision makers, given the likelihood of a loss of decisional capacity during medical treatment.

When caring for patients' physicians should:

(a) Integrate palliative care into treatment.

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* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

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(b) Seek and/or provide palliative care, as necessary, for the management of symptoms and suffering occasioned by any serious illness or condition, at any stage, and at any age throughout the course of illness.

(c) Offer palliative care simultaneously with disease modifying interventions, including attempts for cure or remission.

(d) Be aware of, and where needed, engage palliative care expertise in care.

Physicians as a profession should:

(e) Advocate that palliative care be accessible for all patients, as necessary, for the management of symptoms and suffering occasioned by any serious illness or condition, at any stage, and at any age throughout the course of illness. (I, V, VIII)

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 3-A-25

Subject: Demographic Characteristics of the House of Delegates and AMA Leadership

Presented by: Michelle Berger, MD, Chair

This informational report is prepared in odd numbered years by the Council on Long Range Planning and Development (CLRPD), pursuant to American Medical Association (AMA) Policy G-600.035, "The Demographics of the House of Delegates." This policy states:

(1) A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty. (2) As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year. (3) Future reports on the demographic characteristics of the House of Delegates should, whenever possible, identify and include information on successful initiatives and best practices to promote diversity within state and specialty society delegations.

This report will survey the current demographic makeup of AMA leadership in accordance with AMA Policy G-600.030, "Diversity of AMA Delegations," which states that, "Our AMA encourages…state medical associations and national medical specialty societies to review the composition of their AMA delegations with regard to enhancing diversity..." and AMA Policy G 610.010, "Nominations," which states in part:

Guidelines for nominations for AMA elected offices include the following... (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity…

Like previous reports, this document compares AMA leadership with the entire AMA membership and with the overall U.S. physician population. Medical students are included in all references to the total physician population, which is consistent with past practice. For the purposes of this report, AMA leadership includes delegates; alternate delegates; the Board of Trustees (BOT); and councils and leadership of sections and special groups (hereafter referred to as CSSG; see detailed listing in Appendix A).

Additionally, this report includes information on successful initiatives and best practices to promote diversity of state and specialty society delegations, pursuant to part 3 of Policy G-600.035.

DATA SOURCES

Lists of delegates and alternate delegates are maintained by the Office of House of Delegates (HOD) Affairs and based on official rosters provided by the relevant societies. The lists used in this report reflect year-end 2024 delegation rosters. AMA council rosters as well as listings for the

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governing bodies of each of the sections and special groups were provided by the relevant AMA staff.

Data on demographic characteristics of individuals are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all graduates of U.S. medical schools and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA members and the total physician population are taken from the year-end 2024 Masterfile after it is considered final.

Some key considerations must be kept in mind regarding the information in this report. Members of the BOT, the American Medical Political Action Committee and the Council on Legislation who are not physicians or medical students are not included in any tables. Vacancies in delegation rosters mean the total number of delegates is fewer than the number allotted at the 2024 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment. Race and ethnicity information, which is provided directly by physicians, is missing for nearly one-fourth of AMA members (24.0 percent) and the total U.S. physician population (23.6 percent), limiting the ability to draw firm conclusions.

Readers are reminded that most AMA leadership groups considered herein designate seats for students and resident/fellow physicians. This affects some characteristics, particularly age, as well as the makeup of age-related groups, namely the student, resident, and young physician sections. To provide further clarity on this point, an additional table has been included in the appendix illustrating demographic characteristics and career stage breakdowns of section governing councils.

CHARACTERISTICS OF AMA LEADERSHIP

Table 1 displays the basic demographic characteristics of AMA leadership, AMA members, and all physicians and medical students. Raw counts for Tables 1 and 2 can be found in Appendix A. Upward- and downward-pointing arrows indicate an increase or decrease of at least two percentage points compared to CLRPD Report 1-A-23, “Demographic Characteristics of the House of Delegates and AMA Leadership”; the following observations refer to changes since CLRPD Report 1-A-23. Changes are not highlighted for the BOT due to the small number of Board members. Between year-end 2022 and year-end 2024, AMA membership increased by 16,080 members, a 5.9 percent increase.

- Among alternate delegates, an increase of 3.9 percentage points was observed in the 40-49 age group, while a decrease of 2.3 percentage points was observed in the 60-69 age group. Among leadership of AMA councils, sections and special groups, an increase of 3.0 percentage points was seen in the under 40 age group, while representatives aged 50-59 and 70 and over decreased by 2.0 and 2.2 percentage points respectively.

- Female representation in the HOD increased once again, a continuation of a steady trend of more than a decade. Delegates identifying as female made up 37.2 percent of delegates (a 2.9 percentage point increase since 2022) and 49.5 percent of alternate delegates (a 5.8 percentage point increase). Likewise, female representation among all AMA members increased by 2.1 percentage points.

- Delegates, alternate delegates, and CSSG identifying as white non-Hispanic declined by 2.1 percentage points, 4.5 percentage points and 3.8 percentage points, respectively. Asian/Asian American representation increased among alternate delegates by 3.4 percentage points.

Table 1. Demographic Characteristics of AMA Leadership, December 2024

	Delegates[1]	Alternate Delegates[1]	Board of Trustees[2]	Councils and Leadership of Sections and Special Groups[3]	AMA Members	All Physicians and Medical Students
Count	680	430	20	179	290,796	1,553,690
Mean age (years)[4]	56.5	50.2	55.5	49.9	46.5	52.9
Age Distribution						
Under age 40	14.7%	28.6%	10.0%	33.5%↑	53.1%	30.7%
40-49 years	16.2%	21.6%↑	15.0%	14.0%	11.5%	17.1%
50-59 years	21.5%	18.4%	35.0%	19.6%↓	9.5%	15.5%
60-69 years	26.3%	20.0%↓	35.0%	20.1%	8.6%	15.2%
70 or more	21.3%	11.4%	5.0%	12.8%↓	17.3%	21.5%
Gender						
Male	62.8%↓	50.2%↓	50.0%	52.5%	57.7%↓	61.4%
Female	37.2%↑	49.5%↑	50.0%	47.5%	41.6%↑	37.8%
Unknown	0.0%	0.2%	0.0%	0.0%	0.7%	0.8%
Race/Ethnicity						
White non-Hispanic	63.7%↓	52.8%↓	45.0%	53.1%↓	47.7%	49.0%
Black non-Hispanic	5.9%	6.3%	10.0%	5.0%	5.2%	4.5%
Hispanic	3.1%	4.2%	5.0%	6.1%	4.0%	4.4%
Asian/Asian American	13.5%	19.3%↑	30.0%	20.1%	17.1%	16.6%
Native American	0.3%	0.5%	0.0%	0.6%	0.2%	0.2%
Other[5]	1.8%	1.6%↓	0.0%	1.7%↓	1.8%↓	1.7%
Unknown	11.8%	15.3%↑	10.0%	13.4%↑	24.0%↑	23.6%↑
Education						
US or Canada	90.3%	88.8%	95.0%	87.7%	80.8%	77.2%
IMG	9.7%	11.2%	5.0%	12.3%	19.2%	22.8%

Table 2 displays life stage, present employment, and self-designated specialty of AMA leadership.

- Limited changes were observed to the life stage, employment, and specialty characteristics of delegates to the HOD. Among delegates, an increase of 2.3 percentage points was observed among established physicians, and the share of group practice physicians decreased by 2.2 percentage points. Among alternate delegates, representation of internal

[1] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[2] Numbers do not include the public member of the Board of Trustees, who is not a physician.
[3] Numbers do not include non-physicians on the Council on Legislation and the American Medical Political Action Committee. In addition, Appendix A contains a listing of the AMA Councils, Sections, and Special Groups.
[4] Age as of December 31. Mean age is the arithmetic average.
[5] Includes other self-reported racial and ethnic groups.

medicine specialists increased by 4.2 percentage points.

- Among CSSG, increases were observed among students (2.1 percentage points), group practice physicians (4.4 percentage points), and radiologists (2.6 percentage points), while decreases were observed among established physicians (-2.8 percentage points), self-employed solo practice physicians (-2.4 percentage points), retired/inactive physicians (2.7 percentage points) and internal medicine specialists (-4.9 percentage points).

- The percentage of intern/resident/fellow AMA members increased by 3.0 percentage points.

