AMA
AMERICAN MEDICAL ASSOCIATION
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ORGANIZED MEDICAL STAFF SECTION
Governing Council Report A
Annual 2025 Meeting

Access full text of resolutions/reports in the HOD meeting handbook.

Recommendations key
Instructions for the delegate and alternate delegate are designated as follows:

- *Strongly support* – the delegate/alternate delegate shall support the resolution as written and actively speak in favor of the resolution
- *Support* – the delegate/alternate delegate shall support the resolution as written
- *Monitor* – the delegate/alternate delegate is not instructed to take any action, however, may if they believe it is in the best interest of the OMSS
- *Refer* – the delegate/alternate delegate shall move to refer (the item goes to a Council) or refer for decision (item goes to the Board)
- *Amend* – the delegate/alternate delegate shall move to amend the resolution in the manner prescribed in Report A
- *Oppose* – the delegate/alternate delegate shall oppose the resolution as written
- *Strongly oppose* – the delegate/alternate delegate shall oppose the resolution as written and actively speak in opposition of the resolution

Some items may contain specific instructions not included among those listed above. In such cases, instructions to the delegate/alternate delegate are described in detail alongside the item of business.

Note: Items highlighted in blue have been recommended for reaffirmation.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
1	E&B	BOT 26 – Using Person and Biological Data to Enhance Professional Wellbeing and Reduce Burnout	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;	Delegate instructed to support.

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			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.	
2	E&B	CCB 002 – Concurrent Service on Council and Section Governing Councils	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 *** 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	Delegate instructed to listen.

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			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)	
3	E&B	CEJA 02 – Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	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	Delegate instructed to strongly support.

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			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.	

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			(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)	
4	E&B	CEJA 05 – Protecting Physicians Who Engage in Contracts to Deliver Health Care Services	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	Delegate instructed to support.

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			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;	

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			(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.	

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			(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.	
5	E&B	Res. 001 – Opposition Censuring Medical Societies or Organizations Based on Politics or Policies of Governments (Illinois)	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. (New HOD Policy)	Delegate instructed to strongly support.
6	E&B	Res. 002 – Physician Disclosures of Relationships in Private Equity Held Organizations (Indiana)	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. 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.	Delegate instructed to support.
7	E&B	Res. 005 – Dedicated Interfaith Prayer and Reflection Spaces in Medical Schools and Healthcare Facilities	~~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~~	Delegate instructed to amend as indicated, listen.

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		(Minority Affairs Section)	~~backgrounds (New HOD Policy);~~ ~~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);~~ ~~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);~~ 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)	
8	E&B	Res. 010 – Managing Conflicts of Interest Inherent in New Payment Models—Patient Disclosure (Organized Medical Staff Section)	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); 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).	Delegate instructed to strongly support.
9	E&B	Res. 012 – Carceral Systems and Practices	RESOLVED, that our American Medical Association amend policy H-345.972 (Mental Health Crisis Interventions) by addition and deletion to read as follows:	Delegate instructed to listen.

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		in Behavioral Health Emergency Care (Resident and Fellow Section)	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); 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); 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);	

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			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); 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)	
10	A	Res. 109 – Medicare Advantage Plans Double Standard (Indiana)	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)	Delegate instructed to listen.
11	A	Res. 111 – New Reimbursement System Needed for Rural Hospital Survival (Mississippi)	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)	Delegate instructed to listen.
12	A	Res. 116 – Medicare Coverage of Registered Dietitian (RD) and Certified Nutrition Support Specialist (CNSS) Visits Beyond Type 2 Diabetes and Renal Disease	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); RESOLVED, that our AMA specify that payment for registered dietician or	Delegate instructed to support.

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		(Senior Physicians Section)	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)	
13	B	Res. 204 – Protecting the Prescriptive Authority of Plenary Licensed Physicians (American Academy of Ophthalmology)	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); 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); 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); 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); 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).	Delegate instructed to support.
14	B	Res. 207 – Abolishing Venue Shopping (American College of Surgeons)	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	Delegate instructed to listen.

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			rendering venue shopping illegal in medical professional liability actions. (Directive to Take Action)	
15	B	Res. 208 – Binding Arbitration in Health Insurance Contracts (American Psychiatric Association)	RESOLVED, that our American Medical Association study the effects of binding arbitration in health insurance contracts with physicians. (Directive to Take Action)	Delegate instructed to support.
16	B	Res. 213 – Emergency Department Designation Requires Physician on Site (Indiana)	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)	Delegate instructed to listen – ask to be involved in legislation drafting.
17	B	Res. 220 – Strengthening AMA Policy on Noncompete Clauses in Ownership Transitions (New England)	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); 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); 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)	Delegate instructed to support and listen.

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			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)	
18	B	Res. 221 – Preservation of Medicaid (New England)	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); 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)	Delegate instructed to support.
19	B	Res. 223 – Preservation of Medicaid (New York)	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); RESOLVED, that our AMA opposes any state or federal efforts to impose work requirements as a condition of Medicaid eligibility (New HOD Policy); RESOLVED, that our AMA opposes increasing cost-sharing requirements for Medicaid enrollees (New HOD Policy); RESOLVED, that our AMA makes preservation of federal funding and eligibility for Medicaid an urgent and top legislative advocacy priority (Directive to Take Action); 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)	Delegate instructed to support.

