MEMORIAL RESOLUTIONS
ADOPTED INANIMOUSLY

Michael S. Aronow, MD
Introduced by American Academy of Orthopaedic Surgeons and
American Orthopaedic Foot and Ankle Society

Whereas, Michael S. Aronow, MD, of West Hartford, Connecticut, born on August 5, 1962, in Fort Chaffee, Arkansas, departed this life on March 11, 2025, at the age of 62, leaving behind a legacy of great dedication, service and leadership; and

Whereas, Dr. Aronow lived a life marked by passion and commitment to medicine, education, advocacy, patients, family and community; and

Whereas, Dr. Aronow's academic journey included earning his medical degree from the Harvard Medical School–Massachusetts Institute of Technology Health Sciences and Technology Program, orthopaedic residency and fellowships in research and sports medicine at the University of Massachusetts Medical Center and advanced food and ankle fellowship at the University of Washington School of Medicine and Harborview Medical Center; and

Whereas, Dr. Aronow joined the faculty at the University of Connecticut School of Medicine in 1997, and then in 2012 began working for Orthopaedic Associates of Hartford in Connecticut while continuing to serve as a clinical professor of orthopaedic surgery; and

Whereas, Dr. Aronow became a leader in orthopaedic advocacy, serving as President of the American Orthopaedic Foot and Ankle Society (AOFAS) from 2023-2024, AOFAS delegate to our American Medical Association, AOFAS delegate to the American Academy of Orthopaedic Surgeons (AAOS) Board of Specialty Societies, and chair of the AOFAS Health Policy Committee where he represented orthopaedic surgery before federal, state and local legislatures; and

Whereas, Dr. Aronow was honored for his service with the Harry Gossling, MD, Orthopaedic Residency Educator of the Year Award in 2003, induction into the AAOS OrthoPAC Hall of Fame in 2021 and named Connecticut Orthopaedist of the Year in 2023 by the Connecticut Orthopaedic Society, of which he also served as a board member and president; and

Whereas, internationally recognized as an academic expert, Dr. Aronow authored more than 50 peer-reviewed publications and 22 book chapters, served on two scientific journal editorial boards and presented at orthopaedic meetings around the world; and

Whereas, Dr. Aronow is survived by his wife, Dr. Margaret "Meg" Chaplin, and his five children, Benjamin, Rachel, Max, Miles and Sam; therefore be it

RESOLVED, that our American Medical Association recognize Dr. Michael S. Aronow's passing with a moment of silence; and be it further

RESOLVED, that our AMA record this resolution in the minutes and a copy of this resolution be sent to the family of Dr. Michael S. Aronow

Robert F. Jackson, MD
Introduced by: American Academy of Cosmetic Surgery

Whereas, Robert F. Jackson, MD, of Noblesville, Indiana, departed this life on April 15, 2025, leaving behind a legacy of faith, family, and dedication, service, and leadership to his profession; and

Whereas, Dr. Jackson earned his medical degree from the Indiana University School of Medicine in 1966, and following his general surgery residency at Miami Valley Hospital in Dayton, Ohio, he served in the U.S. Army as a combat trauma surgeon; and

Whereas, Dr. Jackson, a proud Vietnam veteran, trained many medical students, residents, and fellows in the field of surgery and especially in the field of cosmetic surgery, hosted many workshops at his own facility and participated as a faculty member in numerous courses and meetings throughout the United States and abroad; and

Whereas, Dr. Jackson was a Diplomate of the American Board of Cosmetic Surgery, American Academy of Cosmetic Surgery Alternate Delegate to the American Medical Association since 1999, a Fellow of the American Academy of Cosmetic Surgery and the American College of Surgeons, and a Past-President of the American Board of Cosmetic Surgery and the American Academy of Cosmetic Surgery; and

Whereas, Dr. Jackson brought forth many innovations in his 50 plus years of practice with a passion for surgery, teaching his craft to countless students, residents, and over 20 fellows; and

Whereas, Dr. Jackson's legacy will endure through his reputation as an elite cosmetic surgeon, as a groundbreaker in the practice of minimally invasive endoscopic cosmetic surgery techniques, and as author of many articles in national and international medical journals and textbooks; therefore be it

RESOLVED, that our American Medical Association recognize Dr. Robert F. Jackson's passing with a moment of silence; and be it further

RESOLVED, that our AMA record this resolution in the minutes and a copy of this resolution be sent to the family of Dr. Robert F. Jackson.

Charles P. Shoemaker, Jr., MD
Introduced by: New England

Whereas, Charles P. Shoemaker, Jr., MD, was a beloved and respected colleague who served his patients, community, and profession as a Delegate to the American Medical Association for many years and as a leader of the Rhode Island Medical Society, of which he was President 1983-84; and

Whereas, Dr. Shoemaker, having graduated from Albany Medical College and trained as a general surgeon at The Yale-New Haven Medical Center, entered the US Navy under the Barry Plan in 1969 and served on the Navy hospital ship USS Sanctuary off the coast of South Vietnam and at the Naval Hospital in Newport, Rhode Island; and

Whereas, Dr. Shoemaker was a Fellow of the American College of Surgeons and a founding member and officer of the American Society of General Surgeons; and

Whereas, Dr. Shoemaker served as Chief of Surgery and as President of the Medical Staff of Newport Hospital in Newport; and

Whereas, Dr. Shoemaker was a passionate advocate for quality care, patient safety, and liability reform; and

Whereas, Dr. Shoemaker was a friend, teacher, mentor, and advocate for youth of all ages, founding Newport's Baby Steps Program for new parents, making the sport of sailing accessible through Sail Newport, and, in his retirement, serving multiple terms as chair of the Newport, RI, School Committee; and

Whereas, Dr. Shoemaker was a world-class sailor who participated in team racing in England and Ireland, won many local, regional, and national regattas, and was for 50 winters a contender in the Sunday Frostbite sailing event of the Newport Yacht Club, of which he became Commodore; and

Whereas, Dr. Shoemaker passed away on June 4, 2024, and will be fondly remembered for the breadth and generosity of his commitment to his communities, both professional and local; therefore be it

RESOLVED, that our American Medical Association express enduring admiration and gratitude for the life of Charles P. Shoemaker, Jr., MD, and honor his legacy of devotion and service to patients, young people, and the profession he loved

RESOLUTIONS

Note: Testimony on each item is summarized in the reference committee reports.

Alternate resolutions are considered to have been introduced by the reference committee.

REFERENCE COMMITTEE ON ETHICS & BYLAWS

1. OPPOSITION TO CENSURING MEDICAL SOCIETIES OR ORGANIZATIONS BASED ON POLITICS OR POLICIES OF GOVERNMENTS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-65.970

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.

2. PHYSICIAN DISCLOSURES OF RELATIONSHIPS IN PRIVATE EQUITY HELD ORGANIZATIONS
Introduced by Indiana

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: 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.

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.

3. OPPOSITION TO CENSORSHIP IN PUBLIC LIBRARIES
Introduced by LGBTQ+ Section

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: ADOPTED
See Policy H-60.898 and H-65.933

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.

