DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Final Report of Reference Committee A

Cheryl Hurd, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Service Report 9 – Minimum Requirements for Medication Formularies
2. Resolution 101 - Uniform Adoption of Service Intensity Tools to Support Medical Decision-making and Service Gap Analysis
3. Resolution 102 - Access to Single Maintenance and Reliever Therapy for Asthma
4. Resolution 109 - Medicare Advantage Plans Double Standard
5. Resolution 111 - New Reimbursement System Needed for Rural Hospitals to Survive
6. Resolution 120 - Medigap, Pre-Existing Conditions, and Medicare Coverage Education
7. Resolution 121 - Opposing Pharmacy Benefit Manager Spread Pricing

RECOMMENDED FOR ADOPTION AS AMENDED

8. Council on Medical Service Report 2 – Reconsidering AMA Policy on the Affordable Care Act (ACA) Eligibility Firewall
9. Council on Medical Service Report 5 – Medicaid Estate Recovery Reform
10. Council on Medical Service Report 6 – Prescription Medication Price Negotiation
11. Resolution 105 - Development of an Educational Resource on Opting Out of Medicare for Physicians
12. Resolution 106 - Advocating for All Payer Coverage for Custom Breast Prostheses for Patients with History of Mastectomy Secondary to Breast Cancer Treatment
13. Resolution 107 - Advocating for All Payer Coverage of Reconstructive and Cosmetic Surgical Care Related to Cleft Lip and Palate
14. Resolution 108 - Firearm Storage Diagnosis and Counseling Reimbursement
15. Resolution 110 - Study of the Federal Employee Health Benefit Plan (FEHBP)
16. Resolution 115 - Supporting Legislative Efforts to Remove Certain High-Cost Supplies and Equipment from the Medicare Physician Fee Schedule
17. Resolution 118 - Improving Access to Peripartum Pelvic Floor Physical Therapy
18. Resolution 119 - Cancer Survivorship Program Coverage

RECOMMENDED FOR REFERRAL

19. Resolution 103 - Inadequate Reimbursement for Biosimilars
20. Resolution 113 - Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts
21. Resolution 116 - Medicare Coverage of Registered Dietitian (RD) and Certified Nutrition Support Specialist (CNSS) Visits Beyond Type 2 Diabetes and Renal Disease
22. Resolution 117 - Liberalized Remorse Period for Medicare Advantage Plan Insureds

RECOMMENDED FOR REFERRAL FOR DECISION

23. Resolution 114 - An Assessment of Physician Support for Value-Based Payment Models and its Impact on Healthcare to Inform AMA Advocacy Efforts—A Survey

RECOMMENDED FOR NOT ADOPTION

24. Resolution 104 - Study of Whether the HSA Model Could Become an Option for Medicaid Beneficiaries

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

25. Resolution 112 - Continuation of Affordable Connectivity Program

RECOMMENDED FOR ADOPTION

(1) CMS REPORT 9 – MINIMUM REQUIREMENTS FOR MEDICATION FORMULARY

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 9 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 9 be adopted and the remainder of the Report filed.

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:

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)

Your Reference Committee heard exclusively supportive testimony on Council on Medical Service Report 9. Testimony explained the importance of ensuring that formularies are sufficient to include the medications prescribed by physicians and vital to patients. An individual proffered an amendment to ensure that different delivery devices or formulations are also adequately covered in formularies. Your Reference Committee found the proffered amendment to be a logical extension of the work done by the Council however; in-person testimony outlined that this amendment could have adverse consequences and end up inadvertently raising drug prices. Therefore, your Reference Committee recommends that recommendations in Council on Medical Service Report 6 be adopted and the remainder of the report filed.

(2) RESOLUTION 101 – UNIFORM ADOPTION OF SERVICE INTENSITY TOOLS TO SUPPORT MEDICAL DECISION-MAKING AND SERVICE GAP ANALYSIS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 101 be adopted.

HOD ACTION: Resolution 101 be adopted.

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)

Your Reference Committee heard limited but supportive testimony related to Resolution 101. Testimony explained the importance of ensuring that there is payment parity for medically necessary mental health and substance use disorder treatment. In-person testimony was also limited but supportive. Testimony reiterated the importance of ensuring that mental health and substance use disorder treatment have parity and follow best practice. Due to the supportive testimony both in-person and online, your Reference Committee recommends that Resolution 101 be adopted.

(3) RESOLUTION 102 – ACCESS TO SINGLE MAINTENANCE AND RELIEVER THERAPY FOR ASTHMA

RECOMMENDATION:

Your Reference Committee recommends that Resolution 102 be adopted.

HOD ACTION: Resolution 102 be adopted.

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)

Testimony was supportive of Resolution 102 and the need to address payer quantity limits for combination inhalers that are used for both maintenance and rescue. Testimony did not support two proffered amendments to the first Resolved clause. The first asked to delete “remove or” and second, which the author and another delegation

opposed, recommended deletion of “evidence-based guidelines.” Although there was limited support for an amendment to replace “long-acting beta-agonist” with “Formorterol,” your Reference Committee prefers the broader term “long-acting beta-agonist” and recommends that Resolution 102 be adopted.

(4) RESOLUTION 109 – MEDICARE ADVANTAGE PLANS DOUBLE STANDARD

RECOMMENDATION:

Your Reference Committee recommends that Resolution 109 be adopted.

HOD ACTION: Resolution 109 be adopted.

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)

Testimony on Resolution 109 was generally supportive but mixed in suggested disposition. Testimony from sections, delegations, and individuals outlined the importance of ensuring that all payers, including Medicare Advantage (MA) plans, are required to follow uniform standards for utilization management practices. However, other delegations expressed concern as to the specific wording of the resolution and suggested the procedures outlined in the resolution need to be studied in greater detail before policy is adopted. Testimony also reflected the need to ensure that AMA reform and advocacy efforts on utilization management are focused on the most feasible wins, which would require additional study to determine. A delegation proffered an amendment to remove reference to uniform payment denial appeals; however, your Reference Committee was not convinced that the proffered amendment fully addresses the ask of the resolution. Additionally, your Reference Committee believes that the implementation of similar uniform denial requirements in states is evidence that the ask of the resolution is feasible.

In-person testimony on Resolution 109 was generally supportive of the intent, but some concern was raised regarding states or systems that have already implemented better procedures than outlined in the resolution. However, positive testimony outlined how vital it is to reduce administrative burden on physicians by streamlining the process and this resolution would work to reduce utilization management burdens. Additionally, testimony explained that the appeals process can be particularly burdensome for physicians practicing in medically underserved areas and/or in smaller settings. Your Reference Committee wishes to remind the House that the adoption of this policy will not force any state or system to alter current procedures. Rather, the adoption of this policy will allow for AMA advocacy to support states or systems, when invited, in implementing a standardized process. Your Reference Committee believes that this resolution will result in policy that can support physicians and patients in underserved communities and reduce administrative burden, while not forcing change on any one state or system, therefore it is recommended that Resolution 109 be adopted.

(5) RESOLUTION 111 – NEW REIMBURSEMENT SYSTEM NEEDED FOR RURAL HOSPITAL SURVIVAL

RECOMMENDATION:

Your Reference Committee recommends that Resolution 111 be adopted.

HOD ACTION: Resolution 111 be adopted.

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)

Testimony on Resolution 111 was divided between adoption and referral. All testimony echoed the importance of ensuring that rural hospitals remain financially viable and open. Additionally, much of the testimony highlighted the growing need to address the impact of Medicare Advantage on rural hospitals. A delegation and individual testified that the current resolution would better serve the House if referred, allowing the AMA to complete the forthcoming Council on Medical Service report prior to decision on Resolution 111. However, other delegations testified to the importance of this resolution being adopted at the current meeting and not delayed. In-person testimony on this resolution was supportive, including the Council on Medical Service indicating that this resolution, if adopted, will be folded into an existing report to be presented to the House at Interim 2025. Testimony reiterated the need to include how Medicare Advantage plans have grown in popularity and negatively impacted rural physicians, patients, and practices. Your Reference Committee agrees that this resolution is timely, important, and could be incorporated into the forthcoming Interim 2025 Council on Medical Service report and, therefore, recommends that Resolution 111 be adopted.

(6) RESOLUTION 120 – MEDIGAP, PRE-EXISTING CONDITIONS, AND MEDICARE COVERAGE EDUCATION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 120 be adopted.

HOD ACTION: Resolution 120 be adopted as amended to read as follows:

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 that includes Part A, Part B, Part D, and a Medigap policy. (Directive to Take Action).

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).

Your Reference Committee heard testimony that strongly supported Resolution 120, which is intended to addresses gaps in transparency and access to care within Medicare coverage. Although a delegation asked that Resolution 120 be referred, most of the testimony supported adoption. Accordingly, your Reference Committee recommends that Resolution 120 be adopted.

(7) RESOLUTION 121 – OPPOSING PHARMACY BENEFIT MANAGER SPREAD PRICING

RECOMMENDATION:

Your Reference Committee recommends that Resolution 121 be adopted.

HOD ACTION: Resolution 121 be adopted.

RESOLVED, that our American Medical Association:
(1) oppose the use of spread pricing by Pharmacy Benefit Managers (PBMs);
(2) advocate for federal and state legislation and regulation that prohibits the use of spread pricing by PBMs; and
(3) support policies requiring PBMs to use transparent, pass-through pricing models that ensure fair and consistent reimbursement to pharmacies, physicians, and patients.
(Directive to Take Action)

Testimony on Resolution 121 was supportive and highlighted the issues around pharmacy benefit managers (PBMs) generally and their use of spread pricing. Testimony from sections highlighted the importance of ensuring that the AMA has clear policy to advocate against spread pricing, especially in the current context of bipartisan PBM reform legislation. An individual did speak to caution regarding the complexity of the issue, however testimony indicated that this resolution is in line with both existing policy and current AMA advocacy efforts. Therefore, your Reference Committee recommends that Resolution 121 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(8) CMS REPORT 2 – RECONSIDERING AMA POLICY ON THE AFFORDABLE CARE ACT (ACA) ELIGIBILITY FIREWALL

RECOMMENDATION A:

Your Reference Committee recommends that the second Recommendation of Council on Medical Service Report 2 be amended by addition to read as follows:

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, while promoting meaningful coverage and the application of vital consumer and provider protections, such as prompt pay and network adequacy requirements;

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)

RECOMMENDATION B:

Your Reference Committee recommends that the third Recommendation of Council on Medical Service Report 2 be amended by addition and deletion to read as follows:

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~~ fair and equitable rates. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Council on Medical Service Report 2 be amended by addition of a new Recommendation to read as follows:

That our AMA support incrementally lifting the ESI firewall with continual monitoring and consideration of insurance marketplace stability, physician practice sustainability, and other relevant parameters, with the goal of maximizing the number of individuals able to freely choose the health insurance plan that is best for themselves and their families. (New HOD Policy)

RECOMMENDATION D:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 2 be adopted as amended by addition of new recommendations to read as follows with the remainder of the report filed:

That our AMA support incrementally lifting the ESI firewall with continual monitoring and consideration of insurance marketplace stability, if and only if there is documentation that marketplace insurance pays sufficiently to ensure physician practice sustainability, and other relevant parameters, with the goal of maximizing the number of individuals able to freely choose the health insurance plan that is

best for themselves and their families. (New HOD Policy)

That our AMA support any incremental lifting of the firewall must be paired with a pause to review the relevant parameters, and the ability to pause permanently, or reverse if disruptive effects are detected. (New HOD Policy)

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 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)

Your Reference Committee heard mixed testimony on Council on Medical Service Report 2. A member of the Council on Medical Service noted that the Council's previous report on this topic was referred back at the 2024 Annual Meeting to ensure that the recommendations maximize patient access to care while protecting physician practice

revenue and sustainability. Supportive testimony cited the Council's balanced approach to the firewall while prioritizing the needs of patients least able to afford health care.

A former President of the AMA asked that the report be referred back so that AMA policy on individually selected health insurance can be amended to require a cap on insurance company profits. This individual also asked for a study of the affordability of policies that pay for the cost of care with a margin sufficient to allow independent physician practices to thrive. The Council on Medical Service opposed referral and emphasized that these requests are beyond the scope of this report, which focuses specifically on AMA policy on the Affordable Care Act (ACA) firewall.

Testimony was generally supportive of proffered amendments to Recommendations 2 and 3, including language that replaces "prevailing Medicare rates" with "fair and equitable rates" in Recommendation 3. The Council supported these changes but did not support an amendment to Recommendation 1 from a section as the amendment would commit our AMA to supporting the complete elimination of the firewall without fully understanding the implications of even modest adjustments. The Council testified that the question of whether the AMA should ultimately endorse further reductions or elimination of the firewall deserves careful consideration at a future meeting once pertinent data is available for evaluation. The Council also spoke against a proffered new Recommendation that supports incrementally lifting the ESI firewall with continual monitoring of certain indicators; however, this new Recommendation received supportive in-person testimony. Your Reference Committee supports the amendments that were supported in testimony and recommends that Council on Medical Service Report 2 be adopted as amended and the remainder of the report filed.

(9) CMS REPORT 5 – MEDICAID ESTATE RECOVERY REFORM

RECOMMENDATION A:

Your Reference Committee recommends that Recommendation 1 of Council on Medical Service Report 5 be amended by addition and deletion to read as follows:

1. That our AMA ~~support making Medicaid estate recovery optional, instead of mandatory, for states.)~~ 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. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Council on Medical Service Report 5 be adopted as amended and the remainder of the report filed.

HOD ACTION: Recommendations in Council on Medical Service Report 5 be adopted as amended and the remainder of the Report filed.

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.
    g. Collecting and making publicly available important data regarding estates that have been pursued and amounts that have been recovered. (New HOD Policy)

Testimony on Council on Medical Service Report 5 was mixed. There was some support for the recommendations and the concept of Medicaid estate recovery being optional for states. A section proffered a substitute Recommendation 1 that would direct our AMA to oppose federal or state Medicaid estate recovery efforts. The Council on Medical Service opposed this change, emphasizing that states should have the option to continue pursuing estates, with guardrails in place, if they choose to do so, such as when people with financial means have shielded assets to access Medicaid long-term services and supports that they could have paid for themselves. However, your Reference Committee heard testimony that was supportive of this change and recommends that Council on Medical Service Report 5 be adopted as amended and the remainder of the report filed.

(10) CMS REPORT 6 – PRESCRIPTION MEDICATION PRICE NEGOTIATION

RECOMMENDATION A:

Your Reference Committee recommends that the Recommendations of Council on Medical Service Report 6 be amended by addition of a new recommendation to read as follows:

That our AMA oppose drug payment methodologies that result in physician practices being paid at less than the cost of acquisition, inventory, storage, and administration of relevant drugs and other necessary related clinical services. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 6 be adopted as amended with a new recommendation to read as follows and the remainder of the Report filed:

That our AMA support considering both the rate of increase and the absolute price of a medication when selecting medications for Medicare drug price negotiation.

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)

Reference Committee testimony on Council on Medical Service Report 6 was generally supportive. Amendments were proffered by delegations that aimed to reaffirm additional policy, accelerate the timeline in which drugs are added to the negotiation schedule, and allow for the government negotiated prices to be available to all payers. Another delegation outlined concerns surrounding the impact of price negotiation on physician practices. The Council on Medical Service explained that the AMA has an incredibly robust body of policy related to drug pricing negotiation that ensures patients have access to medications and that physicians/physician practices are not unduly harmed. Additionally, the Council on Medical Service, the authors of the report, explained that a rapidly accelerated negotiation schedule would have the potential to significantly harm patients, physicians, and drug innovation. The Council also clarified that the report details the anticipated impact that price negotiation could have on patients and physicians/physician practices. Finally, the authors explained that the government negotiated prices are currently available to all payers and as a result any payer has the ability to utilize these rates in their own negotiations. Your Reference Committee believes that the addition of another reaffirmation is extraneous as the Council has worked to create a well-rounded body of recommendations.

In-person testimony on Council on Medical Service report 6 was also supportive of the intent, but a number of amendments were proffered. Two delegations proffered similar amendments to ensure that physician practices are not losing money on payment for drugs due to storage, acquisition, inventory, or administrative costs. This amendment was supported by other individuals and delegations. Additionally, an amendment was proffered to enable all payers to access Medicare negotiated prices. Your Reference Committee echoes concern from testimony that this could be interpreted as a price mandate and reiterates that there is no reason that all payers cannot utilize negotiated prices in their negotiations as they are made publicly available. A third amendment was proffered by a delegation asking for an additional report back on the impact of the Inflation Reduction Act reforms on delivery system of expensive drugs on both independent hospitals and hospital-based practices. Your Reference Committee believes that this amendment raises an issue of particular importance, but the submission of this as a new resolution at a future AMA HOD meeting would not only be more appropriate but allow the asks of this amendment to be fully explored and not overshadowed by the remainder of the report.

As a result of the testimony presented, both in-person and online, and the response by the authors of the report, your Reference Committee recommends that the recommendations in Council on Medical Service Report 6 be adopted as amended and the remainder of the report filed.

(11) RESOLUTION 105 – DEVELOPMENT OF AN EDUCATIONAL RESOURCE ON OPTING OUT OF MEDICARE FOR PHYSICIANS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolved of Resolution 105 be amended by deletion to read as follows:

RESOLVED, that our AMA 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

RECOMMENDATION B:

Your Reference Committee recommends that the third Resolved of Resolution 105 be deleted.

~~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)~~

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 105 be adopted as amended.

HOD ACTION: Resolution 105 be referred for decision.

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)

Your Reference Committee heard mixed testimony on Resolution 105. Supporters highlighted the need to help interested physicians better understand the concept of opting out of Medicare participation. A call for referral was not supported. Your Reference Committee believes that a proffered amendment to re-allocate the marketing budget used to promote the AMA and its achievements to promoting resources on opting out of Medicare is beyond the scope and intent of this resolution. In response to a commenter's request for information from the AMA's Office of General Counsel (OGC) on how to accomplish the aims of the resolution without causing concerns about anti-competitive behavior, your Reference Committee notes that OGC stated that a legal comment was not necessary.

Your Reference Committee also heard testimony in opposition to Resolution 105, noting that the AMA should not be promoting tools on opting out of Medicare, which could decrease access to care in some communities. Your Reference Committee suggests amending the first Resolved and deleting the third Resolved as a compromise that would allow the AMA to provide the requested information while recognizing the importance of physician choice in Medicare participation. Your Reference Committee recommends that Resolution 105 be adopted as amended.

(12) RESOLUTION 106 – ADVOCATING FOR ALL PAYER COVERAGE FOR CUSTOM BREAST PROSTHESES FOR PATIENTS WITH HISTORY OF MASTECTOMY SECONDARY TO BREAST CANCER TREATMENT

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 106 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA 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 prostheses ~~for patients who have had mastectomy secondary to breast cancer treatment~~ and other custom prostheses for patients who have had extirpative, ablative, and/or reconstructive surgery.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 106 be adopted as amended.

RECOMMENDATION C:

The Title of Resolution 106 be changed:

ADVOCATING FOR ALL PAYER COVERAGE FOR CUSTOM BREAST AND OTHER PROSTHESES

HOD ACTION: Resolution 106 be adopted as amended with a Title change.

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)

Your Reference Committee heard unanimously supportive testimony with amendments offered on Resolution 106. A delegation testified in support explaining that expanding coverage would address inequity in women's health, with a section testifying that this is as much a functional issue as it is a cosmetic issue. An amendment was proffered to broaden coverage beyond patients who have had mastectomy secondary to breast cancer treatment to include custom prostheses for patients who have had extirpative, ablative, and reconstructive surgery, patients who may not be candidates for surgical reconstruction, and other subgroups of patients. Your Reference Committee agreed that the amended language fulfilled the intent of the resolution and, therefore, recommends that Resolution 106 be adopted as amended with a title change.

(13) RESOLUTION 107 – ADVOCATING FOR ALL PAYER COVERAGE OF RECONSTRUCTIVE AND COSMETIC SURGICAL CARE RELATED TO CLEFT LIP AND PALATE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 107 be amended by addition to read as follows:

RESOLVED, that our AMA 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 without restriction as to patient age.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 107 be adopted as amended.

HOD ACTION: Resolution 107 be adopted as amended.

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)

Your Reference Committee heard unanimously supportive testimony with an amendment on Resolution 107. An individual proffered an amendment to explicitly mention that this coverage should apply to all patients regardless of age, which was considered friendly by the author. Your Reference Committee agreed that the amended language fulfilled the intent of the resolution and, therefore, recommends that Resolution 107 be adopted as amended.

(14) RESOLUTION 108 – FIREARM STORAGE DIAGNOSIS AND COUNSELING REIMBURSEMENT

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 108 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate for the creation of an ICD-10-CM code specifically designating counseling for firearm storage and encourage interested national medical specialty societies to seek a new *Current Procedural Terminology* (CPT®) codinge which specifically encompasses the provision of Firearm Storage Counseling, its minimum requirements for qualification, and its reimbursement, and other actions required to determine appropriate payment for this service.

RECOMMENDATION B:

Your Reference Committee recommends that the first Resolved of Resolution 108 be adopted as amended.

HOD ACTION: Resolution 108 be adopted as amended.

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 1 its reimbursement. (Directive to Take Action)

Your Reference Committee heard supportive testimony for Resolution 108, with some amendments suggested to better align the resolution with existing AMA policy. Many delegations, sections, and individuals detailed the importance of ensuring that firearms are properly stored and the important role that physicians play in increasing safe storage. To better align the portion of the resolution that requests the development of a new *Current Procedural Terminology* (CPT®) code with AMA Policy H-70.919, the authors of the resolution proffered amended language. In the same vein, another delegation suggested the removal of reference to CPT® altogether. This delegation explained that while the introduction of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes would be a meaningful tool for researchers, public health officials, and clinicians, the creation of a CPT® code is solely for billing and could potentially confound clinical services with surveillance efforts. In-person testimony reiterated the importance of this resolution and highlighted the need for the inclusion of CPT® codes to ensure that physicians are paid for this service. Some testimony did indicate support for the Preliminary Report language, however your Reference Committee was swayed by the importance of enabling physicians to be paid for their work and therefore recommends that Resolution 108 be adopted as amended.

(15) RESOLUTION 110 – STUDY OF THE FEDERAL EMPLOYEE HEALTH BENEFIT PLAN (FEHBP)

RECOMMENDATION A:

Your Reference Committee recommends that of Resolution 110 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA conduct a thorough study of the FEHBP to understand the successes and failures, strengths and weaknesses of the program and determine~~s~~ 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 A-26 Meeting of our House of Delegates. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 110 be adopted as amended.

HOD ACTION: Resolution 110 be adopted as amended.

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)

Testimony on Resolution 110 was unanimously supportive, emphasizing the potential that this resolution has to improve coverage, patient satisfaction, and competition between insurers. Multiple delegations supported the resolution with an amendment to extend the timeline to A-26. Noting that the second Resolved does not stand on its own, your Reference Committee combined both into one Resolved. Your Reference Committee agreed that the extended timeline fulfilled the intent of the resolution and, therefore, recommends that Resolution 110 be adopted as amended.

(16) RESOLUTION 115 – SUPPORTING LEGISLATIVE EFFORTS TO REMOVE CERTAIN HIGH-COST SUPPLIES AND EQUIPMENT FROM THE MEDICARE PHYSICIAN FEE SCHEDULE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 115 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support the *Current Procedural Terminology* (CPT®) Editorial Panel / RVS Update Committee (RUC) recommendation to the Centers for Medicare & Medicaid Services (CMS) to separately pay for high-cost supplies priced more than $500 ~~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~~.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 115 be amended by addition of a new Resolved to read as follows:

RESOLVED, that our AMA work with the federal government to address flaws in the Medicare Physician Fee Schedule practice expense methodology resulting in reimbursement being less than direct costs for hundreds of services in the office-based setting.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 115 be adopted as amended.

RECOMMENDATION D:

The Title of Resolution 115 be changed:

SUPPORTING LEGISLATIVE EFFORTS TO REMOVE CERTAIN HIGH-COST SUPPLIES FROM THE MEDICARE PHYSICIAN FEE SCHEDULE

HOD ACTION: Resolution 115 be adopted as amended with a Title change.

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)

Testimony on Resolution 115 was extensive and somewhat mixed. Multiple delegations and an individual expressed support for the resolution noting their reasoning echoed the resolution's whereas clauses and, as sponsors, felt that the resolution was timely and essential to providing adequate payment for physicians. Testimony in support of the resolution explained that due to cuts to physician payment, certain non-facility services experience deficits in payment and actual cost for certain procedures requiring high-cost supplies. One delegation suggested that the item be referred; however, many other individuals and delegations voiced serious concern for the resolution's original language or its referral. Testimony explained that there are extensive ongoing efforts from the AMA and the *Current Procedural Terminology* (CPT®) Editorial Panel/Relative Value Scale Update Committee (RUC) to address this issue. Testimony from these delegations and individuals agreed that the issue brought up in the resolution is correct to be classified as a reaffirmation of existing AMA policy and efforts. Experts from the RUC explained that should reaffirmation not be recommended by the Reference Committee; an amendment would be suggested over the original language. Testimony from CPT and RUC experts and delegations supporting reaffirmation and/or amendment explained that in February 2025, the CPT Editorial Panel and RUC recommended that the Centers for Medicare & Medicaid Services (CMS) address the pricing of high-cost supplies by reviewing the costs annually and paying for these specific supplies using separate Healthcare Common Procedure Coding System (HCPCS) codes. Testimony supported a regulatory versus legislative approach. Additionally, many testifiers voiced serious concern about the potential implications of significantly altering the CPT®/RUC recommendation on the payment for all other physician services and that the implementation of the resolution's original language could actually lead to physician net losses. Other testimony echoed these concerns and voiced worry that the adoption of the resolution as written could be misconstrued by current legislative and executive leaders and lead to widespread harmful results for physician payment.

In-person testimony was also extensive and all supportive of the intent of the resolution and the existing Preliminary Report recommendation. However, a delegation proffered an additional amendment asking that the AMA continue to advocate to address flaws in the Medicare Physician Fee Schedule. The majority of testimony on this amendment, including from the RUC and two Councils, was supportive. Additionally, testimony asked

that reference to equipment be removed from the title of the resolution as the focus was on high-cost supplies, not equipment. Based on the testimony provided, your Reference Committee feels that the proffered amendments address the concerns voiced on either side of the issue and thus recommends that Resolution 115 be adopted as amended with a title change.

(17) RESOLUTION 118 – IMPROVING ACCESS TO PERIPARTUM PELVIC FLOOR PHYSICAL THERAPY

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 118 be amended by deletion to read as follows:

RESOLVED, that our AMA advocate 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

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve of Resolution 118 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA supports efforts to improve education for clinicians and patients on the risk factors of pelvic floor dysfunction during childbirth, as well as for other indications, and on the benefits and indications of pelvic floor ~~physical~~ therapy. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 118 be adopted as amended.

RECOMMENDATION D:

The Title of Resolution 118 be changed.

IMPROVING ACCESS TO PELVIC FLOOR THERAPY

HOD ACTION: Resolution 118 be adopted as amended with a Title change.

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)

Testimony on Resolution 118 was generally supportive, but expansion for coverage beyond childbearing was recommended. One individual opposed the resolution and testified that payers are obligated to cover pelvic floor therapy when medically necessary and that payment is the actual problem. However, multiple sections, delegations, and an individual outlined the importance of this coverage and explained that it addresses significant barriers to care and the limited awareness of the benefits of pelvic floor therapy. Among the supportive testimony, an amendment to broaden the resolution to allow coverage for pelvic floor therapy beyond pregnancy or a single gender was proffered. In-person testimony by multiple delegations and sections reiterated the support to broaden this resolution because pelvic floor dysfunction has become more common and patients from all genders would benefit from this coverage. Due to supportive testimony, your Reference Committee recommends that Resolution 118 be adopted as amended with a title change.

(18) RESOLUTION 119 – CANCER SURVIVORSHIP PROGRAM COVERAGE

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 116 be amended by addition to read as follows:

RESOLVED, that our AMA recognizes cancer survivorship and cancer rehabilitation 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 medical care services and supportive care services, including, but not limited to, genetic screening and testing, counseling for those with known pathogenic variants (mutations) as well as discussion of fertility options before and after cancer treatment, aimed at managing the long-term consequences and sequelae of cancer and its treatment (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve of Resolution 116 be amended by addition to read as follows:

RESOLVED, that our AMA advocates for work with key stakeholders to achieve adequate coverage for cancer survivorship and cancer rehabilitation care. (Directive to Take Action)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 119 be adopted as amended.

HOD ACTION: Resolution 119 be adopted as amended.

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)

Testimony strongly supported Resolution 119 and the need to ensure adequate coverage of cancer survivorship services. Two amendments were proffered online to include specific services in this resolution. The first asked to include “genetic screening and testing, counseling for those with known pathogenic variants (mutations) as well as discussion of fertility options before and after cancer treatment” after “supportive care services” in Resolved 1. The second amendment asked that “cancer rehabilitation” be added to each Resolved clause. An amendment offered in-person asked that “medical care services” be added to the first Resolved clause. Your Reference Committee recommends that Resolution 119 be adopted as amended.

RECOMMENDED FOR REFERRAL

(19) RESOLUTION 103 – INADEQUATE REIMBURSEMENT FOR BIOSIMILARS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 103 be referred.

HOD ACTION: Resolution 103 be referred with report back at the 2025 Interim Meeting.

RESOLVED, that our American Medical Association work with stakeholders to advocate 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)

Testimony on Resolution 103 was mixed. Some delegations explained that this proposed policy would help ensure that physicians are adequately reimbursed for biosimilar usage and that this is vital to patient access and sustainability of physician practice. However, one delegation explained that existing AMA policies already address the ask of this resolution and therefore reaffirmation would be more appropriate. Another delegation encouraged amending the language of the resolution to cover all medications, not just biologics. Finally, a section suggested that this resolution be referred to fully explore the challenges surrounding biosimilar implementation and payment.

In-person testimony on this item was supportive of the Preliminary recommendation to refer and echoed the online testimony regarding the importance and timeliness of the resolution and report back. Due to the complexity of the issue, the potential for expansion beyond biologics, and the possible challenges related to implementation your Reference Committee recommends that Resolution 103 be referred.

(20) RESOLUTION 113 – IMPROVING PATIENT ACCESS TO PHARMACIES AND MEDICATIONS IN PHARMACY DESERTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 113 be referred.

HOD ACTION: Resolution 113 be referred.

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)

Your Reference Committee heard testimony supportive of the intent of Resolution 113, but with concerns for the potential consequences. Along with a delegation and section, the Council on Medical Service testified that this resolution should be referred to ensure that there are not unintended consequences on patients or physicians. Testimony echoed the need to ensure that patients in pharmacy deserts have access to medication, but voiced concern around potential for expanded pharmacist scope of practice and conflicts with regulatory authority.

In-person testimony echoed the importance of studying issue and highlighted the potential for pharmacist scope creep. Due to the potential for significant unintended consequences and testimony supporting referral, your Reference Committee recommends that Resolution 113 be referred.

(21) RESOLUTION 116 – MEDICARE COVERAGE OF REGISTERED DIETITIAN (RD) AND CERTIFIED NUTRITION SUPPORT SPECIALIST (CNSS) VISITS BEYOND TYPE 2 DIABETES AND RENAL DISEASE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 116 be referred.

HOD ACTION: Resolution 116 be referred with report back at the 2026 Annual Meeting.

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)

Testimony on Resolution 116 was mixed. Most commenters supported the goal of expanding Medicare coverage for nutrition services to include a range of conditions

beyond diabetes and renal disease. However, in-person testimony cited concerns with each Resolved clause and there were several calls for referral. The Council on Legislation raised scope of practice concerns regarding the first Resolved and the Council on Medical Service and others noted that the second Resolved is not realistic since registered dietician services are already paid under the Medicare Physician Fee Schedule. Both Councils urged referral. Online testimony that shared feedback from the association representing registered dieticians pointed to several concerns with the language used in the resolution and the payment structure cited in the second Resolved that could unintentionally undermine access or introduce confusion if not refined. Your Reference Committee heard significant support for referral and therefore recommends that Resolution 116 be referred.

(22) RESOLUTION 117 – LIBERALIZED REMORSE PERIOD FOR MEDICARE ADVANTAGE PLAN INSUREDS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 117 be referred.

HOD ACTION: Resolution 117 be referred.

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)

Testimony on Resolution 117 was primarily supportive of the intent, ensuring patients have autonomy and information to select the most advantageous Medicare plan, but concerned about the complexity of the issue. Two delegations voiced support for the resolution as written, explaining the importance of flexibility between Medicare Advantage (MA) and traditional Medicare plans. Testimony explained that some individuals may not realize the full scope of an MA plan or may experience life changes, like new illness, that would make transitioning from MA to traditional Medicare advantageous. However, multiple other delegations and the Council on Medical Service explained that the resolution’s original language could disrupt the stability of medical groups and health plans, negatively impacting both patients and physicians. Additionally, testimony outlined the uncertainty in how extension of time to change plans could impact patients and physicians. Your Reference Committee agrees that patients should have autonomy and choice in selecting plan coverage but feels that concerns regarding the complexity of the issue warrants further study of the item. In-person testimony was limited to the authors of this resolution who testified in support of referral. Therefore, your Reference Committee recommends that Resolution 117 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

(23) RESOLUTION 114 – AN ASSESSMENT OF PHYSICIAN SUPPORT FOR VALUE-BASED PAYMENT MODELS AND ITS IMPACT ON HEALTHCARE TO INFORM AMA ADVOCACY EFFORTS—A SURVEY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 114 be referred for decision.

HOD ACTION: Resolution 114 be referred for decision.

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)

Your Reference Committee heard mixed testimony on Resolution 114. A section, delegation, and individual expressed support for the resolution, explaining that there is a need to better understand value-based payment models and their impact on care quality, patient access, and health care sustainability. Multiple delegations expressed opposition to the adoption of this resolution, stating that it duplicates existing research efforts and would lead to unnecessary spending and utilization of staff resources.

However, in-person testimony by multiple delegations, including the resolution's sponsors reiterated support for this resolution based on the value of the data that can be obtained and, therefore, requested that Resolution 114 be referred for decision. Based on online and in-person testimony, your Reference Committee recommends that Resolution 114 be referred for decision.

RECOMMENDED FOR NOT ADOPTION

(24) RESOLUTION 104 – STUDY OF WHETHER THE HSA MODEL COULD BECOME AN OPTION FOR MEDICAID BENEFICIARIES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 104 be not adopted.

HOD ACTION: Resolution 104 be not adopted.

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)

Your Reference Committee heard mixed testimony on Resolution 104. Although the resolution's author and another delegation requested adoption, an individual expressed doubts about the use of Health Savings Accounts (HSAs) in Medicaid. A section and a delegation testified in strong opposition to Resolution 104, noting that funding for HSAs for Medicaid patients would inevitably be at the expense of traditional Medicaid benefits. Although the Council on Medical Service did not take a position, a Council member testified that a report on HSAs is currently being developed and will be considered at the 2025 Interim Meeting. Due to the concerns raised, along with in-person testimony noting that the House of Delegates voted to not adopt a similar resolution at the 2024 Interim Meeting, your Reference Committee recommends that Resolution 104 be not adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(25) RESOLUTION 112 – CONTINUATION OF AFFORDABLE CONNECTIVITY PROGRAM

RECOMMENDATION:

Your Reference Committee recommends that Policies H-478.980 and D-480.963 be reaffirmed in lieu of Resolution 112.

HOD ACTION: Policies H-478.980 and D-480.963 be reaffirmed in lieu of Resolution 112.

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)

Testimony strongly supported the intent of Resolution 112 and the ongoing need to expand access to high-speed internet connectivity so that everyone can have access to telehealth. The Council on Medical Service shared AMA policies that advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas (Policy H-478.980) and also advocate for equitable access to telehealth services including increased funding for broadband and internet-connected devices (Policy D-480.963). The Council suggested reaffirmation of these policies in lieu of Resolution 112. The Council also suggested amending the resolution by deletion of "the Affordable Connectivity Program" since this program ceased to exist a year ago and is unlikely to be brought back, but there are other programs supporting internet connectivity that the AMA supports. Your Reference Committee believes that the aforementioned AMA policies adequately direct the AMA to advocate for programs that seek to ensure that all patients can access telehealth. Therefore, your Reference Committee recommends that Policies H-478.980 and D-480.963 be reaffirmed in lieu of Resolution 112.

INCREASING ACCESS TO BROADBAND INTERNET TO REDUCE HEALTH DISPARITIES H-478.980
Our American Medical Association will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.

COVID-19 EMERGENCY AND EXPANDED TELEMEDICINE REGULATIONS D-480.963
1. Our American Medical Association will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2. 2. Our AMA will advocate that the Federal government, including the Centers for Medicare & Medicaid

Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: a. Provide equitable coverage that allows patients to access telehealth services wherever they are located. b. Provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients. 3. Our AMA will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients. 4. Our AMA supports the use of telehealth to reduce health disparities and promote access to health care.

Madam Speaker, this concludes the report of Reference Committee A. I would like to thank Ilana Addis, MD, Allan Anderson, MD, Christopher Garofalo, MD, Richard Geline, MD, Neil Rens, MD, MBA, MSc, and Jane Simpson, DO.

