REFERRAL CHANGES AND OTHER REVISIONS
2025 Annual Meeting

REVISED RESOLUTIONS

- Res. 602 – Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations (First Resolved Updated)

REVISED REPORTS

- COMP 01 – Report of the House of Delegates Committee on the Compensation of the Officers
- CEJA 03 – Reconsidering the Terminology to Describe Physician Assisted Suicide
- CEJA 07 – Guidelines on Chaperones for Sensitive Exams
- CEJA 08 – Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blinded Model for Organ Procurement and Transplantation
- CEJA 09 – Ethical Impetus for Research in Pregnant and Lactating Individuals
- CEJA 13 – Presumed Consent & Mandated Choice for Organs from Deceased Donors

RESOLUTIONS WITH ADDITIONAL SPONSORS
(Additional sponsors underlined)

- Res. 111 - New Reimbursement System Needed for Rural Hospital Survival
  (Mississippi, Kentucky)
- Res. 115 - Supporting Legislative Efforts to Remove Certain High-Cost Supplies and Equipment from the Medicare Physician Fee Schedule
  (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)
- Res. 117 - Liberalized Remorse Period for Medicare Advantage Plan Insureds
  (Mississippi, Kentucky)
- Res. 207 - Abolishing Venue Shopping
  (American College of Surgeons, Pennsylvania)
- Res. 209 - Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Addiction Medications for Legitimate Medical Purposes
  (American Society of Addiction Medicine, American Academy of Hospice & Palliative Medicine)
- Res. 218 – Distribution of Resident Slots Commensurate with Shortages
  (Medical Student Section, American College of Physicians, American College of Preventive Medicine, International Medical Graduates Section, Integrated Physician Practice Section, American Psychiatric Association)

- Res. 309 – Increasing Education on Physician-Led Care and Advocacy in Residency Training
  (Oklahoma, Mississippi)
- Res. 507 – Clinical and Public Safety Implications of AI-Generated Content and Symbolic Compliance Infrastructure
  (Mississippi, Oklahoma)

ORDER OF BUSINESS
SECOND SESSION

Saturday, June 7, 2025
12:30 PM

1. **Call to Order by the Speaker – Lisa Bohman Egbert, MD**

2. **Report of the Rules and Credentials Committee – Alisha Reiss, MD**

3. **Presentation Correction and Adoption of Minutes from the November 2024 Interim Meeting**

4. **Referral Changes and Other Revisions**

5. **Acceptance of Business**

--REPORTS--

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

01 Annual Report
02 New Specialty Organizations Representation in the House of Delegates
04 AMA 2026 Dues
06 Transparency and Accountability of Hospitals and Hospital Systems
09 Council on Legislation Sunset Review of 2015 House Policies
13 The Uniform Health-Care Decisions Act
14 A Public Health-Centered Criminal Justice System
16 Research Correcting Political Misinformation and Disinformation on Scope of Practice
17 Antidiscrimination Protections for LGBTQ+ Youth in Foster Care
18 Physician Assisted Suicide
19 Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
20 Guardianship and Conservatorship Reform
21 Advocacy for More Stringent Regulations / Restrictions on Distribution of Cannabis
22 Ranked Choice Voting
23 Financial Assistance to Facilitate Attendance at MSS Meetings
24 Creation of an AMA Council with a Focus on Digital Health Technologies and AI
26 Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnou
28* Specialty Society Representation in the House of Delegates - Five-Year Review

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

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

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

01 The AMA Code of Medical Ethics Evolving to Provide Health Care Systems Ethics Guidance
02 Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization

05 Protecting Physicians Who Engage in Contracts to Deliver Health Care Services
06 Amendment to Opinion 1.1.1 "Patient-Physician Relationships"
07 Guidelines on Chaperones for Sensitive Exams
08 Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blinded Model for Organ Procurement and Transplantation
09 Ethical Impetus for Research in Pregnant and Lactating Individuals
10 The Preservation of the Primary Care Relationship
11 CEJA Sunset Review of 2015 House Policies
13 Presumed Consent & Mandated Choice for Organs from Deceased Donors

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

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

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

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

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

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

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

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

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

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

Joint Report(s)
CCB/CLRPD

01 Joint Council Sunset Review of 2015 House Policies

--EXTRACTION OF INFORMATIONAL REPORTS—

Report(s) of the Board of Trustees

03 2024 Grants and Donations
05 Update on Corporate Relationships
07 AMA Performance, Activities and Status in 2024
08 Annual Update on Activities and Progress in Tobacco Control: March 2024 through February 2025
10 American Medical Association Health Equity Annual Report
11 AMA Efforts on Medicare Payment Reform
12 Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted
15 Physician Assistants and Nurse Practitioner Movement Between Specialties
25 AMA Public Health Strategy Update
27 AMA Reimbursement of Necessary HOD Business Expenses for Delegates and Alternates

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

03 Reconsidering Terminology to Describe Physician Assisted Suicide
04 Reconsideration of Physician Assisted Suicide
12 Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report
14* Achieving Gender-Neutral Language in the AMA Code of Medical Ethics

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

01 Palliative Care

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

03 Demographic Characteristics of the House of Delegates and AMA Leadership

Report(s) of the Council on Medical Service

08 Prescription Drug Affordability Boards

--INTRODUCTION OF RESOLUTIONS--

001 Opposition to Censuring Medical Societies or Organizations Based on Politics or Policies of Governments
002 Physician Disclosures of Relationships in Private Equity Held Organizations
003 Opposition to Censorship in Public Libraries
004 Reducing the Harmful Impacts of Immigration Status on Health

005 Dedicated Interfaith Prayer and Reflection Spaces in Medical Schools and Healthcare Facilities

006 Military Deception as a Threat to Physician Ethics

007 Use of Inclusive Language in AMA Policy

008 Humanism in Anatomical Medical Education

009 Patient centered health care as a Determinant of Health

010 Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure

011 Opposition of Health Care Entities from Reporting Individual Patient Immigration Status

012 Carceral Systems and Practices in Behavioral Health Emergency Care

013 Continued Support of World Health Organization (WHO) & United States Agency for International Development (USAID)

014* Protecting Access to Emergency Abortion Care Under EMTALA

015* Addressing Targeting and Workplace Restrictions and Barriers to Healthcare Delivery by International Medical Graduate (IMG) Physicians and other Physicians Based upon Migration Status or Country of Origin within Healthcare Systems

101 Uniform Adoption of Service Intensity Tools to Support Medical Decision-making and Service Gap Analysis

102 Access to Single Maintenance and Reliever Therapy for Asthma

103 Inadequate Reimbursement for Biosimilars

104 Study of Whether the HSA Model Could Become an Option for Medicaid Beneficiaries

105 Development of an Educational Resource on Opting Out of Medicare for Physicians

106 Advocating for All Payer Coverage for Custom Breast Prostheses for Patients with History of Mastectomy Secondary to Breast Cancer Treatment

107 Advocating for All Payer Coverage of Reconstructive and Cosmetic Surgical Care Related to Cleft Lip and Palate

108 Firearm Storage Diagnosis and Counseling Reimbursement

109 Medicare Advantage Plans Double Standard

110 Study of the Federal Employee Health Benefit Plan (FEHBP)

111 New Reimbursement System Needed for Rural Hospital Survival

112 Continuation of Affordable Connectivity Program

113 Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts

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

115 Supporting Legislative Efforts to Remove Certain High-Cost Supplies and Equipment from the Medicare Physician Fee Schedule

116 Medicare Coverage of Registered Dietitian (RD) and Certified Nutrition Support Specialist (CNSS) Visits Beyond Type 2 Diabetes and Renal Disease

117 Liberalized Remorse Period for Medicare Advantage Plan Insureds

118 Improving Access to Peripartum Pelvic Floor Physical Therapy

119 Cancer Survivorship Program Coverage

120 Medigap, Pre-Existing Conditions, and Medicare Coverage Education

121* Opposing Pharmacy Benefit Manager Spread Pricing

201 Inclusion of DICOM Imaging in Federal Interoperability Standards

202 Preservation of the CDC Epilepsy Program Workforce and Infrastructure

203 Supporting SUPPORT Act modifications to enhance care of patients with chronic pain
204 Protecting the Prescriptive Authority of Plenary Licensed Physicians
205 AMA Support for Continuance of the Section 1115 - Social Security Act, Medicaid Waiver Program
206 AMA Support for Renewal of Section 1115 - Social Security Act, Medicaid Waiver Demonstration Projects Supporting Food and Nutrition Services
207 Abolishing Venue Shopping
208 Binding Arbitration in Health Insurance Contracts
209 Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Addiction Medications for Legitimate Medical Purposes
210 Impact of Tariffs on Healthcare Access and Costs
211 Support for State Provider and Managed Care Organization Taxes to Sustain Federal Medicaid Matching Funding
212 Setting Standards for Forensic Toxicology Laboratories Used in Litigation
213 Emergency Department Designation Requires Physician on Site
214 United Health Care and InterQual Monopoly
215 Support for Changing Standards for Minors Working in Agriculture
216 Support for Aging-Out Foster Youth with Mental Health and Psychotropic Needs
217 Regulation and Oversight of the Troubled Teen Industry
218 Distribution of Resident Slots Commensurate with Shortages
219 Opposing Unwarranted National Institutes of Health Research Institute Restructuring
220 Strengthening AMA Policy on Noncompete Clauses in Ownership Transitions
221 Preservation of Medicaid
222 Need for Separate H1B Pathway for IMG Doctors in the USA
223 Preservation of Medicaid
224 Support SAVE Plan and Public Service Loan Forgiveness (PLSF) Applications
225 The Private Practice Physicians in the Community
226 Regulations for Algorithmic-Based Health Insurance Utilization Review
227 Payment Recoupment—Let Sanity Prevail
228 CHIP Coverage of OTC Medications
229 Guaranteeing Timely Delivery and Accessibility of Federal Health Data
230 Advocating to expand private insurance coverage of anti-obesity medications (AOM)
231 Preventing Venue Shopping in Medical Liability to Protect Physician Practices and Access to Care
232 Preservation of Medicaid
233 Increasing Transparency of AMA Medicare Payment Reform Strategy
234 Protection for International Medical Graduates
235 CMS Payment Monitoring Following Government Staff Reductions
236* Preservation of Medicaid
237* Urgent Advocacy to Restore J-1 Visa Processing for International Medical Graduate Physicians
238* Preserving Accreditation Standards on Diversity, Equity, and Inclusion
301 Examining ABMS Processes for New Boards

302 AMA Study of Lifestyle Medicine and Culinary Electives to Reduce Burnout and Bolster Career Satisfaction in Trainees

303 Support for the Establishment of an Indigenous-Led Medical School in the United States

304 Addressing Professionalism Standards in Medical Training

305 Curricular Structure Reform to Support Physician and Trainee Well-Being

306 Innovation and Reform of Medical Education

307 Disclosure of Individual Physician Volunteers Participation in Committee Decision-making to other Organizations, Stakeholders and Joint Providers

308 Streamlining Annual Compliance Training Requirements for Physicians

309 Increasing Education on Physician-Led Care and Advocacy in Residency Training

310 Protections for Trainees Experiencing Retaliation in Medical Education

311 Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter

312 Selection of IMG Residents Based on Merit

401 Reducing Pickleball-Related Ocular Injuries

402 Protecting In-Person Prison Visitations to Reduce Recidivism

403 Promoting Evidence-Based Responses to Measles and Misuse of Vitamin A

404 Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers

405 Health Warning Labels on Alcoholic Beverage Containers

406 Call for Study: Should Petroleum-Powered Emergency Medical Services (EMS) Vehicles in Urban Service Areas be Replaced by Renewably-Powered Electric Vehicles?

407 Sleep Deprivation as a Public Health Crisis

408 Removing Artificial Turf in Schools, Parks, and Public Places

409 Guidelines for Restricting Cell Phones in K-12 Schools

410 Hate Speech is a Public Health Concern

411 Protecting Access to mRNA Vaccines

412 Supporting inclusive long-term care facilities

413 Preservation of Public Funding for Physicians and Hospitals Providing LGBTQ+ Care

414 Expanding Sexually Transmitted Infection Care for Persons with Unstable or No Housing

415 Promoting Child Welfare and Communication Rights in Immigration Detention

416 Culturally and Religiously Inclusive Food Options

417 Updating Alcohol Health Warning Labels to Reflect Evidence-Based Health Risks and Supporting National Labeling and Signage Policy Reform

418 AMA Study on Plastic Pollution Reduction

419 Advocating for Universal Summer Electronic Benefit Transfer Program for Children (SEBTC)

420 Study of Plant-Based & Lab-Grown Meat

421 Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities

422 Protecting the Integrity of the U.S. Healthcare System from Misinformation and Policy

423 Requiring Universal Vaccine reporting to a National Immunization Registry and Access to a National Immunization Information System

424 Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records

425 Alcohol Consumption and Health

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

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

*Contained in Meeting Tote

Report of the AMPAC Board of Directors

Presented by: John W. Poole, MD
Chair

On behalf of the AMPAC Board of Directors, I am pleased to present this report to the House of Delegates regarding our activities this election cycle. As 2025 progresses, our profession continues to face multiple challenges in regard to health care policy which will directly impact our practices and our patients. AMPAC will help our profession, and our patients meet those challenges. We remain committed to our core mission - to provide physicians with opportunities to support physician-friendly candidates who will help advance an advocacy agenda that protects our profession and our patients. In addition, we continue to help physician advocates grow their abilities through our political education programs, which include intensive training sessions that provide them with all the tools necessary to successfully take the next step and work on campaigns or run for office themselves.

AMPAC Membership Fundraising

Thank you to the House of Delegates members who have supported AMPAC this year, especially those contributing at the Capitol Club levels. AMPAC has instituted a new $5,000 Diamond level. I am pleased to report there are now 42 Diamond members and climbing—a special thank you to all of you. Your commitment strengthens AMPAC's ability to support AMA advocacy and support champions of medicine.

As of May 31, receipts for the start of the 2026 election cycle total $594,180 reflecting a 21% overall increase in revenue compared to the same period in the previous cycle. Notably, hard dollar contributions have risen by 27%. Contributions from physicians supporting AMPAC for the first time have increased by 25% over last year, and this influx of new contributors marks a promising expansion of AMPAC's donor base. Meanwhile, participation in AMPAC's Capitol Club remains strong with 529 members and we anticipate a significant boost in Capitol Club membership during this meeting.

Our newly invigorated AMPAC Board has played a vital role in prioritizing AMPAC's fundraising. This is making an impact and positioning AMPAC for even greater success. However, this momentum is only possible with the unwavering support of the leaders within the AMA. The AMA Board of Trustees, the entire House of Delegates, along with AMA Councils and Sections, play a critical role in AMPAC's strength and effectiveness. Leadership starts at the top, and the visible, active engagement of these groups is essential to encouraging wider participation across the organization. I am proud to report that the entire AMPAC BOD has contributed at the Diamond or Platinum level.

To build on our progress, AMPAC has set bold participation goals: 85% engagement from the House of Delegates and 100% participation from AMA Councils and Sections. Meeting these targets will require a shared commitment, but with strong leadership, we are confident we can achieve these ambitious benchmarks. If you haven't supported AMPAC yet, now is the time. Investing in AMPAC means standing up for your patients as we shape the policies that impact how we care for those we serve. We strongly encourage members of the HOD, Councils and Sections to invest in AMPAC by visiting AMPAC's Booth, conveniently located in the foyer outside the Grand Ballroom during this meeting or by visiting https://www.ampaconline.org/

If you are an AMPAC Capitol Club member, we hope to see you at the luncheon on Monday, June 9 at 12:30 p.m., featuring special guest Douglas Brinkley, an acclaimed presidential historian and best-selling author. This event is a great way to connect with colleagues and who have demonstrated their leadership by supporting AMPAC at the Capitol Club level. Dr. William Clark, of Georgia, is the winner of the 2025 AMPAC Political Participation Award which will be presented to him at the luncheon.

AMPAC serves as the bipartisan political action committee of the AMA, established to advance the advocacy

mission outlined by the HOD. By building strong relationships with policymakers, AMPAC helps the AMA guide legislative action that supports physicians and strengthens patient care.

Political Action

The 2026 election cycle is shaping up to be another competitive one, especially in the House, as Republicans hold their slimmest majority since the Great Depression. The focus will be on the roughly 40-50 House districts considered to be among the most competitive in the country which will determine majority control in the next Congress. These districts stretch across the country from Alaska to Florida, Maine to California. Meanwhile in the Senate, even though thirty-five seats are on the ballot, control of the upper chamber is likely to come down to just six or seven competitive contests. Republicans hold a six-seat majority, and Democrats face an uphill battle to regain control. Democrats need to defend four competitive seats, win the two Republican seats considered competitive, and flip two more seats. Their hopes likely depend on the Maine Senate race and Republican Sen. Susan Collins is no stranger to winning competitive and costly elections.

AMPAC will be closely monitoring this highly contentious landscape by looking at opportunities in open-seat races, some of which involve physician candidates, as well as medicine-friendly incumbents to support and further strengthen the relationship with organized medicine. With issues such as prior authorization and Medicare payment reform showing movement, even in Congress' current state, your AMPAC contributions are creating critical strategic interactions with those in the best positions to move key priorities forward. AMPAC is excited to have 21 physicians in the 119th Congress, the most we believe since 1820. And many of these physician members are in key positions to be helpful to organized medicine.

Though the mid-term election is still a little over 500 days away, AMPAC has begun making early, strategic contributions to members of Congress in key positions for organized medicine. AMPAC will continue to monitor congressional retirements, potential redistricting changes in key states, and work to support and advance the AMA's advocacy agenda.

Political Education Programs

The 2025 Candidate Workshop took place, March 28-30, at the AMA offices in Washington, DC. Registration for the program was strong with 22 participants. This included: 17 member physicians and five member residents and students.

During the program participants heard from political experts on both sides of the aisle about what it takes to run a winning campaign. This included sessions on the importance of a disciplined campaign plan and message; the secrets of effective fundraising; what kinds of advertising may be right for your campaign; how to work with the media; as well as how to build your campaign team and a successful grassroots organization. The program also included a keynote session with Representative Bob Onder, MD of Missouri, who shared his stories and insights from the campaign trail as a physician candidate for office.

Promotion is currently underway for the 2025 Campaign School. The program will take place September 11-14 at the AMA offices in Washington, DC. As always, the political education programs remain a member benefit with registration fees heavily discounted for AMA members. Program dates will be announced soon on AMPAConline.org.

Conclusion

On behalf of the AMPAC Board of Directors, I want to extend our sincere appreciation to members of the House of Delegates who continue to support AMPAC and our mission. Your active involvement in both political and grassroots advocacy is essential to amplifying the voice of organized medicine on Capitol Hill. Your dedication not only helps shape sound health care policy but also ensures that the interests of physicians and patients remain front and center in Washington, DC.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (A-25)

Michael S. Aronow, MD

Introduced by: American Academy of Orthopaedic Surgeons,
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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (A-25)

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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (A-25)

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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Supplementary Report of Committee on Rules and Credentials

Presented by: Alisha Reiss, MD, Chair

Saturday, June 7, 2025

Madam Speaker, Members of the House of Delegates:

The Committee on Rules and Credentials met Friday, June 6, to discuss Late Resolutions. The sponsors of the late resolutions met with the committee and were given the opportunity to present for the committee's consideration the reason the resolution could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting.

Recommended for acceptance:

- Late 1003 – Ensuring Accessibility and Inclusivity of CDC Resources
- Late 1005 – Preserving the Specialty of Occupational and Environmental Medicine
- Late 1006 – Opposition to the Decertification of Independent Universities from the Student and Exchange Visitor Program
- Late 1007 – Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research from Politicized Attacks

Recommended against acceptance:

- Late 1001 – Annual Scorecard to Evaluate the AMA's Impact
- Late 1002 – Review of Past Resolutions
- Late 1004 – Preventing Sleep Deprivation and Supporting Medical Student Wellness

Madam Speaker, this concludes the Supplementary Report of the Committee on Rules and Credentials. I would like to thank Mark Bair, MD, RPh; Mary Ann Contogiannis, MD; Amit Ghose, MD; Shelley Glover, MD, MPH; Andrew Lutzkanin, III, MD; and Sarah Marsicek, MD; and on behalf of the committee those who appeared before the committee.

Mark Bair, MD, RPh
Utah

Mary Ann Contogiannis, MD
North Carolina

Amit Ghose, MD
Michigan

Shelley Glover, MD, MPH
Florida

Andrew Lutzkanin, III, MD*
Pennsylvania

Sarah Marsicek, MD
American Academy of Pediatrics

Alisha Reiss, MD, Chair
Ohio

*Alternate Delegate

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1001
(A-25)

Introduced by: Michigan

Subject: Annual Scorecard to Evaluate the AMA's Impact

Referred to: Reference Committee F

Whereas, the American Medical Association aims to promote the art and science of medicine and the betterment of public health; and

Whereas, it is important for the AMA to continuously evaluate its performance to align with evolving healthcare needs and priorities; and

Whereas, a transparent and systematic approach to measuring effectiveness can enhance trust and accountability among members and stakeholders; and

Whereas, there is a need for accountability and transparency in assessing the AMA's impact and effectiveness in achieving its goals; and

Whereas, a systematic and data-driven approach can provide valuable insights into the AMA's performance and areas for improvement; therefore be it

RESOLVED, that our American Medical Association implement a comprehensive scorecard to measure its effectiveness in key areas including, but not limited to, the following specific metrics:

1. Medicare Impact: percent change in the Medicare Physician Fee Schedule;
2. Advocacy Impact: number of federal policies successfully influenced or implemented;
3. House of Delegates Impact: number of AMA policies translated into legislation or federal policy;
4. Financial Impact: percentage of revenue dedicated to advocacy; and
5. Physician Engagement: total number of its member physicians directly engaged in advocacy efforts through contact with lawmakers (Directive to Take Action); and be it further

RESOLVED, that our AMA shall finalize metric definitions and targets by the 2026 AMA Interim Meeting. Any future updates to metrics or targets shall be recommended in a Board of Trustees Report to the AMA House of Delegates so that the AMA HOD can approve final metrics and targets for the subsequent year before or during the AMA Interim Meeting immediately preceding the year the metrics and targets are to take effect (Directive to Take Action); and be it further

RESOLVED, that our AMA shall publish the AMA's scorecard performance for the prior year by the end of the first month of the following year, starting in January 2026. (Directive to Take Action)

Fiscal Note: Modest (Annually) - between $1,000 - $5,000

Received: 5/9/25

RELEVANT AMA POLICY

Actions and Decisions by the AMA House and Policy Implementation G-600.071
1. AMA policy on House actions and decisions includes the following:
A. Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (i) correcting factual errors in AMA reports, (ii) rewording portions of a report that are objectionable, and (iii) rewriting portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible.
B. A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be amended by means of a positive action of the House specifically intended to change that policy.
C. Minor editorial changes to existing policies are allowed for accuracy, so long as such changes are reported to the House of Delegates so as to be transparent. Editorially amended policies, however, do not reset the sunset clock.