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.

4. REDUCING THE HARMFUL IMPACTS OF IMMIGRATION STATUS ON HEALTH
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-65.932

RESOLVED, that our American Medical Association support protecting the human right to seek asylum.

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.

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.

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.

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.

5. DEDICATED INTERFAITH PRAYER AND REFLECTION SPACES IN MEDICAL SCHOOLS AND HEALTHCARE FACILITIES
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-65.931

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 as a component of fostering inclusive, supportive environments for patients, students, and healthcare workers from all religious and spiritual backgrounds.

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 spaces as part of their standards related to diversity, equity, inclusion, and learner well-being.

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.

RESOLVED, that our AMA support the development, evaluation, and dissemination of best practices for implementing inclusive interfaith prayer and reflection spaces in clinical and educational settings, including research on their impact on learner well-being, patient experience, and institutional culture.

6. DECEPTION AS A THREAT TO PHYSICIAN ETHICS
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy H-140.817

RESOLVED, that our American Medical Association oppose 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.

7. USE OF INCLUSIVE LANGUAGE IN AMA POLICY
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: **ADOPTED**
See Policy D-65.969

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.

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.

8. HUMANISM IN ANATOMICAL MEDICAL EDUCATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: **ADOPTED**
See Policy H-295.843

RESOLVED, that our American Medical Association supports the incorporation of humanism in human anatomy education programs, including, but not limited to, time for HIPAA-compliant recognition of donor backgrounds, reflection, discussion, and feedback.

RESOLVED, that our AMA supports accommodations for learners' and donors' cultural observances surrounding the deceased when appropriate.

RESOLVED, that our AMA supports donor memorial ceremonies at centers that utilize cadaveric-based human anatomy education programs.

9. PATIENT CENTERED HEALTH CARE AS A DETERMINANT OF HEALTH
Introduced by New England

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: ADOPTED
See Policy H-140.816

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.

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.

10. MANAGING CONFLICT OF INTEREST INHERENT IN NEW PAYMENT MODELS—PATIENT DISCLOSURE
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-140.946

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.

11. OPPOSITION OF HEALTH CARE ENTITIES FROM REPORTING INDIVIDUAL PATIENT IMMIGRATION STATUS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-373.989 and H-440.876

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; and
    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 health care 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.

RESOLVED, that our AMA supports collection of de-identified patient information regarding immigration status for funding and research purposes only.

12. CARCERAL SYSTEMS AND PRACTICES IN BEHAVIORAL HEALTH EMERGENCY CARE
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-345.970, H-345.969 and H-345.972

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 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.

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.

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.

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 health care team.

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 shackling of youth and adults in carceral custody, with particular attention to the removal of shackles
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13. CONTINUED SUPPORT OF WORLD HEALTH ORGANIZATION (WHO) & UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-250.986

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.

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, or that would withhold funding from critical initiatives supporting agriculture, economic development, environmental protection, education, democracy, human rights, and governance in developing countries.

14. PROTECTING ACCESS TO EMERGENCY ABORTION CARE UNDER EMTALA
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: ADOPTED
See Policy D-5.995, D-5.999 and H-5.979

RESOLVED, that our American Medical Association reaffirm policy D-5.999 Preserving Access to Reproductive Health Services.

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.

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.

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.

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 recommendations and updates on navigating conflicting state and federal regulations on emergency pregnancy care.

15. 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
Introduced by
Organized Medical Staff Section, International Medical Graduates Section

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: **ADOPTED**
See Policy D-255.970

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.

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.

REFERENCE COMMITTEE A

101. UNIFORM ADOPTION OF SERVICE INTENSITY TOOLS TO SUPPORT MEDICAL DECISION-MAKING AND SERVICE GAP ANALYSIS
Introduced by American Academy of Child and Adolescent Psychiatry

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: **ADOPTED**
See Policy D-345.969

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.

102. ACCESS TO SINGLE MAINTENANCE AND RELIEVER THERAPY FOR ASTHMA
Introduced by American College of Chest Physicians

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: **ADOPTED**
See Policy D-185.907

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; 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.

103. INADEQUATE REIMBURSEMENT FOR BIOSIMILARS
Introduced by American Society for Gastrointestinal Endoscopy

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: **REFERRED**
WITH REPORT BACK AT I-25

RESOLVED, that our American Medical Association work with stakeholders to advocate for legislation that will Amend Section 1847A(c)(3) of the Social Security Act to permanently remove manufacturer rebates from the ASP methodology for biologics.

104. STUDY OF WHETHER THE HSA MODEL COULD BECOME AN OPTION FOR MEDICAID BENEFICIARIES
Introduced by Daniel H. Johnson, Jr, MD

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: 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.

105. DEVELOPMENT OF AN EDUCATIONAL RESOURCE ON OPTING OUT OF MEDICARE FOR PHYSICIANS
Introduced by Florida

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: 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.

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.

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.

106. ADVOCATING FOR ALL PAYER COVERAGE FOR CUSTOM BREAST AND OTHER PROSTHESES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-185.904

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 and other custom prostheses for patients who have had extirpative, ablative, and/or reconstructive surgery.

107. ADVOCATING FOR ALL PAYER COVERAGE OF RECONSTRUCTIVE AND COSMETIC SURGICAL CARE RELATED TO CLEFT LIP AND PALATE
Introduced by Illinois

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-185.903

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 without restriction as to patient age.

108. FIREARM STORAGE DIAGNOSIS AND COUNSELING REIMBURSEMENT
Introduced by Indiana

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-70.909

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®) code 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.

109. MEDICARE ADVANTAGE PLANS DOUBLE STANDARD
Introduced by Indiana

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: **ADOPTED**
See Policy H-330.863

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.

110. STUDY OF THE FEDERAL EMPLOYEE HEALTH BENEFIT PLAN (FEHBP)
Introduced by Louisiana

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-185.906

RESOLVED, that our AMA conduct a thorough study of the FEHBP to understand the successes and failures, strengths and weaknesses of the program and 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 A-26 Meeting of our House of Delegates.

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.

111. NEW REIMBURSEMENT SYSTEM NEEDED FOR RURAL HOSPITAL SURVIVAL
Introduced by Mississippi and Kentucky

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: **ADOPTED**
See Policy D-465.994

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.

112. CONTINUATION OF AFFORDABLE CONNECTIVITY PROGRAM
Introduced by New York

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: **POLICIES H-478.980 AND D-480.963 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.

113. IMPROVING PATIENT ACCESS TO PHARMACIES AND MEDICATIONS IN PHARMACY DESERTS
Introduced by Ohio

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: **REFERRED**

RESOLVED, that our American Medical Association support efforts to expand telepharmacy as a potential solution to pharmacy deserts.

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.

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.

114. AN ASSESSMENT OF PHYSICIAN SUPPORT FOR VALUE-BASED PAYMENT MODELS AND ITS IMPACT ON HEALTHCARE TO INFORM AMA ADVOCACY EFFORTS—A SURVEY
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: 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.