Ilana Addis, MD, MPH, MBA, FACOG (Alternate)
Arizona Medical Association

Allan Anderson, MD, MMM, DLFAPA
American Association for Geriatric Psychiatry

Christopher Garofalo, MD, FAAFP
Massachusetts Medical Society

Richard Geline, MD, FAAOS (Alternate)
Illinois State Medical Society

Neil Rens, MD, MBA, MSc
Resident and Fellows Section

Jane Simpson, DO, FAAFP (Alternate)
Medical Society of the State of New York

Cheryl Hurd, MD, MA, DFAPA
American Psychiatric Association
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Final Report of Reference Committee B

Amar Kelkar, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 13 — The Uniform Health-Care Decisions Act
2. Board of Trustees Report 14 — A Public Health-Centered Criminal Justice System
3. Board of Trustees Report 16 — Research Correcting Political Misinformation and Disinformation on Scope of Practice
4. Board of Trustees Report 17 — Antidiscrimination Protections for LGBTQ+ Youth in Foster Care
5. Resolution 208 — Binding Arbitration in Health Insurance Contracts
6. Resolution 211 — Support for State Provider and Managed Care Organization Taxes to Sustain Federal Resolution Medicaid Matching Funding
7. Resolution 220 — Strengthening AMA Policy on Noncompete Clauses in Ownership Transitions
8. Resolution 233 — Increasing Transparency of AMA Medicare Payment Reform Strategy
9. Resolution 235 — CMS Payment Monitoring Following Government Staff Reductions
10. Resolution 239 — Ensuring Accessibility and Inclusivity of CDC Resources
11. Resolution 240 — Preserving the Specialty of Occupational and Environmental Medicine

RECOMMENDED FOR ADOPTION AS AMENDED

12. Board of Trustees Report 09 — Council on Legislation Sunset Review of 2015 House Policies
13. Board of Trustees Report 21 — Advocacy for More Stringent Regulations/ Restrictions on Distribution of Cannabis
14. Resolution 201 — Inclusion of DICOM Imaging in Federal Interoperability Standards
15. Resolution 203 — Supporting SUPPORT Act modifications to enhance care of patients with chronic pain
16. Resolution 204 — Protecting the Prescriptive Authority of Plenary Licensed Physicians
17. Resolution 210 — Impact of Tariffs on Healthcare Access and Costs

18. Resolution 214 — United Health Care and InterQual Monopoly
19. Resolution 215 — Support for Changing Standards for Minors Working in Agriculture
20. Resolution 216 — Support for Aging-Out Foster Youth with Mental Health and Psychotropic Needs
21. Resolution 217 — Regulation and Oversight of the Troubled Teen Industry
22. Resolution 222 — Need for Separate H1B Pathway for IMG Doctors in the USA
23. Resolution 228 — CHIP Coverage of OTC Medications
24. Resolution 229 — Guaranteeing Timely Delivery and Accessibility of Federal Health Data
25. Resolution 234 — Protection for International Medical Graduates
26. Resolution 238 — Preserving Accreditation Standards on Diversity, Equity, and Inclusion
27. Resolution 241 — Opposition to the Decertification of Independent Universities from the Student and Exchange Visitor Program
28. Resolution 242 — Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research from Politicized Attacks

RECOMMENDED FOR ADOPTION IN LIEU OF

29. *Resolution 202 — Preservation of the CDC Epilepsy Program Workforce and Infrastructure
30. Resolution 205 — AMA Support for Continuance of the Section 1115 - Social Security Act, Medicaid Waiver Program
    Resolution 206 — AMA Support for Renewal of Section 1115 - Social Security Act, Medicaid Waiver Demonstration Projects Supporting Food and Nutrition Services
31. *Resolution 207 — Abolishing Venue Shopping
    Resolution 231 — Preventing Venue Shopping in Medical Liability to Protect Physician Practices and Access to Care
32. *Resolution 219 — Opposing Unwarranted National Institutes of Health Research Institute Restructuring
33. *Resolution 221 — Preservation of Medicaid
    Resolution 223 — Preservation of Medicaid
    Resolution 232 — Preservation of Medicaid
    Resolution 236 — Preservation of Medicaid*
34. *Resolution 237- Urgent Advocacy to Restore J-1 Visa Processing for International Medical Graduate Physician

RECOMMENDED FOR REFERRAL

35. Resolution 209 — Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Resolution Addiction Medications for Legitimate Medical Purposes
36. Resolution 212 — Setting Standards for Forensic Toxicology Laboratories Used in Litigation
37. Resolution 230 — Advocating to expand private insurance coverage of anti-obesity medications (AOM)

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

38. Resolution 213 — Emergency Department Designation Requires Physician on Site
39. Resolution 218 — Distribution of Resident Slots Commensurate with Shortages
40. Resolution 224 — Support SAVE Plan and Public Service Loan Forgiveness (PLSF) Applications
41. Resolution 225 — The Private Practice Physicians in the Community
42. Resolution 226 — Regulations for Algorithmic-Based Health Insurance Utilization Review
43. Resolution 227 — Payment Recoupment—Let Sanity Prevail

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 13 — THE UNIFORM HEALTH-CARE DECISIONS ACT

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 13 be adopted, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 13 referred.

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)

Your Reference Committee heard limited testimony on Board of Trustees Report 13. Your Reference Committee heard testimony that was supportive of the preliminary Reference Committee Recommendations and that the AMA should not broadly endorse Uniform Law Commission's Uniform Health Care Decision Act because some provisions conflict with existing AMA policies in important ways. Your Reference Committee also heard testimony supporting the Board's recommendations due to concerns with the Uniform Health Care Decision Act's treatment of mental health directives. Additional testimony was provided in support of referral to ensure AMA policy adequately addressed these important issues; however, the overwhelming majority of the testimony was in support of adoption of Board of Trustees Report 13 as written. Therefore, your Reference Committee recommends that Board of Trustees Report 13 be adopted, and the remainder of the report be filed.

(2) BOARD OF TRUSTEES REPORT 14 — A PUBLIC HEALTH-CENTERED CRIMINAL JUSTICE SYSTEM

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 14 be adopted, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees 14 adopted and the remainder of the Report filed.

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-80.998, "Ending Money Bail to Decrease Burden on Lower Income Communities" (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony on Board of Trustees Report 14. Your Reference Committee heard testimony highlighting the negative public health impacts of prolonged incarceration on individuals. Your Reference Committee considered an amendment that was offered to eliminate certain types of automatic sentencing policies, such as “three strikes” types of laws. Your Reference Committee points out that, while the Report provided background about these laws, the Report ultimately did not make a specific recommendation regarding such laws. Your Reference Committee notes, however, that recommendations in the Report broadly call for our AMA to support ongoing review of sentencing and judicial discretion—two elements that accomplish the intent of the proffered amendments. Your Reference Committee also points out that “three strikes” type of laws are just one type of automatic sentencing, and the Board’s recommendations provide our AMA with the ability to consider the individual and public health effects of a broader range of automatic sentencing policies. Therefore, your Reference Committee

recommends that Board of Trustees Report 14 be adopted, and the remainder of the report be filed.

(3) BOARD OF TRUSTEES REPORT 16 — RESEARCH CORRECTING POLITICAL MISINFORMATION AND DISINFORMATION ON SCOPE OF PRACTICE

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 16 be adopted, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 16 adopted and the remainder of the Report filed.

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)

Your Reference Committee heard limited, but entirely supportive testimony for Board of Trustees Report 16. Testimony highlighted excitement surrounding the outcomes of current AMA field research being conducted in the realm of misinformation and disinformation as it relates to scope of practice. Therefore, your Reference Committee recommends that Board of Trustees Report 16 be adopted, and the remainder of the report be filed.

(4) BOARD OF TRUSTEES REPORT 17 — ANTIDISCRIMINATION PROTECTIONS FOR LGBTQ+ YOUTH IN FOSTER CARE

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 17 be adopted, and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 17 referred.

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)

Your Reference Committee heard mostly supportive testimony for Board of Trustees Report 17. Testimony highlighted the benefits of having Sexual Orientation and Gender Identity (SOGI) data for foster youth, but noted that this was only true if the privacy of these individuals is carefully protected. While the reporting requirements apply primarily to state and Tribal entities, your Reference Committee heard some concerns about the burden on smaller entities, highlighting the need for federal guidance, technical assistance, and funding. Your Reference Committee heard testimony raising privacy concerns and recommending that the resolution be changed to require that foster youth consent to the collection of their information. However, the language of the resolution includes guardrails such as requiring that data be anonymized and aggregated, and it is already a common practice for foster systems to collect this information. Therefore, your Reference Committee recommends that Board of Trustees Report 17 be adopted, and the remainder of the report be filed.

(5) RESOLUTION 208 — BINDING ARBITRATION IN HEALTH INSURANCE CONTRACTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 208 be adopted.

HOD ACTION: Resolution 208 adopted.

RESOLVED, that our American Medical Association study the effects of binding arbitration in health insurance contracts with physicians. (Directive to Take Action)

Your Reference Committee heard supportive testimony for Resolution 208. Testimony highlighted concerns that binding arbitration clauses limit physicians' legal recourse, reduce transparency, and can disproportionately favor insurers. Given the potential implications for physician practice sustainability and patient care, your Reference Committee agrees that this issue warrants further investigation. Therefore, your Reference Committee recommends that Resolution 208 be adopted.

(6) RESOLUTION 211 — SUPPORT FOR STATE PROVIDER AND MANAGED CARE ORGANIZATION TAXES TO SUSTAIN FEDERAL RESOLUTION MEDICAID MATCHING FUNDING

RECOMMENDATION:

Your Reference Committee recommends that Resolution 211 be adopted.

HOD ACTION: Resolution 211 adopted.

RESOLVED, that our American Medical Association (AMA) 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 AMA policy H-385.925 be amended 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 AMA policy D-165.961 be amended 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 policy H-385.941 be amended 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)

Your Reference Committee heard mostly supportive testimony for this resolution, emphasizing that provider and managed care organization (MCO) taxes are essential mechanisms used by states to secure federal Medicaid matching funds. Testimony consistently underscored that these financing tools help sustain access to care and support physician payment rates without directly taxing individual physicians. Your Reference Committee heard additional testimony that these taxes are constitutionally embedded or long-standing components of Medicaid financing in many states, and that their elimination could significantly reduce Medicaid coverage and funding. Your Reference Committee also heard that current federal proposals threaten to restrict these mechanisms, and that the term “provider tax” is often misinterpreted as applying to individual physicians, even though in practice it targets institutional providers. Testimony urged our AMA to clarify its position, prevent misapplication, and support states in preserving these funding tools. Your Reference Committee also heard limited testimony in opposition, expressing concern that the resolution reinforces a flawed and overly complex Medicaid financing model. Testimony cautioned that such mechanisms could be misinterpreted, contradict AMA policy supporting adequate payment, and divert attention from broader reforms needed to strengthen Medicaid sustainably. Your Reference Committee noted that there is no clear AMA policy addressing this specific Medicaid financing mechanism and believes this resolution appropriately fills that gap. Therefore, your Reference Committee recommends that Resolution 211 be adopted.

(7) RESOLUTION 220 — STRENGTHENING AMA POLICY ON NONCOMPETE CLAUSES IN OWNERSHIP TRANSITIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 220 be adopted.

HOD ACTION: Resolution 220 adopted.

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)

Your Reference Committee heard testimony unanimously in support of Resolution 220. Testimony agreed that non-compete clauses hinder physician mobility, compromise patient care, and should be addressed through policy changes. Some testimony acknowledged that there may be a small role for non-competes in protecting small, private practices but additional testimony noted that since this resolution supports new contract negotiations when there is a merger or sale that this would help protect small private practices. Your Reference Committee heard testimony recommending that the third resolved clause be amended to exclude dismissals that are “for cause;” however, the majority of the testimony supported Resolution 220 as written. Additionally, your Reference Committee notes that this resolution as written focused only on ownership transitions where “for cause” dismissals may have a different context than what was discussed in testimony. Therefore, your Reference Committee recommends that Resolution 220 be adopted.

(8) RESOLUTION 233 — INCREASING TRANSPARENCY OF AMA MEDICARE PAYMENT REFORM STRATEGY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 233 be adopted.

HOD ACTION: Resolution 233 adopted.

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)

Your Reference Committee heard testimony overwhelmingly in support of adopting Resolution 233 and in opposition to reaffirming existing policy. Your Reference Committee agrees and therefore recommends that Resolution 233 be adopted.

(9) RESOLUTION 235 — CMS PAYMENT MONITORING FOLLOWING GOVERNMENT STAFF REDUCTIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 235 be adopted.

HOD ACTION: Resolution 235 adopted.

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)

Your Reference Committee heard testimony in strong support of Resolution 235, which directs our AMA to monitor federal staffing reductions, particularly at the Centers for Medicare and Medicaid Services (CMS), and to establish a reporting mechanism for physicians to share information about payment delays and new administrative obstacles. Your Reference Committee heard that recent restructuring at the Department of Health and Human Services (HHS) could significantly reduce CMS staffing levels, raising concerns about the agency's ability to maintain timely reimbursement and support critical functions. Your Reference Committee heard that a reporting pathway would help our AMA identify and document real-time issues that threaten physician practice sustainability and patient access to care.

Additional testimony was provided that even small CMS staffing changes can have significant consequences, including reimbursement delays and instability for independent and safety-net practices. Your Reference Committee also heard testimony that HHS has projected a 25 percent workforce reduction, reinforcing the urgency of equipping our AMA with timely data to advocate for reliable operations and public health infrastructure. Testimony noted that while physicians are paid by Medicare Administrative Contractors (intermediaries) and not directly by CMS, federal staffing reductions can still disrupt the payment process and increase administrative burdens on practices.

Your Reference Committee agrees that this resolution would strengthen our AMA's advocacy by providing timely data and aligns with our efforts to protect physicians from unnecessary administrative burdens. Therefore, your Reference Committee recommends that Resolution 235 be adopted.

(10) RESOLUTION 239 — ENSURING ACCESSIBILITY AND INCLUSIVITY OF CDC RESOURCES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 239 be adopted.

HOD ACTION: Resolution 239 adopted.

RESOLVED, that our American Medical Association encourage the Centers for Disease Control and Prevention to maintain essential medical and public health resources that remain evidence based on their website for continued accessibility to clinicians and patients. (Directive to Take Action)

Your Reference Committee heard generally positive testimony in favor of maintaining evidence-based public health information and resources on the website of the Centers for Disease Control and Prevention (CDC). Your Reference Committee also heard testimony that Resolution 229 covers the same ground as Resolution 239, and that the two resolutions could be considered together. However, additional testimony from the resolution author advocated for keeping the resolutions separate since Resolution 239 is specific to the maintenance of evidence-based resources on the CDC website. Your Reference Committee agrees. Therefore, your Reference Committee recommends that Resolution 239 be adopted.

(11) RESOLUTION 240 — PRESERVING THE SPECIALITY OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 240 be adopted.

HOD ACTION: Resolution 240 adopted.

RESOLVED, that our American Medical Association advocate for National Institute for Occupational Safety and Health (NIOSH) and other federal and non-federal funding mechanisms for continued graduate medical education for OEM in order to maintain and improve the health, safety and productivity of the workforce and the quality, sustainability, and safety of the environment. (Directive to Take Action)

Your Reference Committee heard strong testimony in support of Resolution 240. Testimony focused on the critical role played by the National Institute for Occupational Safety and Health (NIOSH) in the sustainability of the occupational and environment medicine (OEM) specialty, the unique ability of OEM specialists to detect workplace hazards and guide workers to resources such as workers' compensation, and the widespread problem of workplace injuries. Testimony acknowledged existing needs within OEM. Supporters of the resolution argued that shortages within OEM are harming patient access to care and preventing effective preventive medicine, and as such, believe that this specialty should be prioritized in terms of funding. Your Reference Committee heard testimony recommending that existing AMA policy relating to graduate medical education be reaffirmed in lieu of the proposed resolution, but testimony responding to this proposed amendment noted that OEM residencies currently face funding cuts due to their residencies being funded mainly through NIOSH. Your Reference Committee agrees. Therefore, your Reference Committee recommends that Resolution 240 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(12) BOARD OF TRUSTEES REPORT 09 — COUNCIL ON LEGISLATION SUNSET REVIEW OF 2015 HOUSE POLICIES

RECOMMENDATION A:

Your Reference Committee recommends that the Recommendation of Board of Trustees Report 9 be amended by addition to read as follows:

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, except for Policy D-40.990, which should be retained, and the remainder of this report be filed.

RECOMMENDATION B:

Your Reference Committee recommends that the title of Policy D-40.990 be changed to read as follows:

SUPPORT FOR PATHWAYS FOR VETERANS TO TRANSITION TO PARAMEDICS

RECOMMENDATION C:

Your Reference Committee recommends that the title of Policy D-260.993 be changed to read as follows:

LABORATORY REPORTING BURDENS

RECOMMENDATION D:

Your Reference Committee recommends that Policy D-265.990 be amended by addition and deletion to read as follows:

Our AMA will make available, but not as a matter of advocacy priority, model anti-SLAPP legislation protecting ~~physicians?~~physicians' First Amendment rights in the context of proceedings relating to quality of health care.

RECOMMENDATION E:

Your Reference Committee recommends that Board of Trustees Report 9 be adopted as amended and that the remainder of the Report be filed.

HOD ACTION: Board of Trustees 9 adopted as amended and the remainder of the Report filed.

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.

Your Reference Committee heard testimony that Board of Trustees Report 9 should be adopted with a few noted amendments. There was testimony recommending that Policy D-40.990 and D-260.993 be retained with a change to the title to delete the reference to a specific bill. Your Reference Committee agrees and recommends changing the title of Policy D-40.990 to "Support for Pathways for Veterans to Transition to Paramedics," and changing the title of Policy D-260.993 to "Laboratory Reporting Burdens." There was also testimony pointing out a typo in the original language of Policy D-265.990 where a question mark was included after "physicians" instead of an apostrophe. Finally, there was testimony in support of retaining Policy D-180.998, noting a recent news article that the Trump Administration intends to reconsider mental health parity and addiction equity regulations. However, your Reference Committee determined that other existing AMA policies specifically cover mental health and substance use disorder parity (see: H-185.974, "Parity for Mental Health and Substance Use Disorders in Health Insurance Programs;" H-185.916, "Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care;" D-185.971, "Studying Avenues for Parity in Mental Health & Substance Use Coverage;" H-345.975, "Maintaining Mental Health Services by States;" and H-95.914, "Opioid Mitigation") and, since the directive in Policy D-180.998 has been achieved, it should be rescinded. Therefore, your Reference Committee recommends that the Board of Trustees Report 9 be adopted as amended, and that the remainder of the Report be filed.

(13) BOARD OF TRUSTEES REPORT 21 — ADVOCACY FOR MORE STRINGENT REGULATIONS / RESTRICTIONS ON DISTRIBUTION OF CANNABIS

RECOMMENDATION A:

Your Reference Committee recommends that Recommendation 2(b) be amended by addition to read as follows:

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 as well as avenues for legal and financial penalties for marketing to youth;

RECOMMENDATION B:

Your Reference Committee recommends that Recommendation 2(c) be amended by deletion to read as follows:

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~~;

RECOMMENDATION C:

Your Reference Committee recommends that Board of Trustees Report 21 be adopted as amended and the remainder of the Report be filed.

RECOMMENDATION D:

Your Reference Committee recommends that the title of Board of Trustees Report 21 be changed to read as follows:

ADVOCACY FOR MORE PROTECTIVE REGULATIONS ON DISTRIBUTION OF CANNABIS

HOD ACTION: Board of Trustees Report 21 be adopted as amended and the remainder of the Report filed.

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)

Your Reference Committee heard supportive testimony for BOT Report 21. Your Reference Committee heard testimony highlighting the public health harms from cannabis use. Your Committee considered a proposed amendment and agreed that removing the words “restriction” and “stringent” from the title more accurately reflects the policy’s intent to protect public health. The Committee also received an amendment, which it ultimately supported in part, adding language regarding legal and financial penalties for marketing to youth, and recognizing that enforceable mechanisms are essential to prevent youth-targeted advertising. However, your Reference Committee felt that certain aspects of the proposed amendment would unnecessarily narrow the scope of the policy. It was determined that maintaining inclusive language covering all forms of cannabis, including smoked, inhaled, and edible, would best preserve the policy’s public health focus. Your Reference Committee also agreed with testimony to strike language suggesting that cannabis products should be considered as tobacco cessation tools if there was “credible evidence is available, evaluated, and supported by the FDA” of such cannabis products. Therefore, your Reference Committee recommends that the recommendations contained in Board of Trustees Report 21 be adopted as amended, and that the remainder of the report be filed.

(14) RESOLUTION 201 — INCLUSION OF DICOM IMAGING IN FEDERAL INTEROPERABILITY STANDARDS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 201 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~American Medical Association~~ work with other interested specialty and state medical societies to support the addition of Digital Imaging and Communications in Medicine (DICOM) ~~standard~~ imaging to the federal interoperability standards, namely the United States Core Data for Interoperability (USCDI), to promote standardized, interoperable image sharing across healthcare systems; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 201 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support ~~advocate for~~ policies and regulations requiring electronic health record (EHR) vendors, ~~and~~ imaging archive system vendors, and imaging information technology exchange service vendors to support the secure, efficient, and interoperable exchange of DICOM imaging data between healthcare entities.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 201 be adopted as amended.

RECOMMENDATION D:

Your Reference Committee recommends that the title of Resolution 201 be changed to read as follows:

INCLUSION OF DIGITAL IMAGING AND COMMUNICATIONS IN MEDICINE (DICOM) IMAGING IN FEDERAL INTEROPERABILITY STANDARDS

HOD ACTION: Resolution 201 adopted as amended.

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)

Your Reference Committee heard testimony in opposition to the preliminary report recommendation and in strong support of amended language for Resolution 201. Testimony provided by the authors expressed that imaging remains excluded from the federal standards that govern clinical data exchange, which creates a critical gap that burdens patients, delays care, and leads to unnecessary repeat imaging and radiation exposure. Testimony agreed with friendly amendments to language that included "specialty and state medical societies," and spelled out Digital Imaging and Communications in Medicine (DICOM) imaging in the US Core Data for Interoperability (USCDI) and electronic health records (EHR). However, testimony respectfully disagreed with proposed amendments to exclude imaging archive system vendors and viewed that as significantly weakening the resolution. Testimony emphasized that the 21st Century CURES Act has requirements in place that mandate that health data be accessible and shareable amongst diverse platforms. However, additional testimony noted that due to the HITECH Act, since radiologists are not considered to be patient-facing, they were granted an exemption in CMS's reporting program. This exemption has allowed DICOM imaging to remain separate from USCDI up to this point in time. Your Reference Committee heard that this exemption has caused significant problems for radiologists and other physicians when trying to access imaging that is vital to patient care in a timely manner. To remedy this issue, multiple amendments were offered. Your Reference Committee ultimately accepted an amendment that received significant supportive testimony. Therefore, your Reference Committee recommends that Resolution 201 be amended in lieu of adoption.

(15) RESOLUTION 203 — SUPPORTING SUPPORT ACT MODIFICATIONS TO ENHANCE CARE OF PATIENTS WITH CHRONIC PAIN

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 203 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~American Medical Association~~ advocate for legislation allowing ~~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.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 203 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 203 be changed to read as follows:

COMPOUNDED SYRINGE DELIVERY TO PHYSICIAN PRACTICES FOR INTRATHECAL THERAPY

HOD ACTION: Resolution 203 adopted as amended with a change of title.

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)

Your Reference Committee heard supportive testimony in favor of Resolution 203 that emphasized the need for a legislative fix to restore safe and effective access to compounded intrathecal medications. Testimony provided a detailed rationale for the resolution, citing unintended consequences of the SUPPORT Act that now require patients to personally receive syringes of controlled substances—posing safety, logistical, and compliance concerns. Testimony further highlighted multispecialty endorsements of a fix for this issue, noting that our AMA has advocated directly to the Drug Enforcement Administration (DEA) and the US Department of Justice (DOJ), who acknowledge the issue but believe only Congress can resolve it. Your Reference Committee heard testimony indicating that a legislative fix supported by the AMA is included in the current SUPPORT Act reauthorization that directly addresses these concerns. Conversely, some testimony raised concerns about unintended consequences reminiscent of white bagging practices, warning of risks to patient safety, increased inventory costs, and insurer abuse if medications were delivered outside standard distribution channels. Your Reference

Committee also received an amendment, that was supported by multiple testifiers, which proposed removing the specific legislative reference while preserving the intent of the Resolution. Therefore, your Reference Committee recommends that Resolution 203 be adopted as amended.

(16) RESOLUTION 204 — PROTECTING THE PRESCRIPTIVE AUTHORITY OF PLENARY LICENSED PHYSICIANS

RECOMMENDATION A:

Your Reference Committee recommends that the fifth resolve of Resolution 204 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA encourage interprofessional collaboration to clarify scope-of-practice boundaries, educate interested parties ~~stakeholders~~ on the legal authority of plenary licensure, and promote policies that ensure timely patient access to physician~~-directed therapy~~ led care.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 204 be adopted as amended.

HOD ACTION: Resolution 204 adopted as amended.

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).

Your Reference Committee heard unanimous supportive testimony in favor of the spirit of Resolution 204. Testimony universally acknowledged that while pharmacists play an important role as part of a physician-led team, they should not have the authority to unilaterally withhold medication from patients after it has been prescribed by a physician. An amendment was proposed to add that “scope of practice shall be defined by physicians” however, it was noted that scope of practice is determined by each State Board of Medical Examiners, which may include non-physician members. Another amendment was offered to revise the phrase “physician-directed care” to “physician-led care” to better align with existing AMA advocacy language and communication efforts. Your Reference Committee also notes that AMA has existing policy on pharmacy intrusion into medical practice (including but not limited to H-35.961, AMA Response to Pharmacy Intrusion Into Medical Practice) that further supports the sentiment in Resolution 204 and negates the need for further amendments. Therefore, your Reference Committee recommends that Resolution 204 be adopted as amended.

(17) RESOLUTION 210 — IMPACT OF TARIFFS ON HEALTHCARE ACCESS AND COSTS

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 210 be deleted.

~~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; and be it further~~

RECOMMENDATION B:

Your Reference Committee recommends that the third resolve of Resolution 210 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support legislative efforts aimed at mitigating the negative effects of tariffs on the healthcare system, ensuring that patient care, medical supplies, and pharmaceuticals remain~~s~~ accessible and affordable.~~; and be it further~~

RECOMMENDATION C:

Your Reference Committee recommends that the fourth resolve of Resolution 210 be deleted.

~~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.~~

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 210 be adopted as amended.

HOD ACTION: Resolution 210 adopted as amended.

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)

Your Reference Committee heard mostly supportive testimony regarding Resolution 210. Your Reference Committee heard that increased tariffs have the potential to cause health care costs to rise, hurting patient access to care and practice sustainability. Other testimony noted that the Centers for Medicare & Medicaid Services (CMS) will rely on input and advocacy from interested parties like our AMA to keep track of the increased costs of tariffed imported medical supplies. Your Reference Committee also heard testimony that our AMA lacks the expertise needed to effectively advocate on trade policy and that the study of short-term and long-term effects of tariffs on the health care delivery system, proposed by the fourth resolved clause, is neither necessary nor feasible for our AMA to conduct effectively. In alignment with this reasoning, multiple amendments were offered to delete the fourth resolved clause. Amendments were also offered to the third resolved clause to make it more expansive. Therefore, your Reference Committee recommends that Resolution 210 be adopted as amended.

(18) RESOLUTION 214 — UNITED HEALTH CARE AND INTERQUAL MONOPOLY

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 214 be adopted.

RECOMMENDATION B:

Your Reference Committee recommends that the title of Resolution 214 be changed to read as follows:

MANAGED CARE UTILIZATION REVIEW SYSTEMS

HOD ACTION: Resolution 214 adopted with a change of title.

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)

Your Reference Committee heard unanimous support for the spirit of Resolution 214, which opposes anticompetitive managed care utilization review systems that restrict fair access to medical services. Your Reference Committee heard testimony emphasizing the need for antitrust action and AMA advocacy to protect patient care from restrictive insurance policies. One commenter raised concern with the title of the resolution and suggested a title that better reflects the broader focus of the resolution beyond the entities named in the original title. Your Reference Committee agrees and therefore recommends that Resolution 214 be adopted as amended with a change in title.

(19) RESOLUTION 215 — SUPPORT FOR CHANGING STANDARDS FOR MINORS WORKING IN AGRICULTURE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 215 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~American Medical Association strongly~~ supports federal and state efforts to strengthen ~~ensure that~~ child labor protections by implementing effective mechanisms, including increasing employer penalties ~~uniformly apply to children working in agriculture, including raising the~~, maintaining a minimum age of employment, enforcing work hour restrictions, and extending workplace health and safety standards, such as protections against exposures to hazardous substances and unsafe equipment, to all minors, including those working in agriculture.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 215 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 215 be changed to read as follows:

STRENGTHENING CHILD LABOR PROTECTIONS FOR WORKING MINORS

HOD ACTION: Resolution 215 adopted as amended with a change of title.

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)

Your Reference Committee heard testimony in favor of Resolution 215. Testimony was unanimously in support of the resolution and spoke to the importance of child labor protections. Your Reference Committee heard testimony that children who work in the agricultural sector face particular danger, and are often less protected than minors who work in other sectors, due to an existing legal framework that applies fewer protections to children in the agricultural sector compared to other sectors. Testimony also noted that some states are actively rolling back labor protections for minors. Your Reference Committee also heard that children from low-income, migrant, and Latine communities are

disproportionately exploited under existing labor laws. A clarifying amendment was offered by the author of the original resolution. Therefore, your Reference Committee recommends that Resolution 215 be adopted as amended with a change in title.

(20) RESOLUTION 216 — SUPPORT FOR AGING-OUT FOSTER YOUTH WITH MENTAL HEALTH AND PSYCHOTROPIC NEEDS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 216 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~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 comprehensive mental health support, and, when clinically indicated, ~~and~~ access to ~~psychotropic~~ medications~~s~~ or other treatment recommended by their physician as part of an overall treatment plan.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 216 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 216 be changed to read as follows:

SUPPORT FOR AGING-OUT FOSTER YOUTH WITH MENTAL HEALTH NEEDS

HOD ACTION: Resolution 216 adopted as amended with a change of title.

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)

Your Reference Committee heard testimony in favor of Resolution 216. Testimony noted that youth aging out of foster care face special challenges and are at heightened risk for mental health problems and substance use disorders. Additional testimony noted that special programs (such as the Transition Housing Program and the John H Chafee Program for Successful Transition to Adulthood) provide valuable supports and services to youth transitioning from foster care, but that funding for many of these programs has remained flat despite increasing demand. Two amendments were offered that would

broaden the scope of the initiatives supported by the resolution to include support for transition age youth who require access to any kind of medication or treatment recommended by their physician. Additional testimony was received that supported the amended language but noted that the title no longer matched the resolved clauses and as such a new title was needed. Therefore, your Reference Committee recommends that Resolution 216 be adopted as amended with a change in title.

(21) RESOLUTION 217 — REGULATION AND OVERSIGHT OF THE TROUBLED TEEN INDUSTRY

RECOMMENDATION A:

Your Reference Committee recommends that proposed new item 3 of Policy H-60.896 be amended by addition and deletion to read as follows:

Our AMA a) opposes the use of any non-evidence-based therapies, and any abusive measures, in Youth Residential and Other Treatment Programs, b) ~~and~~ supports that only appropriately qualified and certified child and adolescent medical and mental health professionals provide clinical services to participants, and c) supports oversight and review by licensed physicians, mental health professionals, and any other appropriate healthcare professionals.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 217 be adopted as amended.

HOD ACTION: Resolution 217 adopted as amended.

RESOLVED, that our 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)

Your Reference Committee heard testimony in strong support of Resolution 217, which calls for greater oversight and regulation of the adolescent therapeutic service industry to address the issue of unregulated youth programs that often employ punitive rather than therapeutic interventions. On balance, the testimony underscored strong support for regulating youth programs, preventing abusive practices, and ensuring evidence-based care. While some commenters suggested amendments to refine the resolution's language, all contributors agree on the urgency of reform. Finally, your Reference Committee heard testimony recommending removing the phrase "Troubled Teen Industry" in the title of this resolution. However, your Reference Committee notes that because this resolution is amending existing policy, H-60.896 "Youth Residential Treatment Program Regulation", the resolution title itself will not be reflected in Policy Finder, and therefore such an amendment is not necessary. Additional testimony was offered proposing grammatical changes to your Reference Committee's proposed amendment. Therefore, your Reference Committee recommends that Resolution 217 be adopted as amended.

(22) RESOLUTION 222 — NEED FOR SEPARATE H1B PATHWAY FOR IMG DOCTORS IN THE USA

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 222 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~American Medical Association advocate for~~ support the continuance of premium processing and other mechanisms that ~~an~~ expedite~~d~~ H-1B visa application**s** and renewal**s** ~~process~~ for International Medical Graduate physicians. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 222 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 222 be changed to read as follows:

EXPEDITED H-1B PATHWAYS FOR INTERNATIONAL MEDICAL GRADUATE PHYSICIANS IN THE USA

HOD ACTION: Resolution 222 adopted as amended with a change of title.

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 Acton)

Your Reference Committee heard consistent support for our International Medical Graduates (IMG) colleagues across all the testimony received. Your Reference Committee heard that international medical graduates play an irreplaceable role in our healthcare system. Testimony further noted the difficulty that some IMGs have experienced within the immigration system, including concerns about being able to start residencies on time, and highlighted the importance of having an immigration system that is quick and efficient so that our IMG physicians can continue to stay employed and care for their patients. Testimony also stated that H-1B visas can be arduous to obtain, and that help is needed to ensure timely delivery of visas to our IMGs. However, your Reference Committee also heard that U.S. Citizenship and Immigration Services (USCIS) already has a premium processing option. Testimony stated that USCIS guarantees a response (approval, denial, or a Request for Evidence) within 15 days of receiving the petition. Testimony noted that premium processing is already available for H-1B holders and applicants. Moreover, testimony highlighted that it would be a more effective advocacy strategy to support the continuance of premium processing than to ask for an expedited applicant and renewal process since premium processing is already an expedited system that is in use by USCIS. Finally, your Reference Committee heard testimony recommending that the resolution be amended to call for an increase to the H-1B visa cap, but notes that this is beyond the scope of the resolution. Therefore, your Reference Committee recommends that Resolution 222 be adopted as amended.

(23) RESOLUTION 228 — CHIP COVERAGE OF OTC MEDICATIONS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 228 be amended by addition and deletion to read as follows:

> RESOLVED, that our ~~American Medical Association (~~AMA~~)~~ ~~advocate~~ support ~~for~~ expanding coverage ~~of~~ for 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; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 228 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA oppose arbitrary exclusions or limitations on ~~the quantity of~~ FDA-approved over-the-counter medications covered by the Children's Health Insurance Program for enrolled individuals; and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the third resolve of Resolution 228 be amended by addition to read as follows:

RESOLVED, that our AMA oppose copayment or other cost sharing requirements for over-the-counter medications for patients enrolled in CHIP.

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 228 be adopted as amended.

HOD ACTION: Resolution 228 adopted as amended.

RESOLVED, that our American Medical Association (AMA) 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)

Your Reference Committee heard testimony in strong support of Resolution 228. Testimony stated that since its inception, the Children's Health Insurance Program (CHIP) has helped reduce the number of uninsured children. However, testimony also highlighted that many individuals still face barriers to care due to inconsistent coverage of over-the-counter (OTC) medications. Testimony noted the importance of expanded OTC coverage under CHIP to improve children's health outcomes and ease financial burdens on low-income families. Testimony stated that limited OTC access negatively impacts care, with even small costs creating obstacles. Your Reference Committee heard that variations in state-level CHIP coverage, such as limited access in South Dakota, Texas, and Wisconsin, further exacerbate these issues. Additional testimony supported OTC access without age or quantity restrictions, citing precedent that a 12-month supply of contraceptives improves access, reduces unintended pregnancies, and promotes equitable, cost-effective care. Testimony also proffered technical amendments directed at avoiding potential unnecessary barriers to timely coverage while focusing on opposing limitations on OTC medications and clarifying opposition to copayments and any other cost-sharing requirements. Your Reference Committee appreciated testimony that raised the issue of CHIP's block grant financing structure and the danger that the additional cost of covering OTC medications might result in states exhausting their CHIP allotments. However, the Reference Committee would note that the appropriation language that Congress has adopted for CHIP for fiscal years 2024 through 2028 does not limit the amount that is appropriated for state CHIP allotments (see section 2104(a)(27) of the Social Security Act (42 U.S.C. 1397dd(a)(27)) to a specific dollar amount (as was the case in prior fiscal years), allowing for state allotments to grow as program expenditures increase and reducing the danger of states outspending their allotments. Similarly, your Reference Committee appreciated testimony raising concerns that a policy allowing for coverage of OTC medications under CHIP could open the door to abusive practices, but feels that the policy established by Resolution 228 is sufficiently flexible to allow our AMA to oppose proposals to expand CHIP coverage of OTC medications that would invite such practices. Therefore, your Reference Committee recommends that Resolution 228 be adopted as amended.

(24) RESOLUTION 229 — GUARANTEEING TIMELY DELIVERY AND ACCESSIBILITY OF FEDERAL HEALTH DATA

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 229 be amended by addition and deletion to read as follows:

RESOLVED, that our ~~American Medical Association (~~AMA~~)~~ advocate for the immediate reinstatement of dissemination of critical public health information by ~~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 puts the American public at increased risk of ~~exposes all patients who are receiving care to~~ less than optimal health outcomes; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 229 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~promote~~ support 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~~.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 229 be adopted as amended.

HOD ACTION: Resolution 229 adopted as amended.

RESOLVED, that our American Medical Association (AMA) 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)

Your Reference Committee heard generally positive testimony in favor of reinstating the dissemination of critical health data by public health agencies responsible for informing the public and health care professionals of emergent threats to public health. Testimony highlighted that recent actions by the current Administration have curtailed the ability of agencies like the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) to collect and disseminate essential information. An amendment was offered to frame the language in more affirmative terms, and another proposed the addition of the word “immediate” to underscore the urgency of this issue, both of which your Reference Committee supported. Therefore, your Reference Committee recommends that Resolution 229 be adopted as amended.

(25) RESOLUTION 234 — PROTECTION FOR INTERNATIONAL MEDICAL GRADUATES

RECOMMENDATION A:

Your Reference Committee recommends that AMA policies D-160.921 and H-255.988 be reaffirmed in lieu of the first resolve of Resolution 234.

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 234 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~work with~~ support relevant ~~stakeholders~~ interested parties ~~to develop~~ in developing 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 international medical graduate ~~IMG~~ physicians.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 234 be adopted as amended and that AMA policies D-160.921 and H-255.988 be reaffirmed.

HOD ACTION: Resolution 234 adopted as amended and AMA policies D-160.921 and H-255.988 reaffirmed.

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)

Your Reference Committee heard mixed testimony on Resolution 234. Testimony unanimously supported the need to help ensure that medical facilities remain safe for all patients and noted that our AMA should support our international medical graduate (IMG) colleagues and protect them from being treated unfairly or being targeted. However, some testimony highlighted that existing AMA policy already covers the asks in the first resolve noting that our AMA policy already states that healthcare facilities should be designated as sensitive areas and, among other things, opposes the presence of immigration and customs enforcement at healthcare facilities. Additional testimony noted that US Immigration and Customs Enforcement (ICE) has the authority to arrest undocumented immigrants and highlighted that workplaces cannot stop immigration enforcement actions or legitimate audits that follow proper legal procedures. However, a minor amendment was made, and accepted by your Reference Committee, noting that all physicians should be able to report unfair workplace immigration issues, even if it is on behalf of their IMG colleagues. Your Reference Committee received amendments in alignment with these legal limitations. Therefore, your Reference Committee recommends that Resolution 234 be adopted as amended and that existing AMA policies D-160.921 and H-255.988 be reaffirmed.

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921

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.

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.