2. AMA policy on implementation of policy includes the following:
A. Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and report recommendations and specific actions that have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted.
B. Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions.
C. Any resolution which is adopted by our AMA House remains the policy of the Association until amended, rescinded or sunset by the House.

3. Except as noted herein and consistent with the AMA Bylaws, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates. Further, the Board of Trustees has the authority in urgent situations to take those policy actions that the Board deems best represent the interests of patients, physicians, and the AMA. In representing AMA policy in critical situations, the Board will take into consideration existing policy. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.

4. Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1002
(A-25)

Introduced by: Michigan

Subject: Review of Past Resolutions

Referred to: Reference Committee F

Whereas, the American Medical Association is an organization charged to advocate on behalf of their members; and

Whereas, AMA members rely on the AMA House of Delegates to pass resolutions to that effect; and

Whereas, the AMA Board of Trustees is charged with ensuring these resolutions are implemented; and

Whereas, the AMA has not disseminated a detailed aggregate report to ensure the AMA membership is aware that the work of the House is being accomplished; therefore be it

RESOLVED, that our American Medical Association present, by the 2025 AMA Interim Meeting, a detailed and aggregate report that is easily accessible and includes the following data for the past 10 years; the total number of resolutions submitted and passed; the number of those resolutions specific to advocacy on the sustainability of medical practices; a breakdown of these resolutions by Annual and Interim meetings; and the percentage of resolutions that have been successfully implemented. The report shall be produced on an annual basis and included in the Interim meeting handbook. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 5/9/25

RELEVANT AMA POLICY

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A. Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (i) correcting factual errors in AMA reports, (ii) rewording portions of a report that are objectionable, and (iii) rewriting portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible.
B. A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be amended by means of a positive action of the House specifically intended to change that policy.
C. Minor editorial changes to existing policies are allowed for accuracy, so long as such changes are reported to the House of Delegates so as to be transparent. Editorially amended policies, however, do not reset the sunset clock.

2. AMA policy on implementation of policy includes the following:
A. Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and report recommendations and specific actions that have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted.
B. Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions.
C. Any resolution which is adopted by our AMA House remains the policy of the Association until amended, rescinded or sunset by the House.

3. Except as noted herein and consistent with the AMA Bylaws, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates. Further, the Board of Trustees has the authority in urgent situations to take those policy actions that the Board deems best represent the interests of patients, physicians, and the AMA. In representing AMA policy in critical situations, the Board will take into consideration existing policy. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.

4. Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1003
(A-25)

Introduced by: Michigan

Subject: Ensuring Accessibility and Inclusivity of CDC Resources

Referred to: Reference Committee B

Whereas, the Centers for Disease Control and Prevention (CDC) provides critical public health information, including guidelines, toolkits, and educational materials that support clinicians and patients in making informed health decisions; and

Whereas, in February 2025, resources for tracking, preventing, and treating HIV, handling sexually transmitted infections, and contraception were removed from the Centers for Disease Control and Prevention website; and

Whereas, the removal or restriction of access to these resources could negatively impact the ability of health care professionals to stay informed about best practices and emerging public health concerns; and

Whereas, the use of electronic knowledge resources has been shown to positively impact clinician behaviors and patient outcomes through evidence-based practices. The use of electronic knowledge resources was associated with increased success in answering clinical questions; and

Whereas, the use of electronic patient resources and web-based medical information has become increasingly prevalent among both physicians and patients with physicians reporting regularly engaging with patients with more than 80 percent who seek out online health information as part of their daily practice; and

Whereas, studies have shown that over 50 percent of patients stated that they use the internet for medical information and it was concluded that providers should be prepared to offer suggestions for reliable web-based health resources to assist patients in evaluating the quality of medical information available on the internet; and

Whereas, many patients resort to finding the answers to their own medical questions online, but many state that it is hard to know what information is or is not accurate and associate social media websites with misinformation; therefore be it

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. (New HOD Policy)

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

Received: 5/9/25

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RELEVANT AMA POLICY

Medical and Public Health Misinformation Online D-440.915

1. Our American Medical Association encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information.
2. Our AMA encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms.
3. Our AMA will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts.
4. Our AMA will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 1004
(A-25)

Introduced by: Michigan

Subject: Preventing Sleep Deprivation and Supporting Medical Student Wellness

Referred to: Reference Committee C

Whereas, state studies recommend how much sleep adults need to function well. Experts recommend that adults receive 7-9 hours of sleep per night; and

Whereas, studies have found that sleeping less than 7 hours can lead to adverse health outcomes such as impaired immune function, increased pain, decreased performance, and an increased risk of accidents; and

Whereas, medical students and residents who receive less than 7 hours of sleep per night experience higher rates of burnout, decreased motivation for learning, and increased risk of anxiety, depression, and alcohol abuse; and

Whereas, sleep deprivation and extended wakefulness can lead to impaired attention, slowed response time, and increased risk of errors, accidents, and injuries. In addition, studies show that cognitive function is most impaired during the first night of night shift work; and

Whereas, sleep deprivation and its negative effects on performance cannot be overcome by willing oneself to stay awake, nor by motivation, training, or experience. Thus, adequate rest is a necessary prerequisite for effective medical training; and

Whereas, research from the National Heart, Lung and Blood Institute underscores that sleep deprivation cannot simply be repaid through short sleeping periods. Multiple studies have shown that a full night of sleep (7-9 hours) is needed to restore memory and hippocampal-memory association function after one night of total sleep loss; and

Whereas, the Liaison Committee on Medical Education (LCME) works to ensure that every medical school has an effective system of counseling services to encourage medical student wellness; however, there are no guidelines in the LCME Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree on how medical schools should manage student working hours and prevent sleep deprivation; and

Whereas, the Accreditation Council for Graduate Medical Education (ACGME) limits residents work hours to 80 hours per week (averaged over a 4-week period); and

Whereas, duty hour limits include at least 10 hours of rest between duty periods and no more than 24 hours of continuous scheduled clinical assignments (Note: 6-hour extension is permitted for patient continuity and education.); and

Whereas, ACGME also states that residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call; therefore be it

RESOLVED, that our American Medical Association support the development of national standards to act as the official guideline for medical student work-hour limits, time off after a 24-hour shift, and work-hour guidelines. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 5/9/25

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RELEVANT AMA POLICY

Factors Causing Burnout H-405.948
Our American Medical Association recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians.

Resident/Fellow Clinical and Educational Work Hours H-310.907
Our American Medical Association adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as “duty hours”).
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of

specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.

5. Our AMA encourages the ACGME to:
   a. Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
   b. Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
   c. Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
   d. Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
   a. Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.
   b. Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
   c. Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
   d. Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to clinical and educational work hours:
   a. Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: “Total clinical and educational work hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
   b. Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers’ patients, or continuity clinic during that time.
   c. Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
   d. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
   e. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”
   f. Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
   g. Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
   h. Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
   i. Scheduled time providing patient care services of limited or no educational value should be minimized.
   j. Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
   k. The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education,

and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.

l. Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.

m. Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

n. The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.

o. The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.

8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.

9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1005
(A-25)

Introduced by: American College of Occupational & Environmental Medicine

Subject: Preserving the Specialty of Occupational and Environmental Medicine

Referred to: Reference Committee B

Whereas, occupational and environmental medicine (OEM) physicians protect and promote the health, safety, and productivity of workers, and educate healthcare professionals and the public concerning workplace and environmental health, pandemic preparedness, and disaster management through clinical practice, research, policy support and development, and advocacy in state, national and local governments, universities, corporations, small businesses; hospitals, medical centers, and graduate medical education; and

Whereas, the US Centers for Medicare and Medicaid Services (CMS) provides over $20 billion to fund graduate medical education in the United States, a source of funding that is not available to most OEM residents, and no other residencies provide OEM training, meaning that NIOSH is the major source for funding the medical specialty of occupational and environmental medicine; and

Whereas, the closure of occupational and environmental medicine residency programs, and a reduced pipeline of trained occupational health and safety professionals,[3] will impair the ability of academic centers to train OEM physicians to maintain and improve the health, safety, and productivity of workers in the United States, and significant institutional knowledge will be lost, weakening the nation's ability to respond to future occupational hazards[4]; and

Whereas, the American College of Occupational and Environmental Medicine has a longstanding commitment to OEM graduate medical education programs, to the health, safety, and productivity of workers, and to the health of the environment; and

Whereas, section 2(b) of the OSH Act states that one of the purposes of the Act is "… providing for research, information, education, and training in the field of occupational safety and health…" and Section 21 of the Act further states that "The Secretary shall conduct, directly or by grants or contracts, education programs to provide an adequate supply of qualified personnel to carry out the purposes of this Act."; therefore be it

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

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

Received: 5/19/25

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2. https://apnews.com/article/cdc-niosh-hhs-layoffs-2bac1f36b5c6361df7cbca8843d9f01e
3. https://www.cdc.gov/niosh/extramural-programs/php/about/ercs.html
4. https://www.cnsoccmed.com/news/how-mass-layoffs-at-hhs-and-cutting-niosh-will-affect-osha-and-employers/
5. https://safetyequipment.org/niosh-workforce-cuts-threaten-national-safety-infrastructure/
6. https://www.ishn.com/articles/114674-the-demise-of-niosh-could-osha-be-next

RELEVANT AMA POLICY

D-440.912 AMA Public Health Strategy

1. Our American Medical Association will distribute evidence-based information on the relationship between climate change and human health through existing platforms and communications channels, identify advocacy and leadership opportunities to elevate the voices of physicians on the public health crisis of climate change, and centralize our AMA's efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050.

2. Our AMA Board of Trustees will provide an update on loss of coverage and uninsurance rates following the return to regular Medicaid redeterminations and the end of the COVID-19 Public Health Emergency, the ensuing financial and administrative challenges experienced by physicians, physician practices, hospitals, and the healthcare system; and a report of actions taken by the AMA and recommendation for further action to address these issues at I-2023.

3. Our AMA Board of Trustees will provide a strategic plan or outline for the AMA's plan to address and combat the health effects of climate change at I-2023.

4. Our AMA Board of Trustees will provide an update on the efforts and initiatives of the AMA's gun violence task force at I-2023.

5. Our AMA will continue to support increased funding for public health infrastructure and workforce, which should include funding for preventative medicine related residency programs, to increase public health leadership in this country.
[BOT Rep. 17, A-23; Modified: BOT Rep. 05, I-23]

H-365.988 Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies

1. Our American Medical Association supports the integration of occupational health and environmental health and injury prevention programs within existing health departments at the state and local level.

2. Our AMA supports taking a leadership role in assisting state medical societies in implementation of such programs.

3. Our AMA supports working with federal agencies to ensure that "health" is the primary determinant in establishing environmental and occupational health policy.

4. Our AMA recognizes barriers to accessibility and utilization of such programs.

5. Our AMA recognizes inequities in occupational health screenings for pulmonary disease and supports efforts to increase accessibility of these screenings.

6. Our AMA encourages utilization of free and accessible screenings, such as those used in the NIOSH Coal Workers Health Surveillance Program, for other at-risk occupational groups.
[Res. 1, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10: Reaffirmed: CSAPH Rep. 01, A-20; Modified: Res. 403, A-24]

G-640.035: Physician Health Policy Opportunity
Our AMA encourages and supports efforts to educate interested medical students, residents, fellows, and practicing physicians about health policy and assist them in starting or transitioning to careers that involve health policy.

Our AMA: (a) recognizes, encourages, and supports the primary health policy training found in the physician specialties of Public Health / General Preventive Medicine, Occupational and Environmental Medicine, and Aerospace Medicine; (b) will significantly increase its collaborative efforts with the National Academy of Medicine (NAM) to make physicians aware of existing health policy training opportunities and help them to apply for and participate in them; (c) will engage with alumni of health policy training programs and joint degree programs and provide opportunities for them to share their health policy experiences with medical students, residents, fellows, and practicing physicians; (d) will include health policy content in its educational resources for members; (e) will work with the Office of the U.S. Surgeon General to disseminate information to medical students, residents, fellows, and practicing physicians about opportunities to join the Commissioned Corps of the U.S. Public Health Service; and (f) will consider options for funding a 1-year educational training program for practicing physicians who wish to transition from clinical practice to employment within the health policy sector.
[BOT Rep. 6, I-19]

H-425.986: Challenges in Preventive Medicine
It is the policy of the AMA that (1) physicians should become familiar with and increase their utilization of clinical preventive services protocols; (2) individual physicians as well as organized medicine at all levels should increase communication and cooperation with and support of public health agencies. Physician leadership in advocating for a strong public health infrastructure is particularly important; (3) physicians should promote and offer to serve on local and state advisory boards; and (4) in concert with other groups, physicians should study local community needs, define appropriate public health objectives, and work toward achieving public health goals for the community.
[BOT Rep. R, I-91; Reaffirmed by CME Rep. 5, I-95; Reaffirmed and Modified with change in title: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1006
(A-25)

Introduced by: New England

Subject: Opposition to the Decertification of Independent Universities from the Student and Exchange Visitor Program

Referred to: Reference Committee B

Whereas, the Student and Exchange Visitor Program (SEVP) serves as a critical pathway for international students, including aspiring physicians, to pursue higher education in the United States and contribute to our healthcare workforce; and

Whereas, recent federal actions to decertify independent universities from SEVP eligibility threaten the operational status of legitimate institutions that support a diverse and international physician pipeline; and

Whereas, international students constitute approximately 15-20% of enrollment at many American medical schools and contribute significantly to the diversity and global perspective of medical education; and

Whereas, the decertification of such universities risks undermining U.S. academic independence and the autonomy of educational institutions to train global medical talent resulting in highly qualified students pursuing training opportunities in other countries; and

Whereas, international medical students often express commitment to serving in underserved areas upon graduation, with studies showing that many foreign-born physicians practice in rural and medically underserved communities at higher rates than their American-born counterparts; and

Whereas, the U.S. is already facing a projected shortage of over 100,000 physicians by 2034, with underserved and rural areas being disproportionately affected by this deficit, and limiting the ability of qualified foreign students to enter and train in the U.S. further exacerbates this shortage; therefore be it

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

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

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 6/3/25

REFERENCES
1. Association of American Medical Colleges. The Complexities of Physician Supply and Demand: Projections from 2019 to 2034. Washington, DC: AAMC; 2021.
2. Association of American Medical Colleges. Diversity in Medicine: Facts and Figures 2023. Washington, DC: AAMC; 2023.
3. Institute of International Education. Open Doors Report on International Educational Exchange. New York, NY: IIE; 2023.
4. U.S. Department of Homeland Security, Immigration and Customs Enforcement. Student and Exchange Visitor Program Overview. Washington, DC: ICE; 2023.
5. National Association of Advisors for the Health Professions. International Students in U.S. Medical Schools: Trends and Outcomes. Manhattan, KS: NAAHP; 2022.

RELEVANT AMA POLICY

Continued Support for Diversity in Medical Education D-295.963
Our AMA: (1) supports efforts to increase diversity in medical schools through holistic admissions processes; (2) recognizes the value of international perspectives in medical education; and (3) opposes discriminatory practices in medical school admissions based on national origin or immigration status.

Impact of Immigration Barriers on the Nation's Health D-255.980
1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

US Physician Shortage H-200.954
1. Our American Medical Association explicitly recognizes the existing shortage of physicians in many specialties and areas of the US.
2. Our AMA supports efforts to quantify the geographic maldistribution and physician shortage in many specialties.
3. Our AMA supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US.
4. Our AMA encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations.
5. Our AMA encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations.
6. Our AMA encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations.
7. Our AMA will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas.
8. Our AMA will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification.
9. Our AMA will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need.

10. Our AMA continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
11. Our AMA continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
12. Our AMA will:
    a. promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians;
    b. work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and
    c. monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
13. Our AMA will work to augment the impact of initiatives to address rural physician workforce shortages.
14. Our AMA supports opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1007
(A-25)

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
Subject:	Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research from Politicized Attacks
Referred to:	Reference Committee D

Whereas, the practice of medicine fundamentally depends on evidence-based decision-making, robust biomedical research, and strong public health infrastructure to protect the health and safety of patients and communities; and

Whereas, the current U.S. Administration has undertaken historically destructive actions that undermine these pillars of health by:

- rescinding critical funding for state and local public health departments that support vaccination, surveillance, epidemiology, and laboratory capacity,
- abruptly canceling NIH-funded grants and clinical trials, delaying NIH grant reviews, and weakening the peer-review process in favor of politicized funding decisions,
- promoting misinformation and disinformation about vaccine safety and effectiveness, contributing to rising levels of vaccine hesitancy,
- implementing massive workforce reductions at HHS agencies—including CDC, FDA, AHRQ, HRSA, and NIH—thus severely limiting core public health and research capabilities for years to come, and
- eliminating efforts to promote health equity, placing many of our most vulnerable patients at even greater risk for poor health outcomes; and

Whereas, these actions are taking place amidst an alarming resurgence of infectious diseases—including measles, tuberculosis, and pertussis—the most severe influenza season in over a decade, and historically high rates of cancer and chronic illness; and

Whereas, these actions increasingly interfere with evidence-based medical practice, including in areas such as vaccine policy, gender-affirming care, reproductive health, infectious disease and HIV prevention and treatment, and public health data collection; and

Whereas, such interference undermines clinical decision-making, public health infrastructure, and scientific integrity—core pillars of medical professionalism long affirmed in AMA policy; and

Whereas, the AMA has extensive House of Delegates policy supporting robust public health infrastructure, biomedical research funding, vaccine confidence, and science-based clinical practice, including clear opposition to health misinformation; and

Whereas, despite this strong policy foundation, the current pace and scale of AMA's advocacy and public communications do not meet the urgency and magnitude of the threats facing public health, biomedical science, and patient care; and

Whereas, allowing this foundation to erode risks not only clinical integrity but also devalues the physician's role, jeopardizes public trust in the profession, and invites long-term economic consequences for the entire House of Medicine—early signs of which are already emerging, with more certain to come if the AMA does not lead forcefully; and

Whereas, this is a defining moment for the American Medical Association (AMA) to protect the foundation upon which medicine stands: the freedom to follow science in pursuit of the best outcomes for patients, free from interference by shifting political winds; therefore be it

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

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

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

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 6/4/25

RELEVANT AMA POLICY

D-440.922 Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems
Our American Medical Association will champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes. [Res. 407, I-20; Modified: CSAPH Rep. 2, I-21Reaffirmed: CMS Rep. 5, A-22]

H-440.892 Bolstering Public Health Preparedness
Our AMA: (1) supports the concept that enhancement of surveillance, response, and leadership capabilities of state and local public health agencies be specifically targeted as among our nation's highest priorities... [Sub. Res. 407, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 912, I-19]

H-440.847 Pandemic Preparedness
In order to prepare for a pandemic, our American Medical Association… urges ... urges Congress and the Administration to work to ensure adequate funding and other resources … to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to a pandemic or other serious public health emergency. [CSAPH Rep. 5, I-12; Reaffirmation A-15; Modified: Res. 415, A-21; Reaffirmed: CSAPH Rep. 1, I-22; Appended: Res. 924, I-22]

D-440.912 AMA Public Health Strategy
Our AMA will continue to support increased funding for public health infrastructure and workforce, which should include funding for preventative medicine related residency programs, to increase public health leadership in this country. [BOT Rep. 17, A-23; Modified: BOT Rep. 05, I-23]

H-460.941 Science and Biomedical Research
Our AMA will… take steps to become the coordinating point for efforts, both within and outside of the Federation, to promote, enhance, and defend biomedical science; … continue and expand its efforts to advocate for the primacy of science and biomedical research as the basis of quality medical care by working with and influencing both the private sector and the federal government, including the legislative, executive, and judicial branches; … [CSA Rep. 8, A-94; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Appended: Res. 901, I-18]

H-460.926 Funding of Biomedical, Translational, and Clinical Research
Our AMA: (1) reaffirms its long-standing support for ample federal funding of medical research, including basic biomedical research, translational research, clinical research and clinical trials, health services research, outcomes research, and prevention research; and (2) encourages the National Institutes of Health, the Agency for Healthcare Research and Quality and other appropriate bodies to develop a mechanism for the continued funding of translational research. [Sub. Res. 507, I-97; Reaffirmed: CSA Rep. 13, I-99; Modified: Res. 503, and Reaffirmation A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

D-440.997 Support for Public Health
Our AMA House of Delegates request the Board of Trustees to include in their long range plans, goals, and strategic objectives to support the future of public health in order "to fulfill society's interest in assuring the conditions in which people can be healthy." Our AMA…recognizes a crisis of inadequate public health funding, most intense at the local and state health jurisdiction levels, and … recognizes the importance of timely research and open discourse in combatting public health crises and opposes efforts to restrict funding or suppress the findings of biomedical and public health research for political purposes. [Res. 409, A-99; Modified CLRPD Rep. 1, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Appended: Res. 206, A-13; Reaffirmation A-15; Appended: Res. 902, I-16]

G-605.009 Establishing a Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted
Our American Medical Association will convene a task force of appropriate AMA councils and interested state and medical specialty societies… to help guide organized medicine’s response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to… gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications. [Res. 621, A-22; Appended: Res. 816, I-23; Appended: Res. 207, I-24]

H-185.927 Clarification of Evidence-Based Gender-Affirming Care
Our AMA will work with state and specialty societies and other interested stakeholders to … advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence… [Res. 05, A-16; Modified: Res. 015, A-21; Modified: Res. 223, A-23; Appended: Res. 304, A-23; Reaffirmed: CSAPH Rep. 08, A-24; Reaffirmed: BOT Rep. 23, I-24]

