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REPORT OF THE BOARD OF TRUSTEES

BOT Report 17-A-26

Subject:	Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records Report
Presented by:	David H. Aizuss, MD, Chair
Referred to:	Reference Committee D

BACKGROUND

At the 2025 Annual Meeting, resolution 424, "Supporting the Integration of Blood Pressure Variability Date in Electronic Medical Records," was introduced by the Ohio delegation and was referred. It asks the following:

> RESOLVED that our AMA support the integration of blood pressure variability data into electronic medical records, emphasizing automated calculation capabilities similar to those established for body mass index; and be it further
>
> RESOLVED that our AMA support research efforts to establish pathological Blood Pressure Variability thresholds to guide dietary and exercise recommendations, sleep evaluation, risk stratification, and other evidence-based interventions by healthcare providers.

DISCUSSION

Blood pressure (BP) measurement is one of the most common procedures performed in the clinical setting and accurate BP measurement is essential to assess, diagnose, and treat hypertension. Hypertension is the most prevalent, modifiable cardiovascular disease risk factor and is the leading cause of death and disability worldwide.[1] According to the 2026 Heart Disease and Stroke Statistics, the prevalence of hypertension among US adults was 47.3 percent in 2021 to 2023.[2]

Blood pressure naturally varies throughout the day, from the time a person wakes up in the morning through sleeping overnight, due to factors including environmental circumstances, physical activity, and emotional stress. Blood pressure variability (BPV) refers to these changes in blood pressure that occur over different time periods.[3,4] Excessive long-term blood pressure variability is suggested to be defined as variation in measurements greater than 12 mm Hg, determined by deriving the standard deviation of ideally 6-7 or more clinic-based BP measurements, but this has been debated among scientific scholars.[5,6] Long term variability has

been defined as clinic visit-to-visit variability, over months or years, and can be influenced by factors such as time of year (seasonal variability) and vascular stiffness. Very short-term variability occurs beat-to-beat, short-term variability occurs over a 24-hour period, and mid-term variability is defined as variability seen day-to-day (or between days).[7,8] Blood pressure variability can be calculated using standard deviation, the coefficient of variation, or variance, independent of the mean. The coefficient of the mean can be calculated by dividing the standard deviation by the mean blood pressure.[9]

Multiple studies have shown that long term BPV is associated with cardiovascular events (including stroke, myocardial infarction, coronary heart disease, and heart failure) and mortality outcomes, independent of mean blood pressure. Both mid-term and short-term BPV are associated with mortality outcomes and with poor cardiovascular outcomes (noting the link to cardiovascular outcomes is suggested to be supported by limited data).[10]

There is growing recognition of blood pressure variability as an important cardiovascular risk factor and BPV can act as a predictor of cardiovascular risk independent of average blood pressure, however it is not currently included in standardized management guidelines as a therapeutic target.[11] It has been suggested that future research is needed to better understand the pathophysiology of target-organ damage and to define the physiological and pathological ranges of BPV.[12]

Electronic Health Record Integration of Blood Pressure Variability

Integration of blood pressure variability data into electronic health records would provide physicians and clinical teams with additional data to assess visit-to-visit BPV risk.[13] Automated calculation capabilities in the electronic health record (EHR) takes the burden off clinical teams to manually calculate and enter data into the system. Currently, there is no diagnosis code (ICD-10-CM) for blood pressure variability.

Lifestyle Approaches to Reduce Blood Pressure Variability

It has been proven that lifestyle modifications are critically important strategies to prevent or manage high blood pressure and hypertension. A meta-analysis conducted to assess the effectiveness of lifestyle and stress-reduction strategies for lowering BP found that the Dietary Approach to Stop Hypertension (DASH) eating plan was the most effective intervention followed by aerobic exercise, isometric resistance training, and low-sodium/high potassium salt interventions. The 2025 Guideline for the Prevention, Detection, Evaluation and Management of Hypertension outlines the approximate reduction in systolic blood pressure (SBP) for proven interventions for people with and without hypertension; for example, the DASH diet lowers SBP in patients with hypertension by approximately 5 to 8 mm Hg.[14]

The risk of adverse blood pressure variability-related outcomes may be reduced through lifestyle changes. The DASH diet, potassium supplements, reducing salt intake, engaging in moderate intensity and isometric exercises, managing stress, and quality sleep are associated with reducing BPV.[15]

Medication

As a note, several anti-hypertensive medication classes have been shown in trials to reduce blood pressure variability, such as angiotensin-converting enzyme inhibitors (ACEi) and angiotensin receptor blockers (ARBs) compared to other anti-hypertensive medications.[16]

AMA Commitment to Reducing the Burden of Chronic Diseases

The AMA MAP™ Hypertension clinical quality improvement program was designed to improve blood pressure control rates by addressing barriers to blood pressure measurement, treatment intensification, and patient engagement. The program is offered at no cost and has demonstrated effectiveness in a variety of health care settings from large health care organizations (HCO) to community health centers.