(26) RESOLUTION 238 — PRESERVING ACCREDITATION STANDARDS ON DIVERSITY, EQUITY, AND INCLUSION

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 238 be amended by addition and deletion to read as follows:

RESOLVED, that our ~~American Medical Association (~~AMA~~)~~ oppose any federal actions or executive orders that threaten the ability of accreditation bodies, including the Accreditation Council for Graduate Medical Education (ACGME), the Commission on Osteopathic College Accreditation (COCA), and the Liaison Committee on Medical Education (LCME), to enforce appropriate accreditation ~~diversity, equity, and inclusion~~ standards; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 238 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support ~~advocate to relevant federal agencies and officials emphasizing the value of~~ ACGME, COCA, and LCME in advocating for their accreditation standards focused on diversity, equity, and inclusion for the betterment of patient care and public health; and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the third resolve of Resolution 238 be amended by addition and deletion to read as follows:

RESOLVED, that, consistent with applicable laws, our AMA support ~~work collaboratively with~~ allopathic and osteopathic medical education accreditation bodies ~~to restore and~~ in strengthening accreditation standards focused on diversity, equity, and inclusion.

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 238 be adopted as amended.

RECOMMENDATION E:

Your Reference Committee recommends that the title of Resolution 238 be changed to read as follows:

PRESERVING ACCREDITATION STANDARDS ON INCLUSIVE EXCELLENCE

HOD ACTION: Resolution 238 adopted as amended without a change of title.

RESOLVED, that our American Medical Association (AMA) oppose any federal actions or executive orders that threaten the ability of accreditation bodies, including the Accreditation Council for Graduate Medical Education (ACGME) , the Commission on Osteopathic College Accreditation (COCA), and the Liaison Committee on Medical Education (LCME), to enforce appropriate diversity, equity, and inclusion standards; and be it further

RESOLVED, that our AMA advocate to relevant federal agencies and officials emphasizing the value of ACGME, COCA, and LCME accreditation standards focused on diversity, equity, and inclusion for the betterment of patient care and public health; and be it further

RESOLVED, that, consistent with applicable laws, our AMA work collaboratively with allopathic and osteopathic medical education accreditation bodies to restore and strengthen accreditation standards focused on diversity, equity, and inclusion.

Your Reference Committee heard mixed testimony on Resolution 238. Your Reference Committee heard that the Executive Orders have placed pressure on physician accreditation bodies including Accreditation Council for Graduate Medical Education (ACGME), the Commission on Osteopathic College Accreditation (COCA), and the Liaison Committee on Medical Education (LCME) surrounding their diversity equity and inclusion standards. Testimony noted that this pressure from the federal government resulted in these accreditation bodies changing or suspending their standards surrounding diversity, equity, and inclusion. Further testimony highlighted concerns that without these standards institutions would become less inclusive, and as a result our physician and patient population would suffer. However, your Reference Committee also heard that our AMA has strong working relationships with all the physician accreditation bodies including AGCME, COCA, and LCME. Testimony noted that, out of respect for maintaining these relationships, our AMA does and should continue to allow these accreditation bodies to take the lead in advocating for their accreditation standards. Testimony stated that our AMA will continue to aid these organizations in their advocacy work as requested and appropriate. Your Reference Committee heard about the importance of having a holistic and collegial working environment with our accreditation colleagues while still noting the importance of having standards that promote inclusion. Amendments were offered to help reflect these working relations, keep our policy focused on what our AMA supports, and adopt needed language updates to align with currently used terminology in this space. Your Reference Committee accepted these amendments. Therefore, your Reference Committee recommends that Resolution 238 be adopted as amended.

(27) RESOLUTION 241 — OPPOSITION TO THE DECERTIFICATION OF INDEPENDENT UNIVERSITIES FROM THE STUDENT AND EXCHANGE VISITOR PROGRAM

RECOMMENDATION A:

Your Reference Committee recommends that existing AMA policies H-255.988 and D-255.911 be reaffirmed.

RECOMMENDATION B:

Your Reference Committee recommends that the first resolve of Resolution 241 be deleted.

~~RESOLVED, that our American Medical Association publicly advocate against the targeted use of Student and Exchange Visitor Program decertification against independent universities; and be it further~~

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 241 be adopted as amended.

RECOMMENDATION D:

Your Reference Committee recommends that the title of Resolution 241 be changed to read as follows:

PRESERVATION OF IMMIGRATION PATHWAYS FOR INTERNATIONAL MEDICAL STUDENTS

HOD ACTION: Resolution 241 adopted with a change of title and AMA policies H-255.988 and D-255.911 reaffirmed.

RESOLVED, that our American Medical Association publicly advocate against the targeted use of Student and Exchange Visitor Program decertification against independent universities; and be it further

RESOLVED, that our AMA advocate for the preservation of pathways that allow international students to pursue medical education in the United States, recognizing their vital contribution to addressing future physician shortages and diversity in healthcare.

Your Reference Committee heard mixed testimony on Resolution 241. Your Reference Committee heard about the important role that our international medical students play within the educational system and within healthcare in the United States. Testimony noted the ongoing actions that the Administration is taking that are impacting student visas within the Student and Exchange Visitor Program (SEVP) and that certain universities are being targeted and impacted by these actions. However, your Reference Committee also heard

that the SEVP does not apply to J-1 visas, which is the visa type most commonly utilized by international medical students, and instead only applies to F-1 and M-1 visas. Testimony noted that since the main visa type that our international medical students use is not impacted by the SEVP that our AMA should instead allow key parties including impacted universities who have strong standing in this space, to take the lead advocacy role in this space. Further testimony noted that our AMA should focus its engagement on a space where we can have a meaningful impact, and where our work will be most felt by our physicians. An amendment that reflected this sentiment was offered which your Reference Committee accepted. Your Reference Committee also notes that our AMA has existing policy in this space that complements this resolution. Therefore, your Reference Committee recommends that Resolution 241 be adopted as amended and that existing AMA policies H-255.988 and D-255.911 be reaffirmed.

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.

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.

(28) RESOLUTION 242 — PROTECTING EVIDENCE-BASED MEDICINE, PUBLIC HEALTH INFRASTRUCTURE AND BIOMEDICAL RESEARCH FROM POLITICIZED ATTACKS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 242 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~American Medical Association~~ affirm that protecting science, clinical integrity, and the patient-physician relationship ~~in the face of political interference~~ is central to the organization's mission ~~and a defining challenge of this moment in history~~; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 242 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA assertively and publicly lead the House of Medicine in collective, sustained ~~opposition to~~ advocacy for federal and state policies, proposals, and actions that ~~undermine~~ safeguard public health infrastructure, advance biomedical research, improve vaccine confidence, ~~or~~ and maintain the integrity of evidence-based medicine and decision-making processes; and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the third resolve of Resolution 242 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA report back at the 2025~~6~~ Interim Meeting of the AMA House of Delegates on the actions taken to implement this policy.

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 242 be adopted as amended.

RECOMMENDATION E:

Your Reference Committee recommends that the title of Resolution 242 be changed to read as follows:

PROTECTING EVIDENCE-BASED MEDICINE, PUBLIC HEALTH INFRASTRUCTURE AND BIOMEDICAL RESEARCH

HOD ACTION: Resolution 242 adopted as amended with a change of title.

RESOLVED, that our American Medical Association affirm that protecting science, clinical integrity, and the patient-physician relationship in the face of political interference is central to the organization's mission and a defining challenge of this moment in history (New HOD Policy); and be it further

RESOLVED, that our AMA assertively and publicly lead the House of Medicine in collective, sustained opposition to federal and state policies, proposals, and actions that undermine public health infrastructure, biomedical research, vaccine confidence, or evidence-based medicine and decision-making (Directive to Take Action); and be it further

RESOLVED, that our AMA report back at the 2026 Interim Meeting of the AMA House of Delegates on the actions taken to implement this policy.

Your Reference Committee heard strong and extensive testimony in support of Resolution 242. As an initial matter, the authors of the resolution noted that they intended the third resolve of the resolution requested a report back at the 2025 Interim Meeting of our AMA House of Delegates rather than the 2026 Interim Meeting. Further testimony supported this change. More substantively, your Reference Committee heard repeated expressions of support for the spirit and substance of the resolution, with commenters specifically voicing support for resolution language calling on our AMA to act "assertively" and "publicly" to protect science, clinical integrity, public health infrastructure, biomedical research, vaccine confidence, and evidence-based medicine and decision-making processes. Amendments were proposed that would phrase the resolution in the positive, on the grounds that such a change would make the policy more flexible. An amendment was proposed to strike the reference to the current moment being a "defining moment in history," on the grounds that our policy should not be limited to a specific moment in time. Your Reference Committee appreciates both the strong sentiments expressed by the House of Delegates and multiple proposed amendments that were thoughtfully crafted to preserve these sentiments while strengthening the final policy. Therefore, your Reference Committee recommends that Resolution 242 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(29) RESOLUTION 202 — PRESERVATION OF THE CDC EPILEPSY PROGRAM WORKFORCE AND INFRASTRUCTURE

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 202 be adopted in lieu of Resolution 202.

RESOLVED, That our AMA support the adequate funding of the Department of Health and Human Services (HHS) to ensure the preservation of its workforce and evidence-based public health initiatives; and be it further

RESOLVED, That our AMA support efforts by HHS and Congress to prioritize sustained funding and staffing for programs that promote ongoing public health and clinical care advancement.

RECOMMENDATION B:

Your Reference Committee that the title of Alternate Resolution 202 be changed to read as follows:

PRESERVATION OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES WORKFORCE AND INFRASTRUCTURE

HOD ACTION: Alternate Resolution 202 adopted in lieu of Resolution 202 with a change of title.

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)

Your Reference Committee heard limited, but supportive testimony for Resolution 202 and the Centers for Disease Control and Prevention (CDC) Epilepsy Program, emphasizing the importance of continued support since this program improves clinical care. However, your Reference Committee also heard testimony that supported broadening the policy to include the entirety of the Department of Health and Human Services funding and workforce. This testimony highlighted that by broadening this policy our AMA's advocacy would be strengthened because it would allow our AMA to advocate not only for the CDC

Epilepsy Program but also the many other valuable programs housed within HHS. Moreover, testimony noted that by broadening this policy we would not be prioritizing one program over others. Therefore, your Reference Committee recommends that Alternate Resolution 202 be adopted in lieu of Resolution 202.

(30) RESOLUTION 205 — AMA SUPPORT FOR CONTINUANCE OF THE SECTION 1115 - SOCIAL SECURITY ACT, MEDICAID WAIVER PROGRAM

RESOLUTION 206 — AMA SUPPORT FOR RENEWAL OF SECTION 1115 - SOCIAL SECURITY ACT, MEDICAID WAIVER DEMONSTRATION PROJECTS SUPPORTING FOOD AND NUTRITION SERVICES

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 205 be adopted in lieu of Resolutions 205 and 206.

RESOLVED, That our AMA advocate for the approval or renewal of Section 1115 Medicaid waivers that will improve and preserve the Medicaid program as a critical safety net; and be it further

RESOLVED, That our AMA advocates for continued and sustained federal funding for Designated State Health Programs (DSHP) in Medicaid Section 1115 waivers; and be it further

RESOLVED, That our AMA supports the use of Medicaid Section 1115 waivers to address health-related social needs through evidence-based and medically appropriate interventions; and be it further

RESOLVED, That our AMA advocate for the inclusion, renewal, and expansion of food and nutritional services in Medicaid Section 1115 waivers, as a strategy to reduce food insecurity and improve health outcomes among Medicaid beneficiaries.

RECOMMENDATION B:

Your Reference Committee recommends that the title of Alternate Resolution 205 be changed to read as follows:

SUPPORT FOR CONTINUANCE OF SECTION 1115 MEDICAID WAIVERS AND DEMONSTRATION PROJECTS

HOD ACTION: Alternate Resolution 205 adopted in lieu of Resolutions 205 and 206 with a change of title.

Resolution 205 — AMA Support For Continuance Of The Section 1115 - Social Security Act, Medicaid

RESOLVED, that our AMA 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).

Resolution 206 — AMA Support For Renewal Of Section 1115 - Social Security Act, Medicaid Waiver Demonstration Projects Supporting Food And Nutrition Services

RESOLVED, that our AMA that our AMA 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)

Your Reference Committee heard extensive testimony on Resolutions 205 and 206, both of which relate to Section 1115 Medicaid waivers. All testimony was supportive of the resolutions and the Section 1115 Medicaid waiver program, although multiple commenters noted that our AMA does not always support policies implemented by states through Section 1115 waivers. Testimony noted that our AMA has advocated against certain proposed waivers in the past when they were not in the best interest of public health(see, e.g., AMA's 2020 and 2018 letters opposing specific state waivers). An amendment was offered to consolidate the resolutions, clarify that our AMA only supports those Medicaid waivers that improve and preserve the Medicaid program, and remove any references in support of specific types of waivers, such as waivers that support Designated State Health Programs or food and nutrition services. However, while significant testimony supported the language to clarify that our AMA does not automatically support all Section 1115 Medicaid waivers, there was substantial testimony in favor of keeping the language that specifically supports certain types of waivers given their critical importance and the current threats to their approval and renewal. Therefore, your Reference Committee recommends that Alternate Resolution 205 be adopted in lieu of Resolutions 205 and 206.

(31) RESOLUTION 207 — ABOLISHING VENUE SHOPPING

RESOLUTION 231 — PREVENTING VENUE SHOPPING IN MEDICAL LIABILITY TO PROTECT PHYSICIAN PRACTICES AND RESOLUTION ACCESS TO CARE

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 207 be adopted in lieu of Resolutions 207 and 231.

RESOLVED, That our AMA oppose venue shopping in medical professional liability actions; and be it further

RESOLVED, That our AMA study avenues to most effectively combat venue shopping in state and federal medical professional liability actions with report back at A-26.

HOD ACTION: Alternate Resolution 207 adopted in lieu of Resolutions 207 and 231.

Resolution 207 — Abolishing Venue Shopping

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)

Resolution 231 — Preventing Venue Shopping In Medical Liability To Protect Physician Practices And Resolution Access To Care

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)

Your Reference Committee heard testimony recognizing that venue shopping can be a significant problem in some medical liability cases. Multiple amendments were offered on

behalf of the combined Resolutions 207 and 231 and it was widely supported that Resolutions 207 and 231 be considered together. Your Reference Committee also heard testimony noting that venue shopping is an extremely complicated issue involving varying state and federal rules, statutes, cases, and Constitutional issues. Testimony also highlighted that having our AMA advocate for specific venue requirements may have unintended consequences for physicians who are defending allegations of medical liability. However, significant testimony was offered highlighting the problems that can arise for physicians when venue shopping is utilized in medical liability cases. An alternate resolution was offered by the authors of the two resolutions which the Reference Committee largely accepted. Though your Reference Committee considered testimony to the effect that it would be preferable to have the study on this topic performed before taking a stance on this issue, especially given the complexity of the issues surrounding venue shopping, overwhelming testimony was received in support of action being taken on venue shopping immediately. Therefore, your Reference Committee recommends that Alternate Resolution 207 be adopted in lieu of Resolutions 207 and 231.

(32) RESOLUTION 219 — OPPOSING UNWARRANTED NATIONAL INSTITUTES OF HEALTH RESEARCH INSTITUTE RESTRUCTURING

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 219 be adopted in lieu of Resolution 219.

RESOLVED, that our AMA advocate for an independent NIH reorganization advisory commission composed of interested parties, including physicians, scientists, researchers, academics, and patient advocacy organizations, to ensure that any proposed restructuring of the NIH is guided by medical, scientific, and public health expertise and serves the best interests of patients and the scientific community; and be it further

RESOLVED, that our AMA advocates against reorganization or consolidation of the NIH when such action:

1. Lacks transparency or is implemented without meaningful input from the biomedical research and physician communities; and
2. Results in a reduction of funding that jeopardizes ongoing or long-term research through premature cancellation of grants, contracts, or programs essential to public health, biomedical innovation, or patient care; and be it further

RESOLVED, that our AMA support study of the short- and long-term impacts of federal biomedical research funding reductions, including medical innovation, the healthcare

workforce, medical education, public health and local economies and communities.

RESOLVED, that our AMA publicly oppose the reduction of research funding and funding opportunities from the NIH.

HOD ACTION: Alternate Resolution 219 adopted in lieu of Resolution 219.

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)

Your Reference Committee heard testimony in strong support of amended language for Resolution 219. The authors of this resolution supported the proposed amendments and emphasized the timeliness and importance of our AMA addressing this issue. Testimony noted that, since the original drafting of the resolution, there have been multiple proposals to restructure the National Institutes of Health (NIH) by consolidating institutes in a manner that would slash funding and devastate highly specialized research efforts and long-term health projects in numerous fields. Additionally, these proposals have excluded input from physicians, researchers, and patient advocacy groups. Testimony emphasized that the restructuring and reorganization of NIH disproportionately and adversely affects funding for pediatric, maternal health, as well as infectious diseases. Limited testimony found it was not timely to convene a committee and supported referral. Therefore, Your Reference Committee recommends adoption of alternate Resolution 219.

(33) RESOLUTION 221 — PRESERVATION OF MEDICAID

RESOLUTION 223 — PRESERVATION OF MEDICAID

RESOLUTION 232 — PRESERVATION OF MEDICAID

RESOLUTION 236 — PRESERVATION OF MEDICAID

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 221 be adopted in lieu of Resolutions 221, 223, 232, and 236.

RESOLVED, that our AMA elevate Medicaid to an urgent and top legislative advocacy priority alongside Medicare payment reform, specifically advocating for maintaining and expanding Medicaid coverage, access, federal funding, and eligibility, and request report back on the Board of Trustees' actions at I-25.

RESOLVED, that our AMA strongly opposes federal and state efforts to restrict eligibility, coverage, access, and funding for Medicaid and the Children's Health Insurance Program (CHIP).

HOD ACTION: Alternate Resolution 221 adopted in lieu of Resolutions 221, 223, 232, and 236.

Resolution 221 — Preservation Of Medicaid

RESOLVED, that our American Medical Association will 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 Taken 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)

Resolution 223 — Preservation Of Medicaid

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)

Resolution 232 — Preservation Of Medicaid

RESOLVED, that our American Medical Association will 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, 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)

Resolution 236 – Preservation of Medicaid

RESOLVED, that our American Medical Association will make preservation of federal funding and eligibility for all public health insurance programs, including Medicaid and CHIP, an urgent and top legislative advocacy priority, effective immediately at the conclusion of the Annual 2025 House of Delegates Meeting; and be it further

RESOLVED, that our AMA strongly opposes federal and state efforts to restrict eligibility and funding for public health insurance programs, including Medicaid and CHIP. (New HOD Policy)

Your Reference Committee heard substantial testimony on Resolutions 221, 223, 232, and 236 which all relate to the preservation of the Medicaid program. The testimony for all four resolutions was largely the same, with many testifiers providing identical testimony for more than one resolution. As a result, many commenters noted that the resolutions should be consolidated into a single resolution, and no testimony opposed consolidation. An amendment to consolidate the resolutions was offered and received support from multiple commenters. Much of the testimony favored making Medicaid advocacy a top legislative advocacy priority of our AMA. Your Reference Committee believes this would be consistent with our AMA's existing efforts in advocating for the preservation of Medicaid, including two recent letters to the Energy and Commerce Committee of the House of Representatives and the leadership of the House of Representatives expressing our AMA's concern with the Medicaid proposals included in the reconciliation legislation that Congress is currently considering. Further testimony noted that our AMA Center for Health Equity's guide Advancing Health Equity: A Guide to Narrative, Language, and Concepts discourages the use of the term "vulnerable" when referencing the Medicaid

population. Therefore, your Reference Committee recommends that Alternate Resolution 221 be adopted in lieu of Resolutions 221, 223, 232, and 236.

(34) RESOLUTION 237 — URGENT ADVOCACY TO RESTORE J-1 VISA PROCESSING FOR INTERNATIONAL MEDICAL GRADUATE PHYSICIANS

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 237 be adopted in lieu of Resolution 237.

RESOLVED, that our AMA advocate in alignment with Educational Commission for Foreign Medical Graduates (ECFMG) to preserve the timely scheduling of J-1 visa appointments affecting International Medical Graduates and monitor the impact of visa appointment suspensions on patient care and physician workforce stability.

RECOMMENDATION B:

Your Reference Committee recommends that the title of Alternate Resolution 237 be changed to read as follows:

PRESERVATION OF J-1 VISA PROCESSING FOR INTERNATIONAL MEDICAL GRADUATE PHYSICIANS

HOD ACTION: Resolution 237 adopted.

RESOLVED, that our American Medical Association:

1. Publicly advocate to resume the scheduling of new J-1 visa appointments affecting International Medical Graduates;
2. Issue urgent advocacy communications to Congress, the Department of Homeland Security, the Department of State, and other relevant agencies, calling for the immediate resumption of J-1 visa processing for International Medical Graduates;
3. Collaborate with key parties, including program directors, Designated Institutional Officers, medical schools, and healthcare organizations to monitor the impact of visa appointment suspensions on patient care and physician workforce stability;
4. Work proactively and transparently to reverse policies harmful to IMGs and mitigate future disruptions, emphasizing the essential contributions of International Medical Graduates to healthcare delivery in the United States.

Mixed testimony was received for Resolution 237. Your Reference Committee heard about the current pause on the J-1 visa interview appointment process, a necessary step in the process of being granted a J-1 visa. Testimony highlighted that due to this pause, J-1 physicians are worried about not being able to start their residencies in July on time, and future residency cycles. Further testimony noted the extremely important role that international medical graduate physicians (IMGs) play in medical education in the United States healthcare system overall and stated that by not being able to access these visa

appointments, their future as physicians in the United Sates would be in jeopardy. However, your Reference Committee also heard that our AMA strives to maintain broad policies that can be responsive both to the immediate needs that arise within the immigration space as well as address the issues long term and that as a result, our current AMA policies already speak to the importance of maintaining a well-functioning and timely visa application process including working “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.” Testimony also highlighted that, our AMA acknowledges that the Educational Commission for Foreign Medical Graduates (ECFMG) is the universal sponsor for J-1 physicians in the United States. Our AMA consistently works to support ECFMG as the recognized leader in this space. Testimony stated that, due to the deference that our AMA provides to ECFMG, our AMA has a good working relationship with ECFMG and supports ECFMG as requested and appropriate. Therefore, your Reference Committee recommends that Alternate Resolution 237 be adopted in lieu of Resolution 237.

RECOMMENDED FOR REFERRAL

(35) RESOLUTION 209 — REDUCING RISK OF FEDERAL INVESTIGATION OR PROSECUTION FOR PRESCRIBING CONTROLLED RESOLUTION ADDICTION MEDICATIONS FOR LEGITIMATE MEDICAL PURPOSES

RECOMMENDATION A:

Your Reference Committee recommends that item 1 of Resolution 209 be amended by addition and deletion to read as follows:

(1) advance the adoption of a conjunctive ~~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

RECOMMENDATION B:

Your Reference Committee recommends that item 2 of Resolution 209 be referred.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 209 be adopted as amended.

RECOMMENDATION D:

Your Reference Committee recommends that the title of Resolution 209 be changed to read as follows:

REDUCING RISK OF FEDERAL INVESTIGATION OR PROSECUTION FOR PRESCRIBING CONTROLLED SUBSTANCES FOR LEGITIMATE MEDICAL PURPOSES

HOD ACTION: Clause 1 of Resolution 209 adopted as amended with a change of title and clause 2 of Resolution 209 referred.

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)

Your Reference Committee heard supportive testimony for Resolution 209, which seeks to protect physicians prescribing controlled substances for opioid use disorder (OUD) by clarifying the interpretation of the Controlled Substances Act (CSA). While your Reference Committee heard strong support for Resolution 209's goal of preventing undue legal risks for physicians, some commenters were concerned about the definition of "legitimate medical purpose" proposed by the resolution and urged further study of that issue. Your Reference Committee agrees. Your Reference Committee included an editorial amendment to change the word "conjunction" to "conjunctive" in clause one of Resolution 209. Therefore, your Reference Committee recommends that clause one of Resolution 209 be adopted as amended with a change of title and clause two of Resolution 209 be referred.

(36) RESOLUTION 212 — SETTING STANDARDS FOR FORENSIC TOXICOLOGY LABORATORIES USED IN LITIGATION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 212 be referred.

HOD ACTION: Resolution 212 referred.

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)

Your Reference Committee heard minimal testimony for Resolution 212. An amendment was provided to change the title as well as provide new, clarifying language to the resolves. Your Reference Committee also heard testimony which recommended referral as the subject of the Resolution presents scientific, legal, and factual questions that warrant further review before an appropriate recommendation can be made. The authors supported referral of the amended language upon hearing this testimony. Your Reference Committee would encourage the referral of this item to consider the amended language as the report is being drafted. Therefore, Your Reference Committee recommends that Resolution 212 be referred.

(37) RESOLUTION 230 — ADVOCATING TO EXPAND PRIVATE INSURANCE COVERAGE OF ANTI-OBESITY MEDICATIONS (AOM)

RECOMMENDATION:

Your Reference Committee recommends that Resolution 230 be referred.

HOD ACTION: Subclause h of Resolution 230 adopted; subclauses e and g referred; subclause f adopted as amended to read as follows:

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"~~.

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)

Your Reference Committee heard strong mixed testimony on Resolution 230. Testimony in support of adoption raised the fact that there are now several very effective FDA-approved medications to treat obesity. However, in terms of insurance coverage, the outlook is much bleaker. Testimony stressed that obesity is a disease and warrants coverage, but despite this recognition, patients continue to fight overt discrimination from insurance providers and policy makers. Testimony was provided that supported adoption with an amendment to strike “step-therapy” from the language to recognize the cost implications to health plans and the unintended consequences of the drugs becoming cost prohibitive for plans to maintain as part of covered benefits. Testimony was also provided in support of referral to analyze the economic component of this issue before creating policy that would mandate coverage of the drugs despite the knowledge that they are an exorbitant cost on the health system. Testimony recommended taking advantage of the recently released Institute for Clinical and Effective Economic Research (ICER) report examining strategies to ensure affordable access for obesity medications as well as their existing evidence-based analysis of GLP-1s and their return on investment. Testimony in support of referral also expressed that the problem is not with the GLP-1's but rather with the pharmacy industry and the pharmacy benefit managers (PBMs). Therefore, your Reference Committee recommends that Resolution 230 be referred.

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

(38) RESOLUTION 213 — EMERGENCY DEPARTMENT DESIGNATION REQUIRES PHYSICIAN ON SITE

RECOMMENDATION:

Your Reference Committee recommends that AMA policies D-130.958, D-35.976, H-103.929, H-160.949, and H-160.947 be reaffirmed in lieu of Resolution 213.

HOD ACTION: AMA policies D-130.958, D-35.976, H-103.929, H-160.949, and H-160.947 reaffirmed in lieu of Resolution 213.

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)

Your Reference Committee heard testimony both in support of reaffirming existing policy in lieu of Resolution 213 and in favor of adopting the resolution. Those in favor of adopting the resolution explained that the resolution differs from existing policy because it calls for transparency in how emergency departments present themselves to the public, asking for model state legislation reserving the term “emergency department” to those with 24-7 onsite presence of a physician. Overall, those supporting reaffirmation acknowledged the importance of the issue raised in Resolution 213 but noted that this issue has been thoroughly considered and addressed by the House of Delegates, resulting in recently adopted AMA policy that directly aligns with the resolution. Testimony highlighted Policy D-130.958 specifically which affirms that our AMA “supports that all Emergency Departments be staffed 24-7 by a qualified physician.” While Resolution 213 calls for the development of model legislation, testimony highlighted that the American College of Emergency Physicians (ACEP) already offers model state legislation that can be utilized by state medical associations, making further AMA action in this area potentially duplicative. Therefore, your Reference Committee recommends that Policies D-130.958, D-35.976, H-103.929, H-160.949, and H-160.947 be reaffirmed in lieu of Resolution 213.

Staffing Ratios in the Emergency Department D-130.958

1. Our American Medical Association will seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the Emergency Department.
2. Our AMA supports that all Emergency Departments be staffed 24-7 by a qualified physician.

Promoting Supervision of Emergency Care Services in Emergency Departments by Physicians D-35.976

Our American Medical Association will advocate for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an emergency department.

On-Site Physician Requirements for Emergency Departments H-130.929

1. Our American Medical Association recognizes that the preferred model of emergency care is the on-site presence of a physician in the emergency department (ED) whose primary duty is to provide care in that ED, and support state and federal legislation or regulation requiring that a hospital with an ED must have a physician on-site and on duty who is primarily responsible for the emergency department at all times the emergency department is open.
2. Our AMA, in the pursuit of any legislation or regulation requiring the on-site presence of a physician who is primarily responsible for care in the emergency department (ED), supports state medical associations in developing appropriate rural exceptions to such a requirement if, based on the needs of their states, the association chooses to pursue certain alternative supervision models for care provided in EDs in remote rural areas that cannot meet such a requirement due to workforce limitations, ensuring that exceptions only apply where needed. These exceptions shall preserve 24/7 physician supervision of the ED and provide for the availability of a physician to provide on-site care.

Practicing Medicine by Non-Physicians H-160.949

1. Our American Medical Association urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
2. Our AMA continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers.
3. Our AMA continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.
4. Our AMA continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.

5. Our AMA, through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine.
6. Our AMA opposes special licensing pathways for “assistant physicians” (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program, or have not completed at least one year of accredited graduate medical education in the U.S).

Physician Assistants and Nurse Practitioners H-160.947

Our American Medical Association will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

1. The physician is responsible for managing the health care of patients in all settings.
2. Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
3. The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
4. The physician is responsible for the supervision of the physician assistant in all settings.
5. The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
6. The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
7. The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
8. Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
9. The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
10. The physician is responsible for clarifying and familiarizing the physician assistant with their supervising methods and style of delegating patient care.

(39) RESOLUTION 218 — DISTRIBUTION OF RESIDENT SLOTS COMMENSURATE WITH SHORTAGES

RECOMMENDATION:

Your Reference Committee recommends that AMA policies H-200.954 and H-200.955 be reaffirmed in lieu of Resolution 218.

HOD ACTION: AMA policies H-200.954 and H-200.955 reaffirmed in lieu of Resolution 218.

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)

Your Reference Committee heard mixed testimony on Resolution 218. Testimony acknowledged existing shortages in several specialties, including general internal medicine, family medicine, preventive medicine, pediatrics, obstetrics and gynecology, and psychiatry. Supporters of the resolution argued that these shortages are harming patient access to care and noted that these specialties should be prioritized in the distribution of residency slots. Amendments were offered to include additional specialties and some of their unique needs. However, your Reference Committee also heard that our AMA is an umbrella organization representing all specialties, and that physician shortages are projected across the board—estimated at approximately 86,000 by 2036—not just in the fields identified in the resolution. Testimony further emphasized that current AMA policy supports a flexible, needs-based approach to residency slot allocation. Specifically, Policy H-200.955, clause 6, states: “Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.” This policy approach helps avoid repeating the challenges created by the 1996 cap on Medicare-funded residency slots, which has constrained growth and limited the ability to meet evolving community needs. Testimony also noted that, in alignment with this policy, our AMA has supported multiple federal bills that seek to expand residency slots both broadly and in targeted areas of shortage. Therefore, your Reference Committee recommends that existing AMA policies H-200.954 and H-200.955 be reaffirmed in lieu of Resolution 218.

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.

Revisions to AMA Policy on the Physician Workforce H-200.955

It is our American Medical Association policy that:

1. Any workforce planning efforts, done by our AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.
2. Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research.
3. The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.
4. In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.
5. There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups.
6. There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.
7. Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.
8. Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agencys physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.
9. Our AMA will consider physician retraining during all its deliberations on physician workforce planning.

(40) RESOLUTION 224 — SUPPORT SAVE PLAN AND PUBLIC SERVICE LOAN FORGIVENESS (PSLF) APPLICATIONS

RECOMMENDATION:

Your Reference Committee recommends that AMA policies H-305.925 and D-305.984 be reaffirmed in lieu of Resolution 224.

HOD ACTION: AMA policies H-305.925 and D-305.984 reaffirmed in lieu of Resolution 224.

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 (AMA) 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)

Your Reference Committee heard mixed testimony for Resolution 224. Your Reference Committee heard that medical education is expensive and so student loans are a vital part of ensuring that a wide range of individuals can become physicians. The testimony stated how important it was to have a sustainable and fair way to pay for medical school and highlighted the positive aspects of the SAVE Plan. However, further testimony noted that the SAVE Plan was unlikely to be implemented and instead would very likely be rescinded by the current Administration if the courts do not find it illegal first. Further testimony noted the strong policy that our AMA already has in this space. Current policy already includes asks such as advocating for an affordable student loan structure, advocating for a capped interest rate of five percent in student loans, advocating for lower interest rates on student loans, advocating for equal or less expensive loans, and ensuring favorable terms in the Higher Education Act. Your Reference Committee heard that this strong policy that our AMA already possesses allowed our AMA to respond to requests for information regarding the Public Service Loan Forgiveness Program, provide comments to the Administration when the SAVE Plan was being created, support legislation such as the REDI Act which would allow borrowers to qualify for interest-free deferment on their student loans while serving in a residency program, maintain valuable resources for medical student borrowers, and comment on the latest proposed changes to the PSLF, Income-Driven Repayment Plans, and student loan caps in the Continuing Resolution (CR). Therefore, your Reference Committee recommends that existing AMA policies H-305.925 and D-305.984 be reaffirmed in lieu of Resolution 224.

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

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

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit:
   a. inclusion of all medical specialties in need, and
   b. service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 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.

Reduction in Student Loan Interest Rates D-305.984

1. Our American Medical Association will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program.
3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.
4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.

(41) RESOLUTION 225 — THE PRIVATE PRACTICE PHYSICIANS IN THE COMMUNITY

RECOMMENDATION:

Your Reference Committee recommends that AMA policies H-330.932, D-385.945, H-385.900, and H-390.849 be reaffirmed in lieu of Resolution 225.

HOD ACTION: AMA policies H-330.932, D-385.945, H-385.900, and H-390.849 reaffirmed in lieu of Resolution 225.

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)

Your Reference Committee heard mixed testimony on Resolution 225. Those in support of adoption emphasized the urgency of addressing ongoing physician payment cuts—particularly amid rising practice costs and inflation—and called for stronger, more visible advocacy from our AMA. In contrast, supporters of reaffirmation highlighted the extensive work already underway, noting our AMA's robust policy portfolio and its designation of Medicare Physician Payment Reform as a top advocacy priority. Testimony highlighted that our AMA has consistently submitted comments on the Medicare Physician Fee Schedule, sent letters, and engaged in direct lobbying with key legislators on this issue. While some testimony noted that the resolution's novelty lies in its call for a cost-of-living adjustment, your Reference Committee found that this is already addressed under existing AMA Policy H-330.932, clause 5, which states: "Our AMA supports a mandatory annual 'cost-of-living' or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs." Therefore, your Reference Committee recommends that Policies H-330.932, D-385.945, H-385.900, and H-390.849 be reaffirmed in lieu of Resolution 225.

Cuts in Medicare and Medicaid Reimbursement H-330.932

1. Our American Medical Association continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients.
2. Our AMA supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology.

3. Our AMA aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services.
4. If the reimbursement is not improved, our AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee.
5. Our AMA supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases.

Advocacy and Action for a Sustainable Medical Care System D-385.945

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.

Payment for Pre-Certified/Preauthorized Procedures H-385.900

1. Our American Medical Association supports the position that the practice of retrospective denial of payment or payment recoupment for care which has been pre-certified by an insurer should be prohibited under federal statute, except when materially false or fraudulent information has knowingly been given to the insurer by the physician, hospital or ancillary service provider to obtain pre-certification.
2. Our AMA will continue to advocate for legislation, regulation, or other appropriate means to ensure that all health plans including those regulated by ERISA, pay for services that are pre-authorized, or pre-certified by such health plan, including services that are deemed pre-authorized or pre-certified because the physician participates in a “Gold Card” program operated by that health plan.
3. Our AMA encourages legal action against health plans that engage in inappropriate post-service payment denials and payment recoupment.

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.

(42) RESOLUTION 226 — REGULATIONS FOR ALGORITHMIC-BASED HEALTH INSURANCE UTILIZATION REVIEW

RECOMMENDATION A:

Your Reference Committee recommends that AMA policy H-480.931 be reaffirmed in lieu of the first resolve of Resolution 226.

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 226 be adopted.

HOD ACTION: AMA policy H-480.931 reaffirmed in lieu of the first resolve of Resolution 226 and the second resolve of Resolution 226 adopted.

RESOLVED, that our American Medical Association shall 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)

Your Reference Committee heard mixed testimony on Resolution 226. Testimony in support of adoption emphasized growing concerns about the use of artificial intelligence (AI) in insurance utilization review, particularly regarding its lack of transparency, potential for bias, and the risk of harm to patient care. Several testifiers shared personal experiences in which AI-driven denials of prescription renewals or prior authorization requests led to patient harm and distress. However, your Reference Committee also heard testimony that the key asks of this resolution are already addressed by existing AMA policy, and that our AMA is actively advocating on this issue at both the state and federal levels. Supporters of reaffirmation highlighted Policy H-480.931, adopted at I-24, which reflects current AMA positions and was vetted by subject matter experts, relevant Councils, and the Board of Trustees. An amendment was offered to Policy D-480.956, but as that policy was not included in the original resolution, the amendment was deemed not germane at this time. Therefore, your Reference Committee recommends that existing AMA policy H-480.931 be reaffirmed in lieu of the first resolve of Resolution 226 and that the second resolve of Resolution 226 be adopted.

Assessing the Intersection Between AI and Health Care H-480.931

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.

(43) RESOLUTION 227 — PAYMENT RECOUPMENT—LET SANITY PREVAIL

RECOMMENDATION:

Your Reference Committee recommends that AMA policies H-70.926, H-335.981, H-385.900, D-385.944, D-385.965, D-320.991, H-335.963, H-190.969, and H-185.999 be reaffirmed in lieu of Resolution 227.

HOD ACTION: AMA policies H-70.926, H-335.981, H-385.900, D-385.944, D-385.965, D-320.991, H-335.963, H-190.969, and H-185.999 reaffirmed in lieu of Resolution 227.

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).

Your Reference Committee heard mixed testimony on Resolution 227. Testimony reflected broad support for the resolution's intent to protect physicians from unjust recoupment practices, particularly in cases where the physician is not at fault. There was

strong emphasis in the testimony regarding the need for greater transparency, fairness, and for shifting the administrative and financial burden away from physicians. Your Reference Committee also heard that our AMA already maintains comprehensive policy addressing these concerns. Further testimony noted that our AMA has developed resources to help physicians secure accurate claims payments, navigate the overpayment recovery process, appeal incorrect payments, and understand state-specific insurance recoupment laws. In addition, our AMA has provided extensive guidance on the implications of the Supreme Court's decision in *Rutledge v. PCMA*. Our AMA is also in the process of updating our ERISA preemption issue brief to more broadly address preemption of state laws applying directly to ERISA plans, including but not limited to recoupment, and how laws might best be structured to survive ERISA preemption. Therefore, your Reference Committee recommends that existing AMA policies H-70.926, H-335.981, H-385.900, D-385.944, D-385.965, D-320.991, H-335.963, H-190.969, and H-185.999 be reaffirmed in lieu of Resolution 227.