115. SUPPORTING LEGISLATIVE EFFORTS TO REMOVE CERTAIN HIGH-COST SUPPLIES FROM THE MEDICARE PHYSICIAN FEE SCHEDULE
Introduced by Society for Cardiovascular Angiography and Interventions, American Association of Clinical Urologists, American College of Cardiology, American Vein & Lymphatic Society, American Venous Forum, Outpatient Endovascular and Interventional Society, Society of Interventional Radiology

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-400.957

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.

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.

116. MEDICARE COVERAGE OF REGISTERED DIETITIAN (RD) AND CERTIFIED NUTRITION SUPPORT SPECIALIST (CNSS) VISITS BEYOND TYPE 2 DIABETES AND RENAL DISEASE
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: REFERRED
WITH REPORT BACK AT A-26

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; 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.

117. LIBERALIZED REMORSE PERIOD FOR MEDICARE ADVANTAGE PLAN INSUREDS
Introduced by Mississippi and Kentucky

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: 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.

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.

118. IMPROVING ACCESS TO PELVIC FLOOR THERAPY
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-185.902

RESOLVED, that our AMA advocate for all relevant payers to cover timely access to comprehensive pelvic floor therapy in all health care facilities.

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 therapy.

119. CANCER SURVIVORSHIP PROGRAM COVERAGE
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-55.966

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.

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

120. MEDIGAP, PRE-EXISTING CONDITIONS, AND MEDICARE COVERAGE EDUCATION
Introduced by Association for Clinical Oncology

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-330.888

RESOLVED, that our AMA create an educational campaign on both Medicare Advantage (MA) and Medicare Fee-for-Service (FFS) coverage.

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.

121. OPPOSING PHARMACY BENEFIT MANAGER SPREAD PRICING
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED
See Policy H-110.957

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.

REFERENCE COMMITTEE B

201. INCLUSION OF DIGITAL IMAGING AND COMMUNICATIONS IN MEDICINE (DICOM) IMAGING IN FEDERAL INTEROPERABILITY STANDARDS
Introduced by American Association of Neurological Surgeons

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-478.956

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

RESOLVED, that our AMA support policies and regulations requiring electronic health records (EHR) vendors, 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.

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

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ALTERNATE RESOLUTION 202
ADOPTED IN LIEU OF RESOLUTION 202
See Policy H-165.819

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.

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.

203. COMPOUNDED SYRINGE DELIVERY TO PHYSICIAN PRACTICES FOR INTRATHECAL THERAPY
Introduced by American Association of Neurological Surgeons

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-410.990

RESOLVED, that our AMA advocate for legislation allowing for the delivery of compounded syringes of medications intended for the filling of intrathecal pumps directly to the prescribing physician’s practice.

204. PROTECTING THE PRESCRIPTIVE AUTHORITY OF PLENARY LICENSED PHYSICIANS
Introduced by American Academy of Ophthalmology

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-120.920

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.

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.

RESOLVED, that our AMA reaffirm and publicize existing policy opposing unauthorized medication substitution, inappropriate pharmacy inquiries, and unauthorized treatment modification by pharmacists.

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.

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

205. SUPPORT FOR CONTINUANCE OF SECTION 1115 MEDICAID WAIVERS AND DEMONSTRATION PROJECTS

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ALTERNATE RESOLUTION 205 ADOPTED
IN LIEU OF RESOLUTION 205 AND 206
See Policy D-290.971

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.

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

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.

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.

Resolution 206 was considered with Resolution 205. See Resolution 205.

207. ABOLISHING VENUE SHOPPING

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ALTERNATE RESOLUTION 207 ADOPTED
IN LIEU OF RESOLUTION 207 AND 231
See Policy D-435.968

RESOLVED, That our AMA oppose venue shopping in medical professional liability actions.

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.

208. BINDING ARBITRATION IN HEALTH INSURANCE CONTRACTS
Introduced by American Psychiatric Association

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-435.967

RESOLVED, that our American Medical Association study the effects of binding arbitration in health insurance contracts with physicians.

209. REDUCING RISK OF FEDERAL INVESTIGATION OR PROSECUTION FOR PRESCRIBING CONTROLLED SUBSTANCES FOR LEGITIMATE MEDICAL PURPOSES
Introduced by American Society of Addiction Medicine and American Academy of Hospice & Palliative Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ITEM 1 OF RESOLVE ADOPTED AS FOLLOWS
ITEM 2 OF RESOLVE REFERRED
TITLE CHANGED
See Policy H-95.894

RESOLVED, that our American Medical Association support legislative, regulatory, and other advocacy efforts that (1) advance the adoption of a conjunctive 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 *[Editor note: item 1 was adopted]* 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." *[Editor note: item 2 was referred]*

210. IMPACT OF TARIFFS ON HEALTHCARE ACCESS AND COSTS
Introduced by American Society for Gastrointestinal Endoscopy

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-110.981

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.

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 remains accessible and affordable.

211. SUPPORT FOR STATE PROVIDER AND MANAGED CARE ORGANIZATION TAXES TO SUSTAIN FEDERAL MEDICAID MATCHING FUNDING
Introduced by California

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-165.961, H-285.901, H-385.925 and H-385.941

RESOLVED, that our American Medical Association support the use of broad-based, uniform Provider (hospital and nursing home) and Managed Care Organization (MCO) taxes to generate state funds to match with federal Medicaid funding that sustain or improve Medicaid patients' access to care while not financially burdening physician practices.

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.

RESOLVED, that our AMA amend policy H-385.925 as follows:
1. Our American Medical Association strongly opposes the imposition of a selective revenue tax on physicians ~~and other health care providers~~.
2. Our AMA will continue to work with state medical societies on issues relating to physician ~~and other provider~~ taxes, providing assistance and information as appropriate.
3. Our AMA strongly opposes the use of ~~provider~~ physician taxes or fees to fund health care programs or to accomplish health system reform.
4. Our AMA believes that the cost of taxes which apply to medical services should not be borne by physicians, but through adequate broad-based taxes for the appropriate funding of Medicaid and other government health care programs.

RESOLVED, that our AMA amend policy D-165.961 as follows:
Our AMA will (1) proactively and vigorously oppose taxes on physician services, physician-owned facility taxes or "pass-through" taxes on physician medical services; and (2) work closely with national specialty societies and state medical societies to assist with advocacy efforts to combat existing and proposed taxes on physician services and physician-owned facilities.

RESOLVED, that our AMA amend policy H-385.941 as follows:
Our AMA strongly: (1) opposes any attempt on the part of the federal or state governments or other entities to impose user fees, provider taxes, access fees, or bed taxes on physicians ~~and other health care providers~~ to subsidize or fund any health care program; (2) opposes any directive from the CMS to slow down the rate of payment of Medicare claims or reduce administrative services to patients, physicians, and other health care providers; and (3) urges Congress to appropriate sufficient funds to enable the CMS and its carriers to carry out their statutorily required functions.

212. SETTING STANDARDS FOR FORENSIC TOXICOLOGY LABORATORIES USED IN LITIGATION
Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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.

213. EMERGENCY DEPARTMENT DESIGNATION REQUIRES PHYSICIAN ON SITE
Introduced by Indiana

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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.