In 2024, the AMA was awarded multi-year funding as part of the Centers for Disease Control and Prevention's National Partners Cooperative Agreement. One of the initiatives is to prevent heart attacks and strokes, via improvement in blood pressure control and cholesterol management, in populations served by Community Health Centers/Federally Qualified Health Centers.

The AMA endorsed and participated in the writing and evidence-review committees for the 2025 Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. This guideline provides clinical teams with recommendations for patients who have or are at risk for developing cardiovascular disease.

The AMA currently devotes resources towards advancing the functionality of health information technology (HIT), including (EHRs, to support the use of average blood pressure, self-monitoring, and remote patient monitoring. In 2023, the AMA was successful in getting average blood pressure included in the US Core for Data Interoperability (USCDI). The USCDI is a federally mandated data set that EHR systems are required to support. The USCDI contains over 100 elements including patient demographic information, vital signs, problems, and procedures. The USCDI enables EHRs and other certified HIT to capture, exchange, and use standardized medical information. The Centers for Medicare and Medicaid Services also recognizes the USCDI in its physician and hospital reporting programs, e.g., the Quality Payment Program.

The examples above are not inclusive of all the work the AMA has done to improve hypertension control and reduce the burden of chronic disease. AMA's continued work and commitment support ongoing research and policy development to provide physicians and clinical teams with guidance to address BPV and improve patient outcomes.

Existing AMA Policy

Pharmacist in Hypertension Screening H-425.998
(1) Physicians should encourage the establishment of adequate training programs in blood pressure measurement, under the supervision of qualified physicians or other qualified personnel,

for pharmacists and other non-physicians in order to assure adequate personnel for hypertension screening programs. (2) The medical profession should participate in the development of programs which ensure an adequate system for monitoring blood pressure measurement and referring patients when indicated to physicians. (3) Community programs should be established to educate the public on the importance of participation in screening programs and adherence to subsequently prescribed courses of therapy, with periodic blood pressure measurement and evaluation of the effectiveness of the therapeutic regimen by licensed physicians. (4) The particular program to be implemented in any community should receive the full support of the medical profession and be built upon the existing community facilities and health personnel resources, taking into consideration applicable state legal restriction or requirements.

Genomics in Hypertension: Risk Prediction and Treatment H-460.901
Our American Medical Association encourages continued research on the genetic control of blood pressure, including in pediatric populations, and the development of genomic-based tools that may assist health professionals in better predicting risk and targeting therapy for hypertension, and supports the view that hypertension clinical trial designs should attempt to reduce phenotypic heterogeneity in order to improve the quality and interpretation of results.

Non-Physician Measurement of Body Functions H-35.990
In the public interest, the AMA recommends that non-physicians who perform tests such as blood pressure or blood sugar measurements advise the examinee to communicate these findings to their personal physician.

Medical Evaluation of Healthy Persons H-425.994
The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease. (2) The optimal frequency of the periodic evaluation and the procedures to be performed vary with the patient's age, socioeconomic status, heredity, and other individual factors. Nevertheless, the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. (3) These recommendations should be modified as appropriate in terms of each person's age, sex, occupation and other characteristics. All recommendations are subject to modification, depending upon factors such as the sensitivity and specificity of available tests and the prevalence of the diseases being sought in the particular population group from which the person comes. (4) The testing of individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified. (5) Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as hypertension, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs. (6) Continued investigation is required to determine the usefulness of test procedures that may be of value in detecting disease among asymptomatic populations.

CONCLUSION

This report highlights the current known association of blood pressure variability with

cardiovascular events and mortality outcomes. Future research is needed to standardize definitions, e.g. excessive BPV, measurement protocols, and establish pathological BPV thresholds and clinical pathways/protocols to guide physicians and clinical teams in providing evidence-based interventions to improve patient outcomes. AMA has existing policy on the importance of blood pressure measurement in multiple settings but currently has nothing specific to blood pressure variability.

RECOMMENDATION

The Board of Trustees recommends that Resolution 424-A-25 be amended by addition and the remainder of the report be filed.