H-440.817 Protecting the Integrity of Public Health Data Collection
Our AMA will advocate: (1) for the inclusion of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries; including but not limited to the Current Population Survey, United States Census, National Survey of Older Americans Act Participants, all-payer claims databases; and (2) against the removal of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries without plans for updating measures of such demographic data. [Res. 002, I-18]

H-440.830 Education and Public Awareness on Vaccine Safety and Efficacy
Our AMA: (a) supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (b) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (c) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines. [Res. 9, A-15; Modified: CSAPH Rep. 1, I-15; Appended: Res. 411, A-17; Modified: Res. 011, A-19]

D-440.956 Expanding the Vaccines for Children Program
Our American Medical Association will work with its immunization partners to examine methods to improve financing mechanisms for vaccines, including the expansion of the Vaccine for Children program. [Reaffirmed: CSAPH Rep. 1, A-21]

H-440.882Secure National Vaccine Policy
Our American Medical Association advocates for and supports programs that ensure the production, quality assurance and timely distribution of sufficient quantities of those vaccines recommended by the Centers for Disease Control and Prevention to the US population at risk. [Res. 709, I-04; Reaffirmation A-05; Reaffirmed in lieu of Res. 422, A-11: BOT action in response to referred for decision Res. 422, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

H-440.849 Adult Immunization
Our American Medical Association supports the development of a strong adult and adolescent immunization program in the United States. Our AMA encourages third party payers to provide coverage for adult immunizations.
[CSAPH Rep. 5, I-12 Modified: CSAPH Rep. 1, A-22]

H-440.970 Nonmedical Exemptions from Immunizations
Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to:
a. Eliminate non-medical exemptions from mandated immunizations.
b. Limit medical vaccine exemption authority to only licensed physicians.
[CSA Rep. B, A-87;Reaffirmed: Sunset Report, I-97;Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 10, A-15; Modified: CSAPH Rep. 1, I-15; Appended: Res. 416, A-19 Modified: Res. 207, I-21; Reaffirmed: CSAPH Rep. 03, I-24; Modified: Speakers Rep. 02, I-24]

D-440.921 An Urgent Initiative to Support COVID-19 Vaccination and Information Programs
Our AMA will institute a program to promote the integrity of a COVID-19 vaccination information program by … supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations. [Res. 408, I-20; Reaffirmed: Res. 228, A-21; Reaffirmed: Res. 421, A-21; Appended: Res. 408, I-21]

D-440.915 Medical and Public Health Misinformation Online
Our AMA will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts. Our AMA will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information. [Res. 421, A-21; Reaffirmed: BOT Rep. 15, A-22; Reaffirmation: A-23; Modified: Res. 509, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Agenda
Reference Committee on Ethics and Bylaws
In-Person Hearing

John Maa, MD, Chair

June 7, 2025
Regency AB

Hyatt Regency Chicago
Chicago, Illinois

RECOMMENDED FOR ADOPTION

1. BOT Report 02 - New Specialty Organizations Representation in the House of Delegates
2. BOT 18 - Physician Assisted Suicide
3. CCB Report 01 – Bylaws Review Report
4. CCB Report 02 - Concurrent Service on Councils and Section Governing Councils
5. CEJA Report 01 - The AMA Code of Medical Ethics Evolving to Provide Health Care Systems Ethics Guidance
6. CEJA Report 02 - Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization
7. CEJA Report 05 - Protecting Physicians Who Engage in Contracts to Deliver Health Care Services
8. CEJA Report 06 - Amendment to Opinion 1.1.1 “Patient-Physician Relationships”
9. CEJA Report 10 - The Preservation of the Primary Care Relationship
10. CEJA Report 11 - CEJA Sunset Review of 2015 House Policies
11. Resolution 003 - Opposition to Censorship in Public Libraries
12. Resolution 004 - Reducing the Harmful Impacts of Immigration Status on Health
13. Resolution 005 - Dedicated Interfaith Prayer and Reflection Spaces in Medical Schools and Healthcare Facilities
14. Resolution 006 - Military Deception as a Threat to Physician Ethics
15. Resolution 007 - Use of Inclusive Language in AMA Policy
16. Resolution 008 - Humanism in Anatomical Medical Education
17. Resolution 009 - Patient Centered Health Care as a Determinant of Health

RECOMMENDED FOR ADOPTION AS AMENDED

18. BOT 26 - Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
19. CCB Report 03 - Clarifying Bylaw Language
20. CEJA Report 08 - Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blinded Model for Organ Procurement and Transplantation
21. CEJA Report 09 - Ethical Impetus for Research in Pregnant and Lactating Individuals
22. CEJA Report 13 - Presumed Consent & Mandated Choice for Organs from Deceased Donors

23. Resolution 001 - Opposition to Censuring Medical Societies or Organizations Based on Politics or Policies of Governments
24. Resolution 010 - Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure
25. Resolution 011 - Opposition of Health Care Entities from Reporting Individual Patient Immigration Status
26. Resolution 012 – Carceral Systems and Practices in Behavioral Health Emergency Care
27. Resolution 013 - Continued Support of World Health Organization (WHO) & United States Agency for International Development (USAID)

RECOMMENDED FOR REFERRAL

28. CEJA Report 07 - Guidelines on Chaperones for Sensitive Exams

RECOMMENDED NOT FOR ADOPTION

29. Resolution 002 - Physician Disclosures of Relationships in Private Equity Held Organizations

RECOMMENDATION NOT YET DETERMINED

30. Resolution 014 - Protecting Access to Emergency Abortion Care Under EMTALA
31. Resolution 015 - Addressing Targeting and Workplace Restrictions and Barriers to Healthcare Delivery by International Medical Graduate (IMG) Physicians and other Physicians Based upon Migration Status or Country of Origin within Healthcare Systems

Please send amendments and any documentation to:
referencecommitteeeb@ama-assn.org

Livestream of Reference Committee Hearing: Zoom Link

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Agenda

Reference Committee A
In-Person Hearing

Cheryl Hurd, MD, Chair

RECOMMENDED FOR ADOPTION

1. Council on Medical Service Report 6 – Prescription Medication Price Negotiation
2. Resolution 101 - Uniform Adoption of Service Intensity Tools to Support Medical Decision-making and Service Gap Analysis
3. Resolution 102 - Access to Single Maintenance and Reliever Therapy for Asthma
4. Resolution 105 - Development of an Educational Resource on Opting Out of Medicare for Physicians
5. Resolution 106 - Advocating for All Payer Coverage for Custom Breast Prostheses for Patients with History of Mastectomy Secondary to Breast Cancer Treatment
6. Resolution 107 - Advocating for All Payer Coverage of Reconstructive and Cosmetic Surgical Care Related to Cleft Lip and Palate
7. Resolution 109 - Medicare Advantage Plans Double Standard
8. Resolution 110 - Study of the Federal Employee Health Benefit Plan (FEHBP)
9. Resolution 111 - New Reimbursement System Needed for Rural Hospitals to Survive
10. Resolution 116 - Medicare Coverage of Registered Dietitian (RD) and Certified Nutrition Support Specialist (CNSS) Visits Beyond Type 2 Diabetes and Renal Disease
11. Resolution 119 - Cancer Survivorship Program Coverage
12. Resolution 120 - Medigap, Pre-Existing Conditions, and Medicare Coverage Education

RECOMMENDED FOR ADOPTION AS AMENDED

13. Council on Medical Service Report 2 – Reconsidering AMA Policy on the Affordable Care Act (ACA) Eligibility Firewall
14. Council on Medical Service Report 5 – Medicaid Estate Recovery Reform
15. Council on Medical Service Report 9 – Minimum Requirements for Medication Formularies
16. Resolution 108 - Firearm Storage Diagnosis and Counseling Reimbursement
17. Resolution 115 - Supporting Legislative Efforts to Remove Certain High-Cost Supplies and Equipment from the Medicare Physician Fee Schedule
18. Resolution 118 - Improving Access to Peripartum Pelvic Floor Physical Therapy

Amendments and supplemental materials MUST be sent to referencecommitteea@ama-assn.org. Please include the Resolution or Report number in the subject line. Do not send testimony to this email address. This address is only operational for the duration of the Reference Committee A hearing.

Note: Items in *italics* will be considered based on HOD action at the Second Opening Session. At the beginning of the reference committee hearing, the chair will identify those items that will **not** be discussed in the hearing, and these items will **not** be considered by the reference committee.

A Zoom webinar link is provided below. Registration is required to view the zoom. This link is view-only. Testimony cannot be accepted via Zoom. https://events.zoom.us/ev/AjMyLCeOl4SOnk3RV3yfMxQjEJ-u8amHCgUxbnMBeBXvcNzcXklk~AsiDZKIjzjXFxQork8oGIEdMnatY7eDkayjd4ZyOLp9Jww0F2DXZa0-b7q

RECOMMENDED FOR REFERRAL

19. Resolution 103 - Inadequate Reimbursement for Biosimilars
20. Resolution 113 - Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts
21. Resolution 117 - Liberalized Remorse Period for Medicare Advantage Plan Insureds

RECOMMENDED FOR NOT ADOPTION

22. Resolution 104 - Study of Whether the HSA Model Could Become an Option for Medicaid Beneficiaries
23. Resolution 114 - An Assessment of Physician Support for Value-Based Payment Models and its Impact on Healthcare to Inform AMA Advocacy Efforts—A Survey

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

24. Resolution 112 - Continuation of Affordable Connectivity Program

RECOMMENDATION NOT YET DETERMINED

25. Resolution 121 - Opposing Pharmacy Benefit Manager Spread Pricing

Amendments and supplemental materials MUST be sent to referencecommitteea@ama-assn.org. Please include the Resolution or Report number in the subject line. Do not send testimony to this email address. This address is only operational for the duration of the Reference Committee A hearing.

Note: Items in *italics* will be considered based on HOD action at the Second Opening Session. At the beginning of the reference committee hearing, the chair will identify those items that will **not** be discussed in the hearing, and these items will **not** be considered by the reference committee.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Agenda

Reference Committee B

In-Person Hearing

Amar Kelkar, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 13 — The Uniform Health-Care Decisions Act
2. Board of Trustees Report 14 — A Public Health-Centered Criminal Justice System
3. Board of Trustees Report 16 — Research Correcting Political Misinformation and Disinformation on Scope of Practice
4. Board of Trustees Report 17 — Antidiscrimination Protections for LGBTQ+ Youth in Foster Care
5. Resolution 202 — Preservation of the CDC Epilepsy Program Workforce and Infrastructure
6. Resolution 208 — Binding Arbitration in Health Insurance Contracts
7. Resolution 211 — Support for State Provider and Managed Care Organization Taxes to Sustain Federal Resolution Medicaid Matching Funding
8. Resolution 212 — Setting Standards for Forensic Toxicology Laboratories Used in Litigation
9. Resolution 219 — Opposing Unwarranted National Institutes of Health Research Institute Restructuring

Note: During the reference committee hearing, supplemental material may be sent to RefComB@ama-assn.org. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should only be presented orally to the Committee.

When you email your amendment, you will receive a response, indicating that staff has received it. If you do not receive a response, we did NOT receive it, and you must resend. Amendments must be formatted correctly with strikethroughs and underlines.

A Zoom webinar link is provided below. Registration is required to view the meeting via Zoom. The link is view-only. Testimony cannot be accepted via Zoom.
https://events.zoom.us/ev/AjMyLCeOl4SOnk3RV3yfMxQjEJ-u8amHCgUxbnMBeBXvcNzcXklk~AsiDZKIjzjXFxQork8oGIEdMnatY7eDkayjd4ZyOLp9Jww0F2DXZa0-b7g

10. Resolution 220 — Strengthening AMA Policy on Noncompete Clauses in Ownership Transitions
11. Resolution 230 — Advocating to expand private insurance coverage of anti-obesity medications (AOM)
12. Resolution 235 — CMS Payment Monitoring Following Government Staff Reductions

RECOMMENDED FOR ADOPTION AS AMENDED

13. Board of Trustees Report 09 — Council on Legislation Sunset Review of 2015 House Policies
14. Board of Trustees Report 21 — Advocacy for More Stringent Regulations / Restrictions on Distribution of Cannabis
15. Resolution 201 — Inclusion of DICOM Imaging in Federal Interoperability Standards
16. Resolution 203 — Supporting SUPPORT Act modifications to enhance care of patients with chronic pain
17. Resolution 204 — Protecting the Prescriptive Authority of Plenary Licensed Physicians
18. Resolution 210 — Impact of Tariffs on Healthcare Access and Costs
19. Resolution 214 — United Health Care and InterQual Monopoly
20. Resolution 215 — Support for Changing Standards for Minors Working in Agriculture
21. Resolution 216 — Support for Aging-Out Foster Youth with Mental Health and Psychotropic Needs
22. Resolution 217 — Regulation and Oversight of the Troubled Teen Industry
23. Resolution 222 — Need for Separate H1B Pathway for IMG Doctors in the USA
24. Resolution 228 — CHIP Coverage of OTC Medications
25. Resolution 229 — Guaranteeing Timely Delivery and Accessibility of Federal Health Data
26. Resolution 234 — Protection for International Medical Graduates

RECOMMENDED FOR ADOPTION IN LIEU

27. Resolution 205 — AMA Support for Continuance of the Section 1115 - Social Security Act, Medicaid Waiver Program
    Resolution 206 — AMA Support for Renewal of Section 1115 - Social Security Act, Medicaid Waiver Demonstration Projects Supporting Food and Nutrition Services
28. Resolution 221 — Preservation of Medicaid
    Resolution 223 — Preservation of Medicaid
    Resolution 232 — Preservation of Medicaid

RECOMMENDED FOR REFERRAL

29. Resolution 207 — Abolishing Venue Shopping
    Resolution 231 — Preventing Venue Shopping in Medical Liability to Protect Physician Practices and Access to Care
30. Resolution 209 — Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Resolution Addiction Medications for Legitimate Medical Purposes

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

31. Resolution 213 — Emergency Department Designation Requires Physician on Site
32. Resolution 218 — Distribution of Resident Slots Commensurate with Shortages
33. Resolution 224 — Support SAVE Plan and Public Service Loan Forgiveness (PLSF) Applications
34. Resolution 225 — The Private Practice Physicians in the Community
35. Resolution 226 — Regulations for Algorithmic-Based Health Insurance Utilization Review
36. Resolution 227 — Payment Recoupment—Let Sanity Prevail
37. Resolution 233 — Increasing Transparency of AMA Medicare Payment Reform Strategy

RECOMMENDATION NOT YET DETERMINED

38. 236 – Preservation of Medicaid
39. 237 – Urgent Advocacy to Restore J-1 Visa Processing for International Medical Graduate Physicians
40. 238 – Preserving Accreditation Standards on Diversity, Equity, and Inclusion
41. *Late Resolution 1003 - Ensuring Accessibility and Inclusivity of CDC Resources*
42. *Late Resolution 1005 - Preserving the Specialty of Occupational and Environmental Medicine*
43. *Late Resolution 1006 - Opposition to the Decertification of Independent Universities from the Student and Exchange Visitor Program*

** Items in italics will be considered based on HOD action at the Second Opening Session.*

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Agenda

Reference Committee C, In-Person Hearing

Saturday, June 7, 2025 at 1:00pm CST, Regency Ballroom C, Zoom

Christopher Wee, MD, Chair

RECOMMENDED FOR ADOPTION

1. Council On Medical Education Report 2 - International Applicants To U.S. Medical Schools (Resolution 301-A-24)
2. Council On Medical Education Report 3 - Unmatched Graduating Physicians (Resolution 306-A-24)
3. Council On Medical Education 5 - Disaffiliation From The Alpha Omega Alpha Honor Medical Society Due To Perpetuation Of Racial Inequities In Medicine (Res. 309-A-24)
4. Council On Medical Education Report 6 - Reporting Of Total Attempts Of USMLE Step 1 and COMLEX-USA Level 1 Examinations (Res 315-A-24)
5. Council On Medical Education Report 7 - Designation Of Descendants Of Enslaved Africans In America (Resolution 218-A-24)
6. Council On Medical Education Report 8 - Disaggregation Of Demographic Data For Individuals Of Federally Recognized Tribes (Res. 243-A-24)
7. Resolution 311 - Transparency And Access To Medical Training Program

RECOMMENDED FOR ADOPTION AS AMENDED

8. Council on Medical Education Report 1 - Council on Medical Education Sunset Review of 2015 House of Delegates' Policies
9. Council On Medical Education Report 4 - Access To Restricted Health Services When Completing Physician Certification Exams (Res. 307-A-24)
10. Resolution 304 - Addressing Professionalism Standards In Medical Training
11. Resolution 308 - Streamlining Annual Compliance Training Requirements For Physicians
12. Resolution 310 - Protections For Trainees Experiencing Retaliation In Medical Education

RECOMMENDED FOR REFERRAL

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

RECOMMENDED FOR REFERRAL FOR DECISION

14. Resolution 301 - Examining AMBS Processes For New Boards

RECOMMENDED FOR NOT ADOPTION

15. Resolution 305 - Curricular Structure Reform To Support Physician And Trainee Well-Being
16. Resolution 306 - Innovation And Reform Of Medical Education
17. Resolution 307 - Disclosure Of Individual Physician Volunteers Participation In Committee

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

18. Resolution 302 - AMA Study Of Lifestyle Medicine And Culinary Electives To Reduce Burnout And Bolster Career Satisfaction In Trainees
19. Resolution 309 - Increasing Education On Physician-Led Care
20. Resolution 312 - Selection Of IMG Residents Based On Merit

RECOMMENDATION NOT YET DETERMINED

21. *Late 1004 - Preventing Sleep Deprivation and Supporting Medical Student Wellness*

Notes:

- Items in *italics* will be considered based on HOD action at the Second Opening Session.
- Amendments and supplemental material for Ref Com C must be sent to meded@ama-assn.org.
- For technical assistance, email HODMeetingSupport@ama-assn.org or call 800-337-1599.
- Handbook
- Preliminary Report
- Online Reference Committee

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Agenda

Reference Committee D

In-Person Hearing

Kimberly Templeton, MD, FAAOS, FAOA, FAMWA; Chair

RECOMMENDED FOR ADOPTION

1. CSAPH 02 - Addressing Social Determinants of Health Through Closed Loop Referral Systems
2. CSAPH 07 - Addressing the Health Issues Unique to Minority Communities in Rural Areas
3. Resolution 402 - Protecting In-Person Prison Visitations to Reduce Recidivism
4. Resolution 407 - Sleep Deprivation as a Public Health Crisis
5. Resolution 410 - Hate Speech is a Public Health Concern
6. Resolution 412 - Supporting inclusive long-term care facilities
7. Resolution 413 - Preservation of Public Funding for Physicians and Hospitals Providing LGBTQ+ Care
8. Resolution 414 - Expanding Sexually Transmitted Infection Care for Persons with Unstable or No Housing
9. Resolution 415 - Promoting Child Welfare and Communication Rights in Immigration Detention
10. Resolution 416 - Culturally and Religiously Inclusive Food Options
11. Resolution 418 - AMA Study on Plastic Pollution Reduction
12. Resolution 419 - Advocating for Universal Summer Electronic Benefit Transfer Program for Children (SEBTC)
13. Resolution 420 - Study of Plant-Based & Lab-Grown Meat
14. Resolution 421 - Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities
15. Resolution 422 - Protecting the Integrity of the U.S. Healthcare System from Misinformation and Policy
16. Resolution 428 - Public Health Implications of US Food Subsidies
17. Resolution 429 - Addressing the Health Consequences of Microplastics in Humans

    Resolution 432 - Support for Long-Term Sequelae of Pregnancy

RECOMMENDED FOR ADOPTION AS AMENDED

19. BOT 20 – Guardianship and Conservatorship Reform
20. CSAPH 03 - Protections Against Surgical Smoke Exposure

21. CSAPH 04 - Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals
22. CSAPH 06 - Fragrance Regulation
23. Resolution 401 - Reducing Pickleball-Related Ocular Injuries
24. Resolution 403 - Promoting Evidence-Based Responses to Measles and Misuse of Vitamin A
25. Resolution 409 - Guidelines for Restricting Cell Phones in K-12 Schools
26. Resolution 411 - Protecting Access to mRNA Vaccines
27. Resolution 423 - Requiring Universal Vaccine reporting to a National Immunization Registry and Access to a National Immunization Information System
28. Resolution 430 - Addressing the Health Impacts of Ultraprocessed Foods
29. Resolution 431 - Alcohol & Breast Cancer Risk
30. Resolution 433 - Clinical Lactation Care

RECOMMENDED FOR ADOPTION IN LIEU OF

31. Resolution 405 - Health Warning Labels on Alcoholic Beverage Containers
    Resolution 417 - Updating Alcohol Health Warning Labels to Reflect Evidence-Based Health Risks and Supporting National Labeling and Signage Policy Reform
    Resolution 425 - Alcohol Consumption and Health

RECOMMENDED FOR REFERRAL

32. Resolution 404 - Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers
33. Resolution 406 - Call for Study: Should Petroleum-Powered Emergency Medical Services (EMS) Vehicles in Urban Service Areas be Replaced by Renewably-Powered Electric Vehicles?
34. Resolution 408 - Removing Artificial Turf in Schools, Parks, and Public Places
35. Resolution 424 - Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records
36. Resolution 427 - Elevate Obesity as a Strategic Objective

Zoom link to hearing (view only webinar): https://events.zoom.us/ev/AjMyLCeOl4SOnk3RV3yfMxQjEJ-u8amHCgUxbnMBeBXvcNzcXklk~AsiDZKIjzjXFxQork8oGIEdMnatY7eDkayjd4ZyOLp9Jww0F2DXZa0-b7g

During the reference committee hearing, supplemental material may be sent to referencecommitteed@ama-assn.org. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should only be presented in the Online Reference Committee or during in-person testimony. This address is only operational for the duration of the reference committee hearing.