Reasonable Time Limitations on Post-Payment Audits and Recoupments by Third Party Payers H-70.926

Our AMA policy is that post-payment audits, post-payment downcodes and other similar requests for recoupment by third party payers be made within one year of the date the claim is submitted or within the same amount of time permitted for submission of the claim, whichever is less.

Medical Office Screens H-335.981

It is the policy of the AMA to take the following actions:

1. seek specific clarification from CMS on the process, procedures, and criteria of physician office postpayment review and recoupment;
2. lobby for full due process protection for carrier postpayment review and recoupment situation;
3. oppose the concept and application of extrapolation;
4. oppose arbitrary, erratic, or inappropriate components of postpayment review and recoupment; and
5. seek appropriate relief to achieve equitable treatment of physicians in office postpayment review and recoupment situations.

Payment for Pre-Certified/Preauthorized Procedures H-385.900

1. Our American Medical Association supports the position that the practice of retrospective denial of payment or payment recoupment for care which has been pre-certified by an insurer should be prohibited under federal statute, except when materially false or fraudulent information has knowingly been given to the insurer by the physician, hospital or ancillary service provider to obtain pre-certification.
2. Our AMA will continue to advocate for legislation, regulation, or other appropriate means to ensure that all health plans including those regulated by ERISA, pay for services that are pre-authorized, or pre-certified by such health plan, including services that are deemed pre-

authorized or pre-certified because the physician participates in a "Gold Card" program operated by that health plan.

3. Our AMA encourages legal action against health plans that engage in inappropriate post-service payment denials and payment recoupment.

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.

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.

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.

Member Education on Medicare Recovery Audit Contractors H-335.963

Our AMA: (1) will educate our membership about the effect of the program's safeguard contractor activity and Recovery Audit Contractor (RAC) audits on individual physician practices, expansion of the RAC program, and assistance that may be available through our AMA; and (2) will actively support the legislation currently before Congress to require an immediate moratorium on the expansion of the RAC program, and will seek the introduction of subsequent legislation that would limit or exclude physician billings from the authority of RAC audits altogether.

Delay in Payments Due to Disputes in Coordination of Benefits H-190.969

1. Our American Medical Association urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced.
2. Our AMA includes the "birthday rule" as a last resort only after parents/guardians have been allowed a choice of insurer and have failed to choose, and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurances claims.
3. Our AMA urges state medical associations to advocate for the inclusion of the "employer first rule", and "birthday rule" as a last resort only after parents/guardians have been allowed a choice of insurer and have failed to choose, in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits.
4. Our AMA includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays.
5. Our AMA continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation.
6. Our AMA, through its Advocacy Resource Center, continues to coordinate and implement the timely payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA.
7. Our AMA urges private sector health care accreditation organizations to
    a. develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness, and
    b. require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services.

Multiple Coverage in Voluntary Health Insurance H-185.999

1. Over-insurance can arise when an individual is insured under two or more policies of health insurance. When the reimbursement from this multiple coverage exceeds the expenses against which the individual has insured himself, a profit may result. Over-insurance thus encourages wasteful use of the public's health care dollar.
2. A solution to this problem can be accomplished by the use of contract language and the application of coordination of benefits provisions which operate to enable persons covered under two or more group programs to be fully reimbursed for their expenses of insured services

without receiving more in total benefits than the amount of such expenses.

3. Therefore, the AMA encourages the health insurance companies and prepayment plans to adopt policy provisions and mechanisms based upon the preceding principles which would control the adverse effects of over-insurance.

This concludes the report of Reference Committee B. I would like to thank Man-Kit Leung, MD, Ryan Hall, MD, Matthew D. Gold, MD, Sara Coffey, DO, Caleb C. Atkins, MD, Deborah Fletcher, MD, and all those who testified before the Committee.

Man-Kit Leung, MD (Alternate)
California

Sara Coffey, DO
American Psychiatric Association

Ryan Hall, MD (Alternate)
Florida

Caleb C. Atkins, MD
Resident Fellow Section

Matthew D. Gold, MD (Alternate)
Massachusetts

Deborah Fletcher, MD
Louisiana

Amar H. Kelkar, MD, MPH
American Society of Hematology
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Final Report of Reference Committee C

Christopher Wee, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council On Medical Education Report 2 - International Applicants To U.S. Medical Schools (Resolution 301-A-24)

2. Council On Medical Education Report 3 - Unmatched Graduating Physicians (Resolution 306-A-24)

3. Council On Medical Education Report 7 - Designation Of Descendants Of Enslaved Africans In America (Resolution 218-A-24)

4. Resolution 311 - Transparency And Access To Medical Training Program

RECOMMENDED FOR ADOPTION AS AMENDED

5. Council on Medical Education Report 1 - Council on Medical Education Sunset Review of 2015 House of Delegates' Policies

6. Council On Medical Education Report 4 - Access To Restricted Health Services When Completing Physician Certification Exams (Res. 307-A-24)

7. Council On Medical Education 5 - Disaffiliation From The Alpha Omega Alpha Honor Medical Society Due To Perpetuation Of Racial Inequities In Medicine (Res. 309-A-24)

8. Council On Medical Education Report 6 - Reporting Of Total Attempts Of USMLE Step 1 and COMLEX-USA Level 1 Examinations (Res 315-A-24)

9. Council On Medical Education Report 8 - Disaggregation Of Demographic Data For Individuals Of Federally Recognized Tribes (Res. 243-A-24)

10. Resolution 304 - Addressing Professionalism Standards In Medical Training

11. Resolution 305 - Curricular Structure Reform To Support Physician And Trainee Well-Being

12. Resolution 308 - Streamlining Annual Compliance Training Requirements For Physicians Reduce Burnout And Bolster Career Satisfaction In Trainees

13. Resolution 309 - Increasing Education On Physician-Led Care

14. Resolution 310 - Protections For Trainees Experiencing Retaliation In Medical Education

RECOMMENDED FOR ADOPTION IN LIEU OF

15. Resolution 301 - Examining AMBS Processes For New Boards

RECOMMENDED FOR REFERRAL

16. Resolution 303 - Support For The Establishment Of An Indigenous-Led Medical School In The United States

RECOMMENDED FOR NOT ADOPTION

17. Resolution 306 - Innovation And Reform Of Medical Education

18. Resolution 307 - Disclosure Of Individual Physician Volunteers Participation In Committee

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

19. Resolution 302 - AMA Study Of Lifestyle Medicine And Culinary Electives To Reduce Burnout and Bolster Career Satisfaction in Trainees

20. Resolution 312 - Selection Of IMG Residents Based On Merit

Amendments:
If you wish to propose an amendment to an item of business, click here: A25 HOD Amendment.

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON MEDICAL EDUCATION REPORT 2 - INTERNATIONAL APPLICANTS TO U.S. MEDICAL SCHOOLS (RESOLUTION 301-A-24)

RECOMMENDATION:

Your Reference Committee recommends that Council on Medical Education Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 2 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.

The recommendations in Council on Medical Education Report 2 received overall supportive online testimony. One testimony, offered online and in person, sought to amend the third recommendation by addition, including the language "AMA Foundation". However, the AMAF testified online against this addition. Your Reference Committee considered this language but issued caution on the inclusion of private foundations and donors, given that philanthropies are independent with their own boards who set criteria for donations. Your Reference Committee believes the current language in the third recommendation is already inclusive of donors and philanthropies. Your Reference Committee appreciates the Council's work and recommends that CME 2-A-25 be adopted.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 3 - UNMATCHED GRADUATING PHYSICIANS (RESOLUTION 306-A-24)

RECOMMENDATION:

Your Reference Committee recommends that Council on Medical Education Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 3 be adopted 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)

The recommendations in Council on Medical Education Report 3 received largely supportive online testimony. One online testimony noted concern that the report did not explicitly discuss U.S. citizen IMGs; however, your Reference Committee noted that original Resolution 306-A-24 did not call for this delineation and believes the report recommendations are appropriate. In-person testimony offered suggestions for how to improve the body of the report, such as including opportunities at the state level, including state laws allowing unmatched U.S. medical graduates to practice under supervision. In addition, there was in-person testimony that many IMGs are unmatched and that even after the SOAP, there continue to be open residency positions, so root causes need to be identified. However, online and in-person testimony did not oppose the recommendations in the report. Therefore, your Reference Committee recommends that CME 3-A-25 be adopted.

(3) COUNCIL ON MEDICAL EDUCATION REPORT 7 - DESIGNATION OF DESCENDANTS OF ENSLAVED AFRICANS IN AMERICA (RESOLUTION 218-A-24)

RECOMMENDATION:

Your Reference Committee recommends that Council on Medical Education Report 7 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 7 be adopted and the remainder of the report be filed.

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)

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)

The recommendations in Council on Medical Education Report 7 received supportive online testimony and no opposition. One testimony suggested amending the first resolve to strike the word "direct" and replace it with "present-day"; however, your Reference Committee believes the original language reflects a broader perspective. In-person testimony supported your Reference Committee's Preliminary Report recommendation. One in-person testimony indicated the author's intention to put forth a future resolution on this complex issue, but did not oppose or offer amendments to the current report. Thus, your Reference Committee therefore recommends that CME 7-A-25 be adopted.

(4) RESOLUTION 311 - TRANSPARENCY AND ACCESS TO MEDICAL TRAINING PROGRAM UNIONIZATION STATUS, INCLUDING CREATION OF A FREIDA UNIONIZATION FILTER

RECOMMENDATION:

Your Reference Committee recommends that Resolution 311 be adopted.

HOD ACTION: Resolution 311 be adopted.

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)

Resolution 311 received universal supportive online and in-person testimony including from the Council on Medical Education. Your Reference Committee recommends that Resolution 311 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(5) COUNCIL ON MEDICAL EDUCATION REPORT 1 - COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2015 HOUSE OF DELEGATES' POLICIES

RECOMMENDATION A:

Your Reference Committee recommends that Council on Medical Education Report 1 be amended by addition and deletion to read as follows:

H-295.953 Retain clauses (1), (2), (3), (4) – still relevant. ~~Rescind clause (3) - accomplished. Program is now defunct.~~

RECOMMENDATION B:

Your Reference Committee recommends that Council on Medical Education Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 1 be adopted as amended and the remainder of the report be filed.

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. (Directive to Take Action)

The recommendations in Council on Medical Education Report 1 received online testimony seeking to amend the report in order to retain policy D-295.315 and clause 3 of policy H-295.953. Regarding policy D-295.315, your Reference Committee discussed that the AMA does not currently maintain a webpage for pre-medical students while other organizations including the AAMC provide ample information for pre-medical students that does not need to be duplicated by the AMA. Regarding policy H-295.953, it currently reads as follows:

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.

The Council report sought to retain clauses 1, 2, and 4 but rescind clause 3 because the directive had been accomplished and the program became defunct. Testimony sought to retain clause 3. Further, this testimony sought to amend clause 3. However, your Reference Committee notes that the sunset mechanism in policy G-600.110 does not allow for policies in the sunset report to also be amended, except by the reviewing Council. We appreciate testimony that this program was valuable and this policy should be retained to allow for revival of the program. However, the proposed amendment cannot be considered as part of CME 1 as it is not germane to the original directive. It is the Reference Committee's understanding that offering an amendment to H-295.953 would have to be proposed in a new resolution. Your Reference Committee recommends that H-295.953 clause (3) be retained. In-person testimony was supportive of this action. Therefore, your Reference Committee recommends that CME 1-A-25 be adopted as amended.

(6) COUNCIL ON MEDICAL EDUCATION REPORT 4 - ACCESS TO RESTRICTED HEALTH SERVICES WHEN COMPLETING PHYSICIAN CERTIFICATION EXAMS (RES. 307-A-24)

RECOMMENDATION A:

Your Reference Committee recommends that the recommendation in Council on Medical Education Report 4 be amended by addition and deletion to read as follows:

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~~ advocates to relevant parties for the physical and psychological safety of board examination candidates when taking certification examinations through mechanisms such as exam relocation to nonrestrictive states, remote

examination, and/or exemption processes to ensure the protection of all physicians.

RECOMMENDATION B:

Your Reference Committee recommends that Council on Medical Education Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 4 be adopted as amended and the remainder of the report be filed.

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."

The recommendations in Council on Medical Education Report 4 received supportive online testimony; however, some testimony proposed amended language and/or new recommendations to strengthen the report. Proffered amendments encouraged the AMA to take a stronger position in urging boards to permit candidates to take exams remotely or in an alternative location in a protective state. Your Reference Committee is sensitive to the testimony provided by board applicants regarding their personal safety concerns. Your Reference Committee carefully reviewed the language offered and proposed an amendment that clearly articulated this point. In-person testimony unanimously supported these amendments. The Council on Medical Education provided in-person testimony in support of these amendments. Thus, your Reference Committee recommends that CME 4-A-25 be adopted as amended.

(7) COUNCIL ON MEDICAL EDUCATION REPORT 5 - DISAFFILIATION FROM THE ALPHA OMEGA ALPHA HONOR MEDICAL SOCIETY DUE TO PERPETUATION OF RACIAL INEQUITIES IN MEDICINE (RES. 309-A-24)

RECOMMENDATION A:

Your Reference Committee recommends that Council on Medical Education Report 5 be amended by addition of a new recommendation to read as follows:

That our AMA study and report back at the 2030 Annual Meeting on the impact of efforts to increase representation of individuals historically underrepresented in medicine within Alpha Omega Alpha and Sigma Sigma Phi and assess whether institutional disaffiliation from these organizations should be considered based on the progress made.

RECOMMENDATION B:

Your Reference Committee recommends that Council on Medical Education Report 5 be adopted as amended and the remainder of the report be filed.

RECOMMENDATION C:

Your Reference Committee recommends a change in title to read as follows:

DISAFFILIATION FROM ~~THE ALPHA OMEGA ALPHA~~ HONOR MEDICAL ~~SOCIETY~~ SOCIETIES DUE TO PERPETUATION OF RACIAL INEQUITIES IN MEDICINE (RES. 309-A-24)

HOD ACTION: Council on Medical Education Report 5 be adopted as amended and the remainder of the report be filed.

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.

The recommendations in Council on Medical Education Report 5 received generally supportive online testimony. One comment expressed concerns that the report did not fully address the issues in the original Resolution 309-A-24. During in-person testimony,

testimony offered an amendment asking for report back on progress in five years; the Council on Medical Education testified in support of this amendment. Your Reference Committee also proposes a title change to reflect the amendment's call to study multiple honor societies. Therefore, your Reference Committee recommends that CME 5-A-25 be adopted as amended.

(8) COUNCIL ON MEDICAL EDUCATION REPORT 6 - REPORTING OF TOTAL ATTEMPTS OF USMLE STEP 1 AND COMLEX-USA LEVEL 1 EXAMINATIONS (RES 315-A-24)

RECOMMENDATION A:

Your Reference Committee recommends that the third recommendation of Council on Medical Education Report 6 be amended by addition and deletion to read as follows:

3) Encourage communication and transparency between residency programs and applicants ~~involving the rescheduling or~~ in regards to retaking ~~of~~ the USMLE® Step 1 ~~and~~ or COMLEX-USA® Level 1 exam.

RECOMMENDATION B:

Your Reference Committee recommends that Council on Medical Education Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 6 be adopted as amended and the remainder of the report be filed.

The third recommendation of Council on Medical Education Report 6 be amended by deletion.

~~3) Encourage communication and transparency between residency programs and applicants involving the rescheduling or in regards to retaking of the USMLE® Step 1 and or COMLEX-USA® Level 1 exam.~~

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)

The recommendations in Council on Medical Education Report 6 received mixed but supportive testimony. One online testimony opposed the third recommendation and offered that it be amended with alternate language, noting that some applicants are fearful of disclosing such personal information during the residency application process. Another online testimony offered a new recommendation that encourages study of the impact of reporting of attempts on the selection process for residency/fellowship. In-person testimony again offered the same amendment to the third recommendation. However, your Reference Committee believes the original report language appropriately supports holistic review of applications that includes giving important context to applicant exam performance. Your Reference Committee does agree with the Council on Medical Education that the word "rescheduling" be stricken from the third resolve since exam rescheduling is not reported by the examiners. Thus, your Reference Committee recommends that CME 6-A-25 be adopted as amended.

(9) COUNCIL ON MEDICAL EDUCATION REPORT 8 - DISAGGREGATION OF DEMOGRAPHIC DATA FOR INDIVIDUALS OF FEDERALLY RECOGNIZED TRIBES (RES. 243-A-24)

RECOMMENDATION A:

Your Reference Committee recommends that the first recommendation of Council on Medical Education Report 8 be amended by addition and deletion to read as follows:

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)**~~

4. Our AMA affirms that any collection or storage of tribal affiliation or Indigenous identity data must respect tribal data sovereignty and be guided by consultation with tribal leadership organizations and Indigenous-led institutions. (Modify HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Council on Medical Education Report 8 be amended by addition of a new recommendation to read as follows:

3. That our AMA affirm that tribal affiliation represents a distinct political and cultural status, not a racial category, and that, when shared by validating bodies, such information may carry relevance for understanding representation in medical education, access to federal health programs if part of a federally recognized tribe, and eligibility for specific workforce pathways.

RECOMMENDATION C:

Your Reference Committee recommends that Council on Medical Education Report 8 be amended by addition of a new recommendation to read as follows:

4. That our AMA support the ability of individuals to voluntarily self-identify their tribal affiliation on demographic forms used across the medical education continuum, and continue to work with the Association of American Medical Colleges (AAMC), the Accreditation Council for Graduate Medical Education (ACGME), and other relevant partners to explore the feasibility of accepting, storing, and responsibly stewarding such self-reported information within AMA systems, including Physician Professional Data, consistent with legal guidance and tribal data sovereignty principles, and identify opportunities to transparently share progress, barriers, and timelines related to these efforts, where appropriate.

RECOMMENDATION D:

Your Reference Committee recommends that Council on Medical Education Report 8 be amended by addition of a new recommendation to read as follows:

5. That our AMA engage with tribal leadership organizations, such as the Association of American Indian Physicians (AAIP), Indian Health Service (IHS), National Congress of American Indians (NCAI), and National Indian Health Board (NIHB), alongside American Indian and Alaska Native physicians and data

sovereignty experts, to help inform AMA's internal policies, data use practices, and governance models related to tribal affiliation and American Indian and Alaska Native identity data.

RECOMMENDATION E:

Your Reference Committee recommends that Council on Medical Education Report 8 be adopted as amended and the remainder of the report be filed.

RECOMMENDATION F:

Your Reference Committee recommends a change in title to read as follows:

DISAGGREGATION OF DEMOGRAPHIC DATA FOR ~~INDIVIDUALS OF FEDERALLY RECOGNIZED TRIBES~~ INDIGENOUS INDIVIDUALS

HOD ACTION: Council on Medical Education Report 8 be adopted as amended with a change in title and the remainder of the report be filed.

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)

The recommendations in Council on Medical Education Report 8 received generally supportive online testimony. During in-person hearing, one testimony offered several amendments; this testimony received unanimous support including from the Council on Medical Education. Testimony emphasized ongoing critical shortages within the American Indian and Alaska Native workforce, as well as the importance of accurate data and respect for tribal sovereignty. Your Reference Committee also supports these amendments and therefore recommends that CME 8-A-25 be adopted as amended with a change in title to remove "federally recognized".

(10) RESOLUTION 304 - ADDRESSING PROFESSIONALISM STANDARDS IN MEDICAL TRAINING

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 304 be amended by addition and deletion to read as follows:

RESOLVED, that our ~~American Medical Association~~ AMA supports regular institutional review by appropriate entities such as~~, 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

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 304 be amended by addition and deletion to read as follows:

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 e~~stablish professionalism guidelines for residency programs and medical school~~s~~ ~~professionalism policies~~ that ~~encourage institutions to~~ include outline~~ing~~ actions that may constitute a violation (New HOD Policy); and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the third resolve of Resolution 304 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~advocates for AAMC, ACGME, and AACOM to~~ support~~s~~ measures that prevent medical schools and residency programs from ~~using~~ alleging professionalism violations as a means to stop ~~student~~ trainee advocacy measures that are consistent with the AMA Code of Medical Ethics. (Directive to Take Action)

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 304 be adopted as amended.

HOD ACTION: Resolution 304 be adopted as amended.

The third resolve of Resolution 304 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~advocates for AAMC, ACGME, and AACOM to~~ support~~s~~ measures that prevent medical schools and residency programs from ~~using~~ alleging professionalism violations as a means to stop ~~student~~ trainee advocacy measures that are consistent with the AMA ~~Code~~Principles of Medical Ethics. (Directive to Take Action)

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)

Resolution 304 received supportive online testimony, but with differences in how it may be amended. The Council on Medical Education recommended amendments to each of the three resolves. Some online testimony supported the original language, while others supported the first and second resolves but offered amendments to the third resolve.

Regarding the first resolve, in-person testimony was mostly supportive of retaining language on Diversity, Equity and Inclusion (DEI) offices. Your Reference Committee continues to have concerns that were raised online in protection of medical schools and residency programs, given the President's executive order on DEI and subsequent changes to some state laws, but ultimately concurs with the in-person testimony. Your Reference Committee proposes amended language upon legal review that preserves the intent of the author.

The Council on Medical Education offered amended language to the second resolve online and at the live hearing to clarify for the HOD that while they support the development of guidelines, the three organizations listed in the second resolve are accrediting bodies. As accrediting bodies, they develop requirements but do not issue guidelines. Your Reference Committee agrees with sentiment of the Council's amended language of the second resolve but offered further amendments.

In the third resolve, your Reference Committee appreciates the proffered online amendment to change the word "student" to "trainee". Online and in-person testimony noted concern that the most extreme of actions that would truly violate professionalism standards should not be protected under the guise of "advocacy measures", and the AMA Code of Medical Ethics and its definition of professionalism should be the standard of behavior including advocacy. Your Reference Committee recommends adding language that defines the boundary of advocacy behavior by physicians by applying the Code. Therefore, Your Reference Committee recommends that Resolution 304 be adopted as amended.

(11) RESOLUTION 305 - CURRICULAR STRUCTURE REFORM TO SUPPORT PHYSICIAN AND TRAINEE WELL-BEING

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 305 be amended by addition and deletion to read as follows:

RESOLVED, that our ~~American Medical Association~~ AMA 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, and the skills needed to become a practicing physician (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 305 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA discourage ~~physician, resident, fellow, and medical student~~ burnout prevention programs ~~which~~ that impose inflexible requirements, additional time burdens on physicians, residents, fellows, and medical students, mandatory

assignments, or punitive measures, except where required by law (New HOD Policy); and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the third resolve of Resolution 305 be deleted.

~~**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**~~

RECOMMENDATION D:

Your Reference Committee recommends that the fourth resolve of Resolution 305 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA encourage funding entities and training programs to 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)

RECOMMENDATION E:

Your Reference Committee recommends that Resolution 305 be amended by addition of a new resolve to read as follows:

RESOLVED, that our AMA support evidence-based burnout prevention programs that allow for voluntary participation, options to complete any expectations or activities flexibly, and recognize the importance of personal time for burnout prevention and wellbeing while maintaining the core pedagogy of medical training. (New HOD Policy)

RECOMMENDATION F:

Your Reference Committee recommends that Resolution 305 be adopted as amended.

HOD ACTION: Resolution 305 be adopted as amended.

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)

Resolution 305 received online testimony from the Council on Medical Education against adoption, while others supported adoption. Although supportive of the sentiment of the resolution, the Council testified that implementation of an evidence-based strategy that reduces burnout and increases wellness, but reduces the preparation, training, and readiness of the physician workforce could be problematic. They also highlighted the significant and ongoing work at the AMA - in both the ChangeMedEd initiative as well as the AMA's work on professional satisfaction that is designed to reduce burnout and increase well-being. During the live hearing, testimony offered amendments to the original resolution that was supported by the Council on Medical Education and others. There was no testimony opposing the amendments offered. Your Reference Committee is sensitive to concerns regarding physician and trainee well-being and therefore recommends that Resolution 305 be adopted as amended.

(12) RESOLUTION 308 - STREAMLINING ANNUAL COMPLIANCE TRAINING REQUIREMENTS FOR PHYSICIANS

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 308 be amended by addition and deletion to read and follows:

RESOLVED, that our AMA collaborate with relevant ~~stakeholders~~ parties to explore options for fair compensation or continuing medical education (CME) credits for time spent on mandatory compliance training. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 308 be adopted as amended.

HOD ACTION: Resolution 308 be adopted as amended.

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)

Resolution 308 received supportive but mixed online testimony. While the Council on Medical Education recommended that policy H-300.944 be reaffirmed in lieu of this resolution, others supported adoption and opposed reaffirmation. Your Reference Committee is supportive of this resolution but recommended that the word “stakeholder” in the second resolve be changed to “parties”, as the term denotes ownership and commemorates land occupation. Your Reference Committee recommends that Resolution 308 be adopted as amended.

(13) RESOLUTION 309 - INCREASING EDUCATION ON PHYSICIAN-LED CARE

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 309 be amended by addition and deletion to read as follows:

RESOLVED, that our ~~American Medical Association~~ AMA develop, ~~and~~ provide, expand upon, and promote the educational resources in the AMA GME Competency Education Program, as well as toolkits, ~~,~~ and workshops that residency programs can implement to teach residents about physician-led care, advocacy strategies, and how to effectively engage with health care policymakers and organizations (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 309 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA encourage residency programs to ~~include~~ promote 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)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 309 be adopted as amended.

HOD ACTION: Resolution 309 be adopted as amended.

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)

Resolution 309 received supportive but mixed online and in-person testimony. Some testimony supported the original language. The Council on Medical Education offered amended language of both resolves to emphasize the related work of the AMA. Other language offered amended language to the second resolve to address GME payments for advocacy skills training by the Center for Medicaid and Medicare Services (CMS). Additional testimony supported the Council's amendment. Your Reference Committee

discussed the concerns associated with calling out a specific resource in AMA policy, and the unintended consequences of attempting to change current law and CMS regulations on Medicare GME payment. During the live hearing, testimony was given in opposition to reaffirmation, supported the original resolution with the CME amendment or the original resolution. Your Reference Committee acknowledges both the current policy and offerings that support physicians leading interprofessional teams and is supportive of the intent of the resolution. Therefore, your Reference Committee recommends that Resolution 309 be adopted as amended.

(14) RESOLUTION 310 - PROTECTIONS FOR TRAINEES EXPERIENCING RETALIATION IN MEDICAL EDUCATION

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 310 be amended by addition and deletion to read as follows:

RESOLVED, that our ~~American Medical Association~~ AMA supports efforts to protect residents, fellows, faculty, staff, and medical students from disciplinary actions taken by workplaces, institutions, and educational programs that discriminate against an individual based on their identity~~,~~ or beliefs ~~or advocacy~~ (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve Resolution 310 be amended by addition to read as follows:

RESOLVED, that our AMA supports that any disciplinary actions against residents, fellows, faculty, staff, 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)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 310 be adopted as amended.

RECOMMENDATION D:

Your Reference Committee recommends a change in title to read as follows:

PROTECTIONS FOR TRAINEES, FACULTY, AND STAFF EXPERIENCING RETALIATION IN MEDICAL EDUCATION

HOD ACTION: Resolution 310 be adopted as amended with a change in title to read as follows:

RESOLVED, that our ~~American Medical Association~~ AMA supports efforts to protect residents, fellows, faculty, staff, and medical students from disciplinary actions taken by workplaces, institutions, and educational programs that discriminate against an individual based on their identity,, or beliefs ~~or advocacy~~ or advocacy consistent with the AMA ~~Code~~Principles of Medical Ethics (New HOD Policy); and be it further

PROTECTIONS FOR TRAINEES, FACULTY, AND STAFF EXPERIENCING RETALIATION IN MEDICAL EDUCATION

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)

Resolution 310 received supportive but mixed online testimony. Some testimony supported adoption. One testimony noted concerns about the lack of definition of the words “identity” and “beliefs” in the first resolve. The Council on Medical Education offered

amended language to include “faculty” and “staff” in both resolves as well as the title. Other testimony supported the Council’s amendment. Your Reference Committee agreed with the Council’s rationale to safeguard not only trainees but also faculty and staff.

During the live hearing, the author and two others testified in support of the amended language in your Reference Committee’s Preliminary Report and emphasized the importance of protecting trainees and physicians who advocate for underserved communities. Testimony proposed additional amendments due to concerns regarding possible misuse of “advocacy” via harmful actions under the guise of advocacy; it also proposed additional language to delineate types of professional violations requiring more urgent attention. Other testimony opposed this additional language, indicating that even the suggested specifics were broad and subjective. Your Reference Committee concurred that the first resolve should focus on protecting individual identity and beliefs while removing “advocacy,” which may be overly broad. Your Reference Committee recommends that Resolution 310 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(15) RESOLUTION 301 - EXAMINING ABMS PROCESSES FOR NEW BOARDS

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 301 be adopted in lieu of Resolution 301 to read as follows:

RESOLVED, that our American Medical Association study and define principles for recognizing board certifying bodies which offer appropriate assessment of physician competence in balance with patient safety and promoting professional self-regulation, with report back to the HOD at annual 2026. (Directive to Take Action)

HOD ACTION: Alternate Resolution 301 be adopted as amended in lieu of Resolution 301 to read as follows:

RESOLVED, that our American Medical Association study and define principles for ~~recognizing~~ board certifying bodies~~, which offer appropriate~~ including, but not limited to: education and training requirements, initial and ongoing assessment of physician competence in balance with patient safety, and best practices for promoting professional self-regulation, with report back to the HOD at annual 2026. (Directive to Take Action)

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)

Resolution 301 received mixed in-person testimony regarding the Reference Committee's Preliminary Report recommendation to refer for decision. Testimony addressed both support for the belief that board certification is paramount in professional self-governance and that the AMA should not interfere with the ABMS process. Testimony also addressed that that the issue of board certifying bodies had been examined in Council Report 4-I-23, "Recognizing Specialty Certifications for Physicians." The author offered in-person

testimony with an amendment asking the AMA to “study and define principles for recognizing board certifying bodies which offer appropriate assessment of physician competence in balance with patient safety and promoting professional self-regulation,” which was supported by the Council on Medical Education and others. Given the Council Chair is a participant in the ABMS’ review process for new specialties, the Council testified that the second resolve has been accomplished. Your Reference Committee agrees with the Council that the issue of principles for recognizing board certifying bodies warrants further study beyond CME Report 4-I-23. Therefore, Your Reference Committee supports the amended language proffered by the authors and recommends that Alternate Resolution 301 be adopted in lieu of Resolution 301.

RECOMMENDED FOR REFERRAL

(16) RESOLUTION 303 - SUPPORT FOR THE ESTABLISHMENT OF AN INDIGENOUS-LED MEDICAL SCHOOL IN THE UNITED STATES

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 303 be referred.

RECOMMENDATION B:

Your Reference Committee recommends that the third resolve of Resolution 303 be referred.

RECOMMENDATION C:

Your Reference Committee recommends that the fourth resolve of Resolution 303 be referred.

RECOMMENDATION D:

Your Reference Committee recommends that the first resolve of Resolution 303 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support efforts to establish ~~a fully accredited, allopathic,~~ Indigenous-governed medical schools in the United States, with ~~a~~ governance and leadership structures grounded in ~~T~~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)

RECOMMENDATION E:

Your Reference Committee recommends that Resolution 303 be adopted as amended.

RECOMMENDATION F:

Your Reference Committee recommends a change in title to read as follows:

SUPPORT FOR THE ESTABLISHMENT OF ~~AN~~ INDIGENOUS-LED MEDICAL SCHOOLS IN THE UNITED STATES

HOD ACTION: Resolution 303 be adopted as amended with a change in title.

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)

Resolution 303 received mixed online testimony. The Council on Medical Education recommended reaffirmation of policies H-200.954, H-350.977, H-350.976, H-200.951, and H-295.897 in lieu of this resolution. One comment questioned why this resolution specified an “allopathic” school and not osteopathic. Testimony noted that there is an osteopathic medical school on tribal land (e.g., OSU COM at the Cherokee Nation). Some testimony suggested amending the first resolve to support any accredited medical school, whether allopathic or osteopathic. Another testimony shared information about the formation of the OSU COM and noted the challenges of ensuring tribal sovereignty and respecting differing tribal priorities. Your Reference Committee also considered that since the AMA jointly sponsors the LCME, which accredits medical schools, it has not played an advocacy or leadership role in founding specific medical schools as it could call into question the fairness and objectivity of the LCME accreditation process. Federal and legal implications were also discussed. During the live hearing, the author testified against referral and offered an amendment removing “allopathic” from the language. Others testified against

referral and supported the amendment, emphasizing the urgent importance of an Indigenous medical school to improve access to education and health care for Indigenous communities. The Council on Medical Education and one other testimony expressed conceptual support but cautioned about the complexities of these issues, including the need to prioritize tribal sovereignty. Your Reference Committee noted an absence of direct expression of support from tribes or tribal organizations for the resolution's proposal.

Your Reference Committee is sensitive to the urgent need to support action within medical education for the benefit of Indigenous communities, and simultaneously sensitive to the complex nuances of the AMA's role in this process, particularly in deference to tribal leadership and sovereignty. Due to the importance of this topic as well as its complexities, your Reference Committee recommends that the first resolve of Resolution 303 be adopted as amended to promote immediate support for efforts to establish Indigenous medical schools if appropriate, with the other three resolves referred for study to examine the priorities of Indigenous communities in medical education.

RECOMMENDED FOR NOT ADOPTION

(17) RESOLUTION 306 - INNOVATION AND REFORM OF MEDICAL EDUCATION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 306 be not adopted.

HOD ACTION: Resolution 306 be not adopted.

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:

1. 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;
2. 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;
3. 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;
4. 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;
5. Possibility of merging the MCAT and USMLE Step 1/COMLEX Level 1;

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)

Resolution 306 received mixed online and in-person testimony. The Council on Medical Education testified against adoption and clarified that the ChangeMedEd Initiative is not in a position to conduct studies; rather, it supports institutions pursing innovation in medical education via grants. Such grants have funded significant investigations and innovations, which have been trialed at varying institutions and published. Other testimony supported adoption, suggested referral and supported non-adoption. Testimony expressed concerns regarding the specific proposals and lack of a unified rationale of the resolution, and the potential of negative unintended consequences of the proposals. Your Reference Committee appreciates that innovations and reforms in medical education are evolving and ongoing and understands the Council will be submitting reports to I-25 and

beyond related to the future directions of medical education, per the directives adopted in CME 2-I-24. Your Reference Committee appreciates the information provided by the Council and therefore recommends that Resolution 306 not be adopted.

(18) RESOLUTION 307 - DISCLOSURE OF INDIVIDUAL PHYSICIAN VOLUNTEERS PARTICIPATION IN COMMITTEE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 307 be not adopted.

HOD ACTION: Resolution 307 be not adopted.

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)

Resolution 307 received online testimony in opposition and none in support. Online testimony pointed out that there may be a misunderstanding of the ACCME Standards and that there may be conflation of the requirements in "conflict of interest" with those rules governing joint accreditation or joint providership. Your Reference Committee noted that Resolution 307 may conflict with policy H-300.952 that supports the ACCME and its Standards. In-person testimony opposed the resolution and supported the Preliminary Report recommendation to not adopt. Thus, your Reference Committee recommends that Resolution 307 be not adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(19) RESOLUTION 302 - AMA STUDY OF LIFESTYLE MEDICINE AND CULINARY ELECTIVES TO REDUCE BURNOUT AND BOLSTER CAREER SATISFACTION IN TRAINEES

RECOMMENDATION:

Your Reference Committee recommends that Policy H-425.972 be reaffirmed in lieu of Resolution 302.

HOD ACTION: Policy H-425.972 be reaffirmed in lieu of Resolution 302.

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)

Resolution 302 received mixed online testimony. Some online testimony was supportive, while one suggested it not be adopted. The Council on Medical Education recommended reaffirmation of policy H-425.972 in lieu of the resolution, given it broadly covers the spirit of the resolution. Other testimony agreed with the Council. The author testified online with alternate language for 302 along with a change in title. Your Reference Committee considered both the original as well as the alternate language and discussed the difficulties of conducting such a study or survey when there is currently an absence of published data. In-person testimony from the author opposed reaffirmation, again offering the same alternate language; however, your Reference Committee believes it presumes a conclusion that has not yet been proven and still requires study. Other in-person testimony reinforced the lack of data to study as well as the already overcrowded medical curricula. Your Reference Committee concurs with the Council that policy H-425.972 addresses the resolution. Thus, your Reference Committee recommends that policy H-425.972 be reaffirmed in lieu of Resolution 302.

(20) RESOLUTION 312 - SELECTION OF IMG RESIDENTS BASED ON MERIT

RECOMMENDATION:

Your Reference Committee recommends that Policies D-255.991 and H-255.988 be reaffirmed in lieu of Resolution 312.

HOD ACTION: Policies D-255.991 and H-255.988 be reaffirmed in lieu of Resolution 312.

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)

Resolution 312 received supportive but mixed online testimony. Some testimony supported adoption. The Council on Medical Education suggested reaffirmation of policies D-255.991 and H-255.988 in lieu of this resolution. Your Reference Committee is sensitive to the timely concerns raised in the resolution as well as the great value that IMGs contribute to the workforce in the U.S. Your Reference Committee was informed that the AMA's Advocacy unit is actively engaged in monitoring and addressing issues related to IMGs. It is notable that currently there are numerous immigration policy changes that may affect IMGs. The Council on Medical Education noted Intealth (comprised of ECFMG and FAIMER) may be the most appropriate organization to develop and disseminate educational resources, and that current AMA policy is supportive of this organization and related collaboration.

During the live hearing, the author and others opposed reaffirmation. Testimony did not specify the nature of misinformation or disinformation surrounding immigration policy. Testimony emphasized that Intealth (comprised of ECFMG and FAIMER) deals with this topic subsequent to the Match but with limited focus prior to the Match, and that program directors may find additional information useful. The Council re-emphasized that AMA Advocacy is engaged in this important work already. Your Reference Committee discussed the unfortunate reality that currently immigration policy is in flux and it is difficult to provide certainty. Accurate communication to program directors and institutions on immigration policy would require communicating that a significant degree of uncertainty exists due to pending federal executive and judicial decisions, the current federal administration's priorities (such as via Executive Order 14161 and the recent presidential action implementing this by restricting immigration), and many instances of active litigation.