Table 2. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership, December 2024

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of Sections and Special Groups	AMA Members	All Physicians and Medical Students
Count	680	430	20	179	290,796	1,553,690
Life Stage						
Student[6]	4.4%	10.0%	5.0%	11.7%↑	18.2%	7.9%
Resident[6]	6.3%	8.4%	5.0%	12.3%	29.2%↑	11.5%
Young (Under age 40 or first eight years of practice)[7]	6.0%	15.1%	0.0%	12.8%	10.2%	15.4%
Established (Age 40-64)[7]	47.4%↑	45.3%	65.0%	38.5%↓	20.9%	36.1%
Senior (Age 65 or more)[7]	35.9%	21.2%	25.0%	24.6%	21.5%	29.1%
Present Employment						
Self-employed solo practice	11.9%	7.2%	30.0%	8.4%↓	5.4%	6.8%
Two physician practice	1.6%	1.6%	0.0%	0.6%	1.3%	1.7%
Group practice	37.6%↓	38.1%	30.0%	39.1%↑	23.9%	38.7%
Non-government hospital	8.8%	8.4%	10.0%	7.3%	3.0%	4.3%
State or local government hospital	9.7%	9.3%	10.0%	7.8%	3.2%	5.3%
HMO	1.0%	0.7%	0.0%	0.6%	0.2%	0.1%
Medical School	4.0%	2.6%	5.0%	2.8%	0.8%	1.2%
U.S. Government	2.6%	1.4%	5.0%	1.7%	0.7%	1.4%
Locum Tenens	0.3%	0.2%	0.0%	1.7%	0.1%	0.2%
Retired/Inactive	9.6%	5.8%	0.0%	3.9%↓	10.7%	12.9%
Resident/Intern/Fellow	6.3%	8.4%	5.0%	12.3%	29.2%↑	11.5%
Student	4.4%	10.0%	5.0%	11.7%↑	18.2%	7.9%

[6] Students and residents are so categorized without regard to age.
[7] Reflects section/group definition of its membership.

Other/Unknown	2.2%	6.3%	0.0%	2.2%	3.3%	8.0%
Self-designated Specialty[8]						
Family Medicine	12.9%	9.8%	0.0%	10.1%	8.8%	11.3%
Internal Medicine	21.8%	19.3%↑	10.0%	17.3%↓	21.4%	23.0%
Surgery	21.3%	17.7%	40.0%	15.1%	13.0%	13.0%
Pediatrics	4.0%	5.3%	5.0%	6.7%	5.8%	8.6%
OB/GYN	6.3%	7.0%	15.0%	8.9%	4.9%	4.4%
Radiology	5.3%	3.7%	10.0%	5.0%↑	3.5%	4.3%
Psychiatry	3.7%	5.6%	0.0%	5.6%	4.4%	5.2%
Anesthesiology	3.5%	3.3%	5.0%	2.8%	4.1%	4.9%
Pathology	1.6%	4.0%	0.0%	0.6%	1.7%	2.1%
Other specialty	15.2%	14.4%	10.0%	16.2%	14.2%	15.3%
Student	4.4%	10.0%	5.0%	11.7%↑	18.2%	7.9%

For further data, including information on state medical associations and national medical specialty societies, raw counts of the above tables, and detailed state and specialty society data, please see the appendices.

This year, the Council added another metric to the report with the inclusion of a diversity index. The index provides a balanced and robust assessment of diversity and has been widely applied across demographic and clinical research contexts. The Council utilized the Gini-Simpson Diversity Index (GSI) which measures the probability that two individuals selected at random will represent different identities; it is measured from 0 to 1, where 0 represents an absence of diversity and 1 represents the greatest possible diversity. CLRPD assessed diversity trends within the AMA HOD and AMA leadership from 2014 to 2024, specifically focusing on member age, gender, and race/ethnicity. The Council intends to include this metric in future reports on the demographic characteristics of the HOD and AMA leadership as another means of encouraging greater awareness and responsiveness to diversity. To view data on the GSI of the HOD and AMA leadership, please view graphics 1-3 in Appendix A.

PROMOTING DIVERSITY AMONG DELEGATIONS

Policy G-600.035 stipulates that "(f)uture reports on the demographic characteristics of the House of Delegates should, whenever possible, identify and include information on successful initiatives and best practices to promote diversity within state and specialty society delegations."

In 2024, the AMA Center for Health Equity (CHE) surveyed the AMA Federation of Medicine for its annual Health Equity in Organized Medicine (HEIOM) survey, which queried members of the Federation with the goal of developing a shared understanding of health equity initiatives. This report highlights some key findings of that survey related to diversity among delegations, but the Council encourages members of the HOD to access the report in its entirety to view the breadth of efforts being undertaken by organizations within the Federation to improve health equity and increase organizational diversity. The Council plans to collaborate with CHE to include queries about best practices to increase diversity among state and specialty delegations in future HEIOM surveys to improve collaboration and knowledge sharing, and to avoid duplication of effort.

Of the 81 organizations that responded, the HEIOM survey found that nearly one in four had taken at least one action to identify opportunities for improvement. Approximately half of responding

[8] See Appendix B for a listing of specialty classifications.

organizations said that they had achieved or were working toward collecting and stratifying quantitative data regarding organizational leadership and staff to identify inequities, and a similar number said they had undertaken or were in the process of undertaking similar efforts about their organization's membership. Additionally, nearly three in four had taken at least one action to make equity a strategic priority which included ensuring that senior leadership and board members reflected the diversity of the community served by the organization.

The report highlighted an illustrative initiative undertaken by the Tennessee Medical Association (TMA), which recognized the need for younger and more diverse members to better reflect the state's physician demographics. To work toward this goal, TMA created a leadership portfolio to assess diversity in leadership across various demographics, environments, and experiences to develop an understanding of diversity within the organization. The Association built on this work by developing a "leadership scorecard," which defines representation and tracks progress on diversity in leadership roles, including its AMA delegation. The initiative aims to identify key areas lacking diversity and guide the nominating committee when selecting candidates for leadership roles.

Another initiative highlighted in the report came from the American Academy of Orthopaedic Surgeons (AAOS), which developed a publicly shared Governance Diversity Report to provide an analysis of the composition of the organization's volunteer structure, member engagement and applicant selection. The report has helped AAOS understand baseline diversity within its governance, raise awareness of diversity with councils and committees, and increase the number of female and underrepresented minority members holding positions within the AAOS governance structure. Additionally, public sharing of the report has allowed for increased transparency, trust-building, and accountability

APPENDIX A

Table 3. Demographic Characteristics of AMA Leadership, December 2024

	Delegates[1]	Alternate Delegates[1]	Board of Trustees[2]	Councils and Leadership of Sections and Special Groups[3]	AMA Members	All Physicians and Medical Students
Count	680	430	20	179	290,796	1,553,690
Mean age (years)[4]	56.5	50.2	55.5	49.9	46.5	52.9
Age Distribution						
Under age 40	100	123	2	60	154413	476983
40-49 years	110	93	3	25	33442	265681
50-59 years	146	79	7	35	27626	240822
60-69 years	179	86	7	36	25008	236161
70 or more	145	49	1	23	50308	334043
Gender						
Male	427	216	10	94	167789	953966
Female	253	213	10	85	120971	587295
Unknown	0	1	0	0	2036	12430
Race/Ethnicity						
White non-Hispanic	433	227	9	95	138710	761308
Black non-Hispanic	40	27	2	9	15121	69916
Hispanic	21	18	1	11	11632	68362
Asian/Asian American	92	83	6	36	49726	257913
Native American	2	2	0	1	582	3107
Other[5]	12	7	0	3	5234	26413
Unknown	80	66	2	24	69791	366671
Education						
US or Canada	614	382	19	157	234963	1199449
IMG	66	48	1	22	55833	354241

[1] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[2] Numbers do not include the public member of the Board of Trustees, who is not a physician.
[3] Numbers do not include non-physicians on the Council on Legislation and the American Medical Political Action Committee. In addition, Appendix A contains a listing of the AMA Councils, Sections, and Special Groups.
[4] Age as of December 31. Mean age is the arithmetic average.
[5] Includes other self-reported racial and ethnic groups.

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Table 4. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership, December 2024

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of Sections and Special Groups	AMA Members	All Physicians and Medical Students
Count	680	430	20	179	290,796	1,553,690
Life Stage						
Student[6]	30	43	1	21	52925	122742
Resident[1]	43	36	1	22	84912	178674
Young (Under age 40 or first eight years of practice)[7]	41	65	0	23	29661	239268
Established (Age 40-64)[2]	322	195	13	69	60776	560882
Senior (Age 65 or more)[2]	244	91	5	44	62521	452124
Present Employment						
Self-employed solo practice	81	31	6	15	15703	105651
Two physician practice	11	7	0	1	3780	26413
Group practice	256	164	6	70	69500	601278
Non-government hospital	60	36	2	13	8724	66809
State or local government hospital	66	40	2	14	9305	82346
HMO	7	3	0	1	582	1554
Medical School	27	11	1	5	2326	18644
U.S. Government	18	6	1	3	2036	21752
Locum Tenens	2	1	0	3	291	3107
Retired/Inactive	65	25	0	7	31115	200426
Intern/Resident/Fellow	43	36	1	22	84912	178674
Student	30	43	1	21	52925	122742
Other/Unknown	15	27	0	4	9596	124295
Self-designated Specialty[8]						
Family Medicine	88	42	0	18	25590	175567
Internal Medicine	148	83	2	31	62230	357349
Surgery	145	76	8	27	37803	201980
Pediatrics	27	23	1	12	16866	133617
OB/GYN	43	30	3	16	14249	68362
Radiology	36	16	2	9	10178	66809
Psychiatry	25	24	0	10	12795	80792

[6] Students and residents are so categorized without regard to age.
[7] Reflects section/group definition of its membership.
[8] See Appendix B for a listing of specialty classifications.