RECOMMENDED FOR NOT ADOPTION

37. Resolution 426 - Addressing Patient Safety and Environmental Stewardship of Single-Use and Reusable Medical Devices

RECOMMENDATION NOT YET DETERMINED

*38. Late 1007 - Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research from Politicized Attacks**

** Items in italics will be considered based on HOD action at the Second Opening Session.*

Zoom link to hearing (view only webinar): https://events.zoom.us/ev/AjMyLCeOl4SOnk3RV3yfMxQjEJ-u8amHCgUxbnMBeBXvcNzcXklk~AsiDZKIjzjXFxQork8oGIEdMnatY7eDkayjd4ZyOLp9Jww0F2DXZa0-b7g

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Agenda

Reference Committee E

In-Person Hearing

Charles Van Way,MD Chair

RECOMMENDED FOR ADOPTION

1. Council on Science and Public Health Report 5 – Screening for Image Manipulation in Research Publications
2. Resolution 501 – Safer Buttons/Coin Batteries
3. Resolution 504 – Physician Performed Microscopy Designation for Synovial Fluid Crystal Exam: Modify the Clinical Laboratory Amendment of 1988
4. Resolution 508 - Standardizing Safety Requirements for Traditional and Rideshare-Based Non-Emergency Medical Transportation
5. Resolution 511 – Increased Transparency Among Psychotropic Drug Administration in Prisons
6. Resolution 513 - Transparency on Comparative Effectiveness in Direct-to-Consumer Advertising
7. Resolution 516 – Creating a Registry of Potential Side Effects of GIP & GLP-1 Medications
8. Resolution 517 – In Support of a National Drug Checking Registry
9. Resolution 518 – Mandatory Accreditation and Regular Inspections of Hyperbaric Chambers
10. Resolution 522 – Access to Important and Essential Drugs

RECOMMENDED FOR ADOPTION AS AMENDED

11. Council on Science and Public Health Report 1 – Council on Science and Public Health Sunset Review of 2015 House Policies
12. Council on Science and Public Health Report 9 – Rare Disease Advisory Councils
13. Council on Science and Public Health Report 8 – Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms
14. Resolution 502 – NIH Grant Funding for Medical Research
15. Resolution 503 – Safeguarding Neural Data Collected by Neurotechnologies
16. Resolution 506 – Opposing the use of harm reduction items as evidence of commercial sex work
17. Resolution 509 – Allergen Labeling for Spices and Herbs
18. Resolution 510 - Improving Cybersecurity Standards for Healthcare Entities

19. Resolution 512 – Preventing Drug-Facilitated Sexual Assault in Drinking Establishments
20. Resolution 514 – Support for a Nicotine Free Generation
21. Resolution 515 – Nitrous Oxide Abuse

RECOMMENDED FOR REFERRAL

22. Resolution 505 - Mandating Properly Fitting Lead Aprons in Hospitals
23. Resolution 507 Clinical and Public Safety Implications of AI-Generated Content and Symbolic Compliance Infrastructure and Resolution 519 Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making
24. Resolution 520 - Study of Grading Systems in AMA Board Reports

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

25. Resolution 521 – Warning Labels on OTC Sleep Aids

Zoom link to hearing (view only webinar): https://events.zoom.us/ev/AjMyLCeOl4SOnk3RV3yfMxQjEJ-u8amHCgUxbnMBeBXvcNzcXklk~AsiDZKIjzjXFxQork8oGIEdMnatY7eDkayjd4ZyOLp9Jww0F2DXZa0-b7g

During the reference committee hearing, supplemental material may be sent to ReferenceCommitteeE@ama-assn.org. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should be only be presented in on the Online Reference Committee or orally to the committee. This address is only operational for the duration of the reference committee hearing.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Agenda
Reference Committee F
In-Person Hearing

Michael B. Simon, MD, MBA, Chair

RECOMMENDED FOR FILING

1. Board of Trustees Report 1 - Annual Report

RECOMMENDED FOR ADOPTION

2. Board of Trustees Report 4 - AMA 2026 Dues
3. Board of Trustees Report 22 - Ranked Choice Voting
4. Report of the House of Delegates Committee on the Compensation of the Officers
5. Council on Long Range Planning and Development Report 1 - International Medical Graduates Section Five-Year Review
6. Council on Long Range Planning and Development Report 2 - Organized Medical Staff Section Five-Year Review
7. Resolution 603 - Renaming the Minority Affairs Section to the Underrepresented in Medicine Advocacy Section

RECOMMENDED FOR ADOPTION AS AMENDED

8. Board of Trustees Report 23 - Financial Assistance to Facilitate Attendance at MSS Meetings
9. Board of Trustees Report 24 - Creation of an AMA Council with a Focus on Digital Health Technologies and AI
10. Council on Constitution and Bylaws/Council on Long Range Planning and Development Report 1 - Joint Council Sunset Review of 2015 House Policies
11. Resolution 602 - Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations
12. Resolution 604 - Advisory Committee on Tribal Affairs

RECOMMENDED FOR REFERRAL

13. Resolution 601 - AMA to Develop Patient Educational Materials Regarding Ultra-processed Foods for Distribution by AMA Members

RECOMMENDEDATION NOT YET DETERMINED

14. LATE 1001 - Annual Scorecard to Evaluate the AMA's Impact
15. LATE 1002 - Review of Past Resolutions

* *Items in italics will be considered based on HOD action at the Second Opening Session.*

Please email amendment language or additional information to referencecommitteef@ama-assn.org.

Zoom Link:
https://events.zoom.us/ev/AjMyLCeOl4SOnk3RV3yfMxQjEJ-u8amHCgUxbnMBeBXvcNzcXklk~AsiDZKIjzjXFxQork8oGIEdMnatY7eDkayjd4ZyOLp9Jww0F2DXZa0-b7g

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-25)

Agenda

Reference Committee G

In-Person Hearing

Christine Kim, MD, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 19 – Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
2. Council on Medical Service Report 1 – Council on Medical Service Sunset Review of 2015 House Policies
3. Council on Medical Service Report 4 – Requiring Payment for Physician Signatures
4. Council on Medical Service Report 7 – Impact of Patient Non-Adherence on Quality Scores
5. Resolution 703 – Appropriate Use of Data from Surgical Practices
6. Resolution 708 – Advocating Against Prior Authorization for In-Person Visits with Physicians
7. Resolution 710 – Requiring Insurances to Apply Discounted Cost Medication to the Patient's Deductible
8. Resolution 712 – Billing and Collections Transparency
9. Resolution 714 – Root Cause Analysis of the Causes of the Decline of Private Medical Practice
10. Resolution 715 – Grace Period for Timely Filing Due to Technology Failures Regardless of Cause
11. Resolution 717 – Promoting Medication Continuity and Reducing Prior Authorization Burdens

RECOMMENDED FOR ADOPTION AS AMENDED

12. Board of Trustees Report 6 – Transparency and Accountability of Hospitals and Hospital Systems
13. Council on Medical Service Report 3 – Regulation of Corporate Investment in the Health Care Sector
14. Resolution 701 – Electronic Health Records Contract Termination
15. Resolution 702 – Strengthening Health Plan Accountability for Physician Satisfaction
16. Resolution 706 – Increasing Transparency Surrounding Medicare Advantage Plans
17. Resolution 707 – Simplifying Correspondence from Health Insurers
18. Resolution 716 – Minimum Payer Communication Quality Standards

RECOMMENDED FOR REFERRAL

19. Resolution 711 – Study of Practice Models for Physicians Working Across State Lines

RECOMMENDED FOR NOT ADOPTION

20. Resolution 704 – Mitigating the Impact of Excessive Prior Authorization Processes

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

21. Resolution 705 – Elimination of Transaction Fees for Electronic Healthcare Payments
22. Resolution 709 – Allowing Timely Access to Pain Medications in Discharged Hospital and Ambulatory Surgery Patients
23. Resolution 713 – Aiding Members of Medical Staffs

RECOMMENDATION NOT YET DETERMINED

24. Resolution 718 – Safeguarding Medical Staff Bylaws and Accreditation Standards in VA Facilities
25. Resolution 719 – Comprehensive AMA Policy Publication Regarding Employed Physicians

Amendments and supplemental materials MUST be sent to referencecommitteeg@ama-assn.org.

Please include the Resolution or Report number in the subject line. Do not send testimony to this email address. This address is only operational for the duration of the Reference Committee G hearing.

Zoom webinar link (view only): https://events.zoom.us/ev/AjMyLCeOl4SOnk3RV3yfMxQjEJ-u8amHCgUxbnMBeBXvcNzcXklk~AsiDZKIjzjXFxQork8oGIEdMnatY7eDkayjd4ZyOLp9Jww0F2DXZa0-b7g

Reference Committee on Ethics and Bylaws

Report(s) of the Board of Trustees

02	New Specialty Organizations Representation in the House of Delegates
18	Physician Assisted Suicide
26	Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
28*	Specialty Society Representation in the House of Delegates - Five-Year Review

Report(s) of the Council on Constitution and Bylaws

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

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

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

Resolutions

001	Opposition to Censuring Medical Societies or Organizations Based on Politics or Policies of Governments
002	Physician Disclosures of Relationships in Private Equity Held Organizations
003	Opposition to Censorship in Public Libraries
004	Reducing the Harmful Impacts of Immigration Status on Health
005	Dedicated Interfaith Prayer and Reflection Spaces in Medical Schools and Healthcare Facilities
006	Military Deception as a Threat to Physician Ethics
007	Use of Inclusive Language in AMA Policy
008	Humanism in Anatomical Medical Education
009	Patient centered health care as a Determinant of Health
010	Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure
011	Opposition of Health Care Entities from Reporting Individual Patient Immigration Status
012	Carceral Systems and Practices in Behavioral Health Emergency Care

013 Continued Support of World Health Organization (WHO) & United States Agency for International Development (USAID)
014* Protecting Access to Emergency Abortion Care Under EMTALA
015* Addressing Targeting and Workplace Restrictions and Barriers to Healthcare Delivery by International Medical Graduate (IMG) Physicians and other Physicians Based upon Migration Status or Country of Origin within Healthcare Systems

*Contained in Meeting Tote

Reference Committee A

Report(s) of the Council on Medical Service

02	Reconsidering the Affordable Care Act (ACA) Eligibility Firewall
05	Medicaid Estate Recovery Reform
06	Prescription Medication Price Negotiation
09	Minimum Requirements for Medication Formularies

Resolutions

101	Uniform Adoption of Service Intensity Tools to Support Medical Decision-making and Service Gap Analysis
102	Access to Single Maintenance and Reliever Therapy for Asthma
103	Inadequate Reimbursement for Biosimilars
104	Study of Whether the HSA Model Could Become an Option for Medicaid Beneficiaries
105	Development of an Educational Resource on Opting Out of Medicare for Physicians
106	Advocating for All Payer Coverage for Custom Breast Prostheses for Patients with History of Mastectomy Secondary to Breast Cancer Treatment
107	Advocating for All Payer Coverage of Reconstructive and Cosmetic Surgical Care Related to Cleft Lip and Palate
108	Firearm Storage Diagnosis and Counseling Reimbursement
109	Medicare Advantage Plans Double Standard
110	Study of the Federal Employee Health Benefit Plan (FEHBP)
111	New Reimbursement System Needed for Rural Hospital Survival
112	Continuation of Affordable Connectivity Program
113	Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts
114	An Assessment of Physician Support for Value-Based Payment Models and its Impact on Healthcare to Inform AMA Advocacy Efforts—A Survey
115	Supporting Legislative Efforts to Remove Certain High-Cost Supplies and Equipment from the Medicare Physician Fee Schedule
116	Medicare Coverage of Registered Dietitian (RD) and Certified Nutrition Support Specialist (CNSS) Visits Beyond Type 2 Diabetes and Renal Disease
117	Liberalized Remorse Period for Medicare Advantage Plan Insureds
118	Improving Access to Peripartum Pelvic Floor Physical Therapy
119	Cancer Survivorship Program Coverage
120	Medigap, Pre-Existing Conditions, and Medicare Coverage Education
121*	Opposing Pharmacy Benefit Manager Spread Pricing

*Contained in Meeting Tote

Reference Committee B

Report(s) of the Board of Trustees

09 Council on Legislation Sunset Review of 2015 House Policies
13 The Uniform Health-Care Decisions Act
14 A Public Health-Centered Criminal Justice System
16 Research Correcting Political Misinformation and Disinformation on Scope of Practice
17 Antidiscrimination Protections for LGBTQ+ Youth in Foster Care
21 Advocacy for More Stringent Regulations / Restrictions on Distribution of Cannabis

Resolutions

201 Inclusion of DICOM Imaging in Federal Interoperability Standards
202 Preservation of the CDC Epilepsy Program Workforce and Infrastructure
203 Supporting SUPPORT Act modifications to enhance care of patients with chronic pain
204 Protecting the Prescriptive Authority of Plenary Licensed Physicians
205 AMA Support for Continuance of the Section 1115 - Social Security Act, Medicaid Waiver Program
206 AMA Support for Renewal of Section 1115 - Social Security Act, Medicaid Waiver Demonstration Projects Supporting Food and Nutrition Services
207 Abolishing Venue Shopping
208 Binding Arbitration in Health Insurance Contracts
209 Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Addiction Medications for Legitimate Medical Purposes
210 Impact of Tariffs on Healthcare Access and Costs
211 Support for State Provider and Managed Care Organization Taxes to Sustain Federal Medicaid Matching Funding
212 Setting Standards for Forensic Toxicology Laboratories Used in Litigation
213 Emergency Department Designation Requires Physician on Site
214 United Health Care and InterQual Monopoly
215 Support for Changing Standards for Minors Working in Agriculture
216 Support for Aging-Out Foster Youth with Mental Health and Psychotropic Needs
217 Regulation and Oversight of the Troubled Teen Industry
218 Distribution of Resident Slots Commensurate with Shortages
219 Opposing Unwarranted National Institutes of Health Research Institute Restructuring
220 Strengthening AMA Policy on Noncompete Clauses in Ownership Transitions
221 Preservation of Medicaid
222 Need for Separate H1B Pathway for IMG Doctors in the USA
223 Preservation of Medicaid
224 Support SAVE Plan and Public Service Loan Forgiveness (PLSF) Applications
225 The Private Practice Physicians in the Community
226 Regulations for Algorithmic-Based Health Insurance Utilization Review
227 Payment Recoupment—Let Sanity Prevail
228 CHIP Coverage of OTC Medications
229 Guaranteeing Timely Delivery and Accessibility of Federal Health Data

230 Advocating to expand private insurance coverage of anti-obesity medications (AOM)
231 Preventing Venue Shopping in Medical Liability to Protect Physician Practices and Access to Care
232 Preservation of Medicaid
233 Increasing Transparency of AMA Medicare Payment Reform Strategy
234 Protection for International Medical Graduates
235 CMS Payment Monitoring Following Government Staff Reductions
236* Preservation of Medicaid
237* Urgent Advocacy to Restore J-1 Visa Processing for International Medical Graduate Physicians
238* Preserving Accreditation Standards on Diversity, Equity, and Inclusion

*Contained in Meeting Tote

Reference Committee C

Report(s) of the Council on Medical Education

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

Resolutions

301	Examining ABMS Processes for New Boards
302	AMA Study of Lifestyle Medicine and Culinary Electives to Reduce Burnout and Bolster Career Satisfaction in Trainees
303	Support for the Establishment of an Indigenous-Led Medical School in the United States
304	Addressing Professionalism Standards in Medical Training
305	Curricular Structure Reform to Support Physician and Trainee Well-Being
306	Innovation and Reform of Medical Education
307	Disclosure of Individual Physician Volunteers Participation in Committee Decision-making to other Organizations, Stakeholders and Joint Providers
308	Streamlining Annual Compliance Training Requirements for Physicians
309	Increasing Education on Physician-Led Care and Advocacy in Residency Training
310	Protections for Trainees Experiencing Retaliation in Medical Education
311	Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter
312	Selection of IMG Residents Based on Merit

Reference Committee D

Report(s) of the Board of Trustees

20 Guardianship and Conservatorship Reform

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

02 Addressing Social Determinants of Health Through Closed Loop Referral Systems
03 Protections Against Surgical Smoke Exposure
04 Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals
06 Fragrance Regulation (Resolution 501-A-24)
07 Addressing the Health Issues Unique to Minority Communities in Rural Areas

Resolutions

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

424 Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records
425 Alcohol Consumption and Health
426 Addressing Patient Safety and Environmental Stewardship of Single-Use and Reusable Medical Devices
427 Elevate Obesity as a Strategic Objective
428 Public Health Implications of US Food Subsidies
429 Addressing the Health Consequences of Microplastics in Humans
430 Addressing the Health Impacts of Ultraprocessed Foods
431 Alcohol & Breast Cancer Risk
432 Support for Long-Term Sequelae of Pregnancy
433 Clinical Lactation Care
434 Breast Cancer Risk Reduction

Reference Committee E

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

01	Council on Science and Public Health Sunset Review of 2015 House Policies
05	Screening for Image Manipulation in Research Publications
08	Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms
09	Rare Disease Advisory Councils

Resolutions

501	Safer Button / Coin Batteries
502	NIH Grant Funding for Medical Research
503	Safeguarding Neural Data Collected by Neurotechnologies
504	Physician Performed Microscopy Designation for Synovial Fluid Crystal Exam: Modify the Clinical Laboratory Amendment of 1988
505	Mandating Properly Fitting Lead Aprons in Hospitals
506	Opposing the use of harm reduction items as evidence of commercial sex work
507	Clinical and Public Safety Implications of AI-Generated Content and Symbolic Compliance Infrastructure
508	Standardizing Safety Requirements for Traditional and Rideshare-Based Non-Emergency Medical Transportation
509	Allergen Labeling for Spices and Herbs
510	Improving Cybersecurity Standards for Healthcare Entities
511	Increased Transparency Among Psychotropic Drug Administration in Prisons
512	Preventing Drug-Facilitated Sexual Assault in Drinking Establishments
513	Transparency on Comparative Effectiveness in Direct-to-Consumer Advertising
514	Support for a Nicotine Free Generation
515	Nitrous Oxide Abuse
516	Creating a Registry of Potential Side Effects of GIP & GLP-1 Medications
517	In Support of a National Drug Checking Registry
518	Mandatory Accreditation and Regular Inspections of Hyperbaric Chambers
519	Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making
520	Study of Grading Systems in AMA Board Reports
521	Warning labels on OTC sleep aids
522	Access to Important and Essential Drugs

Reference Committee F

Report(s) of the Board of Trustees

01	Annual Report
04	AMA 2026 Dues
22	Ranked Choice Voting
23	Financial Assistance to Facilitate Attendance at MSS Meetings
24	Creation of an AMA Council with a Focus on Digital Health Technologies and AI

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

01	Joint Council Sunset Review of 2015 House Policies

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

01	International Medical Graduates Section Five-Year Review
02	Organized Medical Staff Section Five-Year Review

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

Resolutions

601	AMA To Develop Patient Educational Materials Regarding Ultra-processed Foods for Distribution by AMA members
602	Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations
603	Renaming the Minority Affairs Section to the Underrepresented in Medicine Advocacy Section
604	Advisory Committee on Tribal Affairs

Reference Committee G

Report(s) of the Board of Trustees

06 Transparency and Accountability of Hospitals and Hospital Systems
19 Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout

Report(s) of the Council on Medical Service

01 Council on Medical Service Sunset Review of 2015 House Policies
03 Regulation of Corporate Investment in the Health Care Sector
04 Requiring Payment for Physician Signatures
07 Impact of Patient Non-adherence on Quality Scores

Resolutions

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

*Contained in Meeting Tote

REPORT OF THE BOARD OF TRUSTEES

B of T Report 28-A-25

Subject:	Specialty Society Representation in the House of Delegates - Five-Year Review
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee on Amendments to Ethics and Bylaws

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) required to submit information and materials for the 2025 American Medical Association (AMA) Annual Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic Review Process."

Organizations are required to demonstrate continuing compliance with the guidelines established for representation in the HOD. Compliance with the five responsibilities of professional interest medical associations and national medical specialty organizations is also required as set out in AMA Bylaw 8.2, "Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations."

The following organizations were reviewed for the 2025 Annual Meeting:

American Academy of Otolaryngic Allergy
American Association for Geriatric Psychiatry
American College of Legal Medicine
American College of Mohs Surgery
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Preventive Medicine
American College of Radiology
American College of Surgeons
American Society of Breast Surgeons
American Society of Retina Specialists
American Vein and Lymphatic Society
Heart Rhythm Society
Society of Hospital Medicine
Undersea and Hyperbaric Medical Society

The American Association of Plastic Surgeons, American Society for Metabolic and Bariatric Surgery, and American Society of Cytopathology were also reviewed at this time because they failed to meet the requirements in June 2024 and were granted a one-year grace period.

Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group's

membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

The materials submitted indicate that: American Academy of Otolaryngic Allergy, American Association for Geriatric Psychiatry, American College of Legal Medicine, American College of Mohs Surgery, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Preventive Medicine, American College of Radiology, American College of Surgeons, American Society of Breast Surgeons, American Society of Retina Specialists, Heart Rhythm Society, and Undersea and Hyperbaric Medical Society meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that the American Association of Plastic Surgeons, American Society for Metabolic and Bariatric Surgery, and American Society of Cytopathology met all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that the American Vein and Lymphatic Society and Society of Hospital Medicine did not meet all guidelines and are not in compliance with the five-year review requirements of specialty organizations represented in the AMA HOD.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:

1. The American Academy of Otolaryngic Allergy, American Association for Geriatric Psychiatry, American Association of Plastic Surgeons, American College of Legal Medicine, American College of Mohs Surgery, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Preventive Medicine, American College of Radiology, American College of Surgeons, American Society for Metabolic and Bariatric Surgery, American Society of Breast Surgeons, American Society of Cytopathology, American Society of Retina Specialists, Heart Rhythm Society, and Undersea and Hyperbaric Medical Society retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in the AMA Bylaw B-8.5, the American Vein and Lymphatic Society and Society of Hospital Medicine be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)

Fiscal Note: Less than $500

APPENDIX

Exhibit A - Summary Membership Information

Organization	**AMA Membership of Organization's Total Eligible Membership**
American Academy of Otolaryngic Allergy*	209 of 985 (21%)
American Association for Geriatric Psychiatry	7,122 of 35,038 (20%)
American Association of Plastic Surgeons*	153 of 784 (20%)
American College of Legal Medicine*	94 of 286 (32%)
American College of Mohs Surgery	252 of 1,084 (23%)
American College of Obstetricians and Gynecologists*	12,471 of 42,173 (29%)
American College of Physicians*	24,924 of 79,204 (31%)
American College of Preventive Medicine*	376 of 1,394 (28%)
American College of Radiology*	7,122 of 35,038 (20%)
American College of Surgeons	11,471of 53,116 (21%)
American Society for Metabolic and Bariatric Surgery	381 of 1,765 (21%)
American Society of Breast Surgeons	479 of 2,441 (20%)
American Society of Cytopathology*	340 of 1,197 (28%)
American Society of Retina Specialists	467 of 2,137 (21%)
American Vein and Lymphatic Society	No data submitted
Heart Rhythm Society	1,524 of 3,994 (38%)
Society of Hospital Medicine	2,169 of 11,881 (18%)
Undersea and Hyperbaric Medical Society	89 of 424 (20%)

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

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.