Your Reference Committee also recognizes that existing AMA policy does not solely rely on Intealth, but also supports ongoing AMA work in the areas of concern, including: "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" and "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" (Visa Complications for IMGs in GME D-255.991). This work is of immense importance, and AMA is actively engaged per these policies. Your Reference Committee noted many program directors actively monitor immigration policy that may impact their applicants and residents. Our AMA is actively advocating for IMGs to enter training in the U.S. Unfortunately, your Reference Committee believes adopting this resolution will not alleviate the concerns of program directors in a genuinely concerning environment.

Therefore, your Reference Committee recommends that policies D-255.991 and H-255.988 be reaffirmed in lieu of this resolution.

This concludes the report of Reference Committee C. I would like to thank Reference Committee members Alëna Balasanova, MD, Kylee Borger, MD, MPH, Matthew Burday, DO, Joshua Hartley, Debra Lupeika, MD, Douglas Martin, MD, and all those who testified before the Committee. I would also like to thank AMA staff persons Lena Drake, Tanya Lopez, Richard Pan, MD, MPH, and Amber Ryan for their assistance.

Alëna Balasanova, MD
Delegate, American Academy of Addiction Psychiatry

Kylee Borger, MD, MPH
Delegate, Resident and Fellow Section

Matthew Burday, DO
Alternate Delegate, Medical Society of Delaware

Joshua Hartley
Delegate, Regional Medical Student

Debra Lupeika, MD
Alternate Delegate, California Medical Association

Douglas W. Martin, MD
Delegate, Iowa Medical Society

Christopher Wee, MD
Delegate, Ohio State Medical Association
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Final Report of Reference Committee D

Kim Templeton, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. CSAPH 02 - Addressing Social Determinants of Health Through Closed Loop Referral Systems
2. CSAPH 07 - Addressing the Health Issues Unique to Minority Communities in Rural Areas
3. Resolution 402 - Protecting In-Person Prison Visitations to Reduce Recidivism
4. Resolution 407 - Sleep Deprivation as a Public Health Crisis
5. Resolution 410 - Hate Speech is a Public Health Concern
6. Resolution 412 - Supporting inclusive long-term care facilities
7. Resolution 413 - Preservation of Public Funding for Physicians and Hospitals Providing LGBTQ+ Care
8. Resolution 414 - Expanding Sexually Transmitted Infection Care for Persons with Unstable or No Housing
9. Resolution 415 - Promoting Child Welfare and Communication Rights in Immigration Detention
10. Resolution 416 - Culturally and Religiously Inclusive Food Options
11. Resolution 418 - AMA Study on Plastic Pollution Reduction
12. Resolution 419 - Advocating for Universal Summer Electronic Benefit Transfer Program for Children (SEBTC)
13. Resolution 422 - Protecting the Integrity of the U.S. Healthcare System from Misinformation and Policy
14. Resolution 428 - Public Health Implications of US Food Subsidies
15. Resolution 429 - Addressing the Health Consequences of Microplastics in Humans
16. Resolution 434 - Breast Cancer Risk Reduction

RECOMMENDED FOR ADOPTION AS AMENDED

17. BOT 20 – Guardianship and Conservatorship Reform
18. CSAPH 03 - Protections Against Surgical Smoke Exposure
19. CSAPH 04 - Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals
20. CSAPH 06 - Fragrance Regulation
21. Resolution 401 - Reducing Pickleball-Related Ocular Injuries

22. Resolution 403 - Promoting Evidence-Based Responses to Measles and Misuse of Vitamin A
23. Resolution 406 - Call for Study: Should Petroleum-Powered Emergency Medical Services (EMS) Vehicles in Urban Service Areas be Replaced by Renewably-Powered Electric Vehicles?
24. Resolution 409 - Guidelines for Restricting Cell Phones in K-12 Schools
25. Resolution 411 - Protecting Access to mRNA Vaccines
26. Resolution 420 - Study of Plant-Based & Lab-Grown Meat
27. Resolution 423 - Requiring Universal Vaccine reporting to a National Immunization Registry and Access to a National Immunization Information System
28. Resolution 430 - Addressing the Health Impacts of Ultraprocessed Foods
29. Resolution 431 - Alcohol & Breast Cancer Risk
30. Resolution 433 - Clinical Lactation Care

RECOMMENDED FOR ADOPTION IN LIEU OF

31. Resolution 405 - Health Warning Labels on Alcoholic Beverage Containers
    Resolution 417 - Updating Alcohol Health Warning Labels to Reflect Evidence-Based Health Risks and Supporting National Labeling and Signage Policy Reform
    Resolution 425 - Alcohol Consumption and Health
32. Resolution 426 - Addressing Patient Safety and Environmental Stewardship of Single-Use and Reusable Medical Devices
33. Resolution 427 - Elevate Obesity as a Strategic Objective
34. Resolution 432 - Support for Long-Term Sequelae of Pregnancy

RECOMMENDED FOR REFERRAL

35. Resolution 404 - Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers
36. Resolution 408 - Removing Artificial Turf in Schools, Parks, and Public Places
37. Resolution 421 - Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities
38. Resolution 424 - Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records

RECOMMENDED FOR FILING

39. Board of Trustees Report 25 – AMA Public Health Strategy Update

Amendments

If you wish to propose an amendment to an item of business, click here:
Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 02 - ADDRESSING SOCIAL DETERMINANTS OF HEALTH THROUGH CLOSED LOOP REFERRAL SYSTEMS

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in the Council on Science and Public Health (CSAPH) Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: CSAPH Report 2 be adopted and the remainder of the report be filed.

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)

Your Reference Committee heard unanimously supportive testimony for this report noting that the report carefully considers how closed loop referral systems can be used in addressing SDOH and health-related social needs by connecting clinicians, patients, and community-based organizations. Therefore, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 2 be adopted and the remainder of the report be filed.

(2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 07 - ADDRESSING THE HEALTH ISSUES UNIQUE TO MINORITY COMMUNITIES IN RURAL AREAS

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in the Council on Science and Public Health Report 7 be adopted and the remainder of the report be filed.

HOD ACTION: CSAPH Report 7 be adopted and the remainder of the report be filed.

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.

Your Reference Committee heard overall supportive testimony of the report and the proposed recommendations. There was a proffered amendment by one section to add two clauses to Policy H-350.937 focused on supporting existing research, funding, and surveillance systems for Native American communities, which was supported by another individual. However, others testified, including the report authors, that these amendments were out of scope of the report and noted the existence of other mechanisms to achieve more immediate action. Due to the overall support of the recommendations as written, your Reference Committee recommends adoption of CSAPH Report 7.

(3) RESOLUTION 402 - PROTECTING IN-PERSON PRISON VISITATIONS TO REDUCE RECIDIVISM

RECOMMENDATION:

Your Reference Committee recommends that Resolution 402 be adopted.

HOD ACTION: Resolution 402 be adopted.

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)

Your Reference Committee heard unanimously supportive testimony on Resolution 402 noting that maintaining family and social connections through a primary means of telephone calls, written correspondence (including email), and in-person visits is critical for the mental health of justice-involved individuals. Testimony also noted that protecting in-person visitation aligns with longstanding AMA policies supporting the welfare of incarcerated individuals and that appropriate custodial precautions must be taken to prevent the introduction of illegal substances. Therefore, your Reference Committee recommends that Resolution 402 be adopted.

(4) RESOLUTION 407 - SLEEP DEPRIVATION AS A PUBLIC HEALTH CRISIS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 407 be adopted.

HOD ACTION: Resolution 402 be adopted.

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)

Your Reference Committee heard testimony from multiple delegations, sections and individuals voicing approval of the intent of this resolution. However, an amendment was proposed to the second Resolve to change the wording from public health “crisis” to public health “concern” noting that overusing the term “public health crisis” will dilute its meaning and would take away from current resources used to address other public health crises such as gun violence. It was further noted that it is difficult to implement public health interventions to address sleep given how complex this issue is. This amendment received mixed feedback with some in support but a narrow majority favored the original language noting the importance of sleep hygiene as well as the increasing prevalence of sleep deprivation and its negative health consequences. Due to the overall support for the resolution as originally drafted, your Reference Committee recommends adoption of Resolution 407.

(5) RESOLUTION 410 - HATE SPEECH IS A PUBLIC HEALTH CONCERN

RECOMMENDATION:

Your Reference Committee recommends that Resolution 410 be <u>adopted</u>.

HOD ACTION: Resolution 410 be <u>adopted</u>.

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)

Your Reference Committee heard mostly supportive testimony on this item, noting that calling attention to the public health harms of hate speech is in line with previous AMA policy and principles that physicians should be in favor of to prevent further harm to their patients, colleagues, and communities. Multiple individuals expressed concern, noting that it is difficult to determine what is considered hate speech and stated that hate speech should be clearly defined in the resolution. Given that AMA has existing policy on hate speech and the majority of the testimony supported this item, your Reference Committee recommends that Resolution 410 be adopted.

(6) RESOLUTION 412 - SUPPORTING INCLUSIVE LONG-TERM CARE FACILITIES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 412 be <u>adopted</u>.

HOD ACTION: Resolution 412 be <u>adopted</u>.

RESOLVED, that our American Medical Association supports federal and state policies for making long-term care facilities LGBTQ+ inclusive. (New HOD Policy)

Your Reference Committee heard generally supportive testimony for adoption of this item. Two sections and one delegation were in strong support. Testimony noted that older LGBTQ+ individuals experience higher rates of mental health concerns like depression and anxiety and are also more likely to face discrimination and isolation in long-term care settings. An individual was in support of the recommendation of reaffirmation of existing policy. However, testimony from supporters highlighted that existing policy makes no

specific recommendations regarding the inclusivity of LGBTQ+ older adults in long-term care facilities. Therefore, your Reference Committee recommends Resolution 412 be adopted.

(7) RESOLUTION 413 - PRESERVATION OF PUBLIC FUNDING FOR PHYSICIANS AND HOSPITALS PROVIDING LGBTQ+ CARE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 413 be adopted.

HOD ACTION: Resolution 413 be adopted.

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)

Your Reference Committee heard unanimously supportive testimony on this item. Given that there are increasing limitations in federal funding based on providing evidence-based and life-saving care for transgender and gender diverse people, it is imperative that the AMA supports public funding for physicians and hospitals caring for LGBTQ+ patients. Therefore, your Reference Committee recommends that Resolution 413 be adopted.

(8) RESOLUTION 414 - EXPANDING SEXUALLY TRANSMITTED INFECTION CARE FOR PERSONS WITH UNSTABLE OR NO HOUSING

RECOMMENDATION:

Your Reference Committee recommends Resolution 414 be adopted.

HOD ACTION: Resolution 414 be adopted.

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)

Your Reference Committee heard supportive testimony on adoption of this item. Testimony noted that this resolution addresses the urgent need for equitable, targeted STI care for people with unstable or no housing—particularly those from LGBTQ+ and other marginalized communities. While one individual was in support of the recommendation of reaffirmation, testimony from multiple sections and delegations supported adoption and not reaffirmation of existing policy. Proponents of adoption versus reaffirmation stated that existing policy addresses general principles of STI control, public health funding, and care for LGBTQ+ and homeless populations, but does not explicitly integrate or prioritize

access to STI care for individuals with unstable or no housing. Therefore, your Reference Committee recommends Resolution 414 be adopted.

(9) RESOLUTION 415 - PROMOTING CHILD WELFARE AND COMMUNICATION RIGHTS IN IMMIGRATION DETENTION

RECOMMENDATION:

Your Reference Committee recommends Resolution 415 be adopted.

HOD ACTION: Resolution 415 be adopted.

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)

Your Reference Committee heard mostly supportive testimony on this item. It was noted that this resolution ensures that all detention facilities adopt child-centered, trauma-informed practices, provide developmentally appropriate socioemotional care (such as allowing physical comfort), and guarantee free, unrestricted access to communication for all detainees. An individual noted that this resolution needs clarification as written to define what is meant by “free and unfettered access” and what is meant by “regular” with respect to in-person, telephone, and letter communication. Given that the majority of the testimony was in support of this resolution, your Reference Committee recommends that Resolution 415 be adopted.

(10) RESOLUTION 416 - CULTURALLY AND RELIGIOUSLY INCLUSIVE FOOD OPTIONS

RECOMMENDATION:

Your Reference Committee recommends Resolution 416 be adopted.

HOD ACTION: Resolution 416 be adopted.

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 inclusive food and healthy meal options within all training hospitals.

Your Reference Committee heard mostly supportive testimony on this item. Testimony noted the proposed amendments were important in meeting the varied dietary needs of patients and staff from diverse backgrounds. Those testifying in support felt this policy supported wellness, respect, and dignity in the workplace. Your Reference Committee acknowledges the policy as written covers staff at all times of day and trainees at all levels. One individual was opposed to modifying the current policy and recommended a standalone policy that supported improving access to culturally and religiously inclusive food options in health care facilities. However, other individuals and groups testifying felt the modification of H-150.949 was appropriate and creation of new policy was not warranted. There was no additional testimony in support of making this a standalone policy. Therefore, your Reference Committee recommends that Resolution 416 be adopted.

(11) RESOLUTION 418 - AMA STUDY ON PLASTIC POLLUTION REDUCTION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 418 be adopted.

HOD ACTION: Resolution 418 be adopted.

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)

Your Reference Committee heard largely supportive testimony on this item with one individual preferring an amended resolve clause that would change the resolution from asking AMA to study microplastics to one supporting further research on this topic, citing concerns over the fiscal note. The fiscal note for this item is Modest ($1000 to $5000), which is consistent with any resolution asking our AMA to study a topic. Supportive testimony noted plastic pollution is not only an environmental concern but also a growing public health threat. While there were a few calls for Resolutions 418 and 429 to be combined into one resolution, your Reference Committee felt it was reasonable to keep these as two separate policies as they are sufficiently unique and there was minimal benefit in combining them together. Based on the largely supportive testimony for the resolution as written, your Reference Committee recommends that Resolution 418 be adopted.

(12) RESOLUTION 419 - ADVOCATING FOR UNIVERSAL SUMMER ELECTRONIC BENEFIT TRANSFER PROGRAM FOR CHILDREN (SEBTC)

RECOMMENDATION:

Your Reference Committee recommends that Resolution 419 be <u>adopted</u>.

HOD ACTION: Resolution 419 be <u>adopted</u>.

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)

Your Reference Committed heard unanimously supportive testimony on Resolution 419. Testimony noted the high prevalence of food insecurity among children in the U.S. and the importance of this program in helping address that issue. Therefore, your Reference Committee recommends adoption of Resolution 419.

(13) RESOLUTION 422 - PROTECTING THE INTEGRITY OF THE U.S. HEALTHCARE SYSTEM FROM MISINFORMATION AND POLICY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 422 be <u>adopted</u>.

HOD ACTION: Resolution 422 be <u>adopted</u>.

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)

Your Reference Committee heard testimony that was supportive of this resolution. With the widespread accessibility of information through mobile devices and other technology, it is important to know how to filter this information for accurate, evidence-based materials. The spreading of unreliable information on health topics amplifies vaccine hesitancy, promotes unproven treatments, erodes public trust, contributes to stigma, and is harmful to patients. An amendment sought to clarify the ask of this resolution and potentially decrease the fiscal note. The amendment had limited support, and it was unclear whether it would significantly change the directive or the fiscal note. Therefore, your Reference Committee recommends adoption of Resolution 422.

(14) RESOLUTION 428 - PUBLIC HEALTH IMPLICATIONS OF US FOOD SUBSIDIES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 428 be <u>adopted</u>.

HOD ACTION: Resolution 428 be <u>adopted</u>.

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)

Your Reference Committee heard unanimously supportive testimony for this resolution from multiple sections and societies. Testimony noted that federal food and agricultural policy play a critical role in shaping our food environment and that diet is not shaped solely by individual choices. This proposed study would help elucidate some of the structural causes of our unhealthy food environment in the U.S. and the resulting health disparities, particularly in underserved communities. Testimony also noted that poor nutrition is the leading risk factor for all-cause mortality, highlighting the importance of this proposed study. Therefore, your Reference Committee recommends adoption of Resolution 428.

(15) RESOLUTION 429 - ADDRESSING THE HEALTH CONSEQUENCES OF MICROPLASTICS IN HUMANS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 429 be <u>adopted</u>.

HOD ACTION: Resolution 429 be adopted.

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)

Your Reference Committee heard mostly supportive testimony for this resolution. Testimony noted continued monitoring of the evidence as it evolves is important as this issue is relatively nascent, while others discussed the ubiquitous presence of microplastics in our lives and bodies as a cause for concern and thus the relevance and timeliness of this resolution. While there were limited calls for Resolution 429 and Resolution 418 to be combined, the Reference Committee feels it is more appropriate to keep them as separate, standalone policy (as noted previously). Therefore, your Reference Committee recommends adoption of Resolution 429.

(16) RESOLUTION 434 - BREAST CANCER RISK REDUCTION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 434 be adopted.

HOD ACTION: Resolution 434 be adopted.

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)

Your Reference Committee heard testimony unanimously in support of Resolution 434. It was noted that breast cancer is the second most common cancer among women in the U.S., and the incidence has been increasing. Multiple delegations, sections, and individuals highlighted the importance and value of educating patients and the public about multiple lifestyle-based interventions associated with breast cancer risk and risk mitigation

to improve health outcomes. Therefore, your Reference Committee recommends that this resolution be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(17) BOARD OF TRUSTEES REPORT 20 – GUARDIANSHIP AND CONSERVATORSHIP REFORM

RECOMMENDATION A:

Your Reference Committee recommends that the Recommendations in Board of Trustees Report 20 be amended by addition to read as follows:

3. That our AMA supports efforts to reduce predatory behavior by participants in a guardianship system who may have potential financial conflicts of interest, including private organizations and entities, through education and regulation.

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendations in Board of Trustees Report 20 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 20 be adopted as amended and the remainder of the report be filed.

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.

Your Reference Committee heard limited, but supportive testimony on the recommendations in this Board of Trustees report. Testimony noted that making clinical decisions to support guardianship is complex and there is wide variability across states. A proposed amendment called for the AMA to support efforts to reduce predatory behavior and to regulate parties involved in guardianship. The authors supported this amendment, with minor updates in wording, as an additional measure to proactively guard against predatory actions by entities with potential financial conflicts of interest. Therefore, your Reference Committee recommends that the recommendations of this Board of Trustees report be adopted as amended and the remainder of the report be filed.

(18) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 03 – PROTECTIONS AGAINST SURGICAL SMOKE EXPOSURE

RECOMMENDATION A:

Your Reference Committee recommends that the Recommendation of CSAPH 3 be amended by deletion to read as follows:

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)

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendations in the Council on Science and Public Health Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in CSAPH Report 3 be adopted as amended and the remainder of the report be filed.

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)

Your Reference Committee heard testimony that was mostly supportive of the recommendations in CSAPH Report 3. Testimony noted that this was a well-researched report with an important emphasis on preventive measures. Supportive testimony highlighted the lack of federal standards or regulations for health care professionals who are regularly exposed to surgical smoke and thus the importance of AMA policy on this issue that addresses education and research. Testimony highlighted that ergonomics are something we need to pay attention to, and surgeons need choices that help ensure both comfort and health. These recommendations are flexible enough to accomplish that, while still addressing the issue at hand. One proposed amendment called for the deletion of the reference to human papillomavirus (HPV) in the recommendations as data supporting exposure to HPV via surgical smoke is limited. Your Reference Committee also believes it is prudent to remove reference to operating rooms as these recommendations are applicable to other health care settings as well. Therefore, your Reference Committee recommends CSAPH Report 3 be adopted as amended and the remainder of the report be filed.

(19) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 4 - CONDEMNING THE UNIVERSAL SHACKLING OF EVERY INCARCERATED PATIENT IN HOSPITALS

RECOMMENDATION A:

Your Reference Committee recommends that the second Recommendation in CSAPH Report 4 be amended by addition to read as follows:

2) Our AMA encourages health care facilities in collaboration with carceral facility~~ies~~ leadership 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 the decision-making authority of carceral facilities and hospital security ~~when~~ to allow timely shackle removal when ~~is~~ medically necessary to provide the standard of care. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends CSAPH Report 4 be amended by addition of a fourth Recommendation to read as follows:

4. Our AMA urges through its representation on the National Commission on Correctional Health Care development and implementation of policies that eliminate or reduce universal shackling of patients who are incarcerated while receiving health care.

RECOMMENDATION C:

Your Reference Committee recommends that Council on Science and Public Health Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in CSAPH Report 4 be adopted as amended and the remainder of the report be filed.

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)

Your Reference Committee heard mostly supportive testimony on this item. Testimony in support noted that 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. The authors of this report proffered an amendment to emphasize that "timely" collaboration can keep patients and staff safe while allowing medical personnel to provide standard of care. Your Reference Committee agrees with the amendment. Another amendment was proffered to clarify that efforts should be directed towards correctional staff with authority to make such decisions since not all correctional staff have that authority. Further, a delegation proffered an amendment to add another recommendation that advocates for the implementation of these recommendations through AMA representation at the National Commission on Correctional Health Care (NCCHC). Your Reference Committee agrees given that the authors supported this amendment and that current AMA policy supports NCCHC guidelines. Therefore, your Reference Committee recommends that the Recommendations in CSAPH Report 4 be adopted as amended and the remainder of the report be filed.

(20) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 06 - FRAGRANCE REGULATION

RECOMMENDATION A:

Your Reference Committee recommends that the Recommendation in the Council on Science and Public Health Report 6 be <u>amended by addition</u> to read as follows:

That 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 in consultation with relevant medical specialists when possible.

(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)

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendations in the Council on Science and Public Health Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in CSAPH Report 6 be adopted as amended and the remainder of the report be filed.

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) 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)

Your Reference Committee heard largely supportive testimony on this report. There were two amendments offered. The first amendment suggested adding, “in consultation with relevant specialists (e.g. dermatologists, allergists, occupational and environmental medicine physicians) to ensure policies are evidence-based and patient-centered” to the second clause of the recommendation. However, testimony from CSAPH noted concerns as the proposed amendments could be burdensome. In response to support for the spirit of this amendment, your Reference Committee made a slight revision to the second recommendation to more clearly articulate incorporation of insight from medical specialists in policy design in a manner consistent with available evidence and resources when possible. The second proposed amendment suggested adding, “and encourages the U.S. Food and Drug Administration to establish regulations for fragrance allergen labeling” to the fourth clause. Yet, as noted by the CSAPH, this amendment likely exceeds the scope of the report. In person testimony was supportive of CSAPH’s recommendation. Due to the overall support of the amendment to recommendation two, your Reference Committee recommends adoption of CSAPH Report 6 as amended.

(21) RESOLUTION 401 - REDUCING PICKLEBALL-RELATED OCULAR INJURIES

RECOMMENDATION A:

Your Reference Committee recommends the first Resolve clause of Resolution 401 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate for international, national, and local pickleball organizations, leagues, and recreational facilities to adopt ~~eye~~ pickleball-related injury prevention strategies—such as ~~mandating~~ recommending protective eyewear—particularly for older adults and individuals with pre-existing ~~ocular~~ conditions which could increase their risk for injury while playing pickleball. (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends the second Resolve clause of Resolution 401 be amended by addition and deletion to read as follows:

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~~ pickleball-related injury risks, such as ocular injuries (Directive to Take Action); and be it further

RECOMMENDATION C:

Your Reference Committee recommends the third Resolve clause of Resolution 401 be amended by deletion.

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

RECOMMENDATION D:

Your Reference Committee recommends the fourth Resolve clause of Resolution 401 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA recognize the growing popularity of pickleball among aging populations and encourage physicians to incorporate counseling on ~~sports-~~ pickleball-related ~~eye~~ injury prevention, such as ocular injury, as part of routine patient care. (New HOD Policy)

RECOMMENDATION E:

Your Reference Committee recommends that Resolution 401 be adopted as amended.

RECOMMENDATION F:

Your Reference Committee recommends that the title of Resolution 401 be changed to read as follows:

REDUCING PICKLEBALL-RELATED INJURIES

HOD ACTION: Resolution 401 be adopted as amended with a title change.

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)

Your Reference Committee heard mixed testimony online. One individual supported reaffirmation. Two individuals acknowledged that while existing policy addresses the issue, they highlighted the value of the resolution to raise awareness. Finally, one delegation was supportive of the resolution in spirit, but proposed amendments to expand the language to cover all pickleball related injuries rather than focusing only on ocular injuries. Your Reference Committee agrees with expanding to all pickleball-related injuries but also wanted to include language calling attention to ocular injury given the intent of the original resolution. Since the Reference Committee agreed with the expansion of the resolution to cover a broader array of injuries from pickle-ball, it also felt the title should be changed to reflect that broader focus. In person testimony was limited, but unanimously supportive of the proposed amendments. Therefore, your Reference Committee recommends that Resolution 401 be adopted as amended.

(22) RESOLUTION 403 - PROMOTING EVIDENCE-BASED RESPONSES TO MEASLES AND MISUSE OF VITAMIN A

RECOMMENDATION A:

Your Reference Committee recommends the first Resolve clause of Resolution 403 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~will make~~ will use available materials and references 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 for measles (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends the second Resolve clause of Resolution 403 be amended by addition to read as follows:

RESOLVED, that our AMA will educate the public and healthcare professionals about the proper role of vitamin A in measles management under the supervision of a physician—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

RECOMMENDATION C:

Your Reference Committee recommends the third Resolve clause of Resolution 403 be deleted.

~~**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**~~

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 403 be adopted as amended.

HOD ACTION: Resolution 403 be adopted as amended.

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)

Your Reference Committee heard mostly supportive testimony on this item. Testimony in support from multiple delegations and sections highlighted it is critical that our AMA reaffirm that the best protection against measles is the MMRV vaccine which provides

long-lasting protection, and that Vitamin A does not prevent measles. Testimony also noted that Vitamin A deficiency is relatively uncommon in the U.S. One delegation supported reaffirmation of D-440.915 and H-440.830 in lieu of this item and supported adoption of an alternate resolution asserting that "the AMA unequivocally state that any statements regarding Vitamin A supplementation being a replacement for vaccination is health misinformation and highlight the harms of a Vitamin A overdose." Your Reference Committee heard no further testimony in support of this. Multiple delegations, individuals, and CSAPH supported deletion of the third Resolve clause noting that the way the resolve is worded could be misinterpreted as advocating for the use of Vitamin A in the context of measles. Your Reference Committee agrees with this. Further, the CSAPH proffered an amendment to the second Resolve clause to include language "under the supervision of a physician" to further emphasize that Vitamin A use in measles management is supported only when under the supervision of a physician. Your Reference Committee agrees with this amendment. The author proffered an amendment to the first Resolve clause online to clarify that the AMA will "use available materials and references" rather than "make" them. Another delegation proffered an amendment to the first Resolve clause to clarify that the topic is specifically regarding vitamin A as a self-treatment for measles. Your Reference committee agrees with these amendments, as did the resolution author. Therefore, your Reference Committee recommends that Resolution 403 be adopted as amended.

(23) RESOLUTION 406 - CALL FOR STUDY: SHOULD PETROLEUM-POWERED EMERGENCY MEDICAL SERVICES (EMS) VEHICLES IN URBAN SERVICE AREAS BE REPLACED BY RENEWABLY-POWERED ELECTRIC VEHICLES?

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 406 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association encourages ~~study~~ pilot studies on the ~~potential~~ feasibility of ~~that our nation's~~ urban ambulance fleets being 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; and be it further~~

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve clause of Resolution 406 be deleted.

~~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)**~~

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 406 be adopted as amended.

RECOMMENDATION D:

Your Reference Committee recommends that the title of Resolution 406 be changed to read as follows:

UNDERSTANDING THE FEASIBILITY OF REPLACING PETROLEUM-POWERED EMERGENCY MEDICAL SERVICES (EMS) VEHICLES IN URBAN SERVICE AREAS WITH RENEWABLY-POWERED VEHICLES

HOD ACTION: Resolution 406 be adopted as amended with a title change.

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)

Your Reference Committee heard mixed testimony for this resolution. Supporters of the resolution noted that the proposed resolution was both well aligned with existing AMA policy on climate change and sustainability and would contribute to existing knowledge and inform future considerations in reducing health care's environmental impact. Several individuals and CSAPH testified that they did not believe there was enough data currently available on electric vehicles in the U.S. and that the greenhouse gas emissions from EMS vehicles make up a relatively small portion of overall emissions, therefore the aims of this resolution are too narrow. Additionally, it was noted that the second Resolve seemed overly prescriptive in terms of how the report would be disseminated. A number of individuals felt the Reference Committee's preliminary recommendation for referral was appropriate. Due to the lack of data but noting the importance of the issue, CSAPH proffered an amendment that would encourage others to study the feasibility of renewably powered vehicles as opposed to the AMA, which several others supported. Another individual provided an amendment asking for the deletion of the word 'electric' from vehicles, noting that other new technologies that use renewable energy could be used in vehicles that aren't necessarily 'electric' (e.g. fuel cells). Your Reference Committee believes the amendments provided by CSAPH keep the original intent of the resolution, in that more study is needed on the feasibility of renewably powered EMS vehicles, but more

evidence is needed before AMA takes this on as a study. Thus, your Reference Committee recommends that Resolution 406 be adopted as amended.

(24) RESOLUTION 409 - GUIDELINES FOR RESTRICTING CELL PHONES IN K-12 SCHOOLS

RECOMMENDATION A:

Your Reference Committee recommends the first Resolve clause of Resolution 409 be amended by addition to read as follows:

RESOLVED, that our American Medical Association support the establishment of uniform guidelines for cell phone and smart device access in K-12 schools and best practices for use outside school including recommendations for nighttime device access for children (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends the second Resolve clause of Resolution 409 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support K-12 schools implementing limitations on cell phone and smart device ~~phone~~ usage during school hours that consider individual, school, and community needs (e.g., emergency contact, medical needs, etc.) (New HOD Policy); and be it further

RECOMMENDATION C:

Your Reference Committee recommends the third Resolve clause of Resolution 409 be amended by addition to read as follows:

RESOLVED, that our AMA encourage parents and children to limit children's nighttime cell phone and smart device usage before bedtime. (New HOD Policy)

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 409 be adopted as amended.

HOD ACTION: Resolution 409 be adopted as amended.

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)

Your Reference Committee heard strong support for the spirit of this resolution. Multiple amendments were suggested regarding: (1) adding "smart devices" and "cell phones" to all resolve clauses, and (2) inclusion of provisions to allow use in certain circumstances (e.g., emergency contact, medical needs, etc.). Additionally, concerns were raised about the feasibility of implementation. To address these concerns and allow more flexibility with respect to policy design and implementation, the Reference Committee revised the second clause to add language to, "consider individual, school, and community needs (e.g., emergency contact, medical needs, etc.)." K-12 was also added in all relevant resolved clauses to add clarity and support their ability to stand on their own. Due to unanimous support for the spirit of the resolution, your Reference Committee recommends adoption of Resolution 409 as amended.

(25) RESOLUTION 411 - PROTECTING ACCESS TO MRNA VACCINES

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 411 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA actively ~~lobby for~~ support protections for use, research and development of mRNA vaccines for infectious diseases and cancer treatment; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve clause of Resolution 411 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~develop state level model legislation to promote state level protections for~~ work with interested state and specialty medical associations to oppose state legislation that would limit or ban the use, research ~~and~~ or development of mRNA vaccines ~~with report back at I-25~~.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 411 be <u>adopted as amended</u>.

HOD ACTION: Resolution 411 be <u>adopted as amended</u>.

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)

Your Reference Committee heard unanimously supportive testimony on this item noting that this is a timely issue, given recent legislation introduced in several states aiming to ban or limit the use of mRNA technology. Testimony highlighted how mRNA vaccines have revolutionized approaches to treatment for cancer, infectious disease, and played a critical role in reducing COVID-19-related morbidity and mortality. An amendment was proffered by the Council on Legislation that calls for our AMA to work with state and specialty medical associations to oppose state legislation that would ban mRNA vaccines and to authorize the AMA to support and protect the use, research, and development of mRNA vaccines broadly, and not be limited to lobbying activities. The Council stated support for the intent of the resolution but noted that enacting AMA model legislation would not be effective in preventing state legislators from banning mRNA vaccines in the future. An amendment was proffered to add the word “actively” back into the first Resolve clause to ensure ongoing support for protections. Your Reference Committee agrees with these amendments and therefore recommends that Resolution 411 be adopted as amended.

(26) RESOLUTION 420 - STUDY OF PLANT-BASED & LAB-GROWN MEAT

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 420 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, that our American Medical Association <u>supports further research</u> ~~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)~~<u>(New HOD Policy)</u>

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 420 be adopted as amended.

HOD ACTION: Resolution 420 be adopted as amended.

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)

Your Reference Committee heard limited but mixed testimony on this item. Supportive testimony noted that plant-based and lab-grown meat alternatives have the potential to shift the global food system and that a whole food, plant-based diet is one of the six pillars of the Lifestyle Medicine specialty. There was also CSAPH testimony recommending not adoption of this resolution, noting that there is limited evidence available to justify a study but welcomed the return of this resolution in future meetings. Your Reference Committee believes this is an important issue but agrees with CSAPH's testimony that the lack of available data would make it difficult for the AMA to do a study, and thus amending the resolution to encourage further research addresses the original intent while addressing the lack of evidence concern. Therefore, your Reference Committee recommends Resolution 420 be adopted as amended.

(27) RESOLUTION 423 - REQUIRING UNIVERSAL VACCINE REPORTING TO A NATIONAL IMMUNIZATION REGISTRY AND ACCESS TO A NATIONAL IMMUNIZATION INFORMATION SYSTEM

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 423 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~seek legislation for~~ support the creation of 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.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 423 be adopted as amended.

HOD ACTION: Resolution 423 be adopted as amended.

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)

Your Reference Committee heard mostly supportive testimony on this item noting that Immunization Information Systems would be most effective for pediatricians and other health care professionals if there was a nationwide network and repository of immunization data, given the current limitations of data sharing across jurisdictions. Limited testimony noted that promoting interoperability across state registries may be a more palatable way of approaching this issue. Your Reference committee acknowledges that there may be challenges in implementing a national registry, while acknowledging that current AMA policy already supports using integrated and interoperable systems to facilitate access to accurate and complete immunization data and to improve information-sharing among all vaccine providers (H-440.877) as well as a network of state-based immunization registries that meet a set of minimum standards and allow for access at a national level (D-440.961). Further, a delegation proffered an amendment to support the creation of a national immunization registry, without necessarily requiring a legislative approach. Your Reference Committee agrees and therefore recommends that Resolution 423 be adopted as amended.

(28) RESOLUTION 430 - ADDRESSING THE HEALTH IMPACTS OF ULTRAPROCESSED FOODS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 430 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support and promote public awareness and education about the ~~health risks of~~ differences between healthful foods and unhealthful ultraprocessed foods (UPF) and the benefits of minimally processed and unprocessed foods (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the third Resolve of Resolution 430 be amended by addition to read as follows:

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 unhealthful UPF consumption (New HOD Policy); and be it further

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 430 be adopted as amended.

HOD ACTION: Resolution 430 be adopted as amended.

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)

Your Reference Committee heard overall supportive testimony, particularly in regard to the intent of this resolution, and there were several proposed amendments. Suggested amendments included clarification on differences between healthful foods and unhealthful ultraprocessed foods and the other proposed deletion of the fourth resolve clause, suggesting AMA support of this statement could be construed as politized in the current federal political environment. The resolution authors supported amendments included in the preliminary reference report and there was no further testimony in support of the deletion of the fourth Resolve clause. Your Reference Committee would also like to note that a letter sent earlier this year by the AMA to the US Department of Health and Human Services and the U.S. Department of Agriculture supported continued research into ultraprocessed foods and their health impacts. Therefore, your Reference Committee recommends Resolution 430 be adopted as amended.

(29) RESOLUTION 431 - ALCOHOL & BREAST CANCER RISK

RECOMMENDATION A:

Your Reference Committee recommends the second Resolve clause of Resolution 431 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA supports evidence-based efforts to minimize ~~prevent excessive~~ alcohol use, including eliminating the use of "pinkwashing" to market alcohol products and supporting warning labels on the ingredients and products.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 431 be <u>adopted as amended</u>.

HOD ACTION: Resolution 431 be <u>adopted as amended</u>.

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; 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.

Testimony on Resolution 431 was limited, but supportive. Despite evidence that even low levels of alcohol use increase the risk of several cancers, public awareness remains alarmingly low. One individual testified that the focus of the resolution on breast cancer was too narrow. Another individual called for deletion of the word "excessive" in the second Resolve, to acknowledge the risk of alcohol-related harm, including cancer, begins with any level of consumption. Your Reference Committee agrees with this assessment and acknowledges that deleting the word 'excessive' is better aligned with existing AMA policy. However, when the word excessive was deleted, it was deemed necessary to modify the 'prevent' to 'minimize' to help align the resolution to its original intent. Therefore, your Reference Committee recommends that Resolution 431 be adopted as amended.

(30) RESOLUTION 433 - CLINICAL LACTATION CARE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 433 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, that our American Medical Association recognizes the importance of <u>qualified clinical lactation care and advocates for the use of a multidisciplinary approach that involves clinicians, community lactation support, family members, employers, and childcare providers to help parents overcome obstacles to their desired infant feeding approach</u> ~~clinical lactation care provided by qualified clinicians and clinical professionals~~.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 433 be amended by addition of a second and third Resolve to read as follows:

RESOLVED, that our AMA will collaborate with other physician specialty organizations to support educating physicians on the myriad of lactation personnel with information as to the education and competencies of each credential so that physicians can make appropriate referrals and patients can receive the risk-appropriate care that they need.

RESOLVED, that our AMA, in the interest of patient safety, recognizes the importance of clinical lactation care provided by qualified individuals.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 433 be adopted as amended.

HOD ACTION: Resolution 433 be adopted as amended.

RESOLVED, that our American Medical Association recognizes the importance of clinical lactation care provided by qualified clinicians and clinical professionals.

Your Reference Committee heard unanimously supportive testimony for Resolution 433. However, one delegation proposed an amendment to provide a broader, multidisciplinary approach to what constitutes lactation support. This was unanimously supported in the in-person testimony. One delegation also proposed two new resolves and there was some support for these additional resolve clauses. However, the Reference Committee revised the language of the first resolve clause to more broadly address the importance of clinical lactation care, without highlighting specific certification bodies or health care professionals, which could limit access to care and increase disparities, particularly in rural and other remote settings that don't have access to those certified specialists. Your Reference Committee was also concerned about including specific certifying bodies within policy as these may change over time. Due to the overall supportive proposed amendments, your Reference Committee recommends adoption of Resolution 433 as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(31) RESOLUTION 405 - HEALTH WARNING LABELS ON ALCOHOLIC BEVERAGE CONTAINERS
RESOLUTION 417 - UPDATING ALCOHOL HEALTH WARNING LABELS TO REFLECT EVIDENCE-BASED HEALTH RISKS AND SUPPORTING NATIONAL LABELING AND SIGNAGE POLICY REFORM
RESOLUTION 425 - ALCOHOL CONSUMPTION AND HEALTH

RECOMMENDATION:

Your Reference Committee recommends that alternate Resolution 405 be adopted in lieu of Resolution 405, Resolution 417, and Resolution 425.