Anesthesiology	24	14	1	5	11923	76131
Pathology	11	17	0	1	4944	32627
Other specialty	103	62	2	29	41293	237715
Student	30	43	1	21	52925	122742

Table 5. Demographic Characteristic Cross Sections of AMA Members, December 2024

	White non-Hispanic	Black non-Hispanic	Hispanic	Asian/Asian American	Native American	Other[9]
Count	138,771	15,016	11,703	49,758	466	75,084
Mean age (years)[10]	51.2	42.0	46.4	41.0	41.9	42.5
Under age 40	44.1%↑	57.0%	47.8%	60.7%	49.1%↓	64.8%
40-49 years	10.8%	15.5%	13.6%	15.0%	19.3%↓	9.3%
50-59 years	10.1%	12.2%	15.8%↑	11.6%	23.0%↑	5.5%
60-69 years	10.9%	8.1%	10.0%	5.3%	7.5%↑	6.1%
70 or more	24.0%	7.1%	12.9%	7.5%	1.1%	14.3%
Male	63.5%	43.6%	58.0%	51.5%	50.0%↓	54.0%↑
Female	36.4%	56.3%	41.9%	48.3%	50.0%↑	43.6%↓
Unknown	0.0%	0.0%	0.1%	0.1%	0.0%	2.4%
Student[11]	13.0%↓	19.4%↓	17.9%↓	16.9%↓	17.8%↓	28.4%↑
Resident[3]	24.4%↑	33.3%↓	24.6%	35.3%↑	24.5%↓	34.0%↓
Young (Under age 40 or first eight years of practice)[12]	10.4%	11.8%	7.9%↑	13.2%	13.5%↑	8.0%
Mature (Age 40-64)[4]	22.8%	25.0%	31.9%	25.2%	40.3%	12.0%
Senior (Age 65 or more)[4]	29.5%	10.4%	17.7%	9.5%	3.9%↑	17.6%
US or Canada	91.2%	80.6%↓	75.8%↑	65.7%↓	92.9%	72.5%
IMG	8.8%	19.4%↑	24.2%↓	34.3%↑	7.1%	27.5%

[9] Includes other self-reported racial and ethnic groups.
[10] Age as of December 31. Mean age is the arithmetic average.
[11] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[12] Reflects section/group definition of its membership.

Table 6. Demographic Characteristics of AMA Section Governing Councils, December 2024

	APS	IPPS	IMGS	LGBTQ+	MSS	MAS	OMSS	PPPS	RFS	SPS	WPS	YPS
Mean Age (years)	60.2	53.4	42.5	38.1	26.7	49.9	64.6	53.8	31.4	72.0	40.8	38.4
Student	0.0%	0.0%	0.0%	22.2%	100.0%	12.5%	0.0%	0.0%	0.0%	0.0%	12.5%	0.0%
Resident	0.0%	0.0%	12.5%	11.1%	0.0%	25.0%	0.0%	0.0%	100.0%	0.0%	25.0%	0.0%
Young (Under age 40 or first eight years of practice)[1]	11.1%	12.5%	62.5%	33.3%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	25.0%	85.7%
Mature (Age 40-64)[1]	44.4%	75.0%	25.0%	33.3%	0.0%	50.0%	50.0%	37.5%	0.0%	14.3%	25.0%	14.3%
Senior (Age 65 or over)[1]	44.4%	12.5%	0.0%	0.0%	0.0%	12.5%	50.0%	37.5%	0.0%	85.7%	12.5%	0.0%
Male	77.8%	75.0%	37.5%	55.6%	33.3%	25.0%	50.0%	25.0%	62.5%	71.4%	0.0%	57.1%
Female	22.2%	25.0%	62.5%	44.4%	66.7%	75.0%	50.0%	75.0%	37.5%	28.6%	100.0%	42.9%
Unknown	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
White non-Hispanic	55.6%	62.5%	37.5%	66.7%	11.1%	0.0%	75.0%	62.5%	75.0%	71.4%	12.5%	85.7%
Black non-Hispanic	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%
Hispanic	11.1%	12.5%	12.5%	11.1%	0.0%	37.5%	12.5%	0.0%	12.5%	0.0%	0.0%	0.0%
Asian/Asian American	33.3%	25.0%	37.5%	22.2%	55.6%	0.0%	12.5%	12.5%	12.5%	14.3%	37.5%	14.3%
Native American	0.0%	0.0%	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other[2]	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown	0.0%	0.0%	12.5%	0.0%	33.3%	25.0%	0.0%	25.0%	0.0%	14.3%	25.0%	0.0%
US or Canada	66.7%	62.5%	0.0%	100.0%	100.0%	100.0%	87.5%	75.0%	100.0%	100.0%	100.0%	100.0%
IMG	33.3%	37.5%	100.0%	0.0%	0.0%	0.0%	12.5%	25.0%	0.0%	0.0%	0.0%	0.0%

[1] Reflects section/group definition of its membership.
[2] Includes other self-reported racial and ethnic groups.

Table 7. Characteristics of Specialty Society Delegations, December 2024

	Mean Age[1]	Median Age[1]	% Female	% IMG	% Resident
AMA Members (n = 290,796)	46.5	38	41.6%	19.2%	29.2%
Specialty Society Delegates and Alternates (n = 433)	55.1	54	44.3%	9.7%	2.3%
Family Medicine Delegations (n = 28)	54.9	54	53.6%	10.7%	0.0%
Internal Medicine Delegations (n = 106)	58.4	59	44.3%	17.0%	1.9%
Surgery Delegations (n = 99)	53.7	52	35.4%	8.1%	4.0%
Pediatrics Delegations (n = 11)	52.1	45	81.8%	0.0%	0.0%
OB/GYN Delegations (n = 29)	57.3	58	65.5%	6.9%	0.0%
Radiology Delegations (n = 30)	57.1	60	36.7%	6.7%	0.0%
Psychiatry Delegations (n = 26)	53.4	54	53.8%	3.8%	0.0%
Anesthesiology Delegations (n = 17)	50.9	52	17.6%	5.9%	11.8%
Pathology Delegations (n = 19)	53.5	53	52.6%	10.5%	0.0%
Other specialty Delegations (n = 66)	54.0	52	42.4%	7.6%	3.0%

The specialty delegations listed above contain the following delegations:

Family Medicine: General Practice, Family Medicine
Internal Medicine: Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery: General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics: Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology: Obstetrics and Gynecology
Radiology: Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry: Psychiatry, Child Psychiatry
Anesthesiology: Anesthesiology
Pathology: Forensic Pathology, Pathology
Other Specialty: Aerospace Medicine, Dermatology, Emergency Medicine,
General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

[1] The mean age is the arithmetic average age. The median age is the age at which 50% of the group is older and 50% is younger

Table 8. Mean and Median Age of AMA Members and Delegations by State, December 2024

State	Total AMA Members in State	Mean Age of AMA Members	Median Age of AMA Members	Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates	Median Age of Delegates and Alternate Delegates
Alabama	3,838	43.7	34	7	62.1	68
Alaska	327	55.2	53	0	0.0	0
Arizona	4,136	48.7	39	9	63.1	65
Arkansas	1,926	46.2	37	4	69.3	70
California	36,006	50.6	46	63	55.2	55
Colorado	5,152	45.6	40	9	61.7	67
Connecticut	3,098	47.9	38	9	61.2	67
Delaware	855	54.9	53	2	†	†
District of Columbia	1,843	40.8	32	2	†	†
Florida	15,970	49.2	40	37	60.1	62
Georgia	6,098	47.8	42	10	57.6	57
Guam	19	59.7	58	0	0.0	0
Hawaii	1,081	53.7	48	3	†	†
Idaho	844	47.8	41	3	†	†
Illinois	11,110	48.8	37	21	62.4	66
Indiana	4,950	43.8	33	9	61.0	68
Iowa	3,224	46.8	40	6	60.0	60
Kansas	2,821	43.4	32	7	63.1	66
Kentucky	4,282	44.1	36	9	62.9	64
Louisiana	5,988	41.2	35	9	55.6	57
Maine	1,250	44.3	34	3	†	†
Maryland	5,267	52.1	48	13	59.5	61
Massachusetts	12,806	38.9	32	16	57.6	61
Michigan	13,136	44.4	35	24	57.7	59
Minnesota	4,683	48.5	40	9	61.8	62
Mississippi	2,748	45.2	36	6	58.5	58
Missouri	5,369	41.4	32	7	58.9	63
Montana	620	49.3	40	2	†	†
Nebraska	1,684	42.3	32	3	†	†
Nevada	1,896	44.9	35	4	67.8	66
New Hampshire	853	52.1	50	3	†	†
New Jersey	8,440	49.0	42	14	64.3	68
New Mexico	1,254	51.0	44	3	†	†
New York	22,864	44.9	34	38	58.4	62
North Carolina	5,395	48.4	40	10	57.9	58
North Dakota	1,315	44.1	41	2	†	†
Ohio	10,750	44.0	33	20	52.5	49

† To protect the privacy of these individuals, data for three or fewer persons are not presented in the table, although the data are included in the overall total.