2. The organization must:

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

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

   (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
   (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.

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

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

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

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

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

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

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

Exhibit C

8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

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

8.2.2 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.

8.2.3 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.

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

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

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.5 **Periodic Review Process.** Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society, or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

8.5.1 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting or may take such other action as it deems appropriate.

8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

REVISED

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 03-A-25

Subject: Reconsidering the Terminology to Describe Physician Assisted Suicide

Presented by: Jeremy A. Lazarus, MD, Chair

At the 2023 Interim meeting, Resolution 004-Reconsideration of Medical Aid in Dying (MAID) was referred and asked, "that our AMA study changing our existing position on medical aid in dying, including reviewing government data, health services research, and clinical practices in domestic and international jurisdictions where it is legal." This informational report provides supplemental background and analysis to support Board of Trustees Report 18-A-25, which responds to the referred resolution.

ETHICAL ISSUE

The AMA *Code* and HOD policies use the terminology Physician-Assisted Suicide (PAS) to refer to the practice of facilitating "a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act" [1-2]. In CEJA Report 2-A-19, "Physician-Assisted Suicide," the Council addressed the question of appropriate terminology for this practice [3]. Some have argued that this terminology is divisive due to its moral and political connotations and question whether its use is appropriate [4].

RELEVANT PRACTICAL MATTERS FOR CLINICAL PRACTICE

The terminology used in the AMA *Code of Medical Ethics* to describe this practice offers a clear delineation of intent and action. The use of other terminology to describe this practice has the potential to confuse patients and unduly influence decision making [5]. Descriptors such as Medical Aid in Dying (MAID), physician aid-in-dying, and death with dignity could apply to palliative care practices and compassionate care near the end of life that do not include intending the death of patients. Some have argued that the term 'suicide' may be an affront to patients and negatively affect the patient-physician relationship [6-7]. However, it would be discriminatory only to protect patients who choose to end their lives rationally from the stigma of the term 'suicide' while doing nothing to protect patients struggling with mental illness from the negative consequences of the word.

REVIEW OF RELEVANT LITERATURE

Throughout the history of medicine, this practice has embodied many names including, mercy killing, euthanasia, physician aid-in dying, and medical aid in dying [8]. Currently, the American Medical Association (AMA) refers to this practice as Physician Assisted Suicide (PAS) in both HOD policies and *Code* opinions. There is no consensus regarding the correct terminology to describe PAS in medical, legal, or ethics literature [6]. Notably, however, several prominent philosophers who are in favor of legalization of the practice have argued that physician-assisted suicide is the preferred terminology as it is the clearest and most accurate description of the practice [9-10]. State legislatures, state medical associations, and national medical specialty associations also use varying terminology. In addition to a lack of a national consensus on the use

of terminology, globally varying terminology is utilized including euthanasia and voluntary active euthanasia. Although terminology may vary between nations, it is important to note that both legal and ethical differences in the scope of this practice exist between the United States and other nations. The primary distinction being who administers the lethal dose of medication. When a physician actively administers a lethal dose of medication to the patient upon their request, the practice is referred to as euthanasia or more specifically, voluntary active euthanasia [11]. This practice is distinct from PAS which requires the patient to self-administer the lethal dose of medication themself. All delineations of euthanasia, including voluntary active euthanasia, are neither legal nor ethical in the United States [12].

ETHICAL ANALYSIS

In CEJA Report 2-A-19, "Physician-Assisted Suicide," the Council briefly addressed the question of appropriate terminology for this practice. Below, the terms 'medical aid in dying', 'end of life expanded treatment options', and 'physician assisted suicide' are discussed.

'Medical Aid in Dying' (MAID)

MAID is not a precise or accurate term because physicians provide compassionate aid to patients in the dying process in many ways, including palliative care, which includes comfort care and hospice. The practice of PAS intentionally causes the patient's death, making it ethically distinct from widely accepted standard forms of palliative care that accept but never intentionally hasten death. Attributing the term medical aid in dying to the practice of PAS is neither precise nor accurate and may contribute to the already existing confusion regarding the ethical scope of palliative and hospice care. As stated in CEJA Report 2-A-19, "Physician-Assisted Suicide," terms such as 'aid in dying,' 'medical aid in dying,' 'assisted death,' or 'death with dignity' "could be used to describe either euthanasia or palliative/ hospice care at the end of life and this degree of ambiguity is unacceptable for providing ethical guidance."

'End of Life Expanded Treatment Options'

End of life expanded treatment options are more imprecise and inaccurate than *MAID* and it could refer to expanding access to hospice or psychiatric care at the end of life. Moreover, it does not indicate the precise option to which the phrase is meant to refer.

'Physician Assisted Suicide'

In CEJA Report 2-A-19, "Physician-Assisted Suicide," the Council determined that PAS was the terminology which described the practice best. The report supported this supposition with the following analysis:

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

The Use of Other Terminology

The Council recognizes that others may choose to use other terminology when describing this practice.

Fiscal Note: None.

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REVISED

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

EXECUTIVE SUMMARY

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

REVISED

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 07-A-25

Subject: Guidelines on Chaperones for Sensitive Exams

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaw

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

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

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

BACKGROUND

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

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

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

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

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

ETHICAL ANALYSIS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Use of Chaperone at Physician Request

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

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

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

Use of Chaperone without Patient Consent in Exceptional Circumstances

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

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

Documentation of Patient Preference and Chaperone Use

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

Pediatric & Adolescent Patients

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

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

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

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

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

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

Patients with Diminished or Lacking Decisional Capacity

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

Identifying & Informing Appropriate Chaperones

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

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

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

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

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

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

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

CONCLUSION

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

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends:

1. Opinion 1.2.4 be amended by deletion and addition as follows:

<u>Conducting sensitive examinations in an ethically and clinically sound manner requires physicians to be responsive to both the distinctive characteristics of the individual patient and to the professional boundaries of the patient-physician relationship. While a sensitive exam is typically understood as one involving any examination of, or procedure involving, the genitalia, breasts, perianal region or the rectum, physicians should be aware that a patient's personal history, beliefs or identity may broaden their definition of what constitutes a sensitive examination or procedure. Respecting patient boundaries and promoting patient dignity requires providing a safe and therapeutic clinical encounter during sensitive exams while also empowering patients.</u> ~~Efforts to provide a comfortable and considerate atmosphere for the patient and the physician are part of respecting patients'~~

~~dignity.~~ Such ~~These~~ efforts ~~may~~ include measures that promote patient privacy, such as providing appropriate gowns, private facilities for undressing, sensitive use of draping, and clearly explaining various components of the physical examination. They may also include the use of ~~having~~ chaperones regardless of the gender of the physician or patient ~~available~~. Having chaperones present can ~~also~~ help protect the integrity of the patient-physician relationship ~~prevent misunderstandings between patient and physician~~. Physicians should, as always, also be mindful of any applicable legal or regulatory requirements regarding the use of chaperones. A fair and effective policy on the use of chaperones must balance: (1) respect for patient preferences and the integrity and safety of the clinical encounter; (2) protection of physicians; and (3) boundaries of the patient-physician relationship.

Physicians should:

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

~~(b)~~ ~~Always~~ honor a patient's request ~~to have~~ for a chaperone~~.~~, even if a patient's trusted companion is present.

~~(c) Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.~~

~~(d) In general, use a chaperone even when a patient's trusted companion is present.~~

~~(e)~~(b) Provide an opportunity for private conversation with the patient without the chaperone present~~. Physicians should~~ and minimize inquiries or history taking ~~of a sensitive nature~~ during a chaperoned examination or procedure.

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

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

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

(f) Have an authorized member of the health care team act ~~serve~~ as a chaperone. All

chaperones should be provided with information and understand the responsibilities of the role. Chaperones should be made aware of mechanisms for reporting unprofessional conduct in keeping with ethics guidance and without fear of retaliation. Physicians should establish clear expectations that chaperones will uphold professional and legal standards of privacy and confidentiality.

2. Policy D-140.950 be rescinded as it has been accomplished by this report and the remainder of this report be filed.

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

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REVISED

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 08-A-25

Subject: Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blinded Model for Organ Procurement and Transplantation

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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

BACKGROUND

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

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

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

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

ETHICAL ISSUE

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

REVIEW OF RELEVANT LITERATURE

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

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

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

ETHICAL ANALYSIS

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

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

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

RECOMMENDATION

In consideration of the foregoing, the Council on Ethical and Judicial Affairs recommends the following:

1. That a new Code of Medical Ethics opinion be adopted as follows:

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

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

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

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

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

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

2. That Policy H-370.954 be rescinded as having been accomplished by this report and the remainder of this report be filed.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500

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REVISED

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 09-A-25

Subject: Ethical Impetus for Research in Pregnant and Lactating Individuals

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

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

BACKGROUND

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

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

ETHICAL ISSUES

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

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

being able to appropriately counsel pregnant patients regarding the risks, benefits, and alternatives of treatments. At issue is how to balance respect for pregnant and lactating individuals with the potential benefits and harms of research.

REVIEW OF RELEVANT LITERATURE

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

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

Relevant Laws

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

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

Additionally, as of January 21, 2019, the Common Rule no longer labels pregnant individuals as "vulnerable" with regards to IRBs. This is because while pregnant individuals have historically been deemed vulnerable, it has since been recognized that while some individuals who are pregnant may be vulnerable, being pregnant in and of itself does not automatically denote vulnerability [11,12].

Relevant Code Provision(s)

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

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

ETHICAL ANALYSIS

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

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

Examples of this harm can be seen in the historical use of thalidomide and diethylstilbestrol in pregnant individuals. While the tragic consequences of their use have been cited as reasons to exclude pregnant individuals from clinical trials, it was actually the lack of controlled data from clinical trials that caused such widespread detrimental effects due to the teratogenic effects of these drugs not being examined until post-marketing surveillance data was available. Had smaller scale and better controlled clinical trials been conducted, mass marketing and exposure to these medications for pregnant individuals may have been avoided because the teratogenic effects would have been discovered during trials [13]. Another example is that of ACE inhibitors, which were used in pregnant individuals for three decades prior to the 1996 discovery that its use in the first trimester can cause congenital anomalies [5]. Had it been studied more rigorously through smaller scale clinical trials with individuals consenting to the risks of participating in research, this discovery may have been made much sooner and far fewer individuals would have been exposed to this drug in the first trimester without knowing the risks of doing so.

Historically, concern for pregnant individuals and fetuses has centered on defining this population as "vulnerable", thus needing broad shielding from risks, such as medical research. Such an approach to research practices has been deemed "overly paternalistic, disempowering, or coercive" [14]. Pregnant and lactating individuals are not automatically vulnerable, and this approach does not respect their autonomy to assess the benefits and risks of participation for themselves and their fetuses or newborns [15]. Pregnant and lactating individuals should always be provided the opportunity to decide whether research participation is in their best interest through informed consent. If pregnant or lactating individuals are unable to be included in research, alternative ways to rectify any gap in knowledge should be developed. For example, pregnant and lactating individuals should be instructed on how to participate in research registries and adverse event reporting programs.

CONCLUSION

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

RECOMMENDATION

In consideration of the foregoing, the Council on Ethical and Judicial Affairs recommends the following:

1. That a new Code of Medical Ethics opinion be adopted as follows:

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

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

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

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

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

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

(e) Ensure risks to the fetus or nursing infants are not greater than minimal, especially when the intervention under study is not intended primarily to benefit the fetus or infant, but rather for the development of important biomedical knowledge that cannot be obtained by any other means.

2. Policy D-140.949 be rescinded as having been accomplished by this report and the remainder of this report be filed.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500

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REVISED

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

CEJA Report 13-A-25

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

Presented by: Jeremy A. Lazarus, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

This report is offered in response to a referred resolve clause from resolution 017-A-24, "Addressing the Historical Injustices of Anatomical Specimen Use." It asked that our AMA amend Opinion 6.1.4 "Presumed Consent & Mandated Choice for Organs from Deceased Donors" as follows:

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

BACKGROUND

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

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

Our AMA policy, including the *Code of Medical Ethics*, supports increasing the organ supply (Opinion 6.1.2) and promoting organ donation awareness (D-370.997) while also recognizing the need to "continue to monitor ethical issues related to organ transplantation" (H-370.967). Obtaining consent for organ donation, while an ethical imperative, may present a barrier to increasing organ supply (Opinion 6.1.2). There are three common methods of obtaining consent employed to facilitate organ donation including: 1) voluntary consent; 2) mandated choice; and 3) presumed consent. Although the voluntary consent model is traditionally used in the US and supported by *Code* guidance, our AMA has policy which supports "studies that evaluate the effectiveness of mandated choice and presumed consent models for increasing organ donation" (H-370.959). Additionally, the *Code* provides guidance for physicians who propose to develop or participate in pilot studies of presumed consent and mandated choice (Opinion 6.1.4).

ETHICAL ISSUE

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

ETHICAL ANALYSIS

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

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

countries have reached different conclusions, a trend which is also observed when looking at donation systems at a micro level. For example, in 2015 Wales introduced an opt-out system which over time significantly increased organ donation consent [8]. Whereas Chile, Singapore, and Sweden provide examples of opt-out systems failing to increase donation [9].

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

CONCLUSION

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

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

RECOMMENDATION

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

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 14-A-25

Subject: Achieving Gender-Neutral Language in the AMA *Code of Medical Ethics*

Presented by: Jeremy A. Lazarus, MD, Chair

At the 2024 Annual Meeting of the House of Delegates, Resolution 009, "Updating Language Regarding Families and Pregnant Persons" was adopted as a directive to take action. Resolution 009 contains one resolve which states that the American Medical Association (AMA) "review and update the language used in AMA policy and other resources and communications to ensure that the language used to describe families and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures."

Additionally, at the 2023 Annual Meeting of the House of Delegates, Resolution 602, "Supporting the Use of Gender-Neutral Language" was adopted as House Policy, H-65.942, "Supporting the Use of Gender-Neutral Language." H-65.942 states that the AMA "will recognize the importance of using gender-neutral language such as gender neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity" and that the AMA "will prospectively amend all current AMA policy, where appropriate, to include gender-neutral language by way of the reaffirmation and sunset processes."

RECONCILIATIONS

In response to the House's directives of Resolution 009 and H-65.943, the Council on Ethical and Judicial Affairs (CEJA) has searched the *AMA Code of Medical Ethics* for all *Code* opinions that contain the following non-gender neutral terms: obstetric, pregnant, pregnancy, mother, father, he, she, him, her, his, man, men, woman, and women and have applied appropriate alternate language for these terms. Ongoing review of gendered language should continue prospectively as policy states.

Where changes to *Code* language will be made, additions are shown with underscore and deletions are shown with strikethrough in red font. Given the length of many of the policies, only the affected portions are reproduced.

- Appendix A includes relevant portions of *Code* opinions that contain gendered language and the alternative gender-neutral language.
- Appendix B contains other *Code* opinions with gendered language that is relevant to the intent of the opinion and would substantively change the opinion if replaced with gender neutral language. Therefore, the following policies will be retained as written.

The policy changes reflected in this report do not reset the sunset clock and will be implemented when this report is filed.

Fiscal Note: Less than $500

Appendix A – Alternative gender-neutral language

Code Opinion	Alternative Language
1.1.2 Prospective Patients	Meeting the medical needs of the prospective patient could seriously compromise the physician's ability to provide the care needed by ~~his or her~~their other patients.
1.1.3 Patient Rights	To courtesy, respect, dignity, and timely, responsive attention to ~~his or her~~their needs.
2.1.2 Decisions for Adult Patients Who Lack Capacity	Physicians should engage patients whose capacity is impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on ~~his or her~~their behalf. how the patient constructed ~~his or her~~their life story;
2.1.6 Substitution of Surgeon	A surgeon who allows a substitute to conduct a medical procedure on ~~his or her~~their patient without the patient's knowledge or consent risks compromising the trust-based relationship of patient and physician.
2.2.2 Confidential Health Care for Minors	Explore the minor patient's reasons for not involving ~~his or her~~their parents (or guardian) and try to correct misconceptions that may be motivating the patient's reluctance to involve parents. Encourage the minor patient to involve ~~his or her~~their parents and offer to facilitate conversation between the patient and the parents.
2.2.3 Mandatory Parental Consent to Abortion	Strongly encourage the patient to discuss the pregnancy with ~~her~~their parents (or guardian). Explore the minor patient's reasons for not involving her parents (or guardian) and try to correct misconceptions that may be motivating the patient's reluctance to involve parents. If the patient is unwilling to involve ~~her~~their parents, encourage ~~her~~them to seek the advice and counsel of adults in whom ~~she has~~they have confidence, including professional counselors, relatives, friends, teachers, or the clergy. Not feel or be compelled to require a minor patient to involve ~~her~~their parents before ~~she decides~~they decide whether to undergo an abortion.
2.2.4 Treatment Decisions for Seriously Ill Newborns	Decision makers must also assess whether the choice made for the newborn will abrogate a choice the future individual would want to make for ~~him or herself~~themself,

2.2.5 Genetic Testing of Children	Decisions to test must balance multiple considerations, including likely benefits, the risks of knowing genetic status (including abrogating the child's opportunity to make the choice about knowing genetic status ~~him- or herself~~themself as an adult),
3.2.1 Confidentiality	the patient will seriously harm ~~him/herself~~themself;
3.3.1 Management of Medical Records	This obligation encompasses not only managing the records of current patients, but also retaining old records against possible future need, and providing copies or transferring records to a third party as requested by the patient or the patient's authorized representative when the physician leaves a practice, sells ~~his or her~~their practice, retires, or dies. to the succeeding physician or other authorized person when the physician discontinues ~~his or her~~their practice (whether through departure, sale of the practice, retirement, or death);
3.3.3 Breach of Security in Electronic Medical Records	The degree to which an individual physician has an ethical responsibility to address inappropriate disclosure depends in part on ~~his or her~~their awareness of the breach, relationship to the patient(s) affected, administrative authority with respect to the records, and authority to act on behalf of the practice or institution.
4.2.3 Therapeutic Donor Insemination	Therapeutic donor insemination using sperm from a ~~woman's partner~~prospective patient or a third-party donor can enable a ~~woman~~patient or couple who might not otherwise be able to do so to fulfill the important life choice of becoming a parent (or parents). However, the procedure also raises ethical considerations about safety for the ~~woman~~patient and potential offspring, donor privacy, and the disposition of frozen semen, as well as the use of screening to select the sex of a resulting embryo.
4.2.4 Third-Party Reproduction	Third-party reproduction is a form of assisted reproduction in which a ~~woman~~person agrees to bear a child on behalf of and relinquish the child to an individual or couple who intend to rear the child. They can also raise concerns about the voluntariness of the gestational carrier's participation and about possible psychosocial harms to those involved, such as distress on the part of the gestational carrier at relinquishing the child or on the part of the child at learning of the circumstances of ~~his or her~~their birth. Third-party reproduction can also carry potential to depersonalize carriers, exploit economically

	disadvantaged ~~women~~persons, and commodify human gametes and children.
5.1 Advance Care Planning	Incorporate notes from the advance care planning discussion into the medical record. Patient values, preferences for treatment, and designation of surrogate decision maker should be included in the notes to be used as guidance when the patient is unable to express ~~his or her~~their own decisions. If the patient has an advance directive document or written designation of proxy, include a copy (or note the existence of the directive) in the medical record and encourage the patient to give a copy to ~~his or her~~their surrogate and others to help ensure it will be available when needed. Periodically review with the patient ~~his or her~~their goals, preferences, and chosen decision maker, which often change over time or with changes in health status. Update the patient's medical records accordingly when preferences have changed to ensure that these continue to reflect the individual's current wishes. If applicable, assist the patient with updating ~~his or her~~their advance directive or designation of proxy forms. Involve the patient's surrogate in these reviews whenever possible.
5.2 Advance Directives	Ascertain whether the patient has an advance directive and if so, whether it accurately reflects ~~his/her~~their current values and preferences.
5.3 Withholding or Withdrawing Life-Sustaining Treatment	Decisions to withhold or withdraw life-sustaining interventions can be ethically and emotionally challenging to all involved. However, a patient who has decision-making capacity appropriate to the decision at hand has the right to decline any medical intervention or ask that an intervention be stopped, even when that decision is expected to lead to ~~his or her~~their death and regardless of whether or not the individual is terminally ill.
5.4 Orders Not to Attempt Resuscitation (DNAR)	Physicians should address the potential need for resuscitation early in the patient's course of care, while the patient has decision-making capacity, and should encourage the patient to include ~~his or her~~their chosen surrogate in the conversation. Before entering a DNAR order in the medical record, the physician should: When the patient cannot express preferences regarding resuscitation or does not have decision-making capacity and has not previously indicated ~~his or her~~their preferences, the physician has an ethical responsibility to:

6.1.1 Transplantation of Organs from Living Donors	Secure agreement from all parties to the prospective donation in advance so that, should the donor withdraw, ~~his or her~~their reasons for doing so will be kept confidential.
6.1.5 Umbilical Cord Blood Banking	Physicians who provide obstetrical care should be prepared to inform pregnant ~~women~~individuals of the various options regarding cord blood donation or storage and the potential uses of donated samples. Encourage ~~women~~people who wish to donate umbilical cord blood to donate to a public bank if one is available when there is low risk of predisposition to a condition for which umbilical cord blood cells are therapeutically indicated:
6.2.2 Directed Donation of Organs for Transplantation	Refuse to participate in any transplant that ~~he or she believes~~they believe to be ethically improper and respect the decisions of other health care professionals should they choose not to participate on ethical or moral grounds.
7.1.2 Informed Consent in Research	For these reasons, no person may be used as a subject in research against ~~his or her~~their will. The participant gives ~~his or her~~their assent to participation, where possible. Physicians should respect the refusal of an individual who lacks decision-making capacity.
7.1.4 Conflicts of Interest in Research	Ensure that the research protocol includes provision for funding participants' medical care in the event of complications associated with the research. A physician should not double-bill a third-party payer for additional expenses related to conducting the trial if ~~he or she has~~they have already received funds from a sponsor for those expenses.
7.2.3 Patents & Dissemination of Research Products	A patent grants the holder the right, for a limited time, to prevent others from commercializing ~~his or her~~their inventions.
7.3.2 Research on Emergency Medical Interventions	The prospective participant lacks the capacity to give informed consent at the time ~~he or she~~they must be enrolled due to the emergency situation and requirements of the research protocol and it would not have been feasible to obtain
7.3.4 Maternal-Fetal Research	Maternal-fetal research, i.e., research intended to benefit pregnant ~~women~~individuals and/or their fetuses, must balance the health and safety of the ~~woman~~individual who participates and the well-being of the fetus with the desire to develop new and innovative therapies. One challenge in such research is that pregnant ~~women~~individuals may face external pressure or expectations to enroll from partners, family members, or

	others that may compromise their ability to make a fully voluntary decision about whether to participate. Physicians engaged in maternal-fetal research should demonstrate the same care and concern for the pregnant ~~woman~~individual and fetus that they would in providing clinical care. Enroll a pregnant ~~woman~~individual in maternal-fetal research only when there is no simpler, safer intervention available to promote the well-being of the ~~woman~~individual or fetus. Obtain the informed, voluntary consent of the pregnant ~~woman~~individual. Minimize risks to the fetus to the greatest extent possible, especially when the intervention under study is intended primarily to benefit the pregnant ~~woman~~individual.
7.3.5 Research Using Human Fetal Tissue	However, the use of fetal tissue for research purposes also raises a number of ethical considerations, including the degree to which an ~~woman's~~individual's decision to have an abortion might be influenced by the opportunity to donate fetal tissue. Concerns have also been raised about potential conflict of interest when there is possible financial benefit to those who are involved in the retrieval, storage, testing, preparation, and delivery of fetal tissues. To protect the interests of pregnant ~~women~~individuals as well as the integrity of science, physicians who are involved in research that uses human fetal tissues should: In all instances, obtain the ~~woman's~~individual's voluntary, informed consent in keeping with ethics guidance, including when using fetal tissue from a spontaneous abortion for purposes of research or transplantation. Informed consent includes a disclosure of the nature of the research including the purpose of using fetal tissue, as well as informing the ~~woman~~ individual of a right to refuse to participate. the ~~woman's~~ individual's decision to terminate the pregnancy is made prior to and independent of any discussion of using the fetal tissue for research purposes; decisions regarding the technique used to induce abortion and the timing of the abortion in relation to the gestational age of the fetus are based on concern for the safety of the pregnant ~~woman~~individual.