SUPPORTING LABELING AND DIETARY GUIDELINE CLARITY FOR ALCOHOLIC BEVERAGES

RESOLVED, That our American Medical Association support federal and state legislation and regulations requiring standardized, front-of-package labeling on all alcoholic beverages that discloses:
(a) the number of standard drinks per container and aligns with current guidelines on alcohol consumption; and
(b) the best available science, including appropriate 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 legislation and regulations ensuring:
(a) alcohol labeling is presented with sufficient prominence, legibility, and design features, such as minimum font size, and color contrast, and optional pictorial elements, to enhance readability and support informed decision-making across populations; and
(b) 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 extending alcohol labeling requirements to "non-alcoholic" or "zero proof" beverages that are manufactured, packaged, or marketed in a manner similar to alcoholic beverages, to

ensure consistent transparency regarding alcohol content (New HOD Policy); and be it further

RESOLVED, that our American Medical Association continue to strongly urge the Dietary Guidelines Advisory Committee 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 (Directive to Take Action); and be it further

RESOLVED, That our AMA submit a public comment in response to the Alcohol and Tobacco Tax and Trade Bureau's proposed rule on Alcohol Facts Statements, calling for labeling standards that include standard drink information, health risk disclosures, consumer-centric design, and harmonization with federal dietary guidance and emerging public health evidence (Directive to Take Action); and be it further

RESOLVED, that our AMA support research and evaluation initiatives to determine 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)

HOD ACTION: Alternate Resolution 405 be adopted in lieu of Resolution 405, Resolution 417, and Resolution 425.

RESOLUTION 405 - HEALTH WARNING LABELS ON ALCOHOLIC BEVERAGE CONTAINERS

RESOLVED, that our AMA 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; 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.

RESOLUTION 417 - UPDATING ALCOHOL HEALTH WARNING LABELS TO REFLECT EVIDENCE-BASED HEALTH RISKS AND SUPPORTING NATIONAL LABELING AND SIGNAGE POLICY REFORM

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; 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; 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.

RESOLUTION 425 - ALCOHOL CONSUMPTION AND HEALTH

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; 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 a updated warning label to congress that includes cancer risk.

Online testimony on Resolutions 405, 417, and 425 was mostly supportive, but there were some calls to amend and combine the alcohol-related resolutions and some proposed ways of doing so. In drafting the preliminary report, your Reference Committee agreed that streamlining and combining the related resolutions would make the most sense for our AMA to have clear, consistent policy and to ensure that the policy has the highest impact. At the in-person hearing, alternate Resolution 405 was largely supported, and it was noted that your Reference Committee "really ate with this one." The authors of resolution 425 noted that they would have preferred that their first Resolve be included in this alternate resolution. Your Reference Committee notes that a letter was sent earlier this year by the AMA to the US Department of Health and Human Services and the U.S. Department of Agriculture encouraging them to reassess alcohol limit guidelines as part of the Scientific Report of the 2025 Dietary Guidelines. However, your Reference Committee agrees that it is important to adopt policy that continues to strongly urge the Dietary Guidelines Advisory Committee 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. Therefore, your Reference Committee recommends that alternate Resolution 405 be adopted.

(32) RESOLUTION 426 - ADDRESSING PATIENT SAFETY AND ENVIRONMENTAL STEWARDSHIP OF SINGLE-USE AND REUSABLE MEDICAL DEVICES

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 426 be adopted in lieu of Resolution 426.

RESOLVED, that our American Medical Association encourages appropriate stakeholders to lead the development of standardized, evidence-based life-cycle assessments for single-use versus reusable medical devices, with physician input as end users.

HOD ACTION: Alternate Resolution 426 be adopted in lieu of Resolution 426.

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).

Your Reference Committee heard mixed testimony on this resolution. One individual felt reaffirmation of existing AMA policy D-480.955, *Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room*, was warranted, while another supported the intent of the resolution but felt that the level of technical expertise required on this subject was outside of the purview of the AMA. A delegation commented that while it agreed with the overall intent of the resolution, they opposed the resolution in its current form in part due to issues of feasibility and scope in the first resolve. Another person proposed referral for study. An alternate first Resolve clause was proffered, which was supported by others testifying. Your Reference Committee believes the proposed alternate resolution addresses the original intent of the resolution and does not support referral for study since AMA only recently completed a report on reusable versus single-use equipment in 2023. Thus, your Reference Committee recommends that alternate Resolution 426 be adopted.

(33) RESOLUTION 427 - ELEVATE OBESITY AS A STRATEGIC OBJECTIVE

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 427 be adopted in lieu of Resolution 427.

ELEVATE OBESITY AS AN AMA PUBLIC HEALTH PRIORITY

RESOLVED, that our American Medical Association elevate obesity to be one of its public health priorities (Directive to Take Action).

HOD ACTION: Alternate Resolution 427 be adopted in lieu of Resolution 427.

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).

Your Reference Committee heard mostly supportive testimony on this item. Testimony in support from multiple delegations and sections noted the impact of obesity on the U.S. population and highlighted the importance for the AMA to take action on addressing this issue by making it a priority. Testimony noted it is also important to address prevention and treatment to allow health care professionals to intervene as early as possible to improve health outcomes. The Board of Trustees noted that there would need to be careful consideration on how AMA would get the resources to adequately prioritize this work if it became a strategic objective and proffered an amendment to address this concern while keeping the intent of the resolution. An alternate resolution was proffered that called for elevating obesity to a “public health priority,” along with current AMA priorities of hypertension and pre-diabetes which are often comorbidities associated with obesity. Your Reference Committee agrees with this alternate resolution because it elevates obesity as a priority but also addresses the Board of Trustees concern about calling out obesity as a strategic objective. Your Reference Committee included a title change to accurately reflect the ask in the alternate resolution. Further, a delegation and an individual online were in support of referral of this item noting that before adopting this resolution, there needs to be data supporting that there are no long-term complications or adverse health effects from treatment, and that the potential effects on health care premiums should be examined. However, given the overall support of this resolution, your Reference Committee recommends that alternate Resolution 427 be adopted.

(34) RESOLUTION 432 - SUPPORT FOR LONG-TERM SEQUELAE OF PREGNANCY

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 432 be adopted in lieu of Resolution 432.

ADDRESSING LONG-TERM SEQUELAE OF PREGNANCY

RESOLVED, that our American Medical Association support research to reduce disparities in maternal health outcomes, including research on the long-term health sequelae and treatment of pregnancy-related diseases and diseases diagnosed or identified during pregnancy; and be it further

RESOLVED, that our AMA will support further insurance coverage 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)

HOD ACTION: Alternate Resolution 432 be adopted in lieu of Resolution 432.

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)

Your Reference Committee heard generally supportive testimony with multiple delegations voicing support for the resolution as drafted. One delegation provided a total rewrite of the first Resolve to more accurately describe the long-term health sequelae and treatment of pregnancy-related diseases and diseases diagnosed or identified during pregnancy. The proposed amendment was unanimously supported. Finally, one individual proposed an amendment to the language of second Resolve to ensure insurance was

addressed as broadly as possible. Your Reference Committee also thought a title change would bring clarity to the overall intention of this resolution. In light of the significant amendments to the original resolution, your Reference Committee recommends adoption of alternate Resolution 432.

RECOMMENDED FOR REFERRAL

(35) RESOLUTION 404 - IMPROVING PUBLIC AWARENESS OF LUNG CANCER SCREENING AND CAD IN CHRONIC SMOKERS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 404 be referred.

HOD ACTION: Resolution 404 be referred.

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)

Your Reference Committee heard mixed online testimony. In general, delegations and individuals were supportive of the overall aims of the resolution. However, three delegations support referral for study, whereas two delegations and one individual support the resolution with amendments to: (1) develop and disseminate guidelines for the use of LDCT instead of promoting education and awareness in the first Resolve and (2) add support for population health research on joint outcomes of lung cancer and coronary artery disease screening. In person testimony was almost unanimously supportive of referral. A few sections raised concerns around underutilization of LDCT screening among chronic smokers, the needs of specific populations (e.g., veterans), and the limited data in support of LDCT for lung cancer in detecting coronary artery calcification. Due to the overall support for the spirit of the resolution and acknowledgement of the need for more research, your Reference Committee recommends that Resolution 404 be referred.

(36) RESOLUTION 408 - REMOVING ARTIFICIAL TURF IN SCHOOLS, PARKS, AND PUBLIC PLACES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 408 be referred.

HOD ACTION: Resolution 408 be referred.

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)

Your Reference Committee heard testimony that was largely in support of referral on this resolution. While the resolution authors provided testimony in support of adoption noting the health concerns around chemicals and plastics in artificial turf, increased risk of injury, and absorption of heat, others testifying felt more study was appropriate. Those in support of referral noted that grass fields are more challenging for adaptive-sports users (i.e., wheelchair athletes) and in parts of the country with challenging weather conditions during the winter, and thus considerations should be made to make sports fields accessible for all athletes. Due to the majority of testimony being in support of referral, your Reference Committee recommends referral of Resolution 408.

(37) RESOLUTION 421 - MITIGATING AIR AND NOISE POLLUTION FROM AVIATION IN MINORITY COMMUNITIES DISPROPORTIONATELY IMPACTED AND VULNERABLE COMMUNITIES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 421 be referred.

HOD ACTION: Resolution 404 be referred.

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)

Your Reference Committee heard mixed testimony for this resolution. While there was support for the intent of this resolution, there were multiple calls for referral. Those in support of referral noted that while the resolution addresses an important and preventable public health problem that disproportionately impacts low-income and minority communities, the specific asks within the current resolution (numbers 1 through 5) should not be accepted as official AMA policy without the study to support them. One individual proposed amending the resolution text and separating it into two different polices – one that addresses noise pollution and one that addresses air pollution from aviation. However, no specific amendment text was proffered. Due to multiple delegations in support of referral and the original resolution authors noting they were okay with referral, your Reference Committee recommends referral of Resolution 421.

(38) RESOLUTION 424 - SUPPORTING THE INTEGRATION OF BLOOD PRESSURE VARIABILITY DATA IN ELECTRONIC MEDICAL RECORDS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 424 be referred.

HOD ACTION: Resolution 404 be referred.

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)

Your Reference Committee heard testimony largely in support of referral for further study, noting that more research is needed regarding blood pressure variability thresholds prior to electronic health record integration. Even the resolution author noted further information is warranted and supported referral. Therefore, your Reference Committee recommends Resolution 424 be referred.

RECOMMENDED FOR FILING

(39) BOARD OF TRUSTEES REPORT 25 – AMA PUBLIC HEALTH STRATEGY UPDATE

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 25 be filed.

HOD ACTION: Board of Trustees Report 25 be filed.

This informational report covers activities between March 2024 and March 2025 and is an effort to provide regular updates on the status of the AMA's mission critical public health work to the House of Delegates (HOD).

Board of Trustees Report 25 is an informational report that provides an annual update on the AMA's public health work through March of 2025. This report was extracted, and it was noted by those who testified that this report is missing the point and fails to address recent developments that threaten U.S. public health infrastructure and workforce. However, there was no specific recommendation offered. Since this is an annual report, your Reference Committee encourages the Board of Trustees to further outline how it is addressing the recent, unprecedented threats to public health infrastructure in its next annual report.

This concludes the report of Reference Committee D. I would like to thank Kevin Bernstein, MD, MMS, Jean Hausheer, MD, Daniel Kerekes, MD, MHS, George Morris, MD, Michael Visenio, MD, MPH, Sriharsha Sripadrao, MS, and all those who testified before the Committee as well as our AMA staff Andrea Garcia, Jane Sachs, Lindsey Realmuto, and Mary Soliman.

Kevin Bernstein, MD, MMS
American Academy of Family Physicians

George Morris, MD (Alternate)
Minnesota

Jean Hausheer, MD (Alternate)
Oklahoma

Michael Visenio, MD, MPH
American College of Surgeons

Daniel Kerekes, MD, MHS
Connecticut

Sriharsha Sripadrao, MS
Regional Medical Student Delegate, Georgia

Kim Templeton, MD
American Academy of Orthopaedic Surgeons
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Final Report of Reference Committee E

Charles Van Way, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Science and Public Health Report 5 – Screening for Image Manipulation in Research Publications
2. Resolution 501 – Safer Buttons/Coin Batteries
3. Resolution 504 – Physician Performed Microscopy Designation for Synovial Fluid Crystal Exam: Modify the Clinical Laboratory Amendment of 1988
4. Resolution 513 - Transparency on Comparative Effectiveness in Direct-to-Consumer Advertising
5. Resolution 516 – Creating a Registry of Potential Side Effects of GIP & GLP-1 Medications
6. Resolution 518 – Mandatory Accreditation and Regular Inspections of Hyperbaric Chambers
7. Resolution 519 – Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making

RECOMMENDED FOR ADOPTION AS AMENDED

8. Council on Science and Public Health Report 1 – Council on Science and Public Health Sunset Review of 2015 House Policies
9. Council on Science and Public Health Report 8 – Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms
10. Council on Science and Public Health Report 9 – Rare Disease Advisory Councils
11. Resolution 502 – NIH Grant Funding for Medical Research
12. Resolution 503 – Safeguarding Neural Data Collected by Neurotechnologies
13. Resolution 506 – Opposing the use of harm reduction items as evidence of commercial sex work
14. Resolution 507 Clinical and Public Safety Implications of AI-Generated Content and Symbolic Compliance Infrastructure and Resolution
15. Resolution 509 – Allergen Labeling for Spices and Herbs
16. Resolution 510 - Improving Cybersecurity Standards for Healthcare Entities
17. Resolution 511 – Increased Transparency Among Psychotropic Drug Administration in Prisons
18. Resolution 512 – Preventing Drug-Facilitated Sexual Assault in Drinking Establishments

19. Resolution 515 – Nitrous Oxide Abuse
20. Resolution 517 – In Support of a National Drug Checking Registry
21. Resolution 522 – Access to Important and Essential Drugs

RECOMMENDED FOR ADOPTION IN LIEU OF

22. Resolution 514 – Support for a Nicotine Free Generation

RECOMMENDED FOR REFERRAL

23. Resolution 505 - Mandating Properly Fitting Lead Aprons in Hospitals
24. Resolution 508 - Standardizing Safety Requirements for Traditional and Rideshare-Based Non-Emergency Medical Transportation
25. Resolution 520 - Study of Grading Systems in AMA Board Reports

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

26. Resolution 521 – Warning Labels on OTC Sleep Aids

Amendments

If you wish to propose an amendment to an item of business, click here:
Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 5 - SCREENING FOR IMAGE MANIPULATION IN RESEARCH PUBLICATIONS

RECOMMENDATION:

Your Reference Committee recommends the recommendations in Council on Science and Public Health Report 5 be adopted and the remainder of the report be filed.

HOD ACTION: CSAPH Report 5 be adopted and the remainder of the report be filed.

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:

The policy H-460.972, "Fraud and Misrepresentation in Science," be amended by addition to read as follows:

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;
Our AMA supports the promotion, through AMA publications and other vehicles, of
A clear understanding of the scientific process, possible sources of error, and the difference between intentional and unintentional scientific misrepresentation.
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.
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.
Our AMA supports the sharing of information about scientific misconduct among institutions, funding agencies, professional societies, and biomedical research journals
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.
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.
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)

That policy H-460.980, "Ethical and Societal Considerations in Research" be reaffirmed. (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony for this report, noting the timely need for policy regarding the concerns for augmented intelligence interfering with the authenticity and validity of research and scholarship. The original authors of the resolution, which resulted in this report, supported the report's recommendations despite this study pivoting from their initial request given the feasibility and the potential for duplicating current academic efforts. Therefore, your Reference Committee recommends that Council on Science and Public Health Report 5 be adopted.

(2) RESOLUTION 501 – SAFER BUTTONS/COIN BATTERIES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 501 be <u>adopted</u>.

HOD ACTION: Resolution 501 be <u>adopted</u>.

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)

Your Reference Committee heard unanimously supportive testimony for this resolution, noting the many injuries that batteries can cause to children and infants. Therefore, your Reference Committee recommends this resolution be adopted.

(3) RESOLUTION 504 - PHYSICIAN PERFORMED MICROSCOPY DESIGNATION FOR SYNOVIAL FLUID CRYSTAL EXAM: MODIFY THE CLINICAL LABORATORY AMENDMENT OF 1988

RECOMMENDATION:

Your Reference Committee recommends that Resolution 504 be <u>adopted</u>.

HOD ACTION: Resolution 504 be <u>adopted</u>.

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)

Your Reference Committee heard unanimously supportive testimony on this resolution. It was noted that there previously was a mechanism for physician input into this process, but that mechanism has been closed. Therefore, your Reference Committee recommends that Resolution 504 be adopted.

(4) RESOLUTION 513 - TRANSPARENCY ON COMPARATIVE EFFECTIVENESS IN DIRECT-TO-CONSUMER ADVERTISING

RECOMMENDATION:

Your Reference Committee recommends that Resolution 513 be <u>adopted</u>.

HOD ACTION: Resolution 513 be <u>adopted</u>.

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)

Your Reference Committee heard supportive testimony on Resolution 513. Testimony noted that the proposed policy is in line with existing policy from other physician organizations and that direct-to-consumer advertising is a pervasive issue in the United States. Your Reference Committee notes the similarities with existing policy, but recognizes the resolution broadens the scope and oversight over direct-to-consumer advertising claims. Testimony noted that this should apply not just to television advertising but also to digital and social media advertisements. Your Reference Committee agrees that social media advertising would be an important place for this work but agrees the language in the resolve statement is broad enough to be inclusive of all advertising as written. Therefore, your Reference Committee recommends that Resolution 513 be adopted.

(5) RESOLUTION 516 - CREATING A REGISTRY OF POTENTIAL SIDE EFFECTS OF GIP & GLP-1 MEDICATIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 516 be adopted.

HOD ACTION: Resolution 516 be adopted.

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).

Your Reference Committee heard extensive and mixed testimony on resolution 516. Testimony against this resolution noted that GLP-1 drugs have been available since at least 2006 with almost 20 years of existing data and a sizeable amount of peer-reviewed research demonstrating safety in patients with diabetes. Additionally, testimony noted that a new registry is unnecessary as the FDA has a public registry on adverse drug events, the FDA Adverse Event Reporting System (FAERS). In contrast, considerable testimony raised concerns regarding the widespread usage of GIP and GLP-1 drugs outside of patients with diabetes, especially in relation to pregnancy. The potential side effects associated with long-term usage were also noted repeatedly. Given the broader utilization of GIP and GLP-1 drugs, your Reference Committee recommends that Resolution 516 be adopted.

(6) RESOLUTION 518 - MANDATORY ACCREDITATION AND REGULAR INSPECTIONS OF HYPERBARIC CHAMBERS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 518 be adopted.

HOD ACTION: Resolution 518 be adopted.

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)

Your Reference Committee heard supportive testimony on this resolution noting that there has been widespread usage of hyperbaric chambers for many indications both medical and non-medical. Testimony noted that while there are approximately 1,200 hyperbaric chamber facilities in the U.S., only 200 are accredited. In addition to the recent death of a child in Michigan, there have been numerous other tragedies over decades. In online testimony, one delegation recommended amending the resolution by asking AMA to advocate that accreditation be necessary for payor reimbursement of hyperbaric therapy. There was no additional support for this potential amendment. There was some testimony suggesting a change in the title noting that hyperbaric chambers are inspected and facilities are accredited. Your Reference Committee thought the current title was sufficient. Therefore, your Reference Committee recommends that Resolution 518 be adopted.

(7) RESOLUTION 519 - FRAMEWORK TO CONVEY EVIDENCE-BASED MEDICINE IN AI TOOLS USED IN CLINICAL DECISION MAKING

RECOMMENDATION:

Your Reference Committee recommends that Resolution 519 be <u>adopted</u>.

HOD ACTION: Resolution 519 be <u>adopted</u>.

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)

Your Reference Committee heard copious and passionate testimony regarding Resolution 519. It was noted that augmented intelligence (AI) is moving quickly and there is a strong interest in being proactive with our policy. Authors of this resolution noted the need to build a framework of collaborators, including our AI Task Force among other stakeholders, to fully understand how to effectively and accurately convey the quality of medical evidence for use as a clinical decision-making tool. As such, your Reference Committee recommends that Resolution 519 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(8) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 - COUNCIL ON SCIENCE AND PUBLIC HEALTH SUNSET REVIEW OF 2015 HOUSE POLICIES

RECOMMENDATION A:

Your Reference Committee recommends that Council on Science and Public Health Report 1 be amended by addition to read as follows:

That our AMA policies listed in the appendix to this report be acted upon in the manner indicated, with the exception of policy D-65.995, which should be amended by addition and deletion to read as follows:

Health Disparities Among ~~Gay, Lesbian, Bisexual, Transgender and Queer~~ LGBTQ+ Families

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~~.

RECOMMENDATION B:
Your Reference Committee recommends that Council on Science and Public Health Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 1 be adopted as amended and the remainder of the report be filed.

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)

Your Reference Committee heard limited but supportive testimony for the annual sunset review of 2015 policies, with editorial amendments to align grammar and/or person-first language where appropriate. A CDC representative proposed amendments to expand several policies. The proposed amendments were determined to be outside the scope of the sunset review process, which is limited to retaining the policy, sunsetting the policy, or retaining the policy in part. Therefore, your Reference Committee recommends that the recommendations be adopted as amended.

(9) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 8 - EXPLAINABILITY OF ARTIFICIAL/AUGMENTED INTELLIGENCE AND MACHINE LEARNING ALGORITHMS

RECOMMENDATION A:

Your Reference Committee recommends that the first recommendation of Council on Science and Public Health Report 8 be amended by addition and deletion to read as follows:

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 justified 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 qualified human ~~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)

RECOMMENDATION B:

Your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 8 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 8 be adopted as amended and the remainder of the report be filed.

The Council on Science and Public Health recommends that the following be adopted and that the remainder of the report be filed:

2. 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)

3. 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)

4. 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)

Your Reference Committee heard testimony that was largely supportive of the spirit and content of the report, highlighting the need for transparency of AI products. Additional testimony noted how explainability with AI products cannot be a substitute, but a supportive tool for safe and effective patient care. An amendment was proffered for language alignment across other work in this area. Another amendment with minor language adjustments was proposed to avoid boxing in the policy work of our AMA. Your Council rebutted that one portion of the amendment altered the meaning of the resolve substantially, which your Reference Committee agreed. It is recognized by testimony and by your Reference Committee that this is a novel area that requires continued study as this technology evolves. Therefore, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 8 be adopted as amended.

(10) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 9 – RARE DISEASE ADVISORY COUNCILS

RECOMMENDATION A:

Your Reference Committee recommends that the addition to Policy H-460.880 be amended by addition to read as follows:

Our AMA supports the establishment of Rare Disease Advisory Councils to inform policymakers and other interested parties about the unique challenges faced by patients with rare diseases and their caregivers. Rare Disease Advisory Councils should include voting representation from patients with rare disease and a range of physicians who specialize in the diagnosis and/or treatment of rare disease, among other interested parties.

RECOMMENDATION B:

Your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 9 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 9 be adopted as amended and the remainder of the report be filed.

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"
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.
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.
Our AMA supports the study, approval, and coverage of implantable medical devices and therapeutics via FDA Humanitarian Device Exemption for treatment of orphan diseases.
Our AMA supports the establishment of Rare Disease Advisory Councils to inform policymakers and other interested parties about the unique challenges faced by patients 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.

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)

Your Reference Committee heard mostly supportive testimony on this report, citing the need for awareness and support for patients with rare diseases. One amendment was proffered to ensure a variety of physicians are included in rare disease advisory councils. Another amendment sought to clarify that “range” of physicians means “at least two” physicians. Your Reference Committee recognizes that each state’s rare disease advisory committee is different, and we are therefore hesitant to be overly prescriptive. We ultimately felt that leaving the word “range” was sufficient. Testimony at the in-person hearing noted that an amendment was going to be submitted listing specific rare diseases. However, that amendment language was not received by your Reference Committee, and it was ultimately decided that listing specific rare diseases was unnecessary. Furthermore, an amendment was proposed to help foster specialized training for health care professionals and trainees. While important, your Reference Committee believes this amendment was outside the scope of this report. Your Reference Committee recommends that the recommendations in Council of Science and Public Health Report 9 be adopted as amended.

(11) RESOLUTION 502 - NIH GRANT FUNDING FOR MEDICAL RESEARCH

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 502 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA will work with the National Institutes of Health (NIH), other governmental funding agencies, and ~~other~~ relevant stakeholders to ~~1)~~ oppose arbitrary and unilateral caps on indirect costs, including facilities and administrative reimbursements, in federal grants (including NIH grants and other governmental funding agencies) or any funding policy that restricts critical early-stage and independent research as well as grant-funded training programs. ~~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)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 502 be amended by addition of a second Resolve to read as follows:

RESOLVED, that our AMA will work with the National Institutes of Health (NIH), other governmental funding agencies, and relevant stakeholders to protect the ability of research institutions to negotiate indirect cost rates to ensure the sustainability of federally funded biomedical research. (Directive to Take Action)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 502 be adopted as amended.

HOD ACTION: Resolution 502 be adopted as amended.

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)

Your Reference Committee heard extensive supportive testimony highlighting the urgent need for our AMA to advocate for federal research funding and oppose caps on indirect costs in federal grants, such as NIH grants. There were many amendments proffered online, that were included in the Preliminary Report. In-person testimony noted the importance of indirect funding going to support research and not to simply fund an institution, seeking a focused and sustainable model, and your Reference Committee agreed. As such, your Reference Committee recommends that Resolution 502 be adopted as amended.

(12) RESOLUTION 503 - SAFEGUARDING NEURAL DATA COLLECTED BY NEUROTECHNOLOGIES

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 503 be deleted.

~~**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**~~

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve of Resolution 503 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support legislative and regulatory efforts to protect the privacy and security of individuals' neurological data ~~patients and all people in the United States from risks to mental privacy, identity, and agency,~~ as well as protection from discrimination and inequality that may be caused by the use of neurotechnologies (New HOD Policy).

RECOMMENDATION C:

Your Reference Committee recommends that the third resolve of Resolution 503 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~reaffirm~~ recognizes that neural data is information obtained by measuring the activity of a person's central or peripheral nervous system through the use of neurotechnologies, but ~~and~~ neural data does not include ~~inferential~~ data inferred from nonneural information (New HOD Policy); and be it further

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 503 be adopted as amended.

HOD ACTION: Resolution 503 be adopted as amended.

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)

Your Reference Committee heard mixed but generally supportive testimony on Resolution 503. Online testimony included strong support for this resolution and emphasized the urgent need for regulations on data protection and privacy in commercial neurotechnology products. An amendment was submitted by the original authors to emphasize the definition of neural data. This amendment was agreed upon in further testimony. While other testimony suggested striking out the later resolve clauses to focus on the core intent of the resolution, others disagreed. Therefore, Your Reference Committee agrees with the initial proffered amendment and recommends Resolution 503 be adopted as amended.

(13) RESOLUTION 506 - OPPOSING THE USE OF HARM REDUCTION ITEMS AS EVIDENCE OF COMMERCIAL SEX WORK

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 506 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association supports the availability and access to harm reduction tools for ~~sex workers~~ people who exchange sex for money to protect their health and well-being (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve of Resolution 506 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA opposes the use of harm reduction tools as evidence in the prosecution of ~~sex workers~~ people who exchange sex for money.

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 506 be adopted as amended.

RECOMMENDATION D:

Your Reference Committee recommends that the title be changed of Resolution 506 to read as follows:

OPPOSING THE USE OF HARM REDUCTION ITEMS AS EVIDENCE OF EXCHANGING SEX FOR MONEY

HOD ACTION: Resolution 506 be adopted as amended with a title change.

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)

Your Reference Committee heard supportive testimony on Resolution 506. An amendment was proffered to ensure the usage of person-first language in the resolution. There was one piece of testimony that opposed this amendment, with concern that broadening the language implied that the term “sex-worker” was derogatory. However, others noted that the amendments help to target many groups, including people who are being sex trafficked. Therefore, Your Reference Committee recommends that Resolution 506 be adopted as amended.

(14) RESOLUTION 507 – CLINICAL AND PUBLIC SAFETY IMPLICATIONS OF AI-GENERATED CONTENT AND SYMBOLIC COMPLIANCE INFRASTRUCTURE

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 507 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association recognize the necessity of symbolic safety mechanisms—including, but not limited to 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

RECOMMENDATION B:

Your Reference Committee recommends that the third resolve of Resolution 507 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate for public and private entities developing or deploying generative AI in healthcare, education, and public communication to consider including ~~include~~ symbolic safety features such as authorship attribution, pediatric safeguards, fallback systems, and traceability mechanisms to potentially help ensure ethical and regulatory alignment across all deployment contexts. (Directive to Take Action)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 507 be adopted as amended with a title change .

HOD ACTION: Alternate Resolution 507 be adopted in lieu of Resolution 507 with a title change.

ENSURING TRANSPARENCY AND ACCOUNTABILITY IN CLINICAL USE OF AUGMENTED INTELLIGENCE

RESOLVED, That our American Medical Association (AMA) recognizes the need for clear disclosure to the healthcare provider whenever artificial intelligence (AI) is used in the delivery of clinical care, in order to ensure the safe, transparent, and accountable use of AI-generated content in clinical and public-health settings; and be it further

RESOLVED, That our AMA advocate that entities developing or deploying artificial-intelligence systems—including, but not limited to, generative AI, foundation models, neural networks, and other machine-learning approaches—in healthcare:
(a) establish and maintain a risk-based governance approach proportionate to the system's intended use and potential harm;
(b) implement relevant security measures and privacy protections;
(c) provide for clinically useful transparency, such as clear labeling of AI-generated outputs for end users, including disclosure of the algorithm's level of confidence in those outputs; and,
(d) implement risk management approaches throughout the AI lifecycle with particular emphasis on appropriate monitoring of the system for safety, clinical effectiveness, accuracy, and reliability, to help ensure ethical and regulatory alignment across all deployment contexts.

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)

Your Reference Committee heard copious and mixed testimony on Resolution 507. From all the testimony, it was clear that transparency in AI for clinicians and their patients is quickly evolving, and delegates are interested in policy to support their work. Your Council and others testified that this policy asks for a study while also actively recognizing and advocating for the evidence therein – placing the cart in front of the horse, potentially placing our AMA at risk for advocate in the absence of evidence. Your Reference Committee agreed that advocating for this work without the evidence to support would be premature, but also recognizes the interest for policy to drive work in this fast-moving industry. The resolution was amended to temper the language to support the work but provide flexibility as we gain more information. As such, your Reference Committee recommends Resolution 507 be adopted as amended.

(15) RESOLUTION 509 - ALLERGEN LABELING FOR SPICES AND HERBS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 509 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, that our American Medical Association support requirements for ~~transparent~~ <u>public</u> 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)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 509 be <u>adopted as amended.</u>

HOD ACTION: Resolution 509 be <u>adopted as amended.</u>

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)

Your Reference Committee heard limited but supportive testimony on this resolution. Testimony noted gaps in physicians' ability to diagnose and manage reactions in non-allergens, but was supportive of the amended language. As such, your Reference Committee recommends Resolution 509 be adopted as amended.

(16) RESOLUTION 510 - IMPROVING CYBERSECURITY STANDARDS FOR HEALTHCARE ENTITIES

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 510 be amended by addition and deletion to read as follows:

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, designed to support a risk-based approach with security-by-design principles that are subject to periodic review and updating. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 510 be adopted as amended.

HOD ACTION: Resolution 510 be adopted as amended.

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)

Your Reference Committee heard generally supportive testimony for this resolution. Online testimony noted concerns with the sweeping nature of minimum cybersecurity standards being too onerous financially and practically for smaller practices. Your Reference Committee addressed these concerns in the preliminary report and called for a risk-based approach using security-by-design principles, which provide flexibility and financial stability for cybersecurity, where larger institutions with a higher risk profile may need higher levels of security and can support a higher cost. The in-person testimony noted support for the Reference Committee's approach to this resolution, which provides an equitable solution for smaller practices. As such, your Reference Committee recommends Resolution 510 be adopted as amended.

(17) RESOLUTION 511 - INCREASED TRANSPARENCY AMONG PSYCHOTROPIC DRUG ADMINISTRATION IN PRISONS

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 511 be amended by deletion to read as follows:

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)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 511 be adopted as amended.

HOD ACTION: Resolution 511 be adopted as amended.

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)

Your Reference Committee heard supportive testimony on this resolution. Amendments were suggested to broaden the categorization to include all jails and prisons. Your Reference Committee thought the best approach was to delete reference to “state and federal” to focus the policy on jails and prisons broadly and make it inclusive of privately owned prisons as well. An amendment was proffered removing the requirements of oversight by a physician, however testimony in opposition of this amendment prevailed primarily due to scope of practice concerns. Therefore, your Reference Committee recommends that Resolution 511 be adopted as amended.

(18) RESOLUTION 512 - PREVENTING DRUG-FACILITATED SEXUAL ASSAULT IN DRINKING ESTABLISHMENTS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 512 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support federal, state, and local efforts to prevent drug-facilitated sexual assault, including: 1) the legalization and provision of drug detection equipment in establishments that sell alcohol and 2) ~~through~~ the establishment of public education campaigns. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 512 be adopted as amended.

HOD ACTION: Resolution 512 be adopted as amended.

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)

Your Reference Committee heard limited, but supportive testimony on this resolution. Two amendments were proffered to add in language related to legalization and the establishment of public education campaigns for readability. Your Reference Committee agreed with these amendments. Therefore, your Reference Committee recommends that Resolution 512 be adopted as amended.

(19) RESOLUTION 515 – NITROUS OXIDE ABUSE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 515 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support efforts on the federal level to educate the public regarding the harmful effects of recreational use of inhaled nitrous oxide ~~use~~ and work with all relevant local stakeholders to limit the ability of non-medical facilities to acquire nitrous oxide for recreational inhalation purposes. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 515 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 515 be changed to read as follows:

NITROUS OXIDE MISUSE

HOD ACTION: Resolution 515 be adopted as amended with a title change.

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)

Your Reference Committee heard only supportive testimony on Resolution 515. Amendments were proffered to ensure the delineation between medical use and recreational use of nitrous oxide. The title revision ensures continuity with current AMA language policy. Therefore, your Reference Committee recommends that Resolution 515 be adopted as amended.

(20) RESOLUTION 517 - IN SUPPORT OF A NATIONAL DRUG CHECKING REGISTRY

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 517 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association study the creation of a national drug-checking data system ~~registry~~ that would provide a mechanism whereby community-run drug-checking services may communicate their de-identified results, with legal protections, data use agreements, and user opt-in/opt-out mechanisms. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 517 be adopted as amended.

HOD ACTION: Resolution 517 be adopted as amended.

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)

Your Reference Committee heard supportive testimony on this resolution. An amendment was submitted to avoid the use of the word “registry”, because it implied nefariously tracking people. The amendment recommended the words “data system” as an alternative, which was supported by the authors of the resolution. It was also noted results should be de-identified and there should be legal protections as well as user opt-in/opt-out mechanisms. Testimony was heard in support of the amended language; therefore, your Reference Committee recommends that Resolution 517 be adopted as amended.

(21) RESOLUTION 522 - ACCESS TO IMPORTANT AND ESSENTIAL DRUGS

RECOMMENDATION A:
Your Reference committee recommends that the second resolve clause of Resolution 522 be amended by addition to read as follows:

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 include, but not be limited to the following:

- **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)**

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 522 be adopted as amended.

HOD ACTION: Resolution 522 be adopted as amended.

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)

Your Reference Committee heard mostly supportive testimony for Resolution 522. Drug shortages were noted as a critical issue across practice areas and is a place for our AMA to make significant impact. An amendment was submitted by your Council to ensure the comprehensive approach towards drug shortages was not limited to the four items included in the resolution given the breadth of policy that has been developed on this issue through the Council's fourteen annual reports issued to this House. Your Reference Committee addressed this by keeping the word comprehensive but noting that the approach should not be limited to these four areas given the AMA's extensive existing drug shortage policy. Your Reference Committee recommends Resolution 522 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(22) RESOLUTION 514 - SUPPORT FOR A NICOTINE FREE GENERATION

RECOMMENDATION:

Your Reference Committee recommends that alternate Resolution 514 be adopted in lieu of Resolution 514.

RESOLVED, that our American Medical Association supports jurisdictional attempts to pilot a gradual phaseout of nicotine delivery (combustible and noncombustible) device sales as part of a multi-pronged approach to end the use of commercial tobacco and nicotine products in the United States; and be it further

RESOLVED, that our American Medical Association supports the availability of FDA-approved products for nicotine replacement therapy for cessation purposes when sales of commercial tobacco and all other nicotine products are phased out; and be it further

RESOLVED, that our American Medical Association supports periodic comprehensive evaluations of the impacts of commercial tobacco-free generation policies in jurisdictions that implement them so that pilot results can inform the refinement and potential broader implementation of such policies (Directive to Take Action); and be it further

RESOLVED, that our AMA develop model legislation to support a gradual phaseout of nicotine delivery (combustible and non-combustible) device sales to those born after a defined year throughout their lifetimes (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 jurisdictions where they practice and live. (Directive to Take Action)

HOD ACTION: Alternate Resolution 514 be adopted in lieu of Resolution 514.

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)

Your Reference Committee heard extensive and mixed testimony on Resolution 514. Several members who were in opposition to the resolution noted that it was largely impractical and compared nicotine free generation policies to alcohol prohibition, which was a failure. There was substantial testimony from both individuals and delegations praising nicotine-free policies, noting that some jurisdictions are already implementing nicotine free generations. It was mentioned that nicotine is different than alcohol and “never use” is an effective strategy with nicotine. Approximately 70 percent of people in the U.S. who smoke say they want to quit. Those who testified noted that the AMA should support these efforts. Numerous amendments were proffered to more broadly refer to jurisdictional policy so not to limit policy to local levels. An additional amendment included language to ensure FDA approved nicotine cessation products will not be included in nicotine-free generation policies. Your Reference Committee agreed with several of these amendments and recommends Alternate 514 be adopted in lieu of the original resolution 514.

RECOMMENDED FOR REFERRAL

(23) RESOLUTION 505 - MANDATING PROPERLY FITTING LEAD APRONS IN HOSPITALS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 505 be referred.