State	Total AMA Members in State	Mean Age of AMA Members	Median Age of AMA Members	Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates	Median Age of Delegates and Alternate Delegates
Oklahoma	3,393	42.7	32	7	59.4	56
Oregon	3,294	50.6	46	7	57.0	58
Other	786	81.3	89	1	†	†
Pennsylvania	14,059	48.7	40	26	57.2	61
Puerto Rico	1,460	44.5	31	2	†	†
Rhode Island	1,070	44.6	34	5	59.4	62
South Carolina	3,392	44.0	34	8	62.9	67
South Dakota	1,316	44.4	40	4	61.5	61
Tennessee	5,132	44.7	34	8	63.3	64
Texas	21,053	43.3	34	31	59.3	60
Utah	2,093	45.0	36	3	†	†
Vermont	522	48.0	37	1	†	†
Virgin Islands	28	73.5	73	1	†	†
Virginia	6,776	47.0	40	15	56.5	57
Washington	5,779	51.7	48	10	49.9	45
West Virginia	1,820	42.0	33	2	†	†
Wisconsin	4,733	47.2	38	10	57.9	55
Wyoming	192	60.5	58	2	†	†
TOTAL	290,796	46.5	38	539	58.9	60

Table 9. Women and International Medical Graduates on State Association Delegations, December 2024

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Total Women AMA Members in State	Number of Women Delegates and Alternate Delegates	Total IMG Members in State	Number of IMG Delegates and Alternate Delegates
Alabama	3,838	7	1,532	2	563	0
Alaska	327	0	130	0	39	0
Arizona	4,136	9	1,557	3	685	1
Arkansas	1,926	4	729	0	277	0
California	36,006	63	15,575	25	6,983	5
Colorado	5,152	9	2,362	5	292	0
Connecticut	3,098	9	1,293	4	778	2
Delaware	855	2	295	1	252	0
District of Columbia	1,843	2	953	0	242	0
Florida	15,970	37	5,926	12	4,732	6
Georgia	6,098	10	2,671	3	1,208	1
Guam	19	0	5	0	11	0
Hawaii	1,081	3	406	2	155	0
Idaho	844	3	261	2	45	1
Illinois	11,110	21	4,588	8	2,425	4
Indiana	4,950	9	1,955	5	714	2
Iowa	3,224	6	1,266	3	561	1
Kansas	2,821	7	1,126	3	276	0
Kentucky	4,282	9	1,717	2	603	0
Louisiana	5,988	9	2,643	3	967	2
Maine	1,250	3	618	1	102	0
Maryland	5,267	13	2,346	6	1,338	4
Massachusetts	12,806	16	6,438	5	1,981	1
Michigan	13,136	24	5,277	8	3,027	3
Minnesota	4,683	9	1,835	4	780	0
Mississippi	2,748	6	988	2	333	1
Missouri	5,369	7	2,265	3	720	2
Montana	620	2	236	1	29	0
Nebraska	1,684	3	702	1	143	0
Nevada	1,896	4	699	1	391	1
New Hampshire	853	3	322	1	151	0
New Jersey	8,440	14	3,387	5	2,528	4
New Mexico	1,254	3	525	2	185	0
New York	22,864	38	9,750	13	6,712	6
North Carolina	5,395	10	2,093	6	734	0
North Dakota	1,315	2	510	1	264	0
Ohio	10,750	20	4,429	8	1,855	4
Oklahoma	3,393	7	1,354	3	387	0
Other	786	1	124	1	425	0
Oregon	3,294	7	1,475	2	297	0
Pennsylvania	14,059	26	5,428	4	2,666	5

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Total Women AMA Members in State	Number of Women Delegates and Alternate Delegates	Total IMG Members in State	Number of IMG Delegates and Alternate Delegates
Puerto Rico	1,460	2	660	0	284	1
Rhode Island	1,070	5	491	2	205	0
South Carolina	3,392	8	1,449	1	325	0
South Dakota	1,316	4	543	1	187	0
Tennessee	5,132	8	2,055	2	562	2
Texas	21,053	31	9,085	10	3,787	3
Utah	2,093	3	610	1	101	0
Vermont	522	1	242	0	45	0
Virgin Islands	28	1	9	1	8	0
Virginia	6,776	15	2,911	7	1,219	1
Washington	5,779	10	2,428	6	942	2
West Virginia	1,820	2	707	0	389	0
Wisconsin	4,733	10	1,939	5	797	1
Wyoming	192	2	57	0	20	0
TOTAL	290,796	539	120,977	197	55,727	66

Table 10. Medical Students and Resident Physicians on State Association Delegations, December 2024

State	Total AMA Members in State	Number of State Delegates and Alternate Delegates	Total Medical Student AMA Members in State	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates[1]	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates	Number of Sectional Resident Delegates and Alternate Delegates[2]
Alabama	3,838	7	606	2	2	1,644	0	0
Alaska	327	0	6	0	0	24	0	0
Arizona	4,136	9	858	0	0	1,052	1	0
Arkansas	1,926	4	531	1	1	403	0	0
California	36,006	63	3,231	7	5	7,485	6	4
Colorado	5,152	9	1,523	1	1	691	1	1
Connecticut	3,098	9	474	6	6	963	1	1
Delaware	855	2	21	0	0	128	0	0
District of Columbia	1,843	2	613	0	0	515	0	0
Florida	15,970	37	2,397	3	3	5,098	1	1
Georgia	6,098	10	1,076	0	0	1,430	0	0
Guam	19	0	0	0	0	1	0	0
Hawaii	1,081	3	148	0	0	237	0	0
Idaho	844	3	162	0	0	209	0	0
Illinois	11,110	21	2,462	2	1	2,872	5	4
Indiana	4,950	9	1,037	2	2	1,733	0	0
Iowa	3,224	6	403	1	1	948	0	0
Kansas	2,821	7	1,140	2	2	476	0	0
Kentucky	4,282	9	945	0	0	1,144	0	0
Louisiana	5,988	9	1,225	0	0	1,957	0	0
Maine	1,250	3	481	0	0	200	0	0
Maryland	5,267	13	421	1	1	1,036	1	0
Massachusetts	12,806	16	3,362	3	2	5,778	3	2
Michigan	13,136	24	1,775	2	1	5,267	3	3

[1] The Medical Student Section elects AMA delegates and alternate delegates from Medical Student Regions. There are seven Medical Student Regions defined for the purposes of electing AMA Delegates from Medical Student Regions. Each Region is entitled to delegate and alternate delegate representation based on the number of seats allocated to it by apportionment. A delegate is seated with the state delegation in which his or her medical school resides.

[2] Resident sectional delegates and alternate delegates endorsed by specialty societies were not included in this table. The following specialty societies endorsed sectional resident delegates and alternate delegates: American Academy of Dermatology Association, American Academy of Neurology, American Academy of Ophthalmology, American Academy of Pediatrics, American Academy of Physical Medicine and Rehabilitation, American Association of Neurological Surgeons, American College of Chest Physicians (CHEST), American College of Emergency Physicians, American College of Nuclear Medicine, American College of Obstetricians and Gynecologists, American College of Radiology, American College of Surgeons, American Psychiatric Association, American Society of Anesthesiologists, American Urological Association, Association for Clinical Oncology, College of American Pathologists, Society of Interventional Radiology, and Undersea and Hyperbaric Medical Society.