214. MANAGED CARE UTILIZATION REVIEW SYSTEMS
Introduced by Indiana

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
TITLE CHANGED
See Policy H-285.899

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.

215. STRENGTHENING CHILD LABOR PROTECTIONS FOR WORKING MINORS
Introduced by American Academy of Child and Adolescent Psychiatry

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-60.893

RESOLVED, that our AMA supports federal and state efforts to strengthen child labor protections by implementing effective mechanisms, including increasing employer penalties, 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.

216. SUPPORT FOR AGING-OUT FOSTER YOUTH WITH MENTAL HEALTH NEEDS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-60.892

RESOLVED, that our AMA 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, access to medications or other treatment recommended by their physician as part of an overall treatment plan.

217. REGULATION AND OVERSIGHT OF THE TROUBLED TEEN INDUSTRY
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-60.896

RESOLVED, that our American Medical Association amend Policy H-60.896 "Youth Residential Treatment Program Regulation" by addition to read as follows:

Youth Residential and Other Treatment Program Regulation

1. Our American Medical Association recognizes the need for licensing standards for all youth residential treatment facilities (including private and juvenile facilities) as well as other treatment facilities (including wilderness therapy programs and other programs aimed at treating behavioral and mental health issues in youths) to ensure basic safety and well-being standards for youth.
2. Our AMA supports recommendations including, but not limited to, patient placement criteria and clinical practice guidelines, as developed by of nonprofit health care medical associations and specialty societies, as the standard for regulating youth residential treatment and other relevant youth programs.
3. Our AMA a) opposes the use of any non-evidence-based therapies, and any abusive measures, in Youth Residential and Other Treatment Programs, b) 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.
4. Our AMA supports efforts to improve information sharing between states on promising practices for preventing and addressing maltreatment in residential facilities.

218. DISTRIBUTION OF RESIDENT SLOTS COMMENSURATE WITH SHORTAGES
Introduced by Medical Student Section, American College of Physicians, American College of Preventive Medicine, International Medical Graduates Section, Integrated Physician Practice Section, American Psychiatric Association

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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.

219. OPPOSING UNWARRANTED NATIONAL INSTITUTES OF HEALTH RESEARCH INSTITUTE RESTRUCTURING

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ALTERNATE RESOLTION 219 ADOPTED IN LIEU OF RESOLUTION 219
See Policy D-460.960

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.

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.

220. STRENGTHENING AMA POLICY ON NONCOMPETE CLAUSES IN OWNERSHIP TRANSITIONS
Introduced by New England Delegation

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-265.986

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.

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.

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.

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.

221. PRESERVATION OF MEDICAID

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ALTERNATE RESOLTION 221 ADOPTED
IN LIEU OF RESOLUTION 221, 223, 232 AND 236
See Policy H-290.951

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).

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

Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-255.961

RESOLVED, that our AMA support the continuance of premium processing and other mechanisms that expedite H-1B visa applications and renewals for International Medical Graduate physicians.

Resolution 223 was considered with Resolution 221, 232 and 236. See Resolution 221.

224. SUPPORT SAVE PLAN AND PUBLIC SERVICE LOAN FORGIVENESS (PLSF) APPLICATIONS
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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; and be further

RESOLVED, that this resolution be submitted to the American Medical Association for consideration and advocacy, ensuring that the AMA supports and promotes the reinstatement of the SAVE plan or a similar program at the national level.

225. THE PRIVATE PRACTICE PHYSICIANS IN THE COMMUNITY
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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; 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.

226. REGULATIONS FOR ALGORITHMIC-BASED HEALTH INSURANCE UTILIZATION REVIEW
Introduced by Pennsylvania

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICY H-480.931 REAFFIRMED IN LIEU OF THE FIRST RESOLVE SECOND RESOLVE ADOPTED

[Editor note: Policy reaffirmed in lieu of first resolve]
RESOLVED, that our American Medical Association advocate for state and federal oversight of and/or legislative activity to assure the transparency, patient safety, and biases involved in algorithm usage in utilization review by insurance companies; and be it further

[Editor note: Second resolve adopted]
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).

227. PAYMENT RECOUPMENT—LET SANITY PREVAIL
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICIES D-320.991, D-385.944, D-385.965, H-70.926, H-185.999, . 277 H-335.981, H-385.900, AND H-335.963 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*; 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; 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; 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; and be it further

RESOLVED, that our AMA report back at the 2026 Annual Meeting on the progress of the implementation of this resolution

228. CHIP COVERAGE OF OTC MEDICATIONS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOW
See Policy H-290.950

RESOLVED, that our AMA support expanding coverage for FDA-approved over-the-counter medications under the Children's Health Insurance Program (CHIP) for enrolled individuals, including by expanding medication classes covered under CHIP.

RESOLVED, that our AMA oppose arbitrary exclusions or limitations on FDA-approved over-the-counter medications covered by the Children's Health Insurance Program for enrolled individuals.

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

229. GUARANTEEING TIMELY DELIVERY AND ACCESSIBILITY OF FEDERAL HEALTH DATA
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-440.903

RESOLVED, that our AMA ~~–~~advocate for the immediate reinstatement of dissemination of critical public health information by the CDC, NIH and other pertinent federal agencies~~,~~, 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 less than optimal health outcomes.

RESOLVED, that our AMA support the recognition of the CDC, NIH, and other federal agencies in their efforts to minimize the risks of emerging infections.

230. ADVOCATING TO EXPAND PRIVATE INSURANCE COVERAGE OF ANTI-OBESITY MEDICATIONS (AOM)
Introduced by The Endocrine Society

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 1f and 1h ADOPTED AS FOLLOWS
1e and 1g REFERRED
See Policy H-440.801

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. *[Editor note: 1e referred]*
   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. *[Editor note: 1f adopted]*
   g. Support and cover chronic treatment with anti-obesity medications to maintain weight loss. *[Editor note: 1g referred]*
   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. *[Editors note: 1h adopted]*
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.

Resolution 231 was considered with Resolution 207. See Resolution 207.

Resolution 232 was considered with Resolution 221, 223 and 236. See Resolution 221.

233. INCREASING TRANSPARENCY OF AMA MEDICARE PAYMENT REFORM STRATEGY
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-400.981

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.

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.

234. PROTECTION FOR INTERNATIONAL MEDICAL GRADUATES
Introduced by International Medical Graduates Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICIES D-160.921 AND H-255.988 REAFFIRMED
IN LIEU OF FIRST RESOLVE
SECOND RESOLVE ADOPTED AS FOLLOWS
See Policy H-255.960

[Editor's note: Policies D-160.921 and H-255.988 reaffirmed in lieu of first resolve]
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.

[Editor's note: Second resolve adopted as follows]
RESOLVED, that our AMA support relevant interested parties in developing a confidential mechanism through which physicians can report workplace immigration related interviews in order to identify and address potential instances of unfair treatment or targeting of international medical graduate physicians.