HOD ACTION: Resolution 505 be referred.

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.

Your Reference Committee heard generally supportive testimony on this resolution, regarding the need to ensure radiation safety through the stocking of appropriate personal protective equipment. However, it was also noted that your Council on Science and Public Health is currently studying this topic as directed by the House of Delegates at I-24. Multiple delegations recommended adding the ask of this resolution into the study underway with report back at I-25. As such, your Reference Committee recommends that Resolution 505 be referred.

(24) RESOLUTION 508 - STANDARDIZING SAFETY REQUIREMENTS FOR TRADITIONAL AND RIDESHARE-BASED NON-EMERGENCY MEDICAL TRANSPORTATION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 508 be referred.

HOD ACTION: Resolution 508 be referred.

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)

Your Reference Committee heard mixed testimony on this resolution. Those in support of this resolution noted that there are concerns with non-licensed transport options and this is a call for a study to examine this complex landscape. Those who spoke against this resolution noted that many organizations are already working on this and AMA does not

need to duplicate those efforts. There were also concerns that establishing such requirements on rideshare-based, non-emergency medical transportation may ultimately limit patient access to care and there was a preference to keep it simple. Given the mixed testimony on this item, your Reference Committee recommends Resolution 508 be referred.

(25) RESOLUTION 520 - STUDY OF GRADING SYSTEMS IN AMA BOARD REPORTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 520 be referred.

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)

Your Reference Committee heard limited but supportive testimony on this resolution. The online testimony received noted that since this is a grading system for Board reports, the Board's input would be beneficial, particularly with reporting back to the House of Delegates. The Board of Trustees noted that they were in support of referral of this resolution for study. Therefore, your Reference Committee recommends that this resolution be referred.

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

(26) RESOLUTION 521 - WARNING LABELS ON OTC SLEEP AIDS

RECOMMENDATION:

Your Reference Committee recommends that policy H-100.968 be reaffirmed in lieu of Resolution 521.

HOD ACTION: Policy H-100.968 be reaffirmed in lieu of Resolution 521.

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)

Your Reference Committee heard supportive testimony for reaffirmation of Improving the Quality of Geriatric Pharmacotherapy H-100.968 policy. Thus, your Reference Committee recommends that this policy be reaffirmed in lieu of Resolution 521.

Improving the Quality of Geriatric Pharmacotherapy H-100.968
Our AMA believes that the Food and Drug Administration should encourage manufacturers to develop low dose formulations of medications commonly used by older patients in order to meet the special needs of this group; require geriatric-relevant labeling for over-the-counter medications; provide incentives to pharmaceutical manufacturers to better study medication effects in the frail elderly and oldest-old in pre- and post-marketing clinical trials; and establish mechanisms for data collection, monitoring, and analysis of medication-related problems by age group.

This concludes the report of Reference Committee E. I would like to thank Po-Yin Samuel Huang, MD, FAAFP, Martha Menchaca, MD, Sandhya Malhotra, MD, Michael Medlock, MD, FAANS, FASAM, Erin Schwab, MD, MPH, Shalmali Bhadkamkar, and all those who testified before the Committee.

Po-Yin Samuel Huang, MD, FAAFP
California

Michael Medlock, MD, FAANS, FASAM
Massachusetts

Martha Menchaca, MD
Illinois

Erin Schwab, MD, MPH
American Society of Clinical Oncology

Sandhya Malhotra, MD
New York

Shalmali Bhadkamkar
Medical Student Section

Charles Van Way, MD, FACS
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Final Report of Reference Committee on Ethics and Bylaws

John Maa, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. BOT Report 02 - New Specialty Organizations Representation in the House of Delegates
2. BOT Report 18 - Physician Assisted Suicide
3. BOT Report 28 - Specialty Society Representation in the House of Delegates – Five-Year Review
4. CCB Report 02 - Concurrent Service on Councils and Section Governing Councils
5. CEJA Report 01 - The AMA Code of Medical Ethics Evolving to Provide Health Care Systems Ethics Guidance
6. CEJA Report 02 - Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization
7. CEJA Report 05 - Protecting Physicians Who Engage in Contracts to Deliver Health Care Services
8. CEJA Report 06 - Amendment to Opinion 1.1.1 “Patient-Physician Relationships”
9. CEJA Report 09 - Ethical Impetus for Research in Pregnant and Lactating Individuals
10. CEJA Report 10 - The Preservation of the Primary Care Relationship
11. CEJA Report 11 - CEJA Sunset Review of 2015 House Policies
12. CEJA Report 13 - Presumed Consent & Mandated Choice for Organs from Deceased Donors
13. Resolution 003 - Opposition to Censorship in Public Libraries
14. Resolution 005 - Dedicated Interfaith Prayer and Reflection Spaces in Medical Schools and Healthcare Facilities
15. Resolution 007 - Use of Inclusive Language in AMA Policy
16. Resolution 008 - Humanism in Anatomical Medical Education
17. Resolution 009 - Patient Centered Health Care as a Determinant of Health
18. Resolution 014 - Protecting Access to Emergency Abortion Care Under EMTALA
19. Resolution 015 - Addressing Targeting and Workplace Restrictions and Barriers to Healthcare Delivery by International Medical Graduate (IMG) Physicians and other Physicians Based upon Migration Status or Country of Origin within Healthcare Systems

RECOMMENDED FOR ADOPTION AS AMENDED

20. BOT Report 26 - Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
21. CCB Report 03 - Clarifying Bylaw Language
22. Resolution 001 - Opposition to Censuring Medical Societies or Organizations Based on Politics or Policies of Governments
23. Resolution 004 - Reducing the Harmful Impacts of Immigration Status on Health
24. Resolution 006 - Military Deception as a Threat to Physician Ethics
25. Resolution 010 - Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure
26. Resolution 011 - Opposition of Health Care Entities from Reporting Individual Patient Immigration Status
27. Resolution 012 - Carceral Systems and Practices in Behavioral Health Emergency Care
28. Resolution 013 - Continued Support of World Health Organization (WHO) & United States Agency for International Development (USAID)

RECOMMENDED FOR REFERRAL

29. *CCB Report 01 - Bylaws Review Report
30. CEJA Report 07 - Guidelines on Chaperones for Sensitive Exams
31. CEJA Report 08 - Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blinded Model for Organ Procurement and Transplantation

RECOMMENDED FOR NOT ADOPTION

32. Resolution 002 - Physician Disclosures of Relationships in Private Equity Held Organizations

If you wish to propose an amendment to an item of business, click here:
Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) BOT REPORT 02 - NEW SPECIALTY ORGANIZATIONS REPRESENTATION IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Your Reference Committee recommends that BOT Report 02 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in BOT Report 02 adopted and the remainder of the report filed.

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)

Online testimony was in unanimous support of the report. In-person testimony was minimal and in unanimous support of the report. Your Reference Committee recommends that the report be adopted.

(2) BOT REPORT 18 - PHYSICIAN ASSISTED SUICIDE

RECOMMENDATION:

Your Reference Committee recommends that BOT Report 18 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in BOT Report 02 adopted and the remainder of the report filed.

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.

The voluminous online testimony was generally in support of the report. In-person testimony was also largely in support of the report as written. In-person testimony proffered an amendment to strike the word “legally.” Both online and in-person testimony did not support the amendment. CEJA testified that removing the word “legally” would cause a conflict with the *Code* and recommended that the language not be amended. Additional testimony was offered to amend existing policy; however, the Speaker of the House testified that such policies cannot be amended in this way. Your Reference Committee recommends that the report be adopted.

(3) BOT 28 - SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES - FIVE-YEAR REVIEW

RECOMMENDATION:

Your Reference Committee recommends that BOT 28 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in BOT 28 adopted and the remainder of the report filed.

The Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:

1. The American Academy of Otolaryngic Allergy, American Association for Geriatric Psychiatry, American Association of Plastic Surgeons, American College of Legal Medicine, American College of Mohs Surgery, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Preventive Medicine, American College of Radiology, American College of Surgeons, American Society for Metabolic and Bariatric Surgery, American Society of Breast Surgeons, American Society of Cytopathology, American Society of Retina Specialists, Heart Rhythm Society, and Undersea and Hyperbaric Medical Society retain representation in the American Medical Association House of Delegates.

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in the AMA Bylaw B-8.5, the American Vein and Lymphatic Society and Society of Hospital Medicine be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership.

There was no online testimony due to this resolution being submitted in the tote. In-person testimony was limited and in unanimous support. Your Reference Committee recommends that the report be adopted.

(4) CCB REPORT 02 - CONCURRENT SERVICE ON COUNCILS AND SECTION GOVERNING COUNCILS

RECOMMENDATION:

Your Reference Committee recommends that CCB Report 02 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in CCB Report 02 adopted and the remainder of the report filed.

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 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)

Online testimony was in unanimous support of the report. The limited in-person testimony was in support, with one proffered amendment to include the AMA Foundation and AMPAC. CCB reviewed with legal counsel and testified that our AMA should not name separate corporate entities in the bylaws and are against the amendment. Your Reference Committee recommends that the report be adopted.

(5) CEJA REPORT 01 - THE AMA CODE OF MEDICAL ETHICS EVOLVING TO PROVIDE HEALTH CARE SYSTEMS ETHICS GUIDANCE

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 01 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in CEJA Report 01 adopted and the remainder of the report filed.

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.

Online testimony was mixed. There was no in-person testimony in opposition. Your Reference Committee recommends that the report be adopted.

(6) CEJA REPORT 02 - SUPPORTING EFFORTS TO STRENGTHEN MEDICAL STAFFS THROUGH COLLECTIVE ACTIONS AND/OR UNIONIZATION

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 02 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in CEJA 02 referred.

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)

Online testimony was in general support of the report. In-person testimony was in strong support. Your Reference Committee recommends that the report be adopted.

(7) CEJA REPORT 05 - PROTECTING PHYSICIANS WHO ENGAGE IN CONTRACTS TO DELIVER HEALTH CARE SERVICES

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 05 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in CEJA Report 05 adopted and the remainder of the report filed.

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.

(Modify HOD/CEJA Policy)

Online testimony was in unanimous support of the report. In-person testimony was mixed, with a majority in favor of the report. Testimony in opposition highlighted the need for further AMA policy to address physician contracts with private equity firms. In consideration of the online and in-person testimony, your Reference Committee recommends that the report be adopted.

(8) CEJA REPORT 06 - AMENDMENT TO OPINION 1.1.1 "PATIENT-PHYSICIAN RELATIONSHIPS"

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 06 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in CEJA 06 referred.

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 responsibility~~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)

Online testimony was in unanimous support of the report. In-person testimony was generally in favor of referral out of concern that the report does not address "political and administrative influence." Although these issues were raised, these concerns are addressed by several *Code of Medical Ethics* Opinions, including 1.1.3, 1.1.6, 1.2.10, 3.1.1, 3.1.2, 3.2.1, 10.6, 11.1.1, 11.1.4, 11.2.1, & 11.2.2. Your Reference Committee recommends that the report be adopted.

(9) CEJA REPORT 09 - ETHICAL IMPETUS FOR RESEARCH IN PREGNANT AND LACTATING INDIVIDUALS

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 09 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in CEJA 09 referred.

In consideration of the foregoing, the Council on Ethical and Judicial Affairs recommends the following:

1. That a new Code of Medical Ethics opinion be adopted as follows:

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.

2. Policy D-140.949 be rescinded as having been accomplished by this report and the remainder of this report be filed.

(New HOD/CEJA Policy)

Online testimony was in strong support. In-person testimony recommended referral. One delegation changed their initial online support to referral, calling for language in the report to state that researchers must explain why pregnant and lactating individuals should be automatically excluded from research. However, your Reference Committee notes that this language is already included in this report. Your Reference Committee recommends that the report be adopted.

(10) CEJA REPORT 10 - THE PRESERVATION OF THE PRIMARY CARE RELATIONSHIP

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 10 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendation in CEJA Report 10 adopted and the remainder of the report filed.

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

Online testimony was in unanimous support of the report. There was no in-person testimony in opposition. Your Reference Committee recommends that the report be adopted.

(11) CEJA REPORT 11 - CEJA'S SUNSET REVIEW OF 2015 HOUSE POLICIES

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 11 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations of CEJA Report 011 adopted and the remainder of the report filed.

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)

Online testimony was in unanimous support. There was no in-person testimony in opposition. Your Reference Committee recommends that the report be adopted.

(12) CEJA REPORT 13 - PRESUMED CONSENT & MANDATED CHOICE FOR ORGANS FROM DECEASED DONORS

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 13 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations of CEJA Report 013 adopted and the remainder of the report filed.

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

Online testimony was in unanimous support of the report. Limited in-person testimony was mixed. Your Reference Committee recommends that the report be adopted.

(13) RESOLUTION 003 - OPPOSITION TO CENSORSHIP IN PUBLIC LIBRARIES

RECOMMENATION:

Your Reference Committee recommends that Resolution 003 be adopted.

HOD ACTION: Resolution 003 adopted.

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)

Online testimony was in unanimous support. In-person testimony was in strong support. Your Reference Committee recommends that the resolution be adopted.

(14) RESOLUTION 005 - DEDICATED INTERFAITH PRAYER AND REFLECTION SPACES IN MEDICAL SCHOOLS AND HEALTHCARE FACILITIES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 005 be adopted.

HOD ACTION: First resolve clause of Resolution 005 be amended by deletion as follows:

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

Second resolve clause of Resolution 005 be amended by deletion as follows:

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~~,~~ and 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

Fourth resolve clause of Resolution 005 be amended by deletion as follows:

RESOLVED, that our AMA support the development, evaluation, and dissemination of best practices for implementing inclusive interfaith prayer~~,~~ and 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)

Resolution 005 adopted as amended.

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)

Online testimony was in unanimous support. In-person testimony was in general support. Testimony in opposition raised concerns about costs and feasibility. Your Reference Committee recommends that the resolution be adopted.

(15) RESOLUTION 007 - USE OF INCLUSIVE LANGUAGE IN AMA POLICY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 007 be <u>adopted.</u>

HOD ACTION: Resolution 007 <u>adopted.</u>

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)

Online testimony was in unanimous support. In-person testimony was generally in favor, with an amendment proffered without additional support. Your Reference Committee recommends that the resolution be adopted.

(16) RESOLUTION 008 - HUMANISM IN ANATOMICAL MEDICAL EDUCATION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 008 be adopted.

HOD ACTION: Resolution 008 adopted.

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)

Online testimony was in unanimous support. In-person testimony was mixed with opposition suggesting possible reaffirmation; however, the proposed resolution is not addressed by current AMA policy and thus reaffirmation is not applicable. Your Reference Committee recommends that the resolution be adopted.

(17) RESOLUTION 009 - PATIENT CENTERED HEALTH CARE AS A DETERMINANT OF HEALTH

RECOMMENDATION:

Your Reference Committee recommends that Resolution 009 be adopted.

HOD ACTION: Resolution 009 adopted.

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)

Online testimony was in strong support of the resolution. In-person testimony was in unanimous support. Your Reference Committee recommends that the resolution be adopted.

(18) RESOLUTION 014 - PROTECTING ACCESS TO EMERGENCY ABORTION CARE UNDER EMTALA

RECOMMENDATION:

Your Reference Committee recommends that Resolution 014 be adopted.

HOD ACTION: Resolution 014 adopted.

RESOLVED, that our American Medical Association reaffirm policy D-5.999 Preserving Access to Reproductive Health Services (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA advocate for the reinstatement of federal guidance affirming hospitals' obligation under EMTALA to provide necessary emergency pregnancy care, including, but not limited to, abortion care, to stabilize patients irrespective of state-level abortion restrictions (Directive to Take Action); and be it further

RESOLVED, that our AMA support legal and policy measures that protect physicians and other healthcare providers from criminal, civil, or professional repercussions when providing necessary emergency pregnancy care, including, but not limited to, abortion care, required under EMTALA (New HOD Policy); and be it further

RESOLVED, that our AMA collaborate with relevant stakeholders, including federal agencies, Congress, medical societies, and patient advocacy groups, to educate policymakers and healthcare providers on EMTALA obligations concerning emergency pregnancy care, including, but not limited to, necessary abortion care (Directive to Take Action); and be it further

RESOLVED, that our AMA task force established under AMA Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," provide ongoing 93 recommendations and updates on navigating conflicting state and federal regulations on emergency pregnancy care. (Directive to Take Action)

There was no online testimony due to this resolution being submitted in the tote. In-person testimony was in unanimous support with mention of the importance of the Supremacy Clause in the US Constitution regarding conflicts between state and federal laws. Testimony also conveyed the urgency of this resolution due to ongoing risks to patient health and an evolving legal landscape that place physicians in a position of choosing between upholding ethical standards or the law. Your Reference Committee recommends the resolution be adopted.

(19) RESOLUTION 015 - ADDRESSING TARGETING AND WORKPLACE RESTRICTIONS AND BARRIERS TO HEALTHCARE DELIVERY BY INTERNATIONAL MEDICAL GRADUATE (IMG) PHYSICIANS AND OTHER PHYSICIANS BASED UPON MIGRATION STATUS OR COUNTRY OF ORIGIN WITHIN HEALTHCARE SYSTEMS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 015 be adopted.

HOD ACTION: Resolution 015 adopted.

RESOLVED, that our American Medical Association work with relevant stakeholders to develop model workplace policies to address unfair treatment or targeting of physicians and other healthcare workers, based upon migration status or country of origin, during the regular performance of their duties within healthcare systems (Directive to Take Action); and be it further

RESOLVED, that our AMA study and develop model hospital and workplace policies to provide standardized procedures for addressing situations in which U.S. Immigration and Customs Enforcement (ICE) officers seek entry into “protected areas,” such as hospitals and healthcare settings to produce actions which may impact patient care or physician safety. (Directive to Take Action)

There was no online testimony as this resolution was placed in the tote. In-person testimony was in unanimous support. Your Reference Committee recommends that the resolution be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(20) BOT REPORT 26 - USING PERSONAL AND BIOLOGICAL DATA TO ENHANCE PROFESSIONAL WELLBEING AND REDUCE BURNOUT

RECOMMENDATION A:

Your Reference Committee recommends that BOT 26 be amended by addition of a new third recommendation as follows:

> **3. Any entity that collects physician personal health information or biological data must have transparent policies and procedures for secure data storage as well as its storage duration and deletion protocols.**

RECOMMENDATION B:

That BOT 26 be adopted as amended and the remainder of the report be filed.

> **HOD ACTION: Recommendations in BOT 26 adopted as amended and the remainder of the report filed.**

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.

Online testimony was in support of adoption with minor amendments. In-person testimony was mixed, with a majority in favor of adoption as amended. Your Reference Committee recommends that the report be adopted as amended.

(21) CCB REPORT 03 - CLARIFYING BYLAW LANGUAGE

RECOMMENDATION A:

Your Reference Committee recommends that section 2.1.1. of CCB Report 03 be amended by addition and deletion as follows:

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.

RECOMMENDATION B:

Your Reference Committee recommends that section 6.5.3.1 of CCB Report 03 be amended by addition and deletion as follows:

6.5.3.1 All questions involving membership as provided in the 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~~.

RECOMMENDATION C:

That CCB 03 Report 03 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations of CCB Report 03 adopted as amended and the remainder of the report filed.

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

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1.1.4 International Members

Physicians who have graduated from medical schools located outside the UnitedStates 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.

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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. 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)

Online testimony was in unanimous support of adoption of the report with proffered amendments for clarity and consistency. During in-person testimony, the authors offered an additional amendment for clarity and consistency, which received unanimous support. Your Reference Committee recommends that the report be adopted as amended.

(22) RESOLUTION 001 - OPPOSITION TO CENSURING MEDICAL SOCIETIES OR ORGANIZATIONS BASED ON POLITICS OR POLICIES OF GOVERNMENTS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 001 be amended by addition and deletion:

> **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, of its host government ~~such that the art and science of medicine is kept separate from politics~~. (Directive to Take Action)**

RECOMMENDATION B:

That Resolution 001 be adopted as amended.

> **HOD ACTION: Resolution 001 adopted as amended.**

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)

Online testimony was generally in favor of adoption, with a minor amendment proffered. Limited in-person testimony was unanimously in favor of adoption as amended. Your Reference Committee recommends that the resolution be adopted as amended.

(23) RESOLUTION 004 - REDUCING THE HARMFUL IMPACTS OF IMMIGRATION STATUS ON HEALTH

RECOMMENDATION A:

That the second resolve of Resolution 004 be amended by addition as follows:

RESOLVED, that our AMA support pathways to citizenship for undocumented immigrants who entered the US as minors, including Deferred Action for Childhood Arrivals (DACA), temporary protected status (TPS) recipients, and Dreamers (New HOD Policy); and be it further

RECOMMENDATION B:

That Resolution 004 be adopted as amended.

HOD ACTION: Resolution 004 adopted as amended.

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)

Online testimony was in unanimous support. In-person testimony was in strong support. An amendment was proffered and accepted by the authors. Your Reference Committee recommends that the resolution be adopted as amended.

(24) RESOLUTION 006 - MILITARY DECEPTION AS A THREAT TO PHYSICIAN ETHICS

RECOMMENDATION A:

That the title of Resolution 006 be amended by deletion as follows:

~~Military~~ Deception as a Threat to Physician Ethics.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 006 be adopted as amended.

HOD ACTION: Title of Resolution 006 amended by deletion as follows:

~~Military~~ Deception as a Threat to Physician Ethics

Resolve of Resolution 006 amended by addition and deletion as follows:

RESOLVED, that our American Medical Association oppose ~~the~~ deceptive use of medical, public health, and humanitarian aid for activities that increase risk and/or reduce safety of healthcare personnel and the patient populations they serve. ~~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)

Resolution 005 adopted as amended

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)

Online testimony was in unanimous support. In-person testimony was in general support. An amendment was proffered and accepted by the authors. Your Reference Committee recommends that the resolution be adopted as amended.

(25) RESOLUTION 010 - MANAGING CONFLICT OF INTEREST INHERENT IN NEW PAYMENT MODELS—PATIENT DISCLOSURE

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve clause of Resolution 010 be deleted.

~~**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**~~

RECOMMENDATION B:

That Resolution 010 be adopted as amended.

HOD ACTION: Resolution 010 adopted as amended.

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).

Online testimony was in general support of the resolution with an amendment that the first resolve clause be deleted. During in-person testimony, the authors testified in support of the amendment; no other in-person testimony was offered. Your Reference Committee recommends that the resolution be adopted as amended.

(26) RESOLUTION 011 - OPPOSITION OF HEALTH CARE ENTITIES FROM REPORTING INDIVIDUAL PATIENT IMMIGRATION STATUS

RECOMMENDATION A:

Your Reference Committee recommends that the added subsection to Policy H-440.876 be further amended by addition as follows:

d. withholding federal funds if health care institutions fail to comply with policies which mandate collection of a patient's immigration status.

RECOMMENDATION B:

That Resolution 011 be adopted as amended.

HOD ACTION: Resolution 011 adopted as amended.

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)

Online testimony was in unanimous support. An amendment was proffered for consistency and clarity to recognize that the institutions mentioned refer to health care institutions. In-person testimony was in universal support of adoption as amended. Your Reference Committee recommends that the resolution be adopted as amended.

(27) RESOLUTION 012 - CARCERAL SYSTEMS AND PRACTICES IN BEHAVIORAL HEALTH EMERGENCY CARE

RECOMMENDATION A:

Your Reference Committee recommends that subsection 5(a) of Policy H-345.972 be amended by addition and deletion as follows:

> **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.**

RECOMMENDATION B:

That the fourth resolve of Resolution 012 be amended by addition as follows:

> **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 or necessary for the safety of the healthcare team (Directive to Take Action); and be it further**

RECOMMENDATION C:

That the fifth resolve of Resolution 012 be amended by deletion as follows:

> **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~~.**

RECOMMENDATION D:

That Resolution 012 be adopted as amended.

HOD ACTION: Resolution 012 adopted as amended.

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)

Online testimony was in general support, with minor amendments proffered. In-person testimony was in unanimous support of the resolution as amended, with an additional amendment proffered by CEJA and accepted by the author. Your Reference Committee recommends that the resolution be adopted as amended.

(28) RESOLUTION 013 - CONTINUED SUPPORT OF WORLD HEALTH ORGANIZATION (WHO) & UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

RECOMMENDATION A:

Your Reference Committee recommends that the second resolve of Resolution 013 be amended by addition and deletion as follows:

> **RESOLVED, that our AMA opposes any cuts to USAID (United States Agency for International Development) programs that would increase the risk of infection among vulnerable populations, that would increase the risk or burden of disability, ~~including senior citizens,~~ or that would withhold funding from critical initiatives supporting agriculture, economic development, environmental protection, education, democracy, human rights, and governance in developing countries. (Directive to Take Action)**

RECOMMENDATION B:

That Resolution 013 be adopted as amended.

> **HOD ACTION: Resolution 013 adopted as amended.**

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)

Online testimony was in strong support of the resolution, with proffered amendments citing the need to recognize that the WHO does valuable work related to disabilities and not just infectious diseases, and that a broader definition of vulnerable populations is needed. In-person testimony was in unanimous support of the amended resolution. Your Reference Committee recommends that the resolution be adopted as amended.

RECOMMENDED FOR REFERRAL

(29) CCB REPORT 01 – BYLAWS REVIEW REPORT

RECOMMENDATION:

Your Reference Committee recommends that CCB Report 01 be referred.

HOD ACTION: Recommendations in CCB Report 01 referred.

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 4four-year term.

6.9.3.2 Resident/Fellow Physician Member. If the resident/fellow physician member of these Councils ceases~~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)

Online testimony was mixed regarding whether to adopt the report as written or adopt it with a proffered amendment. In-person testimony was mixed. An amendment was proffered, though there was testimony regarding whether to amend, refer, adopt, or not adopt the report. Testimony in favor of amendment held that the proposed language conflicts with the current selection process and creates a burdensome timeline. Testimony in support of the report as written highlighted that this is meant to create congruency within the bylaws. Due to the strongly conflicting testimony, your Reference Committee recommends the report be referred.

(30) CEJA REPORT 07 - GUIDELINES ON CHAPERONES FOR SENSITIVE EXAMS

RECOMMENDATION:

Your Reference Committee recommends that CEJA Report 07 be referred.

HOD ACTION: Recommendations of CEJA Report 017 referred.

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)

Online testimony was generally in favor of referral. In-person testimony was strongly in favor of referral to address a multitude of different challenges, such as conflicting state laws and policies, patient distrust and refusal, economic sustainability, and varying clinical scenarios. Your Reference Committee recommends that the report be referred.

(31) CEJA REPORT 08 - LAYING THE FIRST STEPS TOWARDS A TRANSITION TO A FINANCIAL AND CITIZENSHIP NEED BLINDED MODEL FOR ORGAN PROCUREMENT AND TRANSPLANTATION

RECOMMENDATION:

That CEJA Report 08 be referred.

HOD ACTION: Recommendations of CEJA Report 08 adopted and the remainder of the report filed.

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)

Online testimony was in unanimous support of the report. In-person testimony was offered by groups that had previously testified online in support to move for referral, citing that the language “clinically relevant” created a “loophole” that weakened the purpose of the report. Your Reference Committee recommends that the report be referred.

RECOMMENDED NOT FOR ADOPTION

(32) RESOLUTION 002 - PHYSICIAN DISCLOSURES OF RELATIONSHIPS IN PRIVATE EQUITY HELD ORGANIZATIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 002 be not adopted.

HOD ACTION: Resolution 002 not adopted.

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)

Online testimony was in general opposition to the resolution. Limited in-person testimony was unanimously in support of not adopting the resolution. Your Reference Committee recommends that the resolution be not adopted.

Madam Speaker, this concludes the report of Reference Committee on Ethics and Bylaws. I would like to thank Dr. Rose Berkun, Dr. Mary Campagnolo, Dr. Stuart Glassman, Dr. Brady Iba, Dr. Leslie Secrest, and Dr. Clarence Chou and all those who testified before the committee.

Rose Berkun, MD
Florida Medical Association

Mary Campagnolo, MD, MBA
Medical Society of New Jersey

Stuart Glassman, MD, MBA
American Academy of Physical Medicine and Rehabilitation

Brady Iba, DO
Oklahoma State Medical Association

Leslie Secrest, MD
Texas Medical Association

Clarence Chou, MD
American Academy of Child and Adolescent Psychiatry

John Maa, MD
California Medical Association
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Final Report of Reference Committee F

Michael B. Simon, MD, MBA, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 4 - AMA 2026 Dues

2. Board of Trustees Report 22 - Ranked Choice Voting

3. Report of the House of Delegates Committee on the Compensation of the Officers

4. Council on Long Range Planning and Development Report 1 - International Medical Graduates Section Five-Year Review

5. Council on Long Range Planning and Development Report 2 - Organized Medical Staff Section Five-Year Review

6. Resolution 603 - Renaming the Minority Affairs Section to the Underrepresented in Medicine Advocacy Section

RECOMMENDED FOR ADOPTION AS AMENDED

7. Board of Trustees Report 23 - Financial Assistance to Facilitate Attendance at MSS Meetings

8. Board of Trustees Report 24 - Creation of an AMA Council with a Focus on Digital Health Technologies and AI

9. Council on Constitution and Bylaws/Council on Long Range Planning and Development Report 1 - Joint Council Sunset Review of 2015 House Policies

10. Resolution 602 - Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations

Amendments
If you wish to propose an amendment to an item of business, click here:
A25 HOD AMENDMENT

11. Resolution 604 - Advisory Committee on Tribal Affairs

RECOMMENDED FOR REFERRAL

12. Resolution 601 - AMA to Develop Patient Educational Materials Regarding Ultra-processed Foods for Distribution by AMA Members

RECOMMENDED FOR FILING

13. Board of Trustees Report 1 - Annual Report

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 4 - AMA 2026 DUES

RECOMMENDATION:

Your Reference Committee recommends that the Recommendation in Board of Trustees Report 4 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 4 adopted and the remainder of the Report filed.

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)

Testimony was limited but generally favorable. While one individual raised concern about the sustainability of the tiered AMA dues structure, the 2024 Annual Report highlights a 3.1% increase in dues-paying members—marking the 13th year of growth in the past 14 years. Your Reference Committee commends our AMA Board of Trustees for their continued fiscal discipline in maintaining dues levels and for their ongoing success in demonstrating a strong value proposition to our members.

Your Reference Committee recommends that Board of Trustees Report 4 be adopted.

(2) BOARD OF TRUSTEES REPORT 22 - RANKED CHOICE VOTING

RECOMMENDATION:

Your Reference Committee recommends that the Recommendation in Board of Trustees Report 22 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 22 adopted and the remainder of the Report filed.

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.

Board of Trustees Report 22 is presented in response to Policy G-610.009, which directs our AMA to study the use of ranked choice voting for all House of Delegates elections. Study findings indicate that ranked choice voting presents concerns with adhering to AMA policy, reporting outcomes, and administering fair and expedient elections. Based on these findings, Board of Trustees Report 22 proposes retention of the current system used in AMA elections and recommends recission of Policy G-610.009.

Testimony in favor of ranked choice voting indicated that it is an efficient and fair system that enhances transparency. Concerns about being able to report vote totals and the impact of eliminating runoff elections were cited in testimony opposed to ranked choice voting. Further opposing testimony noted potential security concerns and the burden of switching to a new election system. Additional testimony called for further study on specific aspects of using ranked choice voting and its implications on our elections.

Your Reference Committee recommends that Board of Trustees Report 22 be adopted.

(3) REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in the Report of the House of Delegates Committee on Compensation of the Officers be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in the Report of the House of Delegates Committee on the Compensation of the Officers adopted and the remainder of the Report filed.

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 representation days.

2. That the definition of the Governance Honorarium be revised as follows:

   The purpose of this payment is to 1) compensate the Board Chair, Chair-Elect, Presidents and Speakers for all Chair-assigned internal and external AMA work and related travel, and 2) compensate other Officers, excluding Board Chair, Chair-Elect, Presidents and Speakers, 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 with organizations in ~~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 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, Chair Elect, Presidents, and Speakers, 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 external 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.

Testimony was limited but generally supportive. One individual expressed concern, citing a comparison between prior authorization calls and governance meetings. While your Reference Committee acknowledges our colleague's frustration, we support the

recommendations put forth by the House of Delegates Committee on Compensation of the Officers.

Your Reference Committee recommends that the Report of the House of Delegates Committee on Compensation of the Officers be adopted.

(4) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 - INTERNATIONAL MEDICAL GRADUATES SECTION FIVE-YEAR REVIEW

RECOMMENDATION:

Your Reference Committee recommends that the Recommendation in Council on Long Range Planning and Development Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Council on Long Range Planning and Development Report 1 adopted and the remainder of the Report filed.

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)

Based on the Council on Long Range Planning and Development's positive review and the favorable testimony for renewal of delineated status for the International Medical Graduates Section, your Reference Committee recommends that CLRPD Report 1 be adopted.

(5) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 2 - ORGANIZED MEDICAL STAFF SECTION FIVE-YEAR REVIEW

RECOMMENDATION:

Your Reference Committee recommends that the Recommendation in Council on Long Range Planning and Development Report 2 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Council on Long Range Planning and Development Report 2 adopted and the remainder of the Report filed.

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)

Supportive testimony was received for renewal of delineated status for the Organized Medical Staff Section. Your Reference Committee recommends that CLRPD Report 2 be adopted.

(6) RESOLUTION 603 - RENAMING THE MINORITY AFFAIRS SECTION TO THE UNDERREPRESENTED IN MEDICINE ADVOCACY SECTION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 603 be adopted.

HOD ACTION: Resolution 603 adopted.

RESOLVED, that our American Medical Association Minority Affairs Section (MAS) be renamed the Underrepresented in Medicine Advocacy Section (UMAS). (Directive to Take Action)

Testimony in response to Resolution 603 was overwhelmingly supportive, noting that the term “minority” is outdated and not inclusive.

There were concerns, however, that the requested name change could pose unintended consequences, such as limiting the function of the section or excluding certain populations from representation. Supportive testimony from the author and others confirmed that the intent of the name change is to be more inclusive of underrepresented physicians without precluding ways to address the needs of specific populations of patients or physicians in the future.

Your Reference Committee wishes to note that AMA Policy B-7.0.1, “Mission of the Sections,” describes activities and responsibilities that facilitate advocacy and representation of the unique interests of each Section. The policy is applicable to all Sections.

Your Reference Committee recommends that Resolution 603 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(7) BOARD OF TRUSTEES REPORT 23 - FINANCIAL ASSISTANCE TO FACILITATE ATTENDANCE AT MSS MEETINGS

RECOMMENDATION A:

Your Reference Committee recommends that the Recommendation in Board of Trustees Report 23 be amended by addition and deletion to read as follows:

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

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 develop a mechanism ~~explore alternate mechanisms~~ to provide financial assistance to facilitate medical student leadership attendance at ~~MSS~~ the Annual and Interim Medical Student Section meetings, ~~with a report back~~ to be implemented no later than ~~at~~ the ~~2025~~ 2026 Annual Meeting, subject to confirmation by the AMA's outside tax counsel that such mechanism will not result in adverse tax or other legal consequences to the AMA. (Modify HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendations in Board of Trustees Report 23 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 23 adopted as amended and the remainder of the Report filed.

The Board of Trustees recommends that the following be adopted and the reminder of the report be filed:

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)

Your Reference Committee notes that the testimony presented by our Board of Trustees emphasized that the primary focus of Board Report 23 is the exploration of alternative funding mechanisms. These mechanisms referenced by the Board are intended to identify funding sources external to our AMA, rather than to propose the expansion of existing AMA grant programs or the establishment of new ones. Furthermore, your Reference Committee acknowledges that Board Report 23 cites potential tax implications for both our AMA and medical students who may receive travel assistance directly from the Association.

Specifically, the amended language reflects that our AMA develop a plan to provide financial support for MSS leaders whose service is integral to the planning and execution of Medical Student Section Annual and Interim Section meetings. It was noted that criteria for providing financial support must consider tax implications for the Association, to reduce the risk of loss to our non-profit status.

Testimony from the Board of Trustees indicated that to reduce the risk to the organization, any direct AMA funding mechanism must include at least, but not limited to: a cap on the number of attendees, an application process, that it not be a subsidy, there be demonstrated financial need, and reporting that shows benefit to the organization.

The Reference Committee encourages the Board of Trustees to work in conjunction with the Medical Student Section in the development of the eligibility criteria for financial support.

Your Reference Committee believes this language enables our Board of Trustees to maintain its fiduciary responsibilities while allowing financial support of medical students actively contributing to the work of the Medical Student Section Assembly Meeting.

Your Reference Committee recommends that Board of Trustees Report 23 be adopted as amended.

(8) BOARD OF TRUSTEES REPORT 24 - CREATION OF AN AMA COUNCIL WITH A FOCUS ON DIGITAL HEALTH TECHNOLOGIES AND AI

RECOMMENDATION A:

Your Reference Committee recommends that the Recommendation in Board of Trustees Report 24 be amended by addition and deletion to read as follows:

The Board of Trustees recommends that our AMA Task Force on AI, Digital Health, and Informatics work toward an informed recommendation on the long-term model for HOD input with a report back at the 2026 Interim meeting ~~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.

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendation in Board of Trustees Report 24 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 24 adopted as amended and the remainder of the Report filed.

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.

Board of Trustees Report 24 describes the formation and work of our AMA Task Force on AI, Digital Health, and Informatics. The report also outlines related AMA resources and policies.

Testimony reflected concern over rescinding AMA Policy G-615.998, "Creation of an AMA Council with a Focus on Digital Health Technologies and AI," noting that the work of the Task Force is ongoing. Based on the testimony presented, our Board of Trustees is supportive of amending the report's recommendation to align with the approved two-year charter for the Task Force.

While your Reference Committee acknowledges testimony in support of establishing a council, it wishes to note that Policy G-615.998 calls for the creation of a task force with the potential to transition to a new council. Additionally, the Board report notes that the Task Force was established "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."

Accordingly, your Reference Committee recommends that Board of Trustees Report 24 be adopted as amended.

(9) COUNCIL ON CONSTITUTION AND BYLAWS/COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 - JOINT COUNCIL SUNSET REVIEW OF 2015 HOUSE POLICIES

RECOMMENDATION A:

Your Reference Committee recommends that the Recommendation in Council on Constitution and Bylaws/Council on Long Range Planning and Development Report 1 be amended by addition to read as follows:

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, with the exception of Policy G-615.035, which should be retained, and the remainder of this report be filed.

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendation in Council on Constitution and Bylaws/Council on Long Range Planning and Development Report 1 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendation in Council on Constitution and Bylaws/Council on Long Range Planning and Development Report 1 adopted as amended and the remainder of the Report filed.