9.4.4 Physicians with Disruptive Behavior	Establish a process to notify a physician that ~~his or her~~their behavior has been reported as disruptive, and provide opportunity for the physician to respond to the report.
9.6.1 Advertising & Publicity	There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize ~~him or herself~~themself as a physician through any commercial publicity or other form of public communication
10.2 Physician Employment by a Nonphysician Supervisee	If maintaining an employment relationship with a midlevel practitioner contributes significantly to the physician's livelihood, the personal and financial influence that employer status confers creates an inherent conflict for a physician who is simultaneously an employee and a clinical supervisor of ~~his or her~~their employer.
10.3 Peers as Patients	Provide information to enable the physician-patient to make voluntary, well-informed decisions about care. The treating physician should not assume that the physician-patient is knowledgeable about ~~his or her~~their medical condition.
10.6 Industry Representatives in Clinical Settings	The representative has agreed to abide by the policies of the health care institution governing ~~his or her~~their presence and clinical activities. The representative does not exceed the bounds of ~~his or her~~their training, is adequately supervised, and does not engage in the practice of medicine.
11.3.1 Fees for Medical Services	Charge only for the service(s) that are personally rendered or for services performed under the physician's direct personal observation, direction, or supervision. If possible, when services are provided by more than one physician, each physician should submit ~~his or her~~their own bill to the patient and be compensated separately.

Appendix B - Policies retained as currently written

4.1.2. Genetic Testing for Reproductive Decision Making	Genetic testing to inform reproductive decisions was once recommended only for women/couples whose family history or medical record indicated elevated risk for a limited set of genetically mediated conditions.

REVISED

REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report, June 2025

Subject: REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Presented by: Evelyn Lewis, MD, Chair

Referred to: Reference Committee F

BACKGROUND

At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on Trustee Compensation, currently named the Committee on Compensation of the Officers (the "Committee"). The Officers, defined in the American Medical Association's (AMA) Constitution and Bylaws, consist of all 21 members of the Board of Trustees, including the President, President-Elect, Immediate Past President, Secretary, and Speaker and Vice Speaker of the HOD, and are collectively referred to in this report as Officers. The composition, appointment, tenure, vacancy process and reporting requirements for the Committee are covered under the AMA Bylaws. Bylaw 2.13.4.5 provides:

> The committee shall present an annual report to the House of Delegates recommending the level of total compensation for the Officers for the following year. The recommendations of the report may be adopted, not adopted, or referred back to the committee, and may be amended for clarification only with the concurrence of the committee.

At A-00, the Committee and the Board jointly adopted the American Compensation Association's definition of "Total Compensation" which was added to the Glossary of the AMA Constitution and Bylaws. Total Compensation is defined as the complete reward/recognition package awarded to an individual for work performance, including: (a) all forms of money or cash compensation; (b) benefits; (c) perquisites; (d) services; and (e) in-kind payments.

Since the inception of this Committee, its reports have documented the process the Committee follows to ensure that current or recommended Officer compensation is based on sound, fair, cost-effective compensation practices as derived from research and use of independent external consultants, expert in Board compensation. Reports beginning in December 2002 documented the principles the Committee followed in creating its recommendations for Officer compensation.

METHODOLOGY

The Committee recently commissioned Willis Towers Watson (WTW), a major compensation consulting firm with expertise in board compensation, to review the Speaker and Vice Speaker Governance Honorariums and consider if a separate larger Honorarium would better recognize the considerable amount of work required of these positions and that the work is different from regular board members. As a result of this review, the Committee also considered if the Per Diem for Internal Representation should be eliminated for all non-leadership board members.

FINDINGS

WTW analyzed the Speaker and Vice Speaker compensation data for the past three terms, 2021/2022, 2022/2023 and 2023/2024. The analysis demonstrated that the Speaker and Vice Speaker roles require a significant time commitment given the volume of work required of each. Based on the analysis, WTW supports a higher honorarium of $125,000 for the Speaker and $115,000 for the Vice Speaker. The increased honorarium would cover all internal representation.

In addition, WTW's analysis also raised questions about the need for a Per Diem for Internal Representation for non-leadership board members. The current Governance Honorarium includes 11 days of internal representation per term. Review of the past three terms showed all board members except the Speakers (and only once for one board member and one medical student) were under the 11 days that are compensated by the Governance Honorarium as currently defined. This Committee recommends eliminating the Internal Representation for all board members and revising the Governance Honorarium definition for all non-officer board members to state that all internal representation days are included in the Honorarium, resulting in a per diem only for External Representation, thus providing greater clarity and simplification of Board compensation.

RECOMMENDATIONS

The Committee on Compensation of the Officers recommends the following recommendations be adopted effective July 1, 2025, and the remainder of this report be filed:

1. That the Governance Honorarium for the Speaker and Vice Speaker be increased to $125,000 and $115,000 respectively and include all representation days.

2. That the definition of the Governance Honorarium be revised as follows:

   The purpose of this payment is to 1) compensate the Board Chair, Chair Elect, Presidents and Speakers for all Chair-assigned internal and external AMA work and related travel, and 2) compensate other Officers, excluding Board Chair, Chair-Elect, Presidents and Speakers, for all Chair-assigned internal AMA work and related travel. This payment is intended to cover the yearly slate of meetings as approved by the Board, which include: Board meetings and additional meetings including but not limited to: State Advocacy Summit, National Advocacy Conference, and Annual and Interim meetings; special Board or Board committee, subcommittee and task force meetings**;** Board orientation, Board development and media training**;** and Board conference calls. This includes any associated review or preparatory work, and all travel days related to all such meetings. The Governance Honorarium also covers all internal representation, such as section and council liaison meetings, any associated review or preparatory work, and all travel days related to all such meetings. ~~The Governance Honorarium also covers Internal Representation, such as section and council liaison meetings (and associated travel) or calls, up to eleven (11) Internal Representation days.~~

3. That the definition of the Per Diem for External Representation and the related Telephonic Per Diem Representation be revised as follows:

   The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is ~~either~~ external to the AMA, or with organizations in ~~with~~ which the AMA has a key role in creating/partnering/facilitating achievement of the respective organization goals such as the AMA Foundation. ~~PCPI, etc. or for Internal Representation days~~

~~above eleven (11).~~ The Board Chair may also approve per diem for special circumstances that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is $1,550 per day.

Definition of Telephone Per Diem for External Representation ~~effective July 1, 2017~~:

Officers, excluding the Board Chair, Chair Elect, Presidents and Speakers, who are assigned by the Board Chair as the AMA representative to outside groups as one of their specific Board assignments ~~or assigned Internal Representation days above eleven (11)~~, receive a per diem for teleconference meetings when the total of all external teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for those meetings would require the approval of the ~~Chair of the~~ Board Chair. The amount of the Telephonic Per Diem will be ½ of the full Per Diem which is $775.

4. That the remainder of the report be filed.

Fiscal Note: minimal

APPENDIX

Board Leadership Compensation

POSITION	**GOVERNANCE HONORARIUM**
President	$298,865
Immediate Past President	$290,659
President-Elect	$290,659
Chair	$285,886
Chair-Elect	$211,630

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 014
(A-25)

Introduced by: Young Physicians Section

Subject: Protecting Access to Emergency Abortion Care Under EMTALA

Referred to: Reference Committee on Ethics and Bylaws

Whereas, the Emergency Medical Treatment and Labor Act (EMTALA) mandates that hospitals receiving Medicare funds provide necessary stabilizing treatment to patients experiencing emergency medical conditions regardless of insurance status or state law[1]; and

Whereas, emergency medical conditions under EMTALA explicitly include complications related to pregnancy, such as ectopic pregnancies, severe preeclampsia, miscarriage complications, and other potentially life-threatening pregnancy conditions; and

Whereas, guidance issued by the U.S. Department of Health and Human Services in 2022 clarified hospitals' obligations under EMTALA to provide emergency abortion care when necessary to stabilize a pregnant patient's condition, even in states with restrictive abortion laws, shielding patients and physicians from legal uncertainty[2]; and

Whereas, there are over 50 reports from across the country of patients receiving different iterations of sub-standard care because of state abortion bans, including being inappropriately discharged with PPROM only to return septic, or being discharged with ectopic pregnancies implanted in C-section scars only to later require a hysterectomy[3]; and

Whereas, multiple hospitals were cited by CMS for violating EMTALA by denying emergency abortion care after the 2022 guidance, underscoring the critical role of clear federal directives[4]; and

Whereas, the Supreme Court of the United States failed to clarify whether EMTALA supersedes state abortion bans, which have multiplied since 2022[5]; and

Whereas, on June 3, 2025, the Trump administration rescinded guidance to provide emergency abortion care under EMTALA, citing legal confusion and misalignment with current policy, elevating risks to patient safety and potentially subjecting physicians to criminal prosecution due to conflicting state and federal requirements[6]; and

Whereas, this recission raises significant concerns among physicians, other healthcare providers, and reproductive rights advocates about delayed or denied emergency medical care for pregnant patients with emergency medical conditions[7]; and

Whereas, AMA policy D-5.999 Preserving Access to Reproductive Health Services opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients, and opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges against patients, patient advocates, physicians,

other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; and

Whereas, AMA policy H-130.950 emphasizes seeking solutions for patient care and legal problems created by current EMTALA rules and opposes regulatory changes increasing ambiguity and liability for providers; and

Whereas, AMA policy H-295.923 supports medical training in medication and procedural abortion, underscoring the critical importance of accessible abortion care as a component of comprehensive medical education; and

Whereas, AMA policy H-5.993 reaffirms abortion as a human right and medical practice issue determined by patient and physician clinical judgment, highlighting the necessity for clear legal protections; and

Whereas, existing AMA policies such as D-130.971 and D-130.975 advocate for financial and legal protections for providers delivering EMTALA-mandated care, further underscoring the need for clear guidance and support to protect physicians; and

Whereas, AMA policy D-5.996 explicitly advocates for broad and equitable access to abortion services, public and private coverage, and the codification of legal protections to ensure access to reproductive care, which directly aligns with ensuring EMTALA protection; and

Whereas, AMA policy H-5.997 opposes violence and intimidation against healthcare providers and facilities, emphasizing the need for clear federal guidance to reduce risks associated with providing necessary emergency pregnancy care; and

Whereas, the absence of explicit AMA policy affirming hospitals' obligation under EMTALA to provide abortion care necessary to stabilize pregnant patients irrespective of state abortion restrictions represents a critical policy and advocacy gap necessitating urgent AMA action; therefore be it

RESOLVED, that our American Medical Association reaffirm policy D-5.999 Preserving Access to Reproductive Health Services (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA advocate for the reinstatement of federal guidance affirming hospitals’ obligation under EMTALA to provide necessary emergency pregnancy care, including, but not limited to, abortion care, to stabilize patients irrespective of state-level abortion restrictions (Directive to Take Action); and be it further

RESOLVED, that our AMA support legal and policy measures that protect physicians and other healthcare providers from criminal, civil, or professional repercussions when providing necessary emergency pregnancy care, including, but not limited to, abortion care, required under EMTALA (New HOD Policy); and be it further

RESOLVED, that our AMA collaborate with relevant stakeholders, including federal agencies, Congress, medical societies, and patient advocacy groups, to educate policymakers and healthcare providers on EMTALA obligations concerning emergency pregnancy care, including, but not limited to, necessary abortion care (Directive to Take Action); and be it further

RESOLVED, that our AMA task force established under AMA Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate

Care Is Banned or Restricted," provide ongoing recommendations and updates on navigating conflicting state and federal regulations on emergency pregnancy care. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 6/6/2025

REFERENCES

1. 42 U.S. Code § 1395dd
2. Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss, https://www.cms.gov/medicareprovider-enrollmentand-certificationsurveycertificationgeninfopolicy-and-memos-states-and/reinforcement-emtala-obligations-specificpatients-who-are-pregnant-or-are-experiencing-pregnancy-0 (QSO-21-22-Hospitals- UPDATED JULY 2022), accessed June 4, 2025
3. Chernoby K, Acunto B. Pregnancy Complications After Dobbs: The Role of EMTALA. West J Emerg Med. 2024 Jan;25(1):79-85. doi: 10.5811/westjem.61457. PMID: 38205988; PMCID: PMC10777191.
4. NWLC Applauds CMS' Action on Mylissa Farmer's Emergency Abortion Complaint, Finding Hospitals Violated Federal Law https://nwlc.org/press-release/nwlc-applauds-cms-action-on-mylissa-farmers-emergency-abortion-complaint-finding-hospitals-violated-federal-law/ (May 1, 2023). Accessed June 5, 2025; Texas hospital that discharged woman with doomed pregnancy violated the law, a federal inquiry finds ttps://www.yahoo.com/news/texas-hospital-discharged-woman-doomed-152837584.html?guccounter=1 (June 4, 2025). Accessed June 5, 2025
5. Supreme Court Dismisses Idaho v. United States Without Making a Decision on Emergency Abortion Care https://www.americanprogress.org/article/supreme-court-dismisses-idaho-v-united-states-without-making-a-decision-on-emergency-abortion-care/ (June 27, 20024). Accessed June 5, 2025
6. CMS Statement on Emergency Medical Treatment and Labor Act (EMTALA) https://www.cms.gov/newsroom/press-releases/cms-statement-emergency-medical-treatment-and-labor-act-emtala (June 3, 2025). Accessed June 4, 2025
7. Christensen, Jen. Trump administration rolls back guidance specifying that ERs must offer abortion care when necessary https://www.cnn.com/2025/06/03/health/emtala-emergency-abortion-care, June 3, 2025, Accessed June 4, 2025

RELEVANT AMA POLICY

Preserving Access to Reproductive Health Services D-5.999
1. Our American Medical Association recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right.
2. Our AMA opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion.
3. Our AMA will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion.
4. Our AMA supports shared decision-making between patients and their physicians regarding reproductive healthcare.
5. Our AMA opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients.
6. Our AMA opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services.
7. Our AMA will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services.
8. Our AMA will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.
[Res. 028, A-22; Reaffirmed: Res. 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res. 317, I-22; Reaffirmation: A-23; Appended: Res. 711, A-23]

Emergency Medical Treatment and Active Labor Act (EMTALA) H-130.950

Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act (EMTALA) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under EMTALA;

(2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act (EMTALA) rules and regulations;

(3) urgently seeks return to the original congressional intent of EMTALA to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and.

(4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous EMTALA requirements.
[Sub. Res. 214, A-97; Reaffirmation I-98; Reaffirmation, A-99; Appended: Sub. Res. 235 and Reaffirmation A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17]

Medical Training and Termination of Pregnancy H-295.923

1. Our American Medical Association supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.

2. Our AMA will advocate for the availability of abortion education and clinical exposure to medication and procedural abortion for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.

3. In the event that medication and procedural abortion are limited or illegal in a home institution, our AMA will support pathways for medical students and resident/fellow physicians to receive this training at another location.

4. Our AMA will advocate for funding for institutions that provide clinical training on reproductive health services, including medication and procedural abortion, to medical students and resident/fellow physicians from other programs, so that they can expand their capacity to accept out-of-state medical students and resident/fellow physicians seeking this training.

5. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the relevant Residency Review Committees.
[Res. 315, I-94; Reaffirmed: CME Rep. 2,A-04; Modified: CME Rep. 2, A-14; Modified: CME Rep. 1, A-15; Appended: Res. 957, I-17; Modified: Res. 309, I-21; Modified: Res. 317, I-22]

Right to Privacy in Termination of Pregnancy H-5.993

1. Our American Medical Association reaffirms existing policy that:

    a. Abortion is a human right and the practice of medicine and should be performed in conformance with standards of good medical practice.
    b. No physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances, a physician or other professional may withdraw from the case so long as the withdrawal is consistent with good medical practice and ethical guidance on the exercise of conscience.

2. The AMA further supports the position that termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the ability to perform the procedure safely.
[Res. 49, I-89; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: CCB/CLRPD Rep. 2, A-14; Modified: BOT Rep. 4, I-22]

The Future of Emergency and Trauma Care D-130.971

1. Our American Medical Association will expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care.
2. Our AMA, with the advice of specific specialty societies, will advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties.
3. Our AMA will continue to advocate for the following: a. Insurer payment to physicians who have delivered EMTALA-mandated, emergency care, regardless of in-network or out-of-network patient status, b. Financial support for providing EMTALA-mandated care to uninsured patients, c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service, d. Federal and state liability protections for physicians providing EMTALA-mandated care.
4. Our AMA will disseminate these recommendations immediately to all stakeholders including but not limited to Graduate Medical Education Program Directors for appropriate action/implementation.
5. Our AMA supports demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care.
6. Our AMA supports the extension of the Federal Tort Claims Act (FTCA) to all Emergency Medical Treatment and Labor Act (EMTALA) mandated care if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by such extension.
7. If an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by extension of the FTCA, our AMA will conduct a legislative campaign, coordinated with national specialty societies, targeted toward extending FTCA protections to all EMTALA-mandated care, and the AMA will assign high priority to this effort.

[BOT Rep. 14, I-06; Reaffirmation A-07; Reaffirmation A-08; BOT action in response to referred by decision Res. 204, A-11; Appended: Res. 221, I-11; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmed: BOT Rep. 09, A-24]

Advocacy Efforts to Persuade All Health Payers to Pay for EMTALA-Mandated Services D-130.975

Our AMA will incorporate into any existing or future legislative efforts regarding EMTALA and/or balance billing, language which would require all insurers to assign payments directly to any health care provider who has provided EMTALA-mandated emergency care, regardless of in-network and out-of-network status.
[BOT Rep. 2, I05; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17]

EMTALA -- Major Regulatory and Legislative Developments D-130.982

Our AMA: (1) continue to work diligently to clarify and streamline the EMTALA requirements to which physicians are subject; (2) continue to work diligently with the Department of Health and Human Services (HHS) to further limit the scope of EMTALA, address the underlying problems of emergency care, and provide appropriate compensation and adequate funding for physicians providing EMTALA-mandated services; (3) communicate to physicians its understanding that following inpatient admission of a patient initially evaluated in an emergency department and stabilized, care will not be governed by the EMTALA regulations; and (4) continue strongly advocating to the Federal government that, following inpatient admission of a patient evaluated in an emergency department, where a patient is not yet stable, EMTALA regulations shall not apply.