235. CMS PAYMENT MONITORING FOLLOWING GOVERNMENT STAFF REDUCTIONS
Introduced by Association for Clinical Oncology

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-330.887

RESOLVED, that our American Medical Association will monitor federal staffing reductions with a focus on those at the Centers for Medicare & Medicaid Services (CMS).

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.

Resolution 236 was considered with Resolution 221, 223 and 232. See Resolution 221.

237. URGENT ADVOCACY TO RESTORE J-1 VISA PROCESSING FOR INTERNATIONAL MEDICAL GRADUATE PHYSICIANS
Introduced by International Medical Graduates Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED**
See Policy D-255.969

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 visa8 appointment suspensions on patient care and physician workforce stability;

4.Work proactively and transparently to reverse policies harmful to IMGs and mitigate10 future disruptions, emphasizing the essential contributions of International Medical11 Graduates to healthcare delivery in the United States.

238. PRESERVING ACCREDITATION STANDARDS ON DIVERSITY, EQUITY, AND INCLUSION
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-310.896

RESOLVED, that our 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 standards.

RESOLVED, that our AMA support 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.

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

239. ENSURING ACCESSIBILITY AND INCLUSIVITY OF CDC RESOURCES
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED**
See Policy H-440.787

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.

240. PRESERVING THE SPECIALTY OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE
Introduced by American College of Occupational & Environmental Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED**
See Policy D-305.947

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.

241. PRESERVATION OF IMMIGRATION PATHWAYS FOR INTERNATIONAL MEDICAL STUDENTS
Introduced by New England

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED AS FOLLOWS AND POLICIES H-255.911 and D-255.968 REAFFIRMED TITLE CHANGED**
See Policy D-255.968

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.

242. PROTECTING EVIDENCE-BASED MEDICINE, PUBLIC HEALTH INFRASTRUCTURE AND BIOMEDICAL RESEARCH
Introduced by
Infectious Diseases Society of America, American Academy of Allergy, Ashma and Immunology, American Academy of Family Physicians, American Academy of Pediatrics, American Association of Public Health Physicians, American College of Physicians, American College of Rheumatology, American Gastroenterological Association, Endocrine Society, Post-Acute and Long-Term Care Medical Association, Society of Critical Care Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy D-440.905

RESOLVED, that our AMA affirm that protecting science, clinical integrity, and the patient-physician relationship is central to the organization's mission.

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

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

REFERENCE COMMITTEE C

301. EXAMINING ABMS PROCESSES FOR NEW BOARDS

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ALTERNATE RESOLUTION 301 ADOPTED
IN LIEU OF RESOLUTION 301
See Policy D-275.943

RESOLVED, that our American Medical Association study and define principles for board certifying bodies 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.

302. AMA STUDY OF LIFESTYLE MEDICINE AND CULINARY ELECTIVES TO REDUCE BURNOUT AND BOLSTER CAREER SATISFACTION IN TRAINEES

Introduced by American College of Lifestyle Medicine

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: POLICY H-425.972 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.

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

Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: FIRST RESOLVED ADOPTED AS FOLLOWS
SECOND, THIRD AND FOURTH RESOLVES REFERRED
TITLE CHANGED
See Policy H-295.840

[Editors note: Resolve adopted as follows]
RESOLVED, that our American Medical Association support efforts to establish Indigenous-governed medical schools in the United States, with governance and leadership structures 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.

[Editors note: following resolves referred]
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.

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.

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.

304. ADDRESSING PROFESSIONALISM STANDARDS IN MEDICAL TRAINING
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-295.298 and H-295.839

RESOLVED, that our AMA supports regular institutional review by appropriate entities such as-Diversity, Equity and Inclusion (DEI) offices, of professionalism policies in medical school and residency programs, ensuring that they do not lead to discriminatory practices.

RESOLVED, that our AMA establish professionalism guidelines for residency programs and medical schools that include outlining actions that may constitute a violation.

RESOLVED, that our AMA supports measures that prevent medical schools and residency programs from alleging professionalism violations as a means to stop trainee advocacy measures that are consistent with the AMA Principles of Medical Ethics.

305. CURRICULAR STRUCTURE REFORM TO SUPPORT PHYSICIAN AND TRAINEE WELL-BEING
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-295.838

RESOLVED, that our 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.

RESOLVED, that our AMA discourage burnout prevention programs that impose inflexible requirements, additional time burdens on physicians, residents, fellows, and medical students, mandatory assignments, or punitive measures, except where required by law.

RESOLVED, that our AMA encourage funding entities and training programs to support the implementation of evidence-based evaluation strategies for the ongoing assessment and improvement of burnout prevention programs.

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.

306. INNOVATION AND REFORM OF MEDICAL EDUCATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: 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:

a) Expansion of three-year pathways and pathways prioritizing residency seats for students entering primary care, OBGYN, psychiatry, and practice in under-resourced, rural, and IHS areas;
b) Re-evaluation of premedical prerequisites for clinical readiness (including organic chemistry, calculus, and calculus-based physics versus high-school physics) and expectation of a bachelor's degree for medical school;
c) Medical school acceptance of prerequisite credit earned in high school or community college or via placement/test-out examinations, to prevent pressure to repeat coursework;
d) Options to shorten preclinical education to better reflect clinical readiness and emphasize clinical exposure, including external asynchronous study aids, placement/test-out examinations, and completion of preclinical education prior to medical school;
e) Possibility of merging the MCAT and USMLE Step 1/COMLEX Level 1;

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.

307. DISCLOSURE OF INDIVIDUAL PHYSICIAN VOLUNTEERS PARTICIPATION IN COMMITTEE DECISION-MAKING TO OTHER ORGANIZATIONS, STAKEHOLDERS AND JOINT PROVIDERS
Introduced by New York

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: 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).

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.

308. STREAMLINING ANNUAL COMPLIANCE TRAINING REQUIREMENTS FOR PHYSICIANS
Introduced by Ohio

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-270.949

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.

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

309. INCREASING EDUCATION ON PHYSICIAN-LED CARE AND ADVOCACY IN RESIDENCY TRAINING
Introduced by Oklahoma and Mississippi

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED**
See Policy H-310.898

RESOLVED, that our AMA develop, 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.

RESOLVED, that our AMA encourage residency programs to 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.

310. PROTECTIONS FOR TRAINEES, FACULTY, AND STAFF EXPERIENCING RETALIATION IN MEDICAL EDUCATION
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy H-295.837

RESOLVED, that our 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 consistent with the AMA Principles of Medical Ethics.

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.

311. TRANSPARENCY AND ACCESS TO MEDICAL TRAINING PROGRAM UNIONIZATION STATUS, INCLUDING CREATION OF A FREIDA UNIONIZATION FILTER
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED**
See Policy H-310.897

RESOLVED, that our American Medical Association supports transparency and access to information about medical training program unionization status.

RESOLVED, that our AMA creates and maintains an up-to-date unionization filter on FREIDA™ for trainees to make informed decisions during the Match.

312. SELECTION OF IMG RESIDENTS BASED ON MERIT
Introduced by International Medical Graduates Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: POLICIES D-255.991 AND H-255.988 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.