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.

The Joint Council Sunset Review of 2015 House Policies called for sunset of AMA Policy G-615.035, "Technology and the Practice of Medicine," which is based on the belief that the policy is superseded by more recent policies, including G-615.998, "Creation of an AMA Council with a Focus on Digital Health Technologies and AI."

Testimony opposing sunset of Policy G-615.035 indicated that Board of Trustees Report 24-A-25, "Creation of an AMA Council with a Focus on Digital Health Technologies and

AI," called for sunset of Policy G-615.998. The latter policy calls for the establishment of a task force with the potential to transition this task force to a new council. Testimony further noted that only the task force has been formed, and the establishment of an AMA council has not yet been fully vetted.

Given our Board of Trustees has committed to issuing a follow-up report at the 2026 Interim Meeting, testimony supported, and your Reference Committee agrees, that there should be no immediate change to current policy. Therefore, your Reference Committee recommends that this report be adopted as amended.

(10) RESOLUTION 602 - ENABLING AMA BOT EXPEDIENCY FOR ACTIONS, ADVOCACY, AND RESPONSES DURING URGENT SITUATIONS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve in Resolution 602 be amended by addition and deletion to read as follows:

4. In urgent situations, the Board of Trustees ~~has the~~ will exercise its authority to take ~~such action as it determines is~~ appropriate action. ~~in urgent situations to take those policy actions that the Board deems best represent the interests of patients, physicians, and the AMA.~~ The Board shall make decisions that it deems to best represent the interests of patients, physicians, and to advocate for science and public health. ~~In representing AMA policy in critical situations, the~~ 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.

RECOMMENDATION B:

Your Reference Committee recommends that AMA Policy G-600.071 be amended by addition and deletion to read as follows:

5. 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 Trustees advocacy and action.

6. 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.

4.7. Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input.

RECOMMENDATION C:

Your Reference Committee recommends that the second and third Resolves in Resolution 602 be amended by deletion to read as follows:

~~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).~~

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 602 be adopted as amended.

HOD ACTION: Resolution 602 adopted as amended.

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).

Testimony provided by the author of Resolution 602 reflected that the intent is to highlight circumstances in which our AMA Board of Trustees should consider responding to urgent and transformational developments affecting public health and science in the United States. The author noted that the resolution's language was re-crafted in collaboration with AMA legal counsel to ensure alignment with the duties and responsibilities of our Board of Trustees as defined in our AMA Bylaws. Amended language for item four was suggested in testimony for purposes of succinctness and clarity, which your Reference Committee found preferable to the amended language proposed by the author.

While acknowledging that the proposed amendments bear resemblance to existing AMA policy, the author asserted that the changes more clearly delineate the circumstances under which our Board of Trustees might be expected to take action on issues of significance. Testimony from others was generally supportive, with minimal opposition. The limited concerns raised primarily related to the perception that the proposed changes are advisory in nature rather than directive.

After careful consideration, your Reference Committee concluded that the final two Resolve clauses do not constitute a new standalone policy. As such, your Reference Committee recommends an amendment to incorporate illustrative examples of transformational events and federal funding reductions into existing AMA policy.

Your Reference Committee recommends that Resolution 602 be adopted as amended.

(11) RESOLUTION 604 - ADVISORY COMMITTEE ON TRIBAL AFFAIRS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 604 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association: (1) ~~consider~~ establish~~ing~~ and report back at the 2025 Interim Meeting on the formation of ~~an Advisory Committee~~ Task Force 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 have direct experience working with AI/AN communities at Indian Health Service federal direct-care, Tribally-operated and/or Urban Indian Health Programs (I/T/U) ~~the Indian Health Service~~ to advise the Board of Trustees on how to implement policy specific to AI/AN communities and that the Task Force report back at the 2026 Annual Meeting with recommendations for the establishment of an Advisory Committee to ensure sustained attention to tribal health equity and Indigenous physician representation; 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)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 604 be adopted as amended.

HOD ACTION: Resolution 604 adopted as amended.

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)

Testimony in response to Resolution 604 was overwhelmingly supportive of establishing a new AMA Advisory Committee on Tribal Affairs. However, the Reference Committee noted testimony from our Board of Trustees, which emphasized that AMA Bylaws Section 5.3.9 assigns responsibility and authority for establishing committees, including advisory committees, to our Board of Trustees. Your Council on Long Range Planning and Development also testified that the established process for special interests is to form a caucus.

Testimony was divided on whether an advisory committee or a caucus would best accomplish the intent of Resolution 604. Your Reference Committee wishes to point out that AMA Policy G-615.002, “AMA Member Component Groups,” defines various aspects of an advisory committee and a caucus. Your Reference Committee suggests exploring these options and the merit of how each entity could support the unique perspectives of this population.

This approach enables our Board of Trustees to consider the broad input provided by our House of Delegates and to return with a formal recommendation for consideration at the 2025 Interim Meeting.

Your Reference Committee recommends that Resolution 604 be adopted as amended.

RECOMMENDED FOR REFERRAL

(12) RESOLUTION 601 - AMA TO DEVELOP PATIENT EDUCATIONAL MATERIALS REGARDING ULTRA-PROCESSED FOODS FOR DISTRIBUTION BY AMA MEMBERS

RECOMMENDATION A:

Your Reference Committee recommends that the first resolve of Resolution 601 be adopted.

HOD ACTION: The first resolve of Resolution 601 adopted.

RECOMMENDATION B:

Your Reference Committee recommends that the second resolve of Resolution 601 be referred.

HOD ACTION: The second resolve of Resolution 601 referred.

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)

Your Reference Committee received generally supportive testimony in response to Resolution 601.

With respect to the first Resolve, testimony indicated that our AMA is already making efforts to accommodate the dietary and religious needs of meeting participants. These efforts include the provision of inclusive and affordable food options at various venues, including our AMA headquarters, without imposing specific preferences.

Regarding the second Resolve, the author's testimony reflected concern over the fiscal note associated with this proposal. The author clarified that the intent was for our AMA to collaborate with interested stakeholders to adapt and utilize existing patient education materials developed by Federation members. It was further anticipated that these materials would be distributed electronically, minimizing associated costs. Given the clarification, your Reference Committee recommends referral of the second Resolve to identify: (a) existing educational materials available among Federation members, (b)

potential for providing these materials in various languages, and (c) potential partners interested in working with our AMA to make this content accessible via our AMA website.

Your Reference Committee recommends that the first Resolve be adopted and the second Resolve be referred.

RECOMMENDED FOR FILING

(13) BOARD OF TRUSTEES REPORT 1 - ANNUAL REPORT

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 1 be filed.

HOD ACTION: Board of Trustees Report 1 filed.

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.

Although limited in scope, the testimony received was supportive of our AMA's financial position. In the Annual Report, our Board of Trustees reaffirmed the organization's top priorities that are collectively promoted under the initiative, "This is why we fight:"

- Reforming Medicare payment;
- Fixing prior authorization;
- Fighting scope creep;
- Reducing physician burnout; and
- Making technology work for physicians.

Your Reference Committee notes that in addition to the testimony several inquiries were raised regarding AMA membership dues, revenue derived from CPT®, and the potential direction of the organization under new executive leadership. Your Reference Committee would like to emphasize that it meets quarterly with our AMA Board of Trustees Finance Committee to review operational and financial matters in greater detail.

Your Reference Committee recommends that the Annual Report be filed.

This concludes the report of Reference Committee F. I would like to thank Emily D. Briggs, MD, MPH, Robert A. Gilchick, MD, MPH, Hillary Johnson-Jahangir, MD, PhD, Richard F. Labasky, MD, MBA, Brandi N. Ring, MD, MBA, Jayesh B. Shah, MD, MHA, and all those who testified before the Committee.

Emily D. Briggs, MD, MPH
American Academy of Family Physicians

Richard F. Labasky, MD, MBA
Utah

Robert A. Gilchick, MD, MPH
American College of Preventive Medicine

Brandi N. Ring, MD, MBA
American College of Obstetricians and Gynecologists

Hillary Johnson-Jahangir, MD, PhD
American Academy of Dermatology Association

Jayesh B. Shah, MD, MHA
Texas

Michael B. Simon, MD, MBA
American Society of Anesthesiologists
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2025 Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Final Report of Reference Committee G

Christine Kim, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 19 – Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
2. Council on Medical Service Report 1 – Council on Medical Service Sunset Review of 2015 House Policies
3. Council on Medical Service Report 4 – Requiring Payment for Physician Signatures
4. Council on Medical Service Report 7 – Impact of Patient Non-Adherence on Quality Scores
5. Resolution 708 – Advocating Against Prior Authorization for In-Person Visits with Physicians
6. Resolution 709 – Allowing Timely Access to Pain Medications in Discharged Hospital and Ambulatory Surgery Patients
7. Resolution 712 – Billing and Collections Transparency
8. Resolution 717 – Promoting Medication Continuity and Reducing Prior Authorization Burdens
9. Resolution 719 – Comprehensive AMA Policy Publication Regarding Employed Physicians

RECOMMENDED FOR ADOPTION AS AMENDED

10. Board of Trustees Report 6 – Transparency and Accountability of Hospitals and Hospital Systems
11. Council on Medical Service Report 3 – Regulation of Corporate Investment in the Health Care Sector
12. Resolution 702 – Strengthening Health Plan Accountability for Physician Satisfaction
13. Resolution 703 – Appropriate Use of Data from Surgical Practices
14. Resolution 706 – Increasing Transparency Surrounding Medicare Advantage Plans
15. Resolution 707 – Simplifying Correspondence from Health Insurers
16. Resolution 714 – Root Cause Analysis of the Causes of the Decline of Private Medical Practice

17. Resolution 715 – Grace Period for Timely Filing Due to Technology Failures Regardless of Cause
18. Resolution 716 – Minimum Payer Communication Quality Standards

RECOMMENDED FOR REFERRAL

19. Resolution 701 – Electronic Health Records Contract Termination
20. Resolution 704 – Mitigating the Impact of Excessive Prior Authorization Processes
21. Resolution 710 – Requiring Insurances to Apply Discounted Cost Medication to the Patient's Deductible
22. Resolution 711 – Study of Practice Models for Physicians Working Across State Lines

RECOMMENDED FOR REFERRAL FOR DECISION

23. Resolution 718 – Safeguarding Medical Staff Bylaws and Accreditation Standards in VA Facilities

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

24. Resolution 705 – Elimination of Transaction Fees for Electronic Healthcare Payments
25. Resolution 713 – Aiding Members of Medical Staffs

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 19 – USING PERSONAL AND BIOLOGICAL DATA TO ENHANCE PROFESSIONAL WELLBEING AND REDUCE BURNOUT

RECOMMENDATION:

Your Reference Committee recommends that the Recommendation in Board of Trustees Report 19 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 19 adopted and the remainder of the report filed.

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.

Your Reference Committee heard unanimously supportive testimony on Board of Trustees Report 19, including from the sponsors of the resolution that prompted this report. Thus, your Reference Committee recommends that the recommendation in Board of Trustees Report 19 be adopted and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 1 - COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2015 HOUSE POLICIES

RECOMMENDATION:

Your Reference Committee recommends that the Recommendation in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendation in Council on Medical Service Report 1 adopted and the remainder of the report filed.

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.

Your Reference Committee heard supportive testimony on Council on Medical Service Report 1. Therefore, your Reference Committee recommends that the recommendation in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 4 - REQUIRING PAYMENT FOR PHYSICIAN SIGNATURES

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 4 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 4 adopted and the remainder of the report filed.

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)

Your Reference Committee heard mostly supportive testimony on Council on Medical Service Report 4. Two delegations and an individual expressed support for the report's recommendations, citing the importance of the broader language offered in Recommendation 1. An individual and a delegation proffered opposing amendments regarding the phrase "established and future CPT codes" in Policy D-320.978. The individual recommended retaining it to ensure that support would not be inadvertently withdrawn for CPT codes dedicated to prior authorization, while the delegation recommended that sections 4a and 4b be reinstated with the specific exception of that phrase, to reflect the intent of the resolution more accurately. No additional testimony was offered in support of either amendment. One delegation testified against the report, citing that advocacy addressing administrative burden would be a better focus than pursuit of additional CPT codes, especially given budget neutrality limitations. Your Reference

Committee believes the recommendations of the report address the concerns of the delegation. With minimal support for the amendments and support for the report's original recommendations, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be adopted and the remainder of the report be filed.

(4) COUNCIL ON MEDICAL SERVICE REPORT 7 - IMPACT OF PATIENT NON-ADHERENCE ON QUALITY SCORES

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 7 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 7 adopted and the remainder of the report filed.

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)

Your Reference Committee heard unanimously supportive testimony on Council on Medical Service Report 7. Testimony indicated that the report appropriately addressed the concerns outlined in the original resolution and balanced the physician's role in adherence with actions that are not under physician control. Therefore, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be adopted and the remainder of the report be filed.

(5) RESOLUTION 708 - ADVOCATING AGAINST PRIOR AUTHORIZATION FOR IN-PERSON VISITS WITH PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 708 be adopted.

HOD ACTION: Resolution 708 adopted.

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)

Testimony on Resolution 708 was overwhelmingly supportive. Testimony supporting the resolution was received from one individual and four delegations, and one delegation submitted a clarification request. The delegation that submitted the clarification request asked for additional information regarding whether this resolution is specific to any procedures, evaluation types, follow-up, and/or office visits, or if this resolution is requesting that prior authorization be removed from any in-person office visit. In addition, this delegation also inquired if there are scenarios where an insurance company requires a patient to meet with a non-physician provider prior to being able to meet with a physician. Support for Resolution 708 was clear, and although your Reference Committee believes

answers to the posed clarifying questions would assist future AMA efforts in implementing this resolution, it is recommended that Resolution 708 be adopted.

(6) RESOLUTION 709 - ALLOWING TIMELY ACCESS TO PAIN MEDICATIONS IN DISCHARGED HOSPITAL AND AMBULATORY SURGERY PATIENTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 709 be adopted.

HOD ACTION: Resolution 709 adopted.

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)

Your Reference Committee heard generally supportive testimony on Resolution 709 as written and against reaffirmation. Online testimony supported reaffirmation of this resolution, but in-person testimony highlighted how Resolution 709 differs from current AMA policy (e.g., H-125.974) and emphasized how this resolution will help ensure that patients can access their prescribed pain medications without having to obtain prior authorization approval or overcome other administrative barriers to care. Your Reference Committee recommends that Resolution 709 be adopted.

(7) RESOLUTION 712 - BILLINGS AND COLLECTIONS TRANSPARENCY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 712 be adopted.

HOD ACTION: Resolution 712 adopted.

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).

Your Reference Committee heard mostly supportive testimony on Resolution 712. There was testimony online and in-person that was supportive of the resolution as written. One delegation supported the spirit of the resolution but suggested that much of the added language is reaffirmation and called for ensuring that the correct entities are addressed to petition these changes. One delegation spoke in favor of reaffirmation. Testimony highlighted that the amendments to Policy H-225.950 in the original resolution were important and are needed to protect physicians from retaliation when they seek to review billing and collections information. An individual suggested a second order amendment to

strike the physician's right to override the initial decisions by revenue cycle management entities, but subsequent testimony addressed these concerns by stating that with proper training, this issue can be addressed. Other testimony in support of the original language stated that the language the second order amendment wanted to strike was a critical part of physician autonomy and should be retained. Your Reference Committee found this testimony compelling and therefore, your Reference Committee recommends that Resolution 712 be adopted.

(8) RESOLUTION 717 - PROMOTING MEDICATION CONTINUITY AND REDUCING PRIOR AUTHORIZATION BURDENS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 717 be adopted.

HOD ACTION: Resolution 717 adopted.

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)

Testimony on Resolution 717 was overwhelmingly supportive. Several delegations supported the resolution as written both online and in-person. Testimony supported this resolution because patients frequently experience care delays and disruptions due to circumstances beyond their control, including losing a job, transitioning between insurance plans, or simply aging out of parental coverage, and these disruptions too often lead to unnecessary prior authorization delays, gaps in medication access, and preventable harms to patient health. Furthermore, testimony stated that reducing these barriers can help protect patients from harm and reduce administrative burdens placed on practices, allowing for more time to focus on care delivery rather than paperwork. Your Reference Committee recommends that Resolution 717 be adopted.

(9) RESOLUTION 719 - COMPREHENSIVE AMA POLICY PUBLICATION REGARDING EMPLOYED PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 719 be adopted.

HOD ACTION: Resolution 719 adopted.

RESOLVED, that our American Medical Association comprehensively review the current landscape of the employment of physicians for report back to the House of Delegates at Annual 2026, including but not limited to:

- The changing context and expectations of different practice models
- Factors which have led to physicians increasingly choosing an employment practice model over independent practice
- The employed physician relationship with healthcare organizations, including those controlled by private equity
- The evolution of collective bargaining by, and unionization of, physicians;

(Directive to Take Action); and be it further

RESOLVED, that our AMA create a comprehensive policy publication, which will be an essential tool for employed physicians with guiding principles, rights, and responsibilities regarding, but not limited to, the following:

- Employment contracting
- Different compensation models
- Professional accountability to, and as a member of, the medical staff
- Primacy of the doctor-patient relationship within the context of employment;

(Directive to Take Action); and be it further

RESOLVED, that our AMA will have a comprehensive policy publication regarding employed physicians available to all physicians, in any employment model, and to all healthcare collaborators with the AMA who directly employ and/or have contracting arrangements with physicians (Directive to Take Action).

Your Reference Committee heard mostly supportive testimony on Resolution 719. Testimony highlighted that even though much of this information is available, it is fragmented, so the resolution aims to bring the information together in a cohesive way. There was concern that the language of the resolution is too narrow; however, the Reference Committee finds the phrasing “including but not limited to” broad enough to address these concerns and thus recommends that Resolution 719 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(10) BOARD OF TRUSTEES REPORT 6 - TRANSPARENCY AND ACCOUNTABILITY OF HOSPITALS AND HOSPITAL SYSTEMS

RECOMMENDATION A:

Your Reference Committee recommends that Recommendation 1 in Board of Trustees Report 6 be amended by addition to read as follows:

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 the Centers for Medicare & Medicaid Services quality websites 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.~~ (Modify HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendations in Board of Trustees Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 6 adopted as amended and the remainder of the report filed.

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.~~ (Modify HOD Policy)
2. That the remainder of this report be filed.

Your Reference Committee heard supportive testimony on Board of Trustees Report 6. One delegation provided testimony in favor of the report recommendations as written. An amendment was suggested by an individual, which the Reference Committee felt

strengthened the original recommendation. The Board of Trustees reviewed and accepted the amendment as in line with the original recommendation. Therefore, your Reference Committee recommends that the recommendations in Board of Trustees Report 6 be adopted as amended and the remainder of the report be filed.

(11) COUNCIL ON MEDICAL SERVICE REPORT 3 - REGULATION OF CORPORATE INVESTMENT IN THE HEALTH CARE SECTOR

RECOMMENDATION A:

Your Reference Committee recommends that Recommendation 1 in Council on Medical Service Report 3 be amended by addition and deletion to read as follows:

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~~ relationships 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~~ relationships 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~~ relationship.

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~~ relationships.

j. Prior to entering into a ~~partnership~~ relationship 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~~ relationships 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 establishes a corporate relationship ~~partners~~. (Modify HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that the Recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 3 adopted as amended and the remainder of the report filed.

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)

Your Reference Committee heard supportive testimony on Council on Medical Service Report 3. Supportive testimony included the individual who authored the resolution that prompted this report in support of the recommendations as written. An amendment was suggested to replace the term “partnerships” with “relationships” throughout the first recommendation, as the former has a legal connotation which may not apply to all situations, and the latter broadens the language of the policy further. The Council on Medical Service provided testimony in support of the amendment. Thus, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

(12) RESOLUTION 702 - STRENGTHENING HEALTH PLAN ACCOUNTABILITY FOR PHYSICIAN SATISFACTION

RECOMMENDATION A:

Your Reference Committee recommends Resolution 702 be amended by addition to read as follows:

RESOLVED, that our American Medical Association advocate for the NCQA to strengthen its health plan measurement framework by incorporating comprehensive, validated, and updated physician satisfaction metrics (Directive to Take Action).

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 702 be adopted as amended.

HOD ACTION: Resolution 702 adopted as amended.

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)

Your Reference Committee heard supportive testimony on Resolution 702. Testimony noted that incorporating physician satisfaction metrics would more accurately ensure a meaningful view of health plans. One individual proffered an amendment to include the language, “validated and updated,” suggesting that incorporating physician satisfaction metrics can be helpful only if they are relevant. Another individual proffered an amendment suggesting specific metrics should be utilized to capture the physician experience more accurately with health plans. However, your Reference Committee does not believe specific metrics are germane to the original intent of resolution and should not be included. Therefore, your Reference Committee recommends that Resolution 702 be adopted as amended.

(13) RESOLUTION 703 - APPROPRIATE USE OF DATA FROM SURGICAL PRACTICES

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 703 be amended by addition to read as follows:

RESOLVED, that our American Medical Association advocate for policies that ensure data collected from surgical practices, including but not limited to surgical video recordings, time on surgical console, operative times, and perioperative outcomes data, are used primarily to support

surgical education, quality improvement, ~~and~~ patient safety, and research and development with appropriate protections to prevent misuse (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 703 be amended by addition of a new second Resolve clause to read as follows:

RESOLVED, that our AMA oppose the use of surgical data collected for education, research and quality improvement as the sole or primary basis for legal proceedings, institutional hiring and firing practices, and reimbursement as they lack surgical context and complexity. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 703 be adopted as amended.

HOD ACTION: Resolution 703 adopted as amended.

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)

Your Reference Committee heard supportive online testimony on Resolution 703. The resolution was recommended for reaffirmation but the author, two delegations, and one individual testified in support of Resolution 703, and against reaffirmation, suggesting that while the policies outlined for reaffirmation appropriately emphasize physician involvement in data use, transparency, and quality improvement, they do not address the exponential growth of surgical data collection made possible by modern technologies. One delegation testified in support of reaffirmation suggesting that AMA policy already addresses the key components of Resolution 703. Additionally, one delegation testified in support of Resolution 703 with a proffered amendment to the first clause to clarify both the type of

data referenced and the second clause to reflect the clinical expertise required to interpret it. While no online testimony was offered in support of this amendment, one delegation, with the support of five other delegations, offered another amendment during in-person testimony to expand protections of and restrict the use of data. Your Reference Committee felt that amended language fulfilled the intent of the resolution and, therefore, recommended Resolution 703 be adopted as amended.

(14) RESOLUTION 706 - INCREASING TRANSPARENCY SURROUNDING MEDICARE ADVANTAGE PLANS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 706 be amended by deletion to read as follows:

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)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 706 be adopted as amended.

HOD ACTION: Resolution 706 adopted as amended.

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)

Your Reference Committee heard mostly supportive testimony on Resolution 706, stating that while transparency does not guarantee reform, it often helps and, therefore, Resolution 706 would bolster financial transparency of Medicare Advantage. One delegation proffered an amendment, suggesting that while networks should be public, contracts should not, and suggested removal of “provider contracts.” While there was no testimony against this amendment, one delegation expressed concern about the potential significant negative market effects that may be caused by total transparency and recommended referral. However, several delegations provided testimony in support of the amended resolution in subsequent testimony. Therefore, your Reference Committee recommends that Resolution 706 be adopted as amended.

(15) RESOLUTION 707 - SIMPLIFYING CORRESPONDENCE FROM HEALTH INSURERS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 707 be amended by deletion to read as follows:

RESOLVED, that our 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)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 707 be adopted as amended.

HOD ACTION: Resolution 707 adopted as amended.

RESOLVED, that our 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)

Your Reference Committee heard limited, but supportive testimony on Resolution 707. One delegation suggested an amendment to strike “regulation and” as it is unclear how correspondence would be regulated and stated that standardization is a reasonable first step toward the goal of this resolution. At the in-person hearing the author of the resolution provided testimony in support of the Reference Committee’s recommendation, which we interpret as acceptance of the proposed amended resolution. Your Reference Committee recommends that Resolution 707 be adopted as amended.

(16) RESOLUTION 714 - ROOT CAUSE ANALYSIS OF THE CAUSES OF THE DECLINE OF PRIVATE MEDICAL PRACTICE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 714 be amended by addition to read as follows:

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
7. Inadequate formal education on the business of medicine
8. Educational debt of early career physicians
9. Evolving lifestyle preference of early career physicians.
10. Overhead expenditures such as Electronic Health Records, personnel, and administrative costs.
11. Provider based facility fees charged by hospital employers but not by private practitioners.

(Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 714 be adopted as amended.

HOD ACTION: Resolution 714 adopted as amended.

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)

Your Reference Committee heard mostly supportive testimony on Resolution 714. Several delegations provided testimony in favor of adoption and believe this study will help the AMA uncover the causes in the shift away from private practice and inform advocacy on how to better support private practice physicians. There was an amendment that suggested to add three more topics of study. This amendment was well-received by the authors and subsequent testimony. One delegation and one individual provided testimony in favor of not adoption stating that while sympathetic to these concerns, many of the stated research proposals are known and it would be difficult to determine how each variable individually contributes to the decline of private practice. Your Reference Committee agrees with testimony stating that the findings of this study will be valuable and recommends that Resolution 714 be adopted as amended.

(17) RESOLUTION 715 - GRACE PERIOD FOR TIMELY FILING DUE TO TECHNOLOGY FAILURES REGARDLESS OF CAUSE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 715 be amended by addition to read as follows:

RESOLVED, that our American Medical Association advocate for a two-year grace period from the date of a claims processing failure due to technology failure, allowing payers to resolve claims before denying them based on a "timely filing limit." (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 715 be adopted as amended.

HOD ACTION: Resolution 715 adopted as amended.

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)

Your Reference Committee heard limited but supportive testimony on Resolution 715. One delegation proffered an amendment online, suggesting a shorter time frame would be more consistent with standard timely filing limits. However, the author recommended not adopting this amendment, citing the original intent of the resolution was to help physicians affected by the February 2024 Change Healthcare data breach. An additional amendment was proffered in-person by a delegation to specify claims processing failures due to technology failure. Your Reference Committee agreed that the amended language fulfilled

the intent of the resolution and therefore, your Reference Committee recommends that Resolution 715 be adopted as amended.

(18) RESOLUTION 716 - MINIMUM PAYER COMMUNICATION QUALITY STANDARDS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 716 be amended by addition of a new Resolve clause to read as follows:

RESOLVED, that our AMA advocate for the adoption of physician/provider satisfaction quality metrics for Medicare Advantage plan star ratings to measure the efficiency of health plan customer service, addressing provider questions and concerns, payment efficiency, and resolution of appeals. (Directive To Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 716 be adopted as amended.

HOD ACTION: Resolution 716 adopted as amended.

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)

Your Reference Committee heard unanimously supportive testimony on Resolution 716. Testimony indicated that augmented intelligence may be used to create efficiencies in the insurance industry and this resolution's intent is to mitigate the potential for these efficiencies to be at the expense of the physician practice. An individual proffered an amendment, suggesting that while the Centers for Medicare & Medicaid Services requires that Medicare Advantage track patient experience, they recommend that each plan be required to report similar metrics. Additional testimony supported the amendment. Your Reference Committee recommends that Resolution 716 be adopted as amended.

RECOMMENDED FOR REFERRAL

(19) RESOLUTION 701 - ELECTRONIC HEALTH RECORDS CONTRACT TERMINATION

RECOMMENDATION:

Your Reference Committee recommends Resolution 701 be referred.

HOD ACTION: Resolution 701 referred for decision.

RESOLVED, that our American Medical Association adopt as policy that Electronic Health Record (EHR) vendors provide physician practices with a minimum 180-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)

Your Reference Committee heard supportive testimony on Resolution 701. Testimony indicated that sudden termination of electronic health records (EHR) contracts can cause disrupted patient care, leading to potential increased risks for morbidity and mortality. The Council on Medical Service proffered amendments to reflect federal certification policy more accurately, adequately capture the legislative authority responsible for EHR vendors, and recommend that the AMA provide standard contract language which can be inserted into EHR contracts. The author was amenable to the Council's amendments but suggested that a 180-day minimum notification should be captured within the amended language as it is necessary to achieve seamless transfer to a new EHR. Further testimony agreed with the author, suggesting that a 180-day notification period would allow for unencumbered transfer of patient records to a different system. A delegation proffered another amendment to align the language with current AMA policy and promote a collaborative environment among the Office of the National Coordinator for Health Information Technology, Office for Science Technology Policy, and the AMA. In-person testimony was mixed, however. Two delegations expressed concern with the nuance of the amended language as it provides an arbitrary notification timeline, which raises concerns about the ability of less-resourced hospitals to meet this timeline. Therefore, testimony recommended referral to study the issue. Your Reference Committee agrees there is sufficient uncertainty regarding the appropriate notification period to warrant further study. Thus, your Reference Committee recommends Resolution 701 be referred.

(20) RESOLUTION 704 - MITIGATING THE IMPACT OF EXCESSIVE PRIOR AUTHORIZATION PROCESSES

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 704 be adopted.

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve clause of Resolution 704 be referred.

RECOMMENDATION C:

Your Reference Committee recommends that the third Resolve clause of Resolution 704 be adopted.

HOD ACTION: The first and third Resolve clauses of Resolution 704 adopted and the second Resolve clause of Resolution 704 referred.

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)

Your Reference Committee heard mixed but generally supportive testimony on Resolution 704; however, there was more support for the first and third resolve clauses than there was for the second resolve clause. Testimony regarding the first and third resolve clauses was primarily supportive, with specific testimony highlighting the value that a prior authorization database, as called for in the first resolve, could provide in support of future prior authorization advocacy efforts. Although one delegation noted that it may be challenging to collect and consolidate prior authorization impact data in a format that will be useful for the AMA's prior authorization advocacy, the general consensus amongst those testifying was that it is necessary to move forward with collecting and storing prior authorization impact data in a database so that the AMA can quantify the impact of prior authorization in an effort to further support the AMA's advocacy efforts.

Some testimony voiced concern about the large fiscal note attached to this resolution; however, additional testimony generally downplayed these fiscal concerns by highlighting that the potential benefits from developing and maintaining a prior authorization impact database would most likely outweigh the costs.

With regard to the second resolve clause, your Reference Committee heard mixed testimony. Some testimony supported class action lawsuits generally. However, other testimony questioned whether the proposed prior authorization database would provide the supporting evidence to ultimately pursue a class action lawsuit. This varying testimony allowed the Reference Committee to appreciate the complexities of the second resolve clause and therefore recommend referral.

There were also questions raised about what rises to the threshold of AMA legal action. The Reference Committee wants to share that the AMA Litigation Center is holding an information session on Sunday, June 8th from 1:30-3:30 PM for those who may be interested. Your Reference Committee recommends that the first and third resolve clauses of Resolution 704 be adopted and the second resolve clause of Resolution 704 be referred.

(21) RESOLUTION 710 - REQUIRING INSURANCES TO APPLY DISCOUNTED COST MEDICATION TO THE PATIENT'S DEDUCTIBLE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 710 be referred.

HOD ACTION: Resolution 710 referred.

RESOLVED, that our American Medical Association advocate for legislation or other appropriate means 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)

Your Reference Committee heard supportive online testimony on Resolution 710. In-person testimony was mixed. Several delegations provided testimony in favor of the resolution, one delegation offered an amendment, and one delegation suggested referral. While there was support for the resolution as written, your Reference Committee found testimony calling for referral compelling. There were important questions raised about which medications and programs should be considered under this umbrella and the nuances discussed in testimony could lead to unintended consequences. Your Reference Committee did not believe that these concerns were addressed by the proposed amendment and a study addressing these questions would ensure that all scenarios are considered in the resulting policy recommendations. Thus, your Reference Committee recommends that Resolution 710 be referred.

(22) RESOLUTION 711 - STUDY OF PRACTICE MODELS FOR PHYSICIANS WORKING ACROSS STATE LINES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 711 be referred.

HOD ACTION: Resolution 711 referred.

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)

Your Reference Committee heard mixed testimony on Resolution 711. Two delegations supported referral of this resolution. Testimony admitted that referral seems redundant since a significant portion of the resolve clauses call for a study; however, there are portions of the language in the resolve clauses that need revision. Specifically, testimony questioned the feasibility of the first and second resolve clauses and noted that the third resolve clause seems to overlap with the first. Testimony further suggested that each state has professional and facility regulations and accreditation standards that address the matter proposed by the resolution and that the AMA should emphasize standards and enforcement at a local level by relevant facility and professional licensure authorities. Finally, testimony addressed the impact of these practice models on emergency departments and recommended that this also be addressed by a report. At the in-person hearing the author of this resolution supported referral, as it achieves the goal of a study, which was the original intent. Your Reference Committee recommends that Resolution 711 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

(23) RESOLUTION 718 - SAFEGUARDING MEDICAL STAFF BYLAWS AND ACCREDITATION STANDARDS IN VA FACILITIES

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 718 be adopted.

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve clause of Resolution 718 be adopted.

RECOMMENDATION C:

Your Reference Committee recommends that the third Resolve clause of Resolution 718 be referred for decision.

RECOMMENDATION D:

Your Reference Committee recommends that the fourth Resolve clause of Resolution 718 be referred for decision.

HOD ACTION: The first and second Resolve clauses of Resolution 718 be adopted and the third and fourth Resolve clauses of Resolution 718 referred for decision.

RESOLVED, that our American Medical Association reaffirms its commitment to medical staff self-governance, as outlined in its AMA Physician's Guide to Medical Staff Organization Bylaws, Seventh edition, and supported by the Organized Medical Staff Section and urges all healthcare institutions, including the U.S. Department of Veterans Affairs, to ensure that any amendments to medical staff bylaws are subject to approval by the medical staff in accordance with Joint Commission standards (Reaffirmation of Policy); and be it further

RESOLVED, that our AMA opposes any administrative action that bypass the organized medical staff's voting authority in revising medical staff bylaws (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that the U.S. Department of Veterans Affairs to restore compliance with Joint Commission Standard MS.01.01.01 by requiring medical staff member approval for any modifications to their bylaws (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for urgent federal-level oversight and corrective action to protect accreditation standards, medical staff governance, and patient care quality at Veterans Affairs facilities nationwide (Directive to Take Action).

Your Reference Committee heard testimony that supported the spirit of the resolution, but there were several questions raised that warrant further study. The first and second resolve clauses received supportive testimony. The questions were mostly directed towards the third and fourth resolve clauses and whether the Joint Commission requirements supersede federal regulations, or vice versa. Further testimony did not offer clarifications on these points and therefore the Reference Committee believes that further scrutiny would allow for better understanding of the process as it stands, as well as what changes will be most impactful for physicians affected by these changes. Because of the timeliness of this issue, your Reference Committee believes that referral for decision is most appropriate for urgent action. Your Reference Committee recommends that the first and second resolve clauses of Resolution 718 be adopted and the third and fourth resolve clauses of Resolution 718 be referred for decision.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(24) RESOLUTION 705 - ELIMINATION OF TRANSACTION FEES FOR ELECTRONIC HEALTHCARE PAYMENTS

RECOMMENDATION:

Your Reference Committee recommends that Policies D-190.968 and H-190.955 be reaffirmed in lieu of Resolution 705.

HOD ACTION: Resolution 705 referred for decision.

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)

Your Reference Committee heard testimony in favor of reaffirmation of AMA policies in lieu of Resolution 705. Online testimony acknowledged the positive intent behind Resolution 705 but supported reaffirmation because the ask is already addressed by AMA policy. At the in-person hearing the author spoke in favor of the original resolution; however, no clarifications were offered to differentiate between the ask of this resolution and existing AMA policy. Additional testimony noted the negative impact that electronic transaction fees have on practice payment rates. An amendment was suggested that called for the AMA to report on implementation of pertinent AMA policies, including D-190.968 and H-190.955, at the 2025 Annual meeting. Because it is impossible to produce a report regarding the implementation progress of these policies in time for the 2025 AMA Annual meeting and the testimony agreed that AMA policy covers the ask of this resolution, your Reference Committee recommends that Policies D-190.968 and H-190.955 be reaffirmed in lieu of Resolution 705.

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)

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)

(25) RESOLUTION 713 - AIDING MEMBERS OF MEDICAL STAFFS

RECOMMENDATION:

Your Reference Committee recommends that Policies H-225.942, H-225.957, and H-235.980 be reaffirmed in lieu of Resolution 713.

HOD ACTION: Resolution 713 adopted.

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).

Your Reference Committee heard mixed testimony on Resolution 713. One delegation provided testimony in support of reaffirmation and the individual author of the resolution spoke against reaffirmation and in support of the resolution as written both online and in-person. Your Reference Committee has reviewed the listed policies and agrees that AMA policy sufficiently covers the ask of this resolution. Additionally, the Physician's Guide to Medical Staff Organization Bylaws, published by the AMA Office of General Counsel and Organized Medical Staff Section, is an additional resource available to physicians who

have questions about adverse institutional actions or policies to practice medicine. Therefore, your Reference Committee recommends that Policies H-225.942, H-225.957, and H-235.980 be reaffirmed in lieu of Resolution 713.

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 their 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.

(BOT Rep. 09, A-17; Modified: BOT Rep. 05, I-17; Appended: Res. 715, A-18; Reaffirmed: BOT Rep. 13, A-19; Modified: BOT Rep. 13, A-21; Modified: CMS Rep. 5, A-21; Reaffirmation: A-22; Modified: Speakers Rep. 02, I-24)

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.

(Res. 828, I-07; Reaffirmed in lieu of Res. 730, A-09; Modified: Res. 820, I-09; Reaffirmed: Res. 725, A-10; Reaffirmation: A-12; Reaffirmed: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 024, A-24)

HOSPITAL MEDICAL STAFF SELF-GOVERNANCE, H-235.980

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 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.

(Sub Res. 201, A-89; Reaffirmed: Sub. Res. 808, A-94; Reaffirmed, Amended, and Appended: Sub Res. 817, I-01; Reaffirmation: A-05; Appended: Res. 730, A-05; Reaffirmed: CMS Rep. 1, A-15)

This concludes the report of Reference Committee G. I would like to thank Anna Brown, MD, MPhil, Chris Bush, MD, Tra'Chella Foy, MD, Maximilian Pany, MD, PhD, Peter Rheinstein, MD, JD, MS, David Whalen, MD, and all those who testified before the Committee.

Anna Brown, MD, MPhil (Alternate)
American College of Radiation Oncology

Chris Bush, MD (Alternate)
Michigan

Tra'Chella Foy, MD
Florida

Maximilian Pany, MD, PhD (Alternate)
Massachusetts

Peter Rheinstein, MD, JD, MS
Academy of Physicians in Clinical Research

David Whalen, MD, MPH (Alternate)
Michigan

Christine Kim, MD (Alternate)
American College of Radiology
Chair