[BOT Rep. 17, I-02; Reaffirmation A-07; Modified: BOT Rep. 22, A-17]

Expanding Support for Access to Abortion Care D-5.996
1. Our American Medical Association will advocate for:
    a. broad and equitable access to abortion services, public and private coverage of abortion services, and funding of abortion services in public programs.
    b. explicit codification of legal protections to ensure broad, equitable access to abortion services.
    c. equitable participation by physicians who provide abortion care in insurance plans and public programs.
2. Our AMA opposes the use of false or inaccurate terminology and disinformation in policymaking to impose restrictions and bans on evidence-based health care, including reproductive health care.
[Res. 229, I-22]

Violence Against Medical Facilities and Health Care Practitioners and Their Families H-5.997
The AMA supports the right of access to medical care and opposes (1) violence and all acts of intimidation directed against physicians and other health care providers and their families and (2) violence directed against medical facilities, including abortion clinics and family planning centers, as an infringement of the individual's right of access to the services of such centers.
[Res. 82, I-84; Reaffirmed by CLRPD Rep. 3, I-94; Res. 422, A-95; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 015
(A-25)

Introduced by: Organized Medical Staff Section, International Medical Graduates Section

Subject: 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

Referred to: Reference Committee on Ethics and Bylaws

Whereas, International Medical Graduates (IMGs) represent a vital portion of the U.S. physician workforce, comprising approximately one-quarter of practicing physicians and often serving in underserved and rural areas; and

Whereas, IMG physicians have historically faced unique challenges in the workplace, including but not limited to discrimination, cultural bias, excessive scrutiny, and inequitable opportunities for advancement; and

Whereas, instances of unfair treatment or targeting of IMG physicians while performing clinical duties have been reported in various healthcare systems, undermining physician morale and patient care quality and limiting access to care by these physicians; and

Whereas, as recently as May 27, 2025 the State Department has halted the scheduling of new visa interviews for foreign students and resident physicians; and

Whereas, on June 4, the White House issued a travel ban affecting travelers from 12 countries and restricting entry by people seeking entry from 7 additional countries, including physicians from those countries who are working in the US, scheduled to begin employment or by those seeking employment within the United States, and

Whereas, our AMA has long advocated for equity and inclusion in medicine, including the fair treatment of all physicians; therefore be it

RESOLVED, that our American Medical Association work with relevant stakeholders to develop model workplace policies to address unfair treatment or targeting of physicians and other healthcare workers, based upon migration status or country of origin, during the regular performance of their duties within healthcare systems (Directive to Take Action); and be it further

RESOLVED, that our AMA study and develop model hospital and workplace policies to provide standardized procedures for addressing situations in which U.S. Immigration and Customs Enforcement (ICE) officers seek entry into “protected areas,” such as hospitals and healthcare settings to produce actions which may impact patient care or physician safety. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 6/6/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 121
(A-25)

Introduced by: Medical Student Section

Subject: Opposing Pharmacy Benefit Manager Spread Pricing

Referred to: Reference Committee A

Whereas, spread pricing occurs when Pharmacy Benefit Managers (PBMs) reimburse pharmacies for medications at a lower rate than they charge insurers and keep the difference as profit, without passing savings onto patients[1]; and

Whereas, spread pricing exacerbates high drug prices, especially for generics, and its use in Medicaid disproportionately impacts low-income patients and increases taxpayer costs[2,5]; and

Whereas, anticompetitive practices by PBMs include dominating local markets and pressuring independent and rural pharmacies into contracts, forcing them to accept lower reimbursements to increase PBM profits from spread pricing[1,3,4]; and

Whereas, over 15 million Americans rely on independent pharmacies, which are rapidly closing due to unsustainable reimbursement and financial pressures[4]; and

Whereas, AMA policy opposes PBMs profiting from manufacturer rebates, but does not address PBMs profiting from spread pricing with insurers and pharmacies[6]; and

Whereas, transparent “pass-through” pricing models eliminate spread pricing by ensuring that PBMs charge health plans the same amount they reimburse pharmacies[7,9]; and

Whereas, the Congressional Budget Office (CBO) estimates that addressing PBM spread pricing in Medicaid and improving PBM transparency would save $1 billion over 10 years[5]; and

Whereas, the current reconciliation bill passed by the US House of Representatives bans PBM spread pricing in Medicaid, requires greater PBM transparency, and is pending in Senate negotiations and due for final vote next month[12]; and

Whereas, urgent AMA advocacy is needed to ensure that the spread pricing ban remains in the bill and is not removed as Senate negotiations continue; therefore be it

RESOLVED, that our American Medical Association:

(1) oppose the use of spread pricing by Pharmacy Benefit Managers (PBMs);

(2) advocate for federal and state legislation and regulation that prohibits the use of spread pricing by PBMs; and

(3) support policies requiring PBMs to use transparent, pass-through pricing models that ensure fair and consistent reimbursement to pharmacies, physicians, and patients.

(Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 06/06/2025

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RELEVANT AMA POLICY

D-110.987 The Impact of Pharmacy Benefit Managers on Patients and Physicians
1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
- Utilization information;
- Rebate and discount information;
- Financial incentive information;
- Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
- Methodology and sources utilized to determine drug classification and multiple source generic pricing;
- Percentage of sole source contracts awarded annually.
6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.
[CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: CSAPH Rep. 02, I-24]

H-110.981 Public Reporting of PBM Rebates
Our AMA will advocate for: (1) Pharmacy Benefit Managers (PBMs) and state regulatory bodies to make rebate and discount reports and disclosures available to the public; and (2) the inclusion of required public reporting of rebates and discounts by PBMs in federal and state PBM legislation. [Res. 813, I-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236
(A-25)

Introduced by: Young Physicians Section

Subject: Preservation of Medicaid

Referred to: Reference Committee B

Whereas, Medicaid provides healthcare coverage to 80 million low-income Americans, including pregnant women, children, adults, seniors, people with disabilities, and LGBT individuals [1]; and

Whereas, Medicaid improves health outcomes, with expansion linked to a 6% reduction in all-cause mortality, a 23% increase in self-reporting health as excellent, and 41% higher likelihood of having a usual care source[2–9]; and

Whereas, Medicaid finances 40% of all births (including nearly 50% of births in rural communities), insures 40% of individuals under 18 years of age, is the largest single payer for behavioral health services, including substance use disorder (SUD) treatment, and is the largest payer of long term care services in the United States[10–12]; and

Whereas, The Children's Health Insurance Program (CHIP) provides essential health coverage to over 7 million children in low-income families who do not qualify for Medicaid but cannot afford private insurance, ensuring access to critical preventive care, vaccinations, and treatment for chronic conditions[13-14]; and

Whereas, CHIP has been shown to improve health outcomes, reduce disparities, and support early childhood development, while also reducing the financial burden on families and the healthcare system, including physicians[15]; and

Whereas, women physicians are more likely to serve patient populations who rely heavily on Medicaid funding and would be disproportionately impacted by federal funding cuts[16]; and

Whereas, previous efforts to cut Medicaid spending via work requirements did not increase employment and instead led to problems paying off medical debt, delayed care, and delayed taking medications due to cost[17,18]; and

Whereas, the federal government finances 69% of Medicaid nationally, ensuring states can provide care without excessive fiscal burden[19]; and

Whereas, reductions to federal funding of Medicaid and CHIP or changes to Medicaid and CHIP eligibility at the federal level would lead to substantial loss of coverage for millions of Americans; and

Whereas, Loss of coverage for patients does not lead to a decrease in need for care or in accessing services, but does result in loss of reimbursement for care provided; and

Whereas, proposed 2025 federal cuts ($2.3 trillion) threaten per capita caps, reduced Affordable Care Act expansion funding, and lower Federal Medical Assistance Percentage rates—policies shown to force coverage reductions[18]; therefore be it

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

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

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 6/6/25

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RELEVANT AMA POLICY

Medicaid Expansion D-290.979

1. Our American Medical Association, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.
2. Our AMA will:
    a. continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823.
    b. work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all.

[Res. 809, I-12; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS rep. 3, I-21; Reaffirmed: Joint CMS/CSAPH rep. 1, I-21; Appended: Res. 122, A-22]

Transforming Medicaid and Long-Term Care H-290.982

1. Our American Medical Association urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients.
2. Our AMA encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.
3. Our AMA encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches.
4. Our AMA calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs.
5. Our AMA calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care.
6. Our AMA urges states to administer their Medicaid and SCHIP programs through a single state agency.
7. Our AMA strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs.
8. Our AMA supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher

percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers forrecipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children.

9. Our AMA advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services.
10. Our AMA calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care.
11. Our AMA supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income.
12. Our AMA supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care.
13. Our AMA supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs.
14. Our AMA supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance.
15. Our AMA supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living.
16. Our AMA supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments.
17. Our AMA urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form.
18. Our AMA urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.
19. To prevent a delay in care, our AMA supports favoring the treating physician’s judgment if the reviewing physician is not available.

[BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep. 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05, Reaffirmation A-05; Reaffirmation: A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Modified: Res. 803, I-23; Appended: Res. 804, I-23]

Medicaid and Efforts to Assure it Maintains its Role as a Safety Net H-290.986

1. Our American Medical Association supports the position that the Medicaid program maintain its role as a safety net for the nation's most vulnerable populations.

[Sub. Res. 204, A-96; Reaffirmation A-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, A-21]

Enhanced CHIP Enrollment, Outreach, and Payment H-290.976

1. It is the policy of our American Medical Association that prior to or concomitant with states' expansion of Children's Health Insurance Programs (CHIP) to adult coverage, our AMA urges all states to maximize their efforts at outreach and enrollment of CHIP eligible children, using all available state and federal funds.
2. Our AMA affirms its commitment to advocating for CHIP and Medicaid payment that is sustainable, reflects the full cost of practice, and the value of the care provided, includes inflation-based updates, and pays no less than 100 percent of RBRVS Medicare allowable.

[Res. 103, I-01; Reaffirmation A-07; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, I-14; Reaffirmation A-15; Reaffirmed: CMS Rep. 3, A-15; Reaffirmation: A-17; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: CMS Rep. 1, I-22; Reaffirmed: Res. 105, A-23; Modified: CMS Rep. 08, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 237
(A-25)

Introduced by: International Medical Graduates Section

Subject: Urgent Advocacy to Restore J-1 Visa Processing for International Medical Graduate Physicians

Referred to: Reference Committee B

Whereas, International Medical Graduate physicians (IMGs) constitute a significant portion of the U.S. physician workforce, comprising approximately 25% of practicing physicians and disproportionately serving underserved and rural communities; and

Whereas, historically, J-1 exchange visitor visas have provided a crucial pathway for IMGs to train, practice, and alleviate physician shortages, particularly through the Conrad 30 J-1 Visa Waiver Program, which allows IMGs to remain in the U.S. to work in underserved areas after training; and

Whereas, the recent decision by the Trump administration to halt scheduling new appointments for J-1 exchange visitor visa applicants severely disrupts medical training programs, impairs continuity of patient care, exacerbates physician shortages, and undermines the stability of healthcare delivery, especially in underserved communities; and

Whereas, existing AMA policy D-255.985 strongly supports reauthorization, expansion, and improvement of the Conrad 30 J-1 Visa Waiver Program to maximize its benefits; and

Whereas, existing AMA policy D-255.993 encourages federal agencies to continue sponsorship and improve coordination for J-1 waiver programs; and

Whereas, existing AMA policy H-255.975 seeks to correct inconsistencies and enhance accountability in the administration of the physician J-1 Visa Exchange Program; and

Whereas, existing AMA policy D-255.976 advocates priority green card visa conversion for J-1 waiver physicians serving underserved areas; and

Whereas, existing AMA policy D-255.972 advocates for visa policies accommodating professional responsibilities within federally mandated workweek requirements; and

Whereas, existing AMA policy D-255.991 emphasizes the importance of minimizing visa processing delays and ensuring unfettered travel for IMGs completing training in the U.S.; and

Whereas, despite these existing policies, a critical policy gap remains in directly addressing the immediate and unprecedented cessation of scheduling new J-1 visa appointments, which will exacerbate existing physician workforce shortages, disrupt residency programs and overall program stability, worsen patient access to care—particularly in underserved and rural areas—and cause other significant downstream impacts, thus necessitating urgent and explicit advocacy; therefore be it

RESOLVED, that our American Medical Association:

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

(Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 6/6/25

RELEVANT AMA POLICY

Visa Complications for IMGs in GME D-255.991

1. Our American Medical Association will
    a. work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice.
    b. promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates.
    c. work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Res. 844, I-03; Reaffirmation A-09; Reaffirmation I-10; Appended: CME Rep. 10, A-11; Appended: Res. 323, A-12; Reaffirmation: A-19; Reaffirmed: Res. 234, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 238
(A-25)

Introduced by: Resident and Fellow Section

Subject: Preserving Accreditation Standards on Diversity, Equity, and Inclusion

Referred to: Reference Committee B

Whereas, on April 23, 2025, an Executive Order entitled "Reforming Accreditation to Strengthen Higher Education," which seeks to prohibit accreditation bodies, including the Accreditation Council for Graduate Medical Education (ACGME) and Liaison Committee on Medical Education (LCME), from enforcing diversity, equity, and inclusion (DEI) standards in medical education[1]; and

Whereas, the Executive Order directs federal agencies to investigate and potentially suspend or terminate federal recognition for accrediting organizations that implement DEI-related accreditation standards, claiming these standards constitute unlawful discrimination[1]; and

Whereas, existing AMA policy H-65.961 strongly supports DEI initiatives in medical education, recognizing that a diverse physician workforce improves patient outcomes, reduces health disparities, and enhances medical education quality[2]; and

Whereas, the ACGME's current DEI accreditation standards emphasize mission-appropriate diversity to strengthen graduate medical education, enhance physician cultural competence, and better serve diverse patient populations[3]; and

Whereas, the LCME similarly has required medical schools to engage in ongoing, systematic, and focused recruitment and retention activities to achieve diversity among students and faculty[4]; and

Whereas, eliminating or weakening DEI standards would jeopardize efforts to reduce health inequities and undermine progress in achieving a healthcare workforce reflective of the diverse patient population physicians serve; and

Whereas, in response to significant concerns regarding compliance with diversity requirements in light of recent state and federal laws, the Executive Committee of the ACGME Board of Directors has suspended enforcement of the Common Program Requirement I.C. and Institutional Requirement III.B.8., as well as related specialty/subspecialty-specific requirements, pending further discussion at its June 2025 meeting[5]; and

Whereas, the timing of this Executive Order necessitates an immediate response from the AMA to ensure ongoing support for diversity and inclusion in medical training programs; therefore be it

RESOLVED, that our American Medical Association oppose any federal actions or executive orders that threaten the ability of accreditation bodies, including the Accreditation Council for Graduate Medical Education (ACGME), the Commission on Osteopathic College Accreditation

(COCA), and the Liaison Committee on Medical Education (LCME), to enforce appropriate diversity, equity, and inclusion standards (New HOD Policy); and be it further

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

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

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 6/6/25

REFERENCES

1. Trump DJ. Reforming Accreditation to Strengthen Higher Education. Executive Order. April 23, 2025. The White House. Available at: https://www.whitehouse.gov/presidential-actions/2025/04/reforming-accreditation-to-strengthen-higher-education/
2. American Medical Association. AMA Policy Finder. Policies D-200.985, H-350.974, and H-65.961. Available at: https://policysearch.ama-assn.org
3. Accreditation Council for Graduate Medical Education. Common Program Requirements. Available at: https://www.acgme.org/programs-and-institutions/programs/common-program-requirements/
4. Liaison Committee on Medical Education (LCME). (2025). Functions and Structure of a Medical School. Published March 2025. Retrieved from https://lcme.org/publications/
5. Accreditation Council for Graduate Medical Education. ACGME Board Executive Committee Action. May 2025. Available at: https://www.acgme.org/newsroom/2025/5/acgme-board-executive-committee-action/

Relevant AMA Policy:

Continued Support for Diversity in Medical Education D-295.963

1. Our American Medical Association will publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training.
2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.
3. Our AMA will work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations.
4. Our AMA will advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population.
5. Our AMA will directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education.
6. Our AMA will advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement.
7. Our AMA will investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty.
8. Our AMA will recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts.

9. Our AMA will collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure. [Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13; Appended: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22; Appended: Res. 319, A-22; Modified: Res. 319, A-23; Reaffirmed: BOT Rep. 31, A-24]

Principles for Advancing Gender Equity in Medicine H-65.961
Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur. [BOT Rep. 27, A-19; Reaffirmed: Res. 604, I-24; Reaffirmed: Res. 606, I-24]

REVISED

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(A-25)

Introduced by: American Thoracic Society

Subject: Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations

Referred to: Reference Committee F

Whereas, our American Medical Association Board of Trustees is reverently and uniquely positioned to uphold the principles and tenets of science and public health, and is entrusted to act on behalf of American physicians; and

Whereas, in existing policy and practice the Board of Trustees sets strategic direction and legislative priorities for report in the Interim Meeting, with the option to take action in between HOD Meetings in urgent situations; and

Whereas, current policy G-600.071 and current practice yield authority to BOT on AMA action in urgent situations, and further allow BOT to make a determination of what it deems best represent the interests of patients, physicians, and the AMA; however, current policy and practice do not require BOT take action in times of national or global crises to health or science; and

Whereas, the 2020 public health emergency of COVID-19 highlighted the need for AMA, particularly AMA leadership and the BOT, to reassess priorities and respond expediently to urgent needs; and

Whereas, in 2025 the first 100 days of the 2nd term for President Donald J. Trump has led to substantial and unprecedented challenges to the structures of science and American health, with many major national institutions and agencies voicing their positions on issues of importance to human health; and

Whereas, the actions of the current federal administration have caused affronts to the core of science and health system funding, policies, and institutions, and have caused disruptions to the healthcare workforce; and

Whereas, the actions of the current administration intend to continue toward cataclysm of fundamental health structures, including but not limited to

(1) disrupting the economic support for evidence-based medicine, which preserves the integrity of scientific inquiry and an open platform for discovery beyond corporate funded research;
(2) reducing the government's contributions to US health care expenditures, which are currently at approximately half (~$2.2 trillion) of total US health care expenditures[1], and upon which our US healthcare systems and hospitals are financially dependent;
(3) challenging the US health care workforce, of which 18.2% are foreign-born, including 26.5% of physicians being foreign-born[2], and its pipeline for creating healthcare workers that mirror the communities they serve, which research shows improves health care in minority populations[3];

(4) disrupting the pipeline of talent for scientific research, as 38.6% of US master's and postdoctoral students in science, engineering, and health are temporary visa holders[4], therefore creating vulnerability to the US scientific research industry, which as of 2023 has an estimated market impact of $320 billion in revenue, substantially due to a historic recognition of and reliance on foreign-born scientific labor and experts[5]; and
(5) discrediting the US as a global leader for using evidence-based findings to drive medical decisions, public policies, and research funding; and

Whereas, AMA advocacy is influential for the trajectory of American health care; and

Whereas, in conditions of transformational affronts to the policies and structures that enable our modern systems and foundational institutions for science and health, we require our AMA advocacy; and

Whereas, in such moments, the AMA HOD and physician members are reliant on the voice of our Board of Trustees to act - responsibly, clearly, and expediently; therefore be it

RESOLVED, that our American Medical Association amend G-600.071, "Actions and Decisions by the AMA House and Policy Implementation" to read

- 3. Except as noted herein and consistent with the AMA Bylaws, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates. ~~Further,~~
- 4. In urgent situations, the Board of Trustees ~~has the~~ will exercise its authority to take such action as it determines is appropriate ~~in urgent situations to take those policy actions that the Board deems best represent the interests of patients, physicians, and the AMA.~~ to advocate for science and public health**.** In representing AMA policy in critical situations, the Board will take into consideration existing AMA policy, recommendations from AMA policy staff, and input solicited or obtained from the House of Delegates or its Councils and Sections to inform its position on the interests of patients, physicians, and the AMA. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.

~~4.~~ 5. Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA considers transformational occurrences, including public health phenomena, sudden changes to national health policies, and sudden disruptions of health and science funding, to be urgent situations worthy of AMA Board of Trustee advocacy and action (New HOD Policy); and be it further

RESOLVED, that our AMA considers sudden federal funding cuts to foundational institutions of science research and public health to be urgent situations and requests the Board of Trustees take immediate action to respond responsibly, clearly, and expediently as an advocate for science, health care, and public health. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 4/22/25

REFERENCES
[1] Peter G. Peterson Foundation. "Healthcare Spending Will be One-Fifth of the Economy within a Decade." Updated Sept 16, 2024. Accessed 4/21/2025 at https://www.pgpf.org/article/healthcare-spending-will-be-one-fifth-of-the-economy-within-a-decade.
[2] Migration Policy Institute. "Immigrant Health-Care Workers in the United States." April 7, 2023. Accessed 4/21/2025 at https://www.migrationpolicy.org/article/immigrant-health-care-workers-united-states-2021.
[3] Silver JK, Bean AC, Slocum C, et al. Physician Workforce Disparities and Patient Care: A Narrative Review. Health Equity. 2019;3(1):360-377.
[4] National Science Foundation: National Center for Science and Engineering Studies. "Graduate Enrollment and Postdoctoral Appointments in Science, Engineering, and Health Rise, Driven Largely by Increases in the Number of Women and Temporary Visa Holders." January 21, 2025. Accessed 4/21/2025 at https://ncses.nsf.gov/pubs/nsf25316.
[5]Walsh B. "The self-inflicted death of American science has already begun." *Vox.* Apr 9 2025.

RELEVANT AMA POLICY

Annual Reporting Responsibilities of the AMA Board of Trustees G-605.050
Our American Medical Association Board provides the following four items to the AMA House:

1. At each Annual Meeting of the House, the Board submits a report to the House that provides highlights on the AMA's performance, activities, and status in the previous calendar year as well as a recommendation for the Association's dues levels for the next year. The report should include information on topics such as:
    a. AMA's performance relative to its strategic plan.
    b. Key indicators of the AMA's financial performance and, if not provided through other communication vehicles, information on the compensation of Board members, elected Officers, the Executive Vice President, and the expenses associated with the AMA Councils, Sections, Special Groups, and AMA's participation in the World Medical Association.
    c. An assessment of the performance, accomplishments, and activities of the Board, including the AMA appearance program and the results of the work of the Board's Audit Committee.
    d. AMA's membership situation, including an assessment of the membership communication and promotion activities;
    e. Highlights of the activities and accomplishments of the Association's major programs, including legislative and private sector advocacy.
    f. A description and assessment of efforts to address high priority issues.
    g. The AMA's relationships and work with other organizations, including Federation organizations, other health related organizations, non-health related organizations, and international organizations.

The Board may include any other topics in this report that it deems important to communicate to the House about the performance, activities, and status of the AMA and the health of the public.

2. As the principal planning agent for the AMA, the Board provides a report at each Interim Meeting of the House that recommends the AMA's strategic directions and plan for the next year and beyond. The report should include a discussion of the AMA's membership strategy.
3. At each Interim Meeting, the Board provides an informational report on the AMA's legislative and regulatory activities, including the Association's accomplishments in the previous 12 months and a forecast of the legislative and regulatory issues that are likely to occupy the Council on Legislation and other components of the AMA's for the next year.