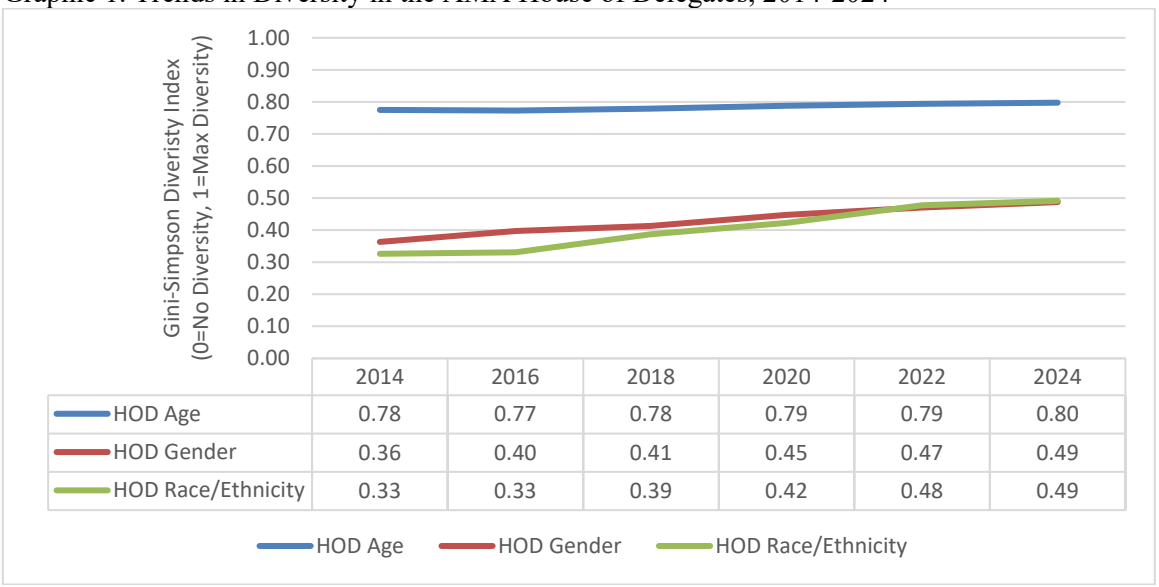
State	Total AMA Members in State	Number of State Delegates and Alternate Delegates	Total Medical Student AMA Members in State	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates[1]	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates	Number of Sectional Resident Delegates and Alternate Delegates[2]
Minnesota	4,683	9	388	0	0	1,563	0	0
Mississippi	2,748	6	640	1	1	771	1	1
Missouri	5,369	7	1,541	2	1	1,757	1	1
Montana	620	2	239	0	0	34	0	0
Nebraska	1,684	3	704	1	1	231	1	1
Nevada	1,896	4	401	1	1	620	0	0
New Hampshire	853	3	96	0	0	170	0	0
New Jersey	8,440	14	1,172	2	2	2,275	1	1
New Mexico	1,254	3	278	0	0	209	1	1
New York	22,864	38	3,699	3	2	10,101	2	1
North Carolina	5,395	10	673	1	1	1,608	0	0
North Dakota	1,315	2	356	0	0	98	0	0
Ohio	10,750	20	2,299	3	3	3,936	2	2
Oklahoma	3,393	7	1,036	1	1	1,036	3	3
Other	3,294	7	401	1	1	473	0	0
Oregon	786	1	22	0	0	48	0	0
Pennsylvania	14,059	26	2,072	3	1	3,670	1	0
Puerto Rico	1,460	2	597	0	0	306	0	0
Rhode Island	1,070	5	251	0	0	341	2	2
South Carolina	3,392	8	1,014	1	1	737	0	0
South Dakota	1,316	4	355	0	0	140	0	0
Tennessee	5,132	8	1,477	1	1	1,330	0	0
Texas	21,053	31	4,468	4	3	7,300	5	4
Utah	2,093	3	718	0	0	336	0	0
Vermont	522	1	119	0	0	119	0	0
Virgin Islands	28	1	0	0	0	0	0	0
Virginia	6,776	15	1,379	2	2	1,572	1	1
Washington	5,779	10	465	0	0	747	0	0
West Virginia	1,820	2	385	0	0	708	0	0
Wisconsin	4,733	10	735	2	2	1,413	1	0
Wyoming	192	2	4	0	0	11	0	0
TOTAL	290,796	539	52,881	62	52	84,951	44	34

Gini-Simpson Diversity Index (GSI) of the House of Delegates and AMA Leadership

A diversity index is a probabilistic measure that two individuals selected at random will represent different identities. The index provides a balanced and robust assessment of diversity and has been widely applied across demographic and clinical research contexts. The Council utilized the Gini-Simpson Diversity Index (GSI) which is the probability that two individuals selected at random will represent different identities; it is measured from 0 to 1, where 0 represents an absence of diversity and 1 represents the greatest possible diversity. CLRPD assessed diversity trends within the AMA HOD and AMA Leadership from 2014 to 2024, specifically focusing on member age, gender, and race/ethnicity.

From 2014 to 2024, the HOD demonstrated gradual but consistent increases in gender and racial/ethnic diversity, rising from 0.36 to 0.49 for gender, and 0.33 to 0.49 for race/ethnicity, while age diversity remained stable around 0.78. The total diversity index for HOD consequently improved from 0.49 to 0.59 over this period.

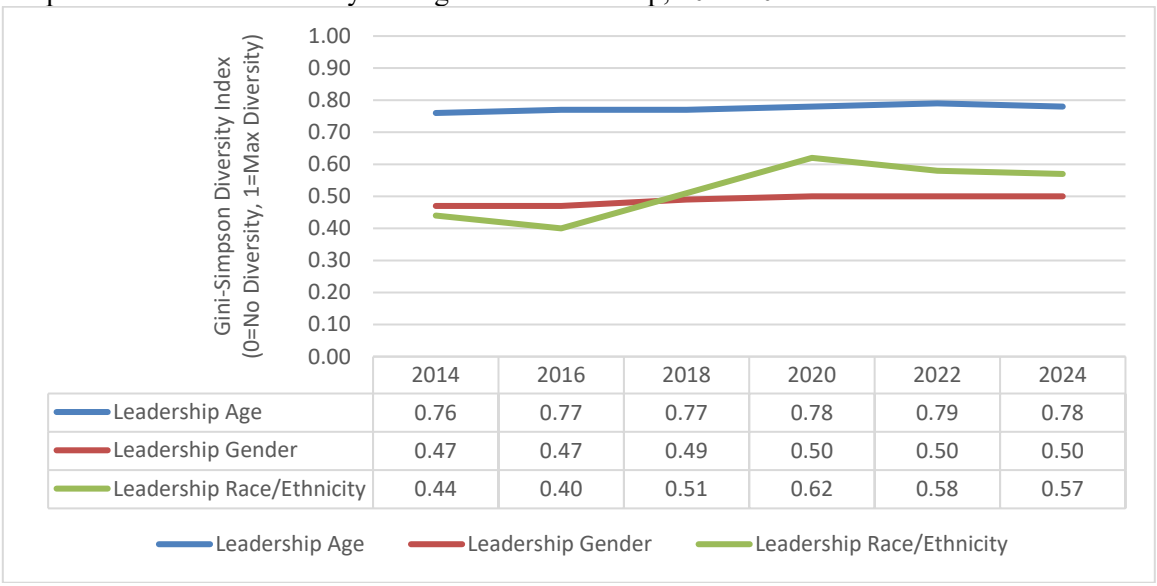
Graphic 1. Trends in Diversity in the AMA House of Delegates, 2014-2024



	2014	2016	2018	2020	2022	2024
HOD Age	0.78	0.77	0.78	0.79	0.79	0.80
HOD Gender	0.36	0.40	0.41	0.45	0.47	0.49
HOD Race/Ethnicity	0.33	0.33	0.39	0.42	0.48	0.49

Among AMA Leadership, a similar trajectory was observed. Gender diversity increased from 0.47 to approximately 0.50, and racial/ethnic diversity rose notably from 0.44 in 2014 to a peak of 0.62 in 2020 before slightly adjusting to 0.57 in 2024. Age diversity remained relatively constant around 0.77. The overall leadership diversity improved from 0.56 in 2014 to 0.62 in 2024, reflecting positive, though modest, gains.

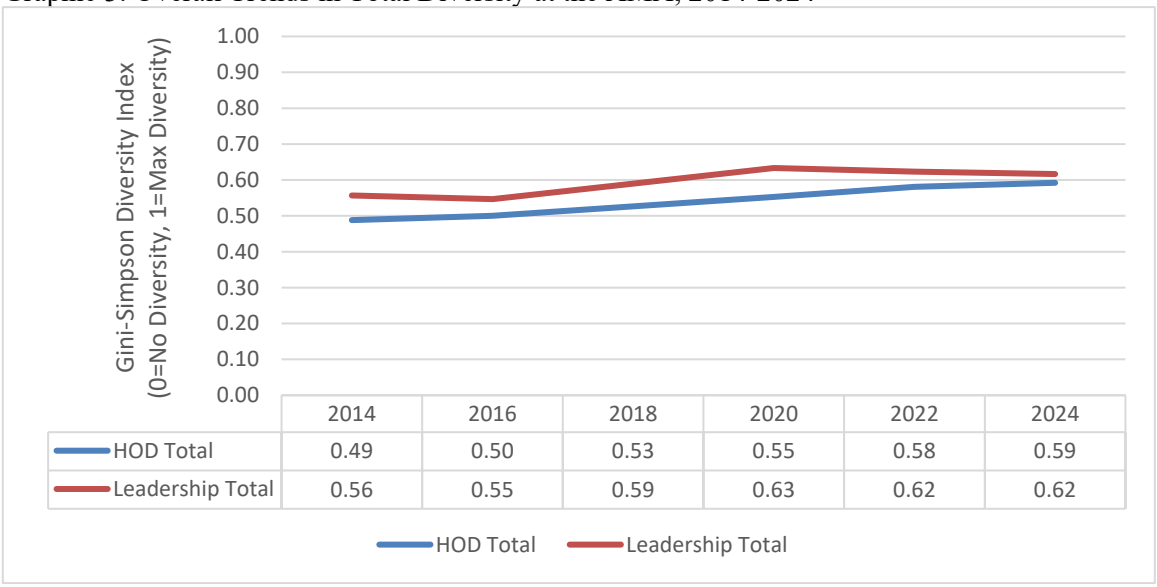
Graphic 2. Trends in Diversity among AMA Leadership, 2014-2024



	2014	2016	2018	2020	2022	2024
Leadership Age	0.76	0.77	0.77	0.78	0.79	0.78
Leadership Gender	0.47	0.47	0.49	0.50	0.50	0.50
Leadership Race/Ethnicity	0.44	0.40	0.51	0.62	0.58	0.57

The GSI illustrates that while diversity has gradually increased within AMA leadership and delegates, continuous efforts are necessary to foster further improvements, particularly in the representation of diverse gender and racial/ethnic identities.