REFERENCE COMMITTEE D

401. REDUCING PICKLEBALL-RELATED OCULAR INJURIES
Introduced by American Academy of Ophthalmology

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy D-470.989 and H-470.950

RESOLVED, that our American Medical Association advocate for international, national, and local pickleball organizations, leagues, and recreational facilities to adopt pickleball-related injury prevention strategies—such as recommending protective eyewear—particularly for older adults and individuals with pre-existing conditions which could increase their risk for injury while playing pickleball.

RESOLVED, that our AMA support targeted educational initiatives on pickleball-related injury prevention, with specific outreach to older adults, high-risk individuals, and healthcare professionals, to promote safe play and increase awareness of pickleball-related injury risks, such as ocular injuries.

RESOLVED, that our AMA encourage continued research and injury surveillance efforts to evaluate the long-term impact of pickleball-related injuries on healthcare costs, rehabilitation outcomes, and the effectiveness of preventive strategies.

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

402. PROTECTING IN-PERSON PRISON VISITATIONS TO REDUCE RECIDIVISM
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED**
See Policy H-430.973

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.

403. PROMOTING EVIDENCE-BASED RESPONSES TO MEASLES AND MISUSE OF VITAMIN A
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-440.792

RESOLVED, that our American Medical Association 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.

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.

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.

404. IMPROVING PUBLIC AWARENESS OF LUNG CANCER SCREENING AND CAD IN CHRONIC SMOKERS

Introduced by American College of Cardiology

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: 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.

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.

405. SUPPORTING LABELING AND DIETARY GUIDELINE CLARITY FOR ALCOHOLIC BEVERAGES

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ALTERNATE RESOLUTION 405 ADOPTED IN LIEU OF RESOLUTION 405, 417 AND 425
See Policy H-30.940

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.

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.

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.

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.

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.

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.

406. UNDERSTANDING THE FEASIBILITY OF REPLACING PETROLEUM-POWERED EMERGENCY MEDICAL SERVICES (EMS) VEHICLES IN URBAN SERVICE AREAS WITH RENEWABLY-POWERED VEHICLES
Introduced by Academic Physicians Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy H-135.939

RESOLVED, that our American Medical Association encourages pilot studies on the feasibility of urban ambulance fleets being replaced with renewably-powered vehicles when current petroleum-powered EMS ambulances become retired from service.

407. SLEEP DEPRIVATION AS A PUBLIC HEALTH CRISIS
Introduced by American Thoracic Society

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED**
See Policy D-440.904 and H-440.791

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.

RESOLVED, that our AMA declare sleep deprivation a public health crisis in the United States and to declare sleep health a public health priority.

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.

RESOLVED, that our AMA advocate for public health interventions and policies to improve sleep health.

408. REMOVING ARTIFICIAL TURF IN SCHOOLS, PARKS, AND PUBLIC PLACES
Introduced by California

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: 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.

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.

409. GUIDELINES FOR RESTRICTING CELL PHONES IN K-12 SCHOOLS
Introduced by California

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-60.894

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.

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

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

410. HATE SPEECH IS A PUBLIC HEALTH CONCERN
Introduced by California

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-65.937

RESOLVED, that our American Medical Association declare hate speech a public health concern.

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.

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.

411. PROTECTING ACCESS TO MRNA VACCINES
Introduced by Colorado

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-440.790

RESOLVED, that our American Medical Association actively support for protections for use, research and development of mRNA vaccines for infectious diseases and cancer treatment.

RESOLVED, that our AMA work with interested state and specialty medical associations to oppose state legislation that would limit or ban the use, research or development of mRNA vaccines.

412. SUPPORTING INCLUSIVE LONG-TERM CARE FACILITIES
Introduced by LGBTQ+ Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-280.943

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

413. PRESERVATION OF PUBLIC FUNDING FOR PHYSICIANS AND HOSPITALS PROVIDING LGBTQ+ CARE
Introduced by LGBTQ+ Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-160.991

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.

414. EXPANDING SEXUALLY TRANSMITTED INFECTION CARE FOR PERSONS WITH UNSTABLE OR NO HOUSING
Introduced by LGBTQ+ Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-440.983

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.

415. PROMOTING CHILD WELFARE AND COMMUNICATION RIGHTS IN IMMIGRATION DETENTION
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-350.955

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.

RESOLVED, that our AMA support efforts to address and mitigate concerns and accusations of child abuse and neglect in detention centers.

416. CULTURALLY AND RELIGIOUSLY INCLUSIVE FOOD OPTIONS
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-150.949

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

Resolution 417 was considered with Resolution 405 and 425. See Resolution 405.

418. AMA STUDY ON PLASTIC POLLUTION REDUCTION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-135.901

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.

419. ADVOCATING FOR UNIVERSAL SUMMER ELECTRONIC BENEFIT TRANSFER PROGRAM FOR CHILDREN (SEBTC)
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-150.916

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.

420. STUDY OF PLANT-BASED & LAB-GROWN MEAT
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-135.973

RESOLVED, that our American Medical Association supports further research on the health- and climate-related effects of consuming plant-based and lab-grown meat.

421. MITIGATING AIR AND NOISE POLLUTION FROM AVIATION IN MINORITY COMMUNITIES DISPROPORTIONATELY IMPACTED AND VULNERABLE COMMUNITIES
Introduced by New York

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: 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.

422. PROTECTING THE INTEGRITY OF THE U.S. HEALTHCARE SYSTEM FROM MISINFORMATION AND POLICY
Introduced by New York

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED**
See Policy D-440.915

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.

423. REQUIRING UNIVERSAL VACCINE REPORTING TO A NATIONAL IMMUNIZATION REGISTRY AND ACCESS TO A NATIONAL IMMUNIZATION INFORMATION SYSTEM
Introduced by New York

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-440.789

RESOLVED, that our American Medical Association 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.

424. SUPPORTING THE INTEGRATION OF BLOOD PRESSURE VARIABILITY DATA IN ELECTRONIC MEDICAL RECORDS
Introduced by Ohio

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **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.

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.

Resolution 425 was considered with Resolution 405 and 417. See Resolution 405.

426. ADDRESSING PATIENT SAFETY AND ENVIRONMENTAL STEWARDSHIP OF SINGLE-USE AND REUSABLE MEDICAL DEVICES

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ALTERNATE RESOLUTION 426 ADOPTED IN LIEU OF RESOLUTION 426
See Policy D-480.955

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.

427. ELEVATE OBESITY AS AN AMA PUBLIC HEALTH PRIORITY

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ALTERNATE RESOLUTION 427 ADOPTED IN LIEU OF RESOLUTION 427
See Policy D-440.980

RESOLVED, that our American Medical Association elevate obesity to be one of its public health priorities

428. PUBLIC HEALTH IMPLICATIONS OF US FOOD SUBSIDIES
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-150.915

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.

429. ADDRESSING THE HEALTH CONSEQUENCES OF MICROPLASTICS IN HUMANS
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-135.901

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.

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.

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.

430. ADDRESSING THE HEALTH IMPACTS OF ULTRAPROCESSED FOODS
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-150.914

RESOLVED, that our American Medical Association support and promote public awareness and education about the differences between healthful foods and unhealthful ultraprocessed foods (UPF) and the benefits of minimally processed and unprocessed foods.