In fulfilling its responsibilities to report to the House on topics and situations, the Board should provide succinct reports to the House. When detailed information on topics is warranted, the Board should

provide the information to interested members of the House through reports that can be downloaded from the AMA web site.
Nothing in this policy precludes the House from requesting that the Board report back to the House on any topic. Further, nothing in this policy should be construed as limiting the number or size of reports that the Board can send to the House.
Sub. Res. 52, A-74 Res. 57, A-81 Reaffirmed: CLRPD Rep. C, A-89 Sub. Res. 83 and 125, A-90 Reaffirmed: CLRPD Rep. F, I-91 Modified by Res. 609 Reaffirmed by 610 and 611, I-94 Res. 622, I-97 Appended by Rep. of the Ad Hoc Cmte. to Study the Sunbeam Matter and Res. 617, A-98 Res. 609, I-99 Reaffirmed: Sunset Report, I-00 Consolidated: CLRPD Rep. 3, I-01 Appended: Rep. of the Ad Hoc Cmte. on Governance and Res. 618, A-02 Modified: CLRPD Rep. 1, A-03 Modified: BOT Rep. 1, I-03 Modified: CCB/CLRPD Rep. 3, A-12 Reaffirmed: CCB/CLRPD Rep. 1, A-22

AMA Stance on the Interference of the Government in the Practice of Medicine H-270.959

1. Our American Medical Association opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.
2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:
    a. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
    b. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
    c. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.
    d. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter.
    Res. 523, A-06Appended: Res. 706, A-13Reaffirmed: Res. 250, A-22

Actions and Decisions by the AMA House and Policy Implementation G-600.071

1. AMA policy on House actions and decisions includes the following:
A. Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (i) correcting factual errors in AMA reports, (ii) rewording portions of a report that are objectionable, and (iii) rewriting portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible.
B. A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be amended by means of a positive action of the House specifically intended to change that policy.
C. Minor editorial changes to existing policies are allowed for accuracy, so long as such changes are reported to the House of Delegates so as to be transparent. Editorially amended policies, however, do not reset the sunset clock.
2. AMA policy on implementation of policy includes the following:
A. Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and report recommendations and specific actions that have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted.
B. Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions.
C. Any resolution which is adopted by our AMA House remains the policy of the Association until amended, rescinded or sunset by the House.

3. Except as noted herein and consistent with the AMA Bylaws, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates. Further, the Board of Trustees has the authority in urgent situations to take those policy actions that the Board deems best represent the interests of patients, physicians, and the AMA. In representing AMA policy in critical situations, the Board will take into consideration existing policy. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.
4. Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 718
(A-25)

Introduced by: Organized Medical Staff Section

Subject: Safeguarding Medical Staff Bylaws and Accreditation Standards in VA Facilities

Referred to: Reference Committee G

Whereas, the Veterans Affairs Central Office (VACO) issued amendments to Section 3.01 Paragraph 3 of the Veterans Affairs Medical Staff Bylaws, Rules, and Regulations that removed explicit nondiscrimination language regarding, “lawful partisan political affiliation, marital status, physical or mental handicap when the individual is qualified to do the work, age, membership or non-membership in a labor organization, or on the basis of any other criteria unrelated to professional qualifications” without affording organized medical staffs the opportunity to review or vote on the revisions; and

Whereas, Joint Commission Standard MS.01.01.01 mandates that the organized medical staff shall have the exclusive right to self-governance, including the development and amendment of its own bylaws through a voting process by its members; and

Whereas, American Medical Association policy H-235.980 affirms that hospital medical staffs have the exclusive right to develop, adopt, and amend medical staff bylaws, and explicitly opposes any administrative attempts to reengineer or split bylaws into unincorporated policies that bypass medical staff approval, recognizing that such actions violate core principles of self-governance and Joint Commission standards; and

Whereas, unilateral amendment of medical staff bylaws by an administrative body, without formal vote or approval of the medical staff, constitutes a direct violation of Joint Commission accreditation requirements; and

Whereas, loss of compliance with Joint Commission standards poses a significant risk to hospital accreditation status, which could in turn jeopardize federal funding, clinical training programs, veteran care delivery, and public trust in the VA healthcare system; and

Whereas, adherence to medical staff self-governance is a foundational safeguard for quality assurance, credentialing, privileging standards, and physician accountability in any accredited healthcare institution; and

Whereas, failure to follow nationally recognized accreditation protocols sets a dangerous precedent for administrative overreach, threatening the structural integrity and independence of organized medical staffs across the healthcare system; and

Whereas, the American Medical Association has consistently upheld the principle that physicians must retain authority over medical staff bylaws, policies, and governance as a core component of professional self-regulation and patient safety; therefore be it

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 (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA opposes any administrative action that bypass the organized medical staff's voting authority in revising medical staff bylaws (New HOD Policy); and be it further

RESOLVED, that our AMA advocate that the U.S. Department of Veterans Affairs to restore compliance with Joint Commission Standard MS.01.01.01 by requiring medical staff member approval for any modifications to their bylaws (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for urgent federal-level oversight and corrective action to protect accreditation standards, medical staff governance, and patient care quality at Veterans Affairs facilities nationwide. (Directive to Take Action).

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 6/6/25

RELEVANT AMA POLICY

Hospital Medical Staff Self-Governance H-235.980

1. Our AMA: supports essentials of self-governance for hospital medical staffs which, at a minimum include the right to: (a) initiation, development and adoption of medical staff bylaws, rules and regulations; (b) approval or disapproval of amendments to the medical staff bylaws, rules and regulations; (c) selection and removal of medical staff officers; (d) establishment and enforcement of criteria and standards for medical staff membership; (e) establishment and maintenance of patient care standards; (f) accessibility to and use of independent legal counsel; (g) credentialing and delineation of clinical privileges; (h) medical staff control of its funds; and (i) successor-in-interest rights.

2. Our AMA opposes any attempts to reengineer or otherwise amend medical staff bylaws or split the bylaws into a variety of separate and unincorporated manuals or policies, thereby eliminating the control and approval rights of the medical staff as required by the principles of medical staff self-governance.

3. Our AMA will ask its Commissioners to the Joint Commission on Accreditation of Healthcare Organizations to require that JCAHO medical staff standards require the following components to be an integral part of the medical staff bylaws, and not separate "governance documents," requiring approval by the entire medical staff. The medical staff is responsible for the following:
(a) Application, reapplication, credentialing and privileging standards;
(b) Fair hearing and appeal process;
(c) Selection, election and removal of medical staff officers;
(d) Clinical criteria and standards which manage quality assurance, utilization review;
(e) Structure of the medical staff organization;
(f) Rules and regulations that affect the entire medical staff.

4. Our AMA recognizes that hospital non-compliance with JCAHO Standard MS 1.20 will be treated in the same way as hospital non-compliance with any other standard.
Citation: Sub. Res. 201, A-89; Reaffirmed; Sub. Res. 808, A-94; Reaffirmed, Amended, and Appended: Sub. Res. 817, I-01; Reaffirmed: A-05; Appended: Res. 730, A-05; Reaffirmed: CMS Rep. 1, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 719
(A-25)

Introduced by: Organized Medical Staff Section

Subject: Comprehensive AMA Policy Publication Regarding Employed Physicians

Referred to: Reference Committee G

Whereas, the number and percentage of physicians who are employed have exponentially increased in the last decade; and

Whereas, the American Medical Association has recognized, by creating the Employed Physician Caucus, the significance and implications that employed status has on physicians, and that their presence in turn has on the healthcare system; and

Whereas, the AMA has developed several resources regarding employed physicians, including CMS Report 7-A-19 on Physician Trends and Employment Principles; and

Whereas, specific principles for employed physicians as defined by the AMA were reported in BOT Report 29-A-14 and then modified in Speakers Report 002-I-24; and

Whereas, these reports provide foundational principles regarding the employment of physicians, thereby reflecting the value of employed physicians; and

Whereas, these resources are limited and do not address the full range of needs and concerns of employed physicians nor the concept of sustainability of this practice model; therefore be it

RESOLVED, that our American Medical Association comprehensively review the current landscape of the employment of physicians for report back to the House of Delegates at Annual 2026, including but not limited to:

- The changing context and expectations of different practice models
- Factors which have led to physicians increasingly choosing an employment practice model over independent practice
- The employed physician relationship with healthcare organizations, including those controlled by private equity
- The evolution of collective bargaining by, and unionization of, physicians;

(Directive to Take Action); and be it further

RESOLVED, that our AMA create a comprehensive policy publication, which will be an essential tool for employed physicians with guiding principles, rights, and responsibilities regarding, but not limited to, the following:

- Employment contracting
- Different compensation models
- Professional accountability to, and as a member of, the medical staff
- Primacy of the doctor-patient relationship within the context of employment;

(Directive to Take Action); and be it further

RESOLVED, that our AMA will have a comprehensive policy publication regarding employed physicians available to all physicians, in any employment model, and to all healthcare collaborators with the AMA who directly employ and/or have contracting arrangements with physicians, (Directive to Take Action)

Fiscal Note: Major - $25,000 staff and external expert.

Received: 6/6/25

RELEVANT AMA POLICY

AMA Principles for Physician Employment H-225.950

1. Addressing Conflicts of Interest
    a. Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
    b. In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
    c. Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
    d. A physician's paramount responsibility is to their patients. Additionally, given that an employed physician occupies a position of significant trust, they owe a duty of loyalty to their employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
        i. No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to their religious beliefs or moral convictions.
        ii. No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because they either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates their religious beliefs or moral convictions.
    e. Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession
    a. Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
    b. Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting
    a. Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
    b. Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
    c. When a physician's compensation is related to the revenue they generate, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
    d. Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under their care. When a physician's employment status is unilaterally terminated by an employer, the physician and their employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in theirnew practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of their patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
    e. Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
    f. Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
    g. Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
    h. Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a. Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
b. Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
c. Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
d. Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations
    a. All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
    b. Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
    c. Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
    d. Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
    e. Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
    f. Upon termination of employment with or without cause, an employed physician generally should not be required to resign their hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
        i. The agreement is for the provision of services on an exclusive basis.
        ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985.
        iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements
    a. Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
    b. Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.
Citation: BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed; CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19; Reaffirmed: A-22; Reaffirmed: BOT Rep. 29, A-24; Modified: Speakers Rep. 02, I-24

Establishing a Formal Definition of "Employed Physician" H-405.945
Our American Medical Association adopts the following as its definition of "employed physician":
An employed physician is any physician who derives compensation, financial or otherwise, from a contractual relationship with a practice, hospital, or other funding entity and has no direct controlling interest in the entity.
Citation: Res. 017, A-23

Physician Employment Trends and Principles H-225.947
1. Our AMA encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with the following principles: A. Physician clinical autonomy is preserved. B. Physicians are included and actively involved in integrated leadership opportunities. C. Physicians are encouraged and guaranteed the ability to organize under a formal self-governance and management structure. D. Physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care. E. A mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care. F A clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures.
2. Our AMA encourages continued research on the effects of integrated health care delivery models (that employ physicians) on patients and the medical profession.
Citation: CMS Rep. 5, I-15; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19

Summary of Fiscal Notes (A-25)

Report(s) of the Board of Trustees

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

Summary of Fiscal Notes (A-25)

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

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

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

01	Joint Council Sunset Review of 2015 House Policies	

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

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

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

01	Palliative Care	Info. Report

Summary of Fiscal Notes (A-25)

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

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

Report(s) of the Council on Medical Education

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

Report(s) of the Council on Medical Service

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

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

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

Summary of Fiscal Notes (A-25)

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

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

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

Resolutions

001	Opposition to Censuring Medical Societies or Organizations Based on Politics or Policies of Governments	Modest
002	Physician Disclosures of Relationships in Private Equity Held Organizations	Minimal
003	Opposition to Censorship in Public Libraries	Minimal
004	Reducing the Harmful Impacts of Immigration Status on Health	Minimal
005	Dedicated Interfaith Prayer and Reflection Spaces in Medical Schools and Healthcare Facilities	Moderate
006	Military Deception as a Threat to Physician Ethics	Minimal
007	Use of Inclusive Language in AMA Policy	Modest
008	Humanism in Anatomical Medical Education	Minimal
009	Patient centered health care as a Determinant of Health	Minimal
010	Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure	Modest
011	Opposition of Health Care Entities from Reporting Individual Patient Immigration Status	Minimal
012	Carceral Systems and Practices in Behavioral Health Emergency Care	Moderate
013	Continued Support of World Health Organization (WHO) & United States Agency for International Development (USAID)	Modest
014	Protecting Access to Emergency Abortion Care Under EMTALA	Moderate
015	Addressing Targeting and Workplace Restrictions and Barriers to Healthcare Delivery by International Medical Graduate (IMG) Physicians and other Physicians Based upon Migration Status or Country of Origin within Healthcare Systems	Moderate
101	Uniform Adoption of Service Intensity Tools to Support Medical Decision-making and Service Gap Analysis	Modest
102	Access to Single Maintenance and Reliever Therapy for Asthma	Modest
103	Inadequate Reimbursement for Biosimilars	Modest

Summary of Fiscal Notes (A-25)

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

Summary of Fiscal Notes (A-25)

209	Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Addiction Medications for Legitimate Medical Purposes	Minimal
210	Impact of Tariffs on Healthcare Access and Costs	Moderate
211	Support for State Provider and Managed Care Organization Taxes to Sustain Federal Medicaid Matching Funding	Moderate
212	Setting Standards for Forensic Toxicology Laboratories Used in Litigation	Modest
213	Emergency Department Designation Requires Physician on Site	Modest
214	United Health Care and InterQual Monopoly	Modest
215	Support for Changing Standards for Minors Working in Agriculture	Minimal
216	Support for Aging-Out Foster Youth with Mental Health and Psychotropic Needs	Minimal
217	Regulation and Oversight of the Troubled Teen Industry	Minimal
218	Distribution of Resident Slots Commensurate with Shortages	Minimal
219	Opposing Unwarranted National Institutes of Health Research Institute Restructuring	Minimal
220	Strengthening AMA Policy on Noncompete Clauses in Ownership Transitions	Modest
221	Preservation of Medicaid	Moderate
222	Need for Separate H1B Pathway for IMG Doctors in the USA	Modest
223	Preservation of Medicaid	Moderate
224	Support SAVE Plan and Public Service Loan Forgiveness (PLSF) Applications	Modest
225	The Private Practice Physicians in the Community	Moderate
226	Regulations for Algorithmic-Based Health Insurance Utilization Review	Modest
227	Payment Recoupment—Let Sanity Prevail	Modest
228	CHIP Coverage of OTC Medications	Moderate
229	Guaranteeing Timely Delivery and Accessibility of Federal Health Data	Modest
230	Advocating to expand private insurance coverage of anti-obesity medications (AOM)	Minimal
231	Preventing Venue Shopping in Medical Liability to Protect Physician Practices and Access to Care	Moderate
232	Preservation of Medicaid	Moderate
233	Increasing Transparency of AMA Medicare Payment Reform Strategy	$108,308 hire consultants to conduct research and prepare reports
234	Protection for International Medical Graduates	Moderate
235	CMS Payment Monitoring Following Government Staff Reductions	Moderate
236	Preservation of Medicaid	Moderate

Summary of Fiscal Notes (A-25)

237	Urgent Advocacy to Restore J-1 Visa Processing for International Medical Graduate Physicians	Moderate
238	Preserving Accreditation Standards on Diversity, Equity, and Inclusion	Moderate
301	Examining ABMS Processes for New Boards	Minimal
302	AMA Study of Lifestyle Medicine and Culinary Electives to Reduce Burnout and Bolster Career Satisfaction in Trainees	Minimal
303	Support for the Establishment of an Indigenous-Led Medical School in the United States	Moderate
304	Addressing Professionalism Standards in Medical Training	Minimal
305	Curricular Structure Reform to Support Physician and Trainee Well-Being	Minimal
306	Innovation and Reform of Medical Education	Minimal
307	Disclosure of Individual Physician Volunteers Participation in Committee Decision-making to other Organizations, Stakeholders and Joint Providers	Minimal
308	Streamlining Annual Compliance Training Requirements for Physicians	Modest
309	Increasing Education on Physician-Led Care and Advocacy in Residency Training	Moderate
310	Protections for Trainees Experiencing Retaliation in Medical Education	Minimal
311	Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter	Minimal
312	Selection of IMG Residents Based on Merit	Modest
401	Reducing Pickleball-Related Ocular Injuries	Minimal
402	Protecting In-Person Prison Visitations to Reduce Recidivism	Minimal
403	Promoting Evidence-Based Responses to Measles and Misuse of Vitamin A	$102,954 contract to develop educational content
404	Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers	$43,166 initiate a public health campaign
405	Health Warning Labels on Alcoholic Beverage Containers	Minimal
406	Call for Study: Should Petroleum-Powered Emergency Medical Services (EMS) Vehicles in Urban Service Areas be Replaced by Renewably-Powered Electric Vehicles?	Modest
407	Sleep Deprivation as a Public Health Crisis	Modest
408	Removing Artificial Turf in Schools, Parks, and Public Places	Minimal
409	Guidelines for Restricting Cell Phones in K-12 Schools	Minimal
410	Hate Speech is a Public Health Concern	Minimal
411	Protecting Access to mRNA Vaccines	Moderate
412	Supporting inclusive long-term care facilities	Minimal
413	Preservation of Public Funding for Physicians and Hospitals Providing LGBTQ+ Care	Minimal

Summary of Fiscal Notes (A-25)

414	Expanding Sexually Transmitted Infection Care for Persons with Unstable or No Housing	Minimal
415	Promoting Child Welfare and Communication Rights in Immigration Detention	Modest
416	Culturally and Religiously Inclusive Food Options	Minimal
417	Updating Alcohol Health Warning Labels to Reflect Evidence-Based Health Risks and Supporting National Labeling and Signage Policy Reform	Minimal
418	AMA Study on Plastic Pollution Reduction	Modest
419	Advocating for Universal Summer Electronic Benefit Transfer Program for Children (SEBTC)	Modest
420	Study of Plant-Based & Lab-Grown Meat	Modest
421	Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities	Modest
422	Protecting the Integrity of the U.S. Healthcare System from Misinformation and Policy	$102,954 contract to develop educational content
423	Requiring Universal Vaccine reporting to a National Immunization Registry and Access to a National Immunization Information System	Modest
424	Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records	Minimal
425	Alcohol Consumption and Health	Minimal
426	Addressing Patient Safety and Environmental Stewardship of Single-Use and Reusable Medical Devices	Modest
427	Elevate Obesity as a Strategic Objective	$293,127 adopt strategic objective
428	Public Health Implications of US Food Subsidies	Modest
429	Addressing the Health Consequences of Microplastics in Humans	Modest
430	Addressing the Health Impacts of Ultraprocessed Foods	Modest
431	Alcohol & Breast Cancer Risk	$70,454 contract to develop educational content
432	Support for Long-Term Sequelae of Pregnancy	Moderate
433	Clinical Lactation Care	Minimal
434	Breast Cancer Risk Reduction	Minimal
501	Safer Button / Coin Batteries	Modest
502	NIH Grant Funding for Medical Research	Moderate
503	Safeguarding Neural Data Collected by Neurotechnologies	Minimal
504	Physician Performed Microscopy Designation for Synovial Fluid Crystal Exam: Modify the Clinical Laboratory Amendment of 1988	Minimal
505	Mandating Properly Fitting Lead Aprons in Hospitals	Moderate

Summary of Fiscal Notes (A-25)

506	Opposing the use of harm reduction items as evidence of commercial sex work	Minimal
507	Clinical and Public Safety Implications of AI-Generated Content and Symbolic Compliance Infrastructure	Modest
508	Standardizing Safety Requirements for Traditional and Rideshare-Based Non-Emergency Medical Transportation	Modest
509	Allergen Labeling for Spices and Herbs	Minimal
510	Improving Cybersecurity Standards for Healthcare Entities	Minimal
511	Increased Transparency Among Psychotropic Drug Administration in Prisons	Modest
512	Preventing Drug-Facilitated Sexual Assault in Drinking Establishments	Minimal
513	Transparency on Comparative Effectiveness in Direct-to-Consumer Advertising	Minimal
514	Support for a Nicotine Free Generation	Resolve 1 - Modest Resolve 2 - Minimal
515	Nitrous Oxide Abuse	Minimal
516	Creating a Registry of Potential Side Effects of GIP & GLP-1 Medications	Minimal
517	In Support of a National Drug Checking Registry	Modest
518	Mandatory Accreditation and Regular Inspections of Hyperbaric Chambers	Modest
519	Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making	Modest
520	Study of Grading Systems in AMA Board Reports	Modest
521	Warning labels on OTC sleep aids	Modest
522	Access to Important and Essential Drugs	Moderate
601	AMA To Develop Patient Educational Materials Regarding Ultra-processed Foods for Distribution by AMA members	$65,179 annually to develop educational materials
602	Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations	Minimal
603	Renaming the Minority Affairs Section to the Underrepresented in Medicine Advocacy Section	Minimal
604	Advisory Committee on Tribal Affairs	$74,321 annually for advisory committee
701	Electronic Health Records Contract Termination	Modest
702	Strengthening Health Plan Accountability for Physician Satisfaction	Minimal
703	Appropriate Use of Data from Surgical Practices	Minimal
704	Mitigating the Impact of Excessive Prior Authorization Processes	$545,376 database research and legal analysis
705	Elimination of Transaction Fees for Electronic Healthcare Payments	Minimal

Summary of Fiscal Notes (A-25)

706	Increasing Transparency Surrounding Medicare Advantage Plans	Minimal
707	Simplifying Correspondence from Health Insurers	Modest
708	Advocating Against Prior Authorization for In-Person Visits with Physicians	Modest
709	Allowing Timely Access to Pain Medications in Discharged Hospital and Ambulatory Surgery Patients	Modest
710	Requiring Insurances to apply discounted cost medication to the patient's deductible	Modest
711	Study of Practice Models for Physicians Working Across State Lines	Moderate
712	Billings and Collections Transparency	Resolve 1 - Modest Resolve 2 - Moderate
713	Aiding Members of Medical Staffs	Moderate
714	Root Cause Analysis of the Causes of the Decline of Private Medical Practice	Moderate
715	Grace Period for Timely Filing Due to Technology Failures Regardless of Cause	Modest
716	Minimum Payer Communication Quality Standards	Modest
717	Promoting Medication Continuity and Reducing Prior Authorization Burdens	Modest
718	Safeguarding Medical Staff Bylaws and Accreditation Standards in VA Facilities	Moderate
719	Comprehensive AMA Policy Publication Regarding Employed Physicians	$25,000 staff and external expert