Graphic 3. Overall Trends in Total Diversity at the AMA, 2014-2024



	2014	2016	2018	2020	2022	2024
HOD Total	0.49	0.50	0.53	0.55	0.58	0.59
Leadership Total	0.56	0.55	0.59	0.63	0.62	0.62

APPENDIX B

Specialty classification using physicians' self-designated specialties

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

American Medical Association Councils and Sections

COUNCILS

- American Medical Political Action Committee
- Council on Constitution and Bylaws
- Council on Ethical and Judicial Affairs
- Council on Legislation
- Council on Long Range Planning and Development
- Council on Medical Education
- Council on Medical Service
- Council on Science and Public Health

SECTIONS

- Academic Physicians Section
- Integrated Physician Practice Section
- International Medical Graduates Section
- LGBTQ+ Section
- Medical Student Section
- Minority Affairs Section
- Organized Medical Staff Section
- Private Practice Physicians Section

- Resident and Fellow Section
- Senior Physicians Section
- Young Physicians Section
- Women Physicians Section

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-A-25

Subject: Prescription Drug Affordability Boards

Presented by: Stephen Epstein, MD, MPP, Chair

Policy D-110.984 was adopted at the 2024 Annual Meeting and asks our American Medical Association (AMA) to study how upper payment limits (UPLs) established as a part of prescription drug affordability boards (PDABs) impact physician reimbursement and patient access to medications. The following informational report discusses the background of PDABs, the current state of these boards, potential impacts on patients and physicians, and existing AMA policy on the topic.

BACKGROUND

Drug prices in the United States (U.S.) make up nine to ten percent of total medical spending each year, or over $700 billion annually.[1] Research demonstrates that over the last 65 years, the prices of prescription medications have increased faster than both inflation and non-prescription medications.[2] This is due largely to high-priced branded drugs, which make up about 80 percent of U.S. drug spending.[1] American spending is also significantly higher than other comparable nations, with estimates of spending on prescription drugs over 200 percent higher per capita. This higher level of spending does not appear to result from American patients purchasing a higher quantity of medication, as the same study found that U.S. consumers purchased 12 percent fewer days of medications than patients in the other similar nations.[2] Rather, the high drug costs in the U.S. are a result of an incredibly complex, and largely opaque, system. While not all-encompassing, experts specify that the higher spending comes from a combination of higher transaction prices, selection of more expensive medications, monopoly pricing, patent extensions/gaming, and influential rebates.[1,2,3]

In an attempt to combat high drug prices and patient out-of-pocket (OOP) costs for medications, some states have begun to pass legislation to implement PDABs.[4,5] The first PDAB was established in Maryland in 2019 and in recent years more states have enacted legislation creating PDABs.[5] However, few states have actually begun to implement the work that is outlined in legislation, making the impact of these PDABs difficult to assess. Generally, PDABs are designed to both evaluate the jurisdiction's (typically a state's) spending on prescription drugs and to establish methods for lowering this spending. While there is a wide variety in the makeup, scope, and power of these boards, most focus on a specific set of prescription medications and release reports evaluating the state's spending and recommendations to increase affordability.[6] PDABs are often made up of health care providers, advocates, payer representatives, and patients/patient group representatives. Members are typically selected via an application process or by gubernatorial/congressional appointment.[6,7]

The majority of the states that have enacted PDABs utilized the National Academy for State Health Policy's (NASHP) model legislation, originally released in 2017 and updated in 2022, which includes references to federal legislation on drug pricing.[8] This model legislation is designed to

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give states the authority to establish a framework that defines which medications are "unaffordable." The NASHP model bill includes PDAB authority to define upper payment limits (UPLs) for medications that are designated as "unaffordable."[8] UPLs are designed to set a maximum price for a specific drug based on its cost-effectiveness and affordability.[7] UPLs are intended to prevent price gouging and ensure that patients have access to essential medications. While state PDABs do not automatically have authority to establish UPLs, some states have chosen to include this authority.[7,8]

STATE PDABs

As of March 2025, 11 states (CO, ME, MD, MA, MN, NH, NJ, NY, OH, OR, and WA), have enacted legislation and some have begun to implement PDABs.[9] Details of each of the existing state PDABs can be found in Appendix A. Some states have limited the impact of PDABs to only public plan enrollees, others have incorporated the boards as a part of Medicaid plans only, while other states have indicated the intent for expansion to all enrollees, regardless of payer type. While many states have chosen not to include UPLs, four states, Colorado, Maryland Minnesota, and Washington, have included authority to establish UPLs.[9,10]

Each state has outlined different methods for selecting board members and medications, funding the work, and the reach of authority. Some states, like New York and Massachusetts have incorporated PDAB authorities into existing governmental organizations, NY Medicaid and MA Health and Human Services, respectively.[11,12] As a result, no additional funding or employees were allocated to those states' boards. However, other states have made significant investments in establishing a PDAB. For example, Oregon, Washington, and New Jersey have allocated at least $1.5 million each for the startup of the boards.[13,14,15] Funding origins are also diverse with some states, like Colorado, listing it as a state budget line while others have alternative funding sources.[16] Specifically, states like Oregon and Maryland plan to generate future funding via fees on drug manufactures, insurance carriers, wholesale distributors, and/or Pharmacy Benefit Managers (PBMs).[13,17]

States also vary in the makeup of boards and the impacted population(s). In addition to the employees that some states have hired (or plan to hire) to run the PDAB, states have chosen various methods to select board members. Most states utilize/plan to utilize a combination of appointments from congressional leaders and/or the governor. However, the makeup of expertise on the board varies from state to state.[6,8] Many states encourage or require that patients or patient advocates be a part of the board, while other states, like Colorado and Washington, require a certain level of drug pricing policy or clinical expertise for a certain subset of board members.[14,16] Further, states vary in the length of time board members can serve and if they must be confirmed by the state legislature. Additionally, states vary greatly in the populations that will be impacted by the outcome of PDAB decisions. Many states, like Maine, Maryland, and New Hampshire, have chosen to focus only on public plan beneficiaries.[17,18,19] However, other states, like Colorado, Minnesota, and Washington, have chosen to focus on all consumers with minor exceptions for plans preempted by the Employee Retirement Income Security Act that chose to opt out.[14,16,20]

In addition to the differences in the structure and authority of PDABs, states differ in which drugs are eligible to be covered. A few states have relatively open criteria while others have more stringent requirements. States like New Hampshire and Maine focus on any prescription medications that are purchased by public payers and may cause "affordability challenges."[18,19] However, the majority of states have more strict criteria typically centering around drugs with high wholesale acquisition cost (WAC) launch prices, have substantial percentage WAC increases, those with a certain WAC price, and/or generics that are not a specified percentage less expensive than

the reference medication. For example, in Maryland for a drug to be considered by the PDAB it must meet the following criteria:

- if the medication is brand name and has a WAC of $30,000+ or a $3,000+ price increase in 12 months; or
- if the medication is a biosimilar and has a WAC that is less than 15 percent lower than the reference medication; or
- if the medication is generic and has a WAC of more than $100 for a 30-day prescription or an increase in WAC over 200 percent.[17]

While the details vary by state, those with more specific criteria tend to be comparable to the aforementioned requirements in Maryland. However, Oregon has unique criteria in that the legislation outlines the selection of 10 drugs to be reviewed each calendar year. One of the selected drugs must be an insulin product and the other nine are selected from the state's Prescription Drug Price Transparency Program, excluding any medication designed to treat a Food and Drug Administration (FDA) designated rate disease or condition.[13] Additionally, some states, like Ohio, have chosen to not focus on specific drugs but, rather, to focus on strategies to reduce overall drug spending, increase transparency, and optimize resources and bargaining power.[21]

An important distinction in state legislation is whether PDABs are given the authority to set UPLs. Of the 11 states that have enacted PDAB legislation, only four have granted authority to set UPLs: Colorado, Maryland (pending legislative approval), Minnesota, and Washington. Within states with UPL authority, Washington is only able to set UPLs for up to 12 drugs, while Colorado and Minnesota do not have a limit for establishing UPLs on PDAB-reviewed drugs.[14,16,17,20] Each of these states have unique processes for establishing the UPL based on a combination of cost and value measures. For example, in Washington if a drug is ruled as "unaffordable" by the board, the following must be taken into account when setting an UPL: the cost of administering the medication; the cost of delivering the drug to the patient, if the drug is included in the FDA drug shortage list; and any relevant administrative costs related to the delivery and/or production of the drug. Additionally, the board must monitor the drug for future drug shortages and can suspend the UPL should a shortage occur. Finally, the board must assess the value that the drug has for those who utilize it to enhance health and/or elongate life.[14] While each state with UPL authority has different specific requirements, they all generally follow the above-mentioned requirements. Nonetheless, at the time this report was written, no state had set an UPL.