ORGANIZED MEDICAL STAFF SECTION
Governing Council Report A
Interim 2024 Meeting

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
20	B	Res. 232 – Preservation of Medicaid (Women Physicians Section)	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); 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)	Delegate instructed to support.
21	D	CSAPH 03 – Protections Against Surgical Smoke Exposure	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)	Delegate instructed to strongly support.
22	D	CSAPH 04 – Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals	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	Delegate instructed to strongly support.

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			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)	
23	D	CSAPH 06 – Fragrance Regulation (Resolution 501-A-24)	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.~~	Delegate instructed to amend as indicated, promote “fragrance aware” language instead of “fragrance free” language.

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			(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)	
24	D	Res 412 – Supporting Inclusive Long-Term Care Facilities (LGBTQ+ Section)	RESOLVED, that our American Medical Association supports federal and state policies for making long-term care facilities LGBTQ+ inclusive. (New HOD Policy)	Delegate instructed to listen.
25	D	Res. 416 – Culturally and Religiously Inclusive Food Options (Minority Affairs Section)	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 Culturally and Religiously Inclusive Food Options in Health Care Facilities H-150.949 1. Our American Medical Association encourages healthful, culturally and religiously inclusive 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. Improving access to culturally and religiously inclusive food options. 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, culturally and religiously	Delegate instructed to listen.

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			inclusive food and healthy meal options within all training hospitals. (Modify Current HOD Policy)	
26	D	Res. 426 – Addressing Patient Safety and Environmental Stewardship of Single-Use and Reusable Medical Devices (Organized Medical Staff Section)	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); 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).	Delegate instructed to strongly support.
27	E	CSAPH 08 – Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms	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	Delegate instructed to support.

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			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)	
28	E	Res. 505 – Mandating Properly Fitting Lead Aprons in Hospitals (Indiana)	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)	Delegate instructed to support.
29	E	Res. 510 – Improving Cybersecurity Standards for Healthcare Entities (Medical Student Section)	RESOLVED, that our American Medical Association support the establishment of ~~minimum~~ appropriate cybersecurity standards~~, including, but not limited to, the use of multi-factor authentication, timely updates, and encryption for HIPAA covered entities~~. (New HOD Policy)	Delegate instructed to amend as indicated, listen.
30	E	Res. 519 – Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making (Washington State)	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)	Delegate instructed to refer.

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31	E	Res. 520 – Study of Grading Systems in AMA Board Reports (Young Physicians Section)	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)	Delegate instructed to listen.
32	F	CLRPD 01 – International Medical Graduates Section Five-Year Review	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)	Delegate instructed to support.
33	F	CLRPD 02 – Organized Medical Staff Section Five-Year Review	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)	Delegate instructed to strongly support.
34	F	Res. 602 – Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations (American Thoracic Society)	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	Delegate instructed to support.

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			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).	
35	G	BOT 06 – Transparency and Accountability of Hospitals and Hospital Systems	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	Delegate instructed to support.

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			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.	
36	G	CMS 03 – Regulation of Corporate Investment in the Health Care Sector	*Refer to report CMS 03 for recommendations.*	Delegate instructed to support.
37	G	CMS 07 – Impact of Patient Non-Adherence on Quality Scores	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	Delegate instructed to strongly support.

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			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) 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)	

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38	G	Res. 702 – Strengthening Health Plan Accountability for Physician Satisfaction (The American Academy of Family Physicians)	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 RESOLVED, that our AMA advocate for the NCQA to strengthen its health plan measurement framework by incorporating comprehensive physician satisfaction metrics. (Directive to Take Action)	Delegate instructed to listen.
39	G	Res. 703 – Appropriate Use of Data from Surgical Practices (American Association of Gynecologic Laparoscopists)	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 (Directive to Take Action); 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)	Delegate instructed to listen.
40	G	Res. 704 – Mitigating the Impact of Excessive Prior Authorization Processes (Florida)	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	Delegate instructed to support.

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			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)	
41	G	Res. 706 – Increasing Transparency Surrounding Medicare Advantage Plans (Illinois)	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)	Delegate instructed to support.
42	G	Res 708 – Advocating Against Prior Authorization for in-Person Visits with Physicians (New York)	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)	Delegate instructed to support.
43	G	Res. 709 – Allowing Timely Access to Pain Medications in Discharged Hospital and Ambulatory Surgery Patients (New York)	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)	Delegate instructed to support.
44	G	Res. 712 – Billings and Collections Transparency	RESOLVED, that our American Medical Association amend policy H-225.950, Principles for Physician Employment, to include a new section to read as follows:	Delegate instructed to strongly support.

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		(Organized Medical Staff Section)	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	

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			to itemized statements of billing and remittances for medical services they provide (Directive to Take Action).	
45	G	Res. 713 – Aiding Members of Medical Staffs (Organized Medical Staff Section)	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).	Delegate instructed to strongly support.
46	G	Res. 717 – Promoting Medication Continuity and Reducing Prior Authorization Burdens (Young Physicians Section)	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)	Delegate instructed to support.

END