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.

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.

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.

431. ALCOHOL & BREAST CANCER RISK
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-30.934

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.

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

432. ADDRESSING LONG-TERM SEQUELAE OF PREGNANCY

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ALTERNATE RESOLUTION 432 ADOPTED IN LIEU OF RESOLUTION 432
See Policy H-185.917

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.

RESOLVED, that our AMA will support further insurance coverage for conditions related to long-term sequelae of pregnancy.

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.

433. CLINICAL LACTATION CARE
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-35.959

RESOLVED, that our American Medical Association recognizes the importance of 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.

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.

434. BREAST CANCER RISK REDUCTION
Introduced by Medical Society of the District of Columbia

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-55.965

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.

RESOLVED, that our AMA encourages physicians to regularly discuss with their individual patients the benefits of lifestyle changes that may reduce cancer risk.

REFERENCE COMMITTEE E

501. SAFER BUTTON / COIN BATTERIES
Introduced by American Academy of Otolaryngology – Head and Neck Surgery

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED
See Policy D-480.953

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.

RESOLVED, that our AMA advocate for industry development and employment of safer button battery technology.

502. NIH GRANT FUNDING FOR MEDICAL RESEARCH
Introduced by American College of Rheumatology

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTEDAS FOLLOWS
See Policy D-460.961

RESOLVED, that our AMA will work with the National Institutes of Health (NIH), other governmental funding agencies, and relevant stakeholders to 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.

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.

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.

503. SAFEGUARDING NEURAL DATA COLLECTED BY NEUROTECHNOLOGIES
Introduced by Colorado

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-315.957

RESOLVED, that our AMA support legislative and regulatory efforts to protect the privacy and security of individuals' neurological data as well as protection from discrimination and inequality that may be caused by the use of neurotechnologies.

RESOLVED, that our AMA 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 neural data does not include data inferred from nonneural information.

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.

504. PHYSICIAN PERFORMED MICROSCOPY DESIGNATION FOR SYNOVIAL FLUID CRYSTAL EXAM: MODIFY THE CLINICAL LABORATORY AMENDMENT OF 1988
Introduced by Georgia

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: **ADOPTED**
See Policy H-260.960

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.

505. MANDATING PROPERLY FITTING LEAD APRONS IN HOSPITALS
Introduced by Indiana

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: **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.

506. OPPOSING THE USE OF HARM REDUCTION ITEMS AS EVIDENCE OF EXCHANGING SEX FOR MONEY
Introduced by LGBTQ+ Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy H-95.895

RESOLVED, that our American Medical Association supports the availability and access to harm reduction tools for people who exchange sex for money to protect their health and well-being.

RESOLVED, that our AMA opposes the use of harm reduction tools as evidence in the prosecution of people who exchange sex for money.

507. ENSURING TRANSPARENCY AND ACCOUNTABILITY IN CLINICAL USE OF AUGMENTED INTELLIGENCE

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ALTERNATE RESOLUTION 507 ADOPTED IN LIEU OF RESOLUTION 507
See Policy D-480.952

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.

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.

508. STANDARDIZING SAFETY REQUIREMENTS FOR TRADITIONAL AND RIDESHARE-BASED NON-EMERGENCY MEDICAL TRANSPORTATION

Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: 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).

509. ALLERGEN LABELING FOR SPICES AND HERBS

Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-150.913

RESOLVED, that our American Medical Association support requirements for public 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.

510. IMPROVING CYBERSECURITY STANDARDS FOR HEALTHCARE ENTITIES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-478.974

RESOLVED, that our American Medical Association support the establishment of 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.

511. INCREASED TRANSPARENCY AMONG PSYCHOTROPIC DRUG ADMINISTRATION IN PRISONS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-430.990

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.

RESOLVED, that our AMA support increased transparency from 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.

512. PREVENTING DRUG-FACILITATED SEXUAL ASSAULT IN DRINKING ESTABLISHMENTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-515.973

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) the establishment of public education campaigns.

513. TRANSPARENCY ON COMPARATIVE EFFECTIVENESS IN DIRECT-TO-CONSUMER ADVERTISING
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED
See Policy H-105.984

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.

514. SUPPORT FOR A NICOTINE FREE GENERATION

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ALTERNATE RESOLUTION 514 ADOPTED IN LIEU OF RESOLUTION 514
See Policy D-490.972

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.

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.

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.

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.

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.

515. NITROUS OXIDE MISUSE
Introduced by New York

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS TITLE CHANGED
See Policy D-95.951

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 and work with all relevant local stakeholders to limit the ability of non-medical facilities to acquire nitrous oxide for recreational inhalation purposes.

516. CREATING A REGISTRY OF POTENTIAL SIDE EFFECTS OF GIP & GLP-1 MEDICATIONS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: **ADOPTED**
See Policy D-100.960

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.

517. IN SUPPORT OF A NATIONAL DRUG CHECKING REGIST
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-95.950

RESOLVED, that our American Medical Association study the creation of a national drug-checking data system 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.

518. MANDATORY ACCREDITATION AND REGULAR INSPECTIONS OF HYPERBARIC CHAMBERS
Introduced by Undersea and Hyperbaric Medical Society

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: **ADOPTED**
See Policy D-270.981

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.

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.

RESOLVED, that our AMA support legislative efforts to establish uniform national standards for the operation and maintenance of hyperbaric chambers.

519. FRAMEWORK TO CONVEY EVIDENCE-BASED MEDICINE IN AI TOOLS USED IN CLINICAL DECISION MAKING
Introduced by Washington State

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: **ADOPTED**
See Policy D-480.951

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.

520. STUDY OF GRADING SYSTEMS IN AMA BOARD REPORTS
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: 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.

521. WARNING LABELS ON OTC SLEEP AIDS
Introduced by New York

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: POLICY H-100.968 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.

522. ACCESS TO IMPORTANT AND ESSENTIAL DRUGS
Introduced by Association for Clinical Oncology

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-100.959

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.

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 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.

REFERENCE COMMITTEE F

601. AMA TO DEVELOP PATIENT EDUCATIONAL MATERIALS REGARDING ULTRA-PROCESSED FOODS FOR DISTRIBUTION BY AMA MEMBERS
Introduced by American College of Lifestyle Medicine

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: **FIRST RESOLVED ADOPTED**
SECOND RESOLVED REFERRED
See Policy G-630.140

[Editors note: the first resolved was adopted]
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.

[Editors note: the second resolved was referred]
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.

602. ENABLING AMA BOT EXPEDIENCY FOR ACTIONS, ADVOCACY, AND RESPONSES DURING URGENT SITUATIONS
Introduced by American Thoracic Society

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy G-600.071

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 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 best represent the interests of patients, physicians, and to advocate for science and public health. ~~In representing AMA policy in critical situations, t~~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.

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.

603. RENAMING THE MINORITY AFFAIRS SECTION TO THE UNDERREPRESENTED IN MEDICINE ADVOCACY SECTION
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: **ADOPTED**
See Policy D-615.975

RESOLVED, that our American Medical Association Minority Affairs Section (MAS) be renamed the Underrepresented in Medicine Advocacy Section (UMAS).