Of important note, some state PDABs have faced legislative and legal challenges that limit their implementation. For example, in 2019, Ohio successfully passed legislation outlining the creation and implementation of a state PDAB. However, in 2021, an amendment to the statute that originally authorized the PDAB was made that essentially nullifies the state's PDAB in practice.[22] In addition to legislative challenges, PDABs are facing legal challenges, often from drug manufacturers. For example, after Colorado's PDAB ruled that the drug Enbrel® was "unaffordable," paving the way for the establishment of a UPL, the drug's manufacturer, Amgen, sued the state, claiming that the PDAB law violates several state constitutional provisions and attempts to regulate federal health care programs.[23] At the time this report was written, the outcome of this case is unknown. However, it is highly likely that more lawsuits will begin to materialize as additional states make claims of unaffordability and, in some cases, establish UPLs.

State Example: Colorado

The Council highlights Colorado as an example in this report as its PDAB is perhaps the furthest along in the process and includes UPLs authority. In 2021, legislation to establish a PDAB in

Colorado became law. The board is overseen by the Division of Insurance of the Colorado Department of Regulatory Agencies (DORA). The board consists of up of five members who have advanced degree(s) or experience in health care economics or clinical medicine and are appointed by the governor and confirmed by the state senate. The board began meeting in late 2021 and in 2024, Colorado's PDAB voted to determine the affordability of the first five drugs. This process included presentations by experts, testimony from witnesses, including open public testimony, and deliberation of the board members. Two medications were ruled as "not unaffordable" and the other three were ruled "unaffordable" to Colorado consumers. For the three medications that were ruled "unaffordable," the PDAB is working to establish UPLs. Per the original design, the board has a preset process that was anticipated to take approximately six months. However, due to certain barriers, such as legal challenges from the manufacturer, this process has been drawn out and UPLs have not yet been established for the three medications ruled "unaffordable." The first UPL rulemaking hearing was scheduled to be held in early March 2025, which will begin the process of establishing the payment limit for the specific medication.[16]

POTENTIAL IMPACTS

PDABs and UPLs are novel to the drug pricing landscape and, as a result, much of the information regarding their impact is speculative. Many states have established policies to create PDABs, but the majority of boards have either not yet started meeting or started very recently. While researchers have theorized how these boards and/or limits may impact patients and physicians, data to establish firm, research-based conclusions of the actual impacts are not available at this time.

Proponents of PDABs and UPLs explain that these strategies are designed to rein in out-of-control drug prices, ensure that patients have access to their medications at a reasonable price, and lower state drug spending.[24,25] Supporters point to similar practices in the non-medical communities, such as public utility commissions. Each state has its own public utility commission which works to regulate providers to ensure that the prices that consumers pay for public utilities are fair for all involved. While these commissions have been relatively successful in controlling utility costs, the difference between the structure of utility pricing and delivery and drug pricing and delivery is quite significant.[26] Additionally, it is a reasonably common practice for states to set payment rates for health care services to ensure they are affordable and accessible to patients. For example, fee schedules are commonly set by state and federal governments that list the maximums that a physician or provider is paid for a service. Some anticipate that PDABs and UPLs could function in a similar way to control costs.[25] Supporters of PDABs believe that by focusing on the drug payment rate specifically, patent preemption (i.e., breaking the patent) is avoided while also allowing for control of drug cost. At the core, those who champion PDABs argue that medications are exceptionally expensive and these boards will lower drug prices, thus making drugs more accessible and affordable to patients.[24,25]

While most experts agree that prescription medications in the US are prohibitively expensive, some experts have expressed concern regarding the impact that PDABs and UPLs may have on patients and physicians.[7,27] Concern has been expressed that the implementation of these boards will negatively impact patient access to medications. One specific concern centers around medication formulary placement. If a medication is given an UPL, payers may choose to place it on a less desirable formulary tier. This could result in patients not being able to access the most effective medication affordably and/or increase required utilization management for that medication.[7,27] Further, this could result in limits to physician payment and disrupt physician/practice ability to purchase medications in a fiscally responsible manner. This is especially salient if the drug's UPL is less than the acquisition cost, as purchasers would not be able to affordably stock the medication.[10]

Concern also has been raised that patient assistance programs could suffer for selected medications. These concerns are particularly salient for patients who are on essential, specified, and expensive prescriptions, especially HIV, cancer, and Hepatitis C treatments/medications.[27] For example, research has suggested that patients on HIV medications saved 91 percent of their OOP costs due to copay assistance programs. Should these medications be given UPLs, it is possible that manufacturers could reassess assistance programs. This could lead to a situation where the medication cost may be below the UPL, but patients may be required to pay greater OOP costs due to lessened or removed assistance programs.[7,27] Research has suggested that even a minor increase in patient OOP spending impacts patient adherence. For example, a recent study found that a minor increase from $0 to $10 OOP cost doubled the abandonment rate for patients using oral HIV pre-exposure prophylaxis (PrEP). This study, along with others linking increases in patient OOP costs to lower treatment adherence, exemplifies the potential impact of even a small change to programs designed to relieve patient OOP costs.[28] There is ample concern that the implementation of PDABs, especially those with UPL authority, could significantly impact programs designed to relieve patient OOP costs potentially impacting treatment adherence.[27]

Additionally, advocacy groups have recently raised concerns around the disproportionate impact of PDABs on people with disabilities. While the states that have released lists of selected medications are still relatively limited, initial lists indicate that the vast majority of selected medications are disproportionately used to treat conditions that are likely or highly likely to be classified as "disabling" under the Americans with Disabilities Act (ADA).[29,30] Even while Washington state has the lowest rate of medications used to treat potentially disabling diagnoses, it still amounts to over 86 percent. Across the published lists, each state has at least one HIV antiretroviral, with medications to treat cancer, genetic disorders, autoimmune disorders, and endocrine disorders also disproportionately represented.[29] Serious concerns have been raised that the selection of these medications could cause disparate impacts on the disability community and limit patient access to essential medications. Experts explain that the potential downline supply chain disruptions and lack of guaranteed patient cost savings, paired with the aforementioned unknown impact on patient assistance programs, could lead to significant barriers in patient access.[29,30]

While it remains to be seen how PDABs and their UPLs will impact patients and physicians, it is important to acknowledge the enforcement potential of these boards. Experts agree that while PDABs are likely very well intentioned, there is not much enforcement to back up the recommendations that are made. This is especially relevant for states that have not granted UPL authority to their PDAB. However, even among the states that have given authority to grant UPLs, there are significant questions as to whether these limits will impact actual drug prices. For example, there is current discussion as to whether these UPLs will apply to insurers that are not regulated by the state. In other words, federal or interstate plans may be outside the scope of authority for state PDABs.[23,31] Without effective enforcement, which no PDAB seems to have at the present time, it is unlikely that manufacturers, payers, and PBMs will adhere to the suggested prices.

AMA POLICY AND ADVOCACY

The AMA has a robust body of policy to ensure that prescription medications are affordable and accessible to patients. Specifically, Policy H-110.997 outlines support for programs that are designed to mitigate the cost of prescription medications, physician autonomy to prescribe the most appropriate and effective medication to their patient, and for payers to cover prescribed medications. Policy H-110.987 builds on the aforementioned policy to ensure that pharmaceutical companies and their proxies are not participating in anticompetitive behaviors or mergers/acquisitions that unduly raise the cost of prescription medications. This policy also

addresses the need to ensure that prescription prices are reasonable and do not exceed the pace of inflation. Policy H-330.864 focuses specifically on reforming Medicare drug reimbursement and ensuring that it is done in a manner that allows for patient access and also reimburses physicians fairly. Finally, Policy H-100.964 outlines AMA support to ensure that prescription medications are covered by payers in a manner that keeps them affordable and accessible to patients.

Additionally, the AMA has a robust history of drug pricing advocacy. Over the last few years, numerous letters and testimonies have been sent to regulators (CMS 2023, CMS 2024), legislators (House 2023, House 2023(a), Senate 2024), and payers (NAIC 2023) working to mitigate the high price of prescription drugs and ensure that patients are able to afford their medications. In addition to this advocacy work, the AMA has a longstanding grassroots campaign, TruthinRx, that is designed to increase transparency of drug pricing and decrease costs.

In addition to policy and advocacy surrounding drug pricing, AMA policy addresses concerns raised by sceptics of PDABs and UPLs. The AMA has a long history of working to lessen utilization management, especially prior authorization via campaigns (e.g., Fix Prior Auth) and policy. Specifically, Policies H-320.939 and D-320.982 outline the AMA's stance against prior authorization and efforts to ensure that physicians are not overburdened by these requirements. Additionally, Policy H-125.991 outlines the AMA's efforts to ensure that payer formularies are fair and inclusive of physician-prescribed medications.

DISCUSSION

Proponents of PDABs believe that they will do what they intend—lower drug prices in the U.S. and create a more affordable system for patients. However, critics voice concerns around the actual impacts. Concern has been expressed that PDABs, especially those with the authority to establish UPLs, may increase physician administrative burden, increase costs for patients and physicians, and disproportionately impact patients with ADA disabling conditions. Additionally, concerns have been raised that if UPLs are set below the acquisition cost for a physician administered drug, there may be an adverse impact on medication availability and could result in market distortions. Others question the actual enforcement authority these boards have, or will have, on regulating drug prices. Since PDABs and UPLs are relatively new, it will take time to see if these strategies result in their intended goal—to lower drug prices and make prescription medications more affordable for patients.

CONCLUSION

The Council believes that the AMA has robust advocacy efforts and clear policy supporting the need for prescription drugs to be affordable and accessible to patients. However, due to the relative recency of PDABs, there is no research yet available on actual impacts or outcomes of the boards. Therefore, the Council will continue to monitor this issue and report back when a reasonable body of research has been established in which to form conclusions and guide additional, well-informed policy on the impact of PDABs and UPLs on patients and physicians.

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Appendix A
State Prescription Drug Affordability Boards

State	Initiative	Budget/Funding	UPL Authority?	Membership	Populations	Drug Inclusion Criteria
Colorado	CO SB 175-2021	State budget line. *Approximately $750,000/year.*	Yes.	2 FTE and 2 PTE employee allocation. Additional contractors approved with board review. Additional $250,000 allocated. The Board consists of 5 members appointed by the governor and confirmed by the senate. All must have either an advanced degree and experience or expertise in health care economics or clinical medicine.	All consumers. *Exemption for state funded plans that choose to opt out.*	Drugs that meet 3+ of the following: - Brand-name drugs and biologics that have a wholesale acquisition cost (WAC) of $30,000+ - Brand-name drugs and biologics that have a WAC increase of 10%+ in the last 12 months - Biosimilars that launch at a WAC that is not at least 15% less than the reference - Generics that have a WAC of over $100/30 days
Maine	ME LD 120 (2021)	Absorbed by existing budgets.	No.	0 FTE. Board supported by the Office of Affordable Health Care. The Board consists of 13 members, 6 appointed by the Senate President, 5 by the Speaker of the House, 2 state commissioners (non-voting).	Public plan beneficiaries.	Drugs that are purchases by public payers and may cause "affordability challenges."
Maryland	MD HB 768-2019	Start up costs provided by the State budget. Annual funding from fees on drug manufacturers, PBMs, carriers, and wholesale distributors. *2024*	Yes. *If legislative approval is gained.*	5 FTE and 1 PTE. Additional contractors approved with board review. Additional $250,000 allocated. The Board consists of 5 members appointed by the governor, President of the Senate, Speaker of the House, Attorney General, and jointly	Public plan beneficiaries. *Have indicated potential to attempt expansion to all payers.*	Drugs that meet the following criteria: - Brand-name that launch with a WAC of over $30,000/yr - Brand-name with a price increase of $3,000+/year - Biosimilars that launch at a WAC that is not at least 15% less than the reference

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Appendix A
State Prescription Drug Affordability Boards

		budget: 1.4 million+		by the House Speaker and Senate President.		- Generics that have a WAC of over $100/30 days OR increased by 200%+ in the last year
Massachusetts	HB 4000 – Section 46 of FY 2020 Budget	No additional funding appropriated.	No.	Implemented through MA Medicaid agency and Health Policy Commission.	Medicaid beneficiaries.	Drugs covered by Medicaid that cost more than $25,000/yr per person or $10 million to the program. Excludes medications in which a supplemental rebate agreement is reached.
Minnesota	MN SF 2744-Section 62J.85	Base appropriation of at least $500,000/year from the State budget.	Yes.	1 FTE with the potential for more. Board to be supported by the Commissioner of Health and Attorney General. The Board consists of 9 members. 7 voting members appointed by the governor, 1 nonvoting member appointed by the senate majority leader, and 1 nonvoting member appointed by the speaker of the house.	All consumers. *Plans preempted by ERISA can choose to opt out.*	Drugs that meet the following criteria: - Brand name/biologics that have a WAC increase of over 15% or more than $3,000 annually or during the course of treatment after adjusting for Consumer Price Index - Brand name/biologics with a WAC of over $60,000 per year or course of treatment - Biosimilars that launch at a WAC that is not at least 20% less than the reference - Generics that have a WAC of over $100/30 days, a course of treatment, or one unit - Generics that have a price increase by 200%+ in the last year The Board may identify additional drugs that impose significant affordability challenges.
New Hampshire	NH HB 1280-2020	Appropriation of approximately $350,000/annually.	No.	N/A The Board consists of two members appointed by the president of the senate, two members appointed by the speaker of the house, and one appointed by the governor.	Public plan beneficiaries.	Drugs that are purchases by public payers and may cause “affordability challenges.”

Appendix A
State Prescription Drug Affordability Boards

New Jersey	P.L. 2023, c. 106	Appropriation of $1.5 million to implement the initial bill.	No.	The Board consists of 5 public members; 3 appointed by the governor; 1 on recommendation of the senate president, and 1 on recommendation of the house speaker. Will work in tandem with the Drug Affordability Council/Drug Affordability Unit.	N/A	Drug practice reports are reviewed and the board is able to make recommendations to increase affordability.
New York	PHL Sec 280-2017	No additional funding appropriated.	No.	Implemented through NY Medicaid Agency's Medicaid Drug Benefit Cap.	Medicaid beneficiaries.	- Drugs that will exceed the state's Medicaid drug cap (set annually) - Newly launched drugs that are "high cost" or meet the following o Brand-name that launch with a WAC of over $30,000/yr o Brand-name with a price increase of $3,000+/year o Biosimilars that launch at a WAC that is not at least 15% less than the reference o Generics that have a WAC of over $100/30 days o Gene therapies
Ohio	OH HB 166-133 2019	N/A. 2021 amendment to the authorizing statute mitigated authority. Board is still technically intact.	No.	The board is comprised of 17 individuals. 6 state employees (director of administrative services; director of health; Medicaid director; director of mental health and addiction services; administrator of workers' compensation) and 12 members who work in drug affordability and availability and are appointed by the governor, senate	N/A.	Not focused on specific drugs, instead the Board is tasked in creating reports including the following information: - How the state can best achieve drug price transparency - Avenues/payment models to increase/create affordability - Levering the state's purchasing power - Creating efficiencies to reduce costs

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				president, and house speaker (3 appointments each).		- Outcomes to be measured to improve state's purchasing of drugs - How existing resources cab be optimized
Oregon	OR SB 844-2021	$1.7+ million appropriated to the Department of Consumer and Business Services with the intent for reimbursement from manufacturer fees. The ongoing budget will come from fees.	No.	5 FTE. The Board consists of 5 members all appointed by the governor.	N/A.	Nine drugs and one insulin product each year based on drugs reported in OR's Prescription Drug Price Transparency Program. Excludes any drug designated by the FDA to treat a rare disease/condition.
Washington	WA SB 5532/Chapter 153-2022	Initial appropriation of $1.5 million over the first 3 years.	Yes. *For up to 12 drugs.*	4 FTE. The Board consists of 5 members appointed by the governor with expertise in health care economics or clinical medicine.	All consumers. *Exemption for state funded plans that choose to opt out.*	Drugs that have been on the market for 7+ years, are not designated by the FDA to treat a rare disease/condition, and meet the following criteria: - Brand name/biologics with a WAC of over $60,000 per year or course of treatment - Brand name/biologics that have a WAC increase of over 15% over 1 year or 50% over 3 years - Biosimilars that launch at a WAC that is not at least 15% less than the reference - Generics that have a WAC of over $100/30 days, a course of treatment, or have a price increase by 200%+ in the last year
Adapted from the NASHP Comparison of State Prescription Drug Affordability Review Initiatives and source legislation.						