604. ADVISORY COMMITTEE ON TRIBAL AFFAIRS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-615.976

RESOLVED, that our American Medical Association: (1) establish and report back at the 2025 Interim Meeting on the formation of Task Force on Tribal Affairs composed of AMA members who themselves identify as American Indian and Alaska Native (AI/AN), 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) 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.

REFERENCE COMMITTEE G

701. ELECTRONIC HEALTH RECORDS CONTRACT TERMINATION
Introduced by American Association of Clinical Urologists

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, that our American Medical Association adopt as policy that Electronic Health Record (EHR) vendors provide physician practices with a minimum180-day notification of contract termination without cause.

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.

702. STRENGTHENING HEALTH PLAN ACCOUNTABILITY FOR PHYSICIAN SATISFACTION
Introduced by The American Academy of Family Physicians

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-450.948

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.

703. APPROPRIATE USE OF DATA FROM SURGICAL PRACTICES
Introduced by American Association of Gynecologic Laparoscopists

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-406.985

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, patient safety, and research and development with appropriate protections to prevent misuse.

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.

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.

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.

704. MITIGATING THE IMPACT OF EXCESSIVE PRIOR AUTHORIZATION PROCESSES
Introduced by Florida

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: FIRST AND THIRD RESOLVES ADOPTED
SECOND RESOLVE REFERRED
See Policy D-320.971

[Editors note; the following resolve adopted]
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.

[Editors note: the following resolve referred]
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.

[Editors note; the following resolve adopted]
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.

705. ELIMINATION OF TRANSACTION FEES FOR ELECTRONIC HEALTHCARE PAYMENTS
Introduced by Georgia

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: 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.

706. INCREASING TRANSPARENCY SURROUNDING MEDICARE ADVANTAGE PLANS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-330.862

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, and provider networks.

707. SIMPLIFYING CORRESPONDENCE FROM HEALTH INSURERS
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-180.977

RESOLVED, that the American Medical Association advocate for the standardization of correspondence from health insurers for the goal of simplifying the message, making it more readable, more quickly processed, and more efficiently reviewed.

708. ADVOCATING AGAINST PRIOR AUTHORIZATION FOR IN-PERSON VISITS WITH PHYSICIANS
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED
See Policy D-320.970

RESOLVED, that our American Medical Association advocate against health insurance plan policies that require prior authorization for in-person visits with a physician.

709. ALLOWING TIMELY ACCESS TO PAIN MEDICATIONS IN DISCHARGED HOSPITAL AND AMBULATORY SURGERY PATIENTS
Introduced by New York

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED
See Policy D-120.921

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.

710. REQUIRING INSURANCES TO APPLY DISCOUNTED COST MEDICATION TO THE PATIENT'S DEDUCTIBLE
Introduced by New York

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association advocate for legislation or other appropriate mans to ensure that all payment made by patients for prescription medications outside of their insurance coverage (such as pharmaceutical discount programs) count towards that patient's annual deductible and out of pocket maximum.

711. STUDY OF PRACTICE MODELS FOR PHYSICIANS WORKING ACROSS STATE LINES
Introduced by Oklahoma

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: 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.

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.

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.

712. BILLINGS AND COLLECTIONS TRANSPARENCY
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED
See Policy H-225.950 and H-385.939

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.

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.

713. AIDING MEMBERS OF MEDICAL STAFFS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED
See Policy D-225.972

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.

714. ROOT CAUSE ANALYSIS OF THE CAUSES OF THE DECLINE OF PRIVATE MEDICAL PRACTICE
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-405.965

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.

715. GRACE PERIOD FOR TIMELY FILING DUE TO TECHNOLOGY FAILURES REGARDLESS OF CAUSE
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-190.967

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".

716. MINIMUM PAYER COMMUNICATION QUALITY STANDARDS
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-180.976

RESOLVED, that our American Medical Association advocate for payer minimum quality standards to include immediate access to a live representative during business hours.

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.

717. PROMOTING MEDICATION CONTINUITY AND REDUCING PRIOR AUTHORIZATION BURDENS
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED
See Policy D-320.969

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; 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.

718. SAFEGUARDING MEDICAL STAFF BYLAWS AND ACCREDITATION STANDARDS IN VA FACILITIES
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: FIRST AND SECOND RESOLVES ADOPTED
THIRD AND FOURTH RESOLVES REFERRED FOR DECISION
See Policy H-225.939

[Editor's note: the following Resolves were adopted]
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.

RESOLVED, that our AMA opposes any administrative action that bypass the organized medical staff's voting authority in revising medical staff bylaws.

[Editor's note: the following Resolves were referred for decision]
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.

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.

719. COMPREHENSIVE AMA POLICY PUBLICATION REGARDING EMPLOYED PHYSICIANS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: **ADOPTED**
See Policy D-225.971

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;

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;

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.

EMERGENCY RESOLUTION

The following emergency resolution was submitted for the consideration of the House of Delegates on Tuesday, June 11, 2025. The House voted to accept the resolution as business. Emergency resolutions are considered by the House and not referred to a reference committee.

1001. ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES

Introduced by American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American Association of Public Health Physicians, Infectious Diseases Society of America, American College of Medical Quality, American Society for Reproductive Medicine, American College of Gastroenterology, American Association of Gynecologic Laparoscopists, Endocrine Society, American Academy of Hospice and Palliative Medicine, American College of Lifestyle Medicine, American Association of Clinical Endocrinology, American College of Preventive Medicine, American College of Chest Physicians, American College of Medical Genetics and Genomics, American Geriatrics Society, GLMA: Health Professionals Advancing LGBTQ+ Equality, California Medical Association, Illinois State Medical Society, Medical Society of New Jersey, North Carolina Medical Society, Oklahoma State Medical Association, Medical Association of the State of Alabama, Medical Society of Virginia, South Dakota State Medical Association, Indiana State Medical Association, Washington State Medical Association, PacWest, LGBTQ+ Section, Medical Student Section, Women Physicians Section, Integrated Physicians Practice Section, Senior Physician Section, Preventive Medicine Section Council, Kansas Medical Society, Society of American Gastrointestinal and Endoscopic Surgeons

HOD ACTION: ADOPTED
See Policy D-440.902

RESOLVED, that our American Medical Association initiate sustained public advocacy in support of the current Advisory Committee on Immunization Practices structure, including the liaison representative program.

RESOLVED, that our AMA immediately send a letter to the Secretary of Health and Human Services calling for an immediate reversal of the recent changes to the Advisory Committee on Immunization Practices.

RESOLVED, that our AMA immediately send a letter to the Senate Committee on Health, Education, Labor and Pensions (HELP) and request an investigation into the actions of the Secretary regarding his administration of the Centers for Disease Control and Prevention and Advisory Committee on Immunization Practices.

RESOLVED, that our AMA will identify and evaluate alternative evidence-based vaccine advisory structures and invest resources in such initiatives, as necessary.