> That our AMA support additional research efforts to establish pathological Blood Pressure Variability thresholds to guide dietary and exercise recommendations, sleep evaluation, risk stratification, and other evidence-based interventions by healthcare providers; and be it further (New HOD Policy)
>
> That our American Medical Association support the integration of blood pressure variability data into electronic medical records, emphasizing automated calculation capabilities similar to those established for body mass index once additional research has been published on this topic, including peer-reviewed evidence establishing clinical utility, reproducibility of blood pressure variability metrics, and such research has informed recommendations or guidance from relevant clinical and public health authorities. (New HOD Policy)

Fiscal Note: Significant Fiscal Impact

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 29-A-26

Subject: Educational Materials Regarding Ultra-processed Foods

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee D

At the 2025 Annual Meeting of the American Medical Association (AMA) House of the Delegates (HOD), the first Resolve of 601-A-25 was adopted while the second was referred, which asked that:

> Our AMA work with select organizations in the HOD to develop patient educational materials in English and Spanish with regards to the health impact of ultra processed foods as well as pathways for personal dietary options as alternatives to ultra processed foods; and, that such developed materials will be provided by the AMA to members who request them for distribution to their patients.

BACKGROUND

An overwhelming majority of food in our modern society has been 'processed' to some degree (e.g., through fermentation, pasteurization, milling, or refining) but ultra-processed foods (UPFs) represent a category of food that are produced almost entirely from industrially processed ingredients. UPF are generally considered foods that are made with "formulations of ingredients, mostly of exclusive industrial use, that result from a series of industrial processes."[1] While there is not a single standard definition of "ultra-processed," the NOVA classification system, a system created by Brazilian nutrition researchers in 2009 that defines foods as ultra-processed based on the level of industrial processing the foods are subjected to, is among one of the most influential (see Appendix to view the different categories of processed food under the NOVA classification system).[2]

UPFs do not represent a 'new' dietary product, but in fact have been a growing component of the food system since World War II. During the war, there were important advances made in food technology and packaging, which accelerated the distribution of processed food which helped prevent starvation for many at the time.[3] Following the war, UPFs were introduced and heavily advertised to the American public.[3] Almost immediately following the introduction of UPFs, there were concerns raised among some physicians about the nutritional quality of these foods and how they could impact health.[3] These concerns have grown over the last thirty years.[3] For example, the number of research papers mentioning UPFs published between 2021 to 2023 increased by over 300 percent compared to the period between 2017 and 2020.[3]

Public health concerns over UPFs are driven by the fact that they are made with little to no whole food ingredients and are produced through numerous industrial processes that can reduce the nutritional value of the product or introduce harmful elements.[4] UPFs also frequently contain large amounts of sodium, sugars, and saturated fats, which have negative health impacts in their own right, as well as artificial colors and other additives to make them more palatable and increase their shelf life.[5] Examples of UPFs include packaged snacks, mass-produced baked goods, breakfast

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'cereals,' hot dogs, sausages, pre-prepared pasta and pizza dishes. The following discussion summarizes the evidence on health risks associated with UPF consumption, as well as challenges for research in this area, followed by an overview of available educational resources on UPFs for both patients and physicians.

DISCUSSION

Health Impacts of UPF Consumption

Currently, UPFs make up a substantial share of the American diet, and their consumption has grown over time. UPFs have gained prominence in the modern diet due to their affordability, extended shelf life, and convenience.[6] The consumption of ultra-processed foods has grown from 53.5 percent of calories since 2001-2002 to 57 percent in 2017-2018, while the consumption of whole foods has decreased by a similar percentage over the same period.[7] A study looking at data from August 2021–August 2023 found that 55 percent all calories consumed by Americans age one year and older are from UPFs (as defined under the NOVA system).[8] Among youth ages 1–18, the share of calories consumed from UPFs is even higher (61.9 percent).[8] Research has also shown that child-oriented marketing strategies, such as compelling graphic elements (i.e., bright colors); promotional, licensed, or cartoon characters; celebrity endorsers; sportspersons; graphic references to fun and play; and premium collectible offers with toys and child-friendly lettering, are commonly used on labels of UPFs, making them more desirable for young children.[9]

That UPFs constitute such a high proportion of the American diet is a serious concern given the growing evidence showing an association between UPFs and poor health. UPFs, as defined under the NOVA system, are associated with a wide range of health conditions.[10] A 2025 review of the available evidence on UPFs noted plausible mechanisms for adverse health impacts include "nutrient imbalances, overeating, reduced consumption of health-protective phytochemicals, toxic contaminants from processing or packaging, harmful additives and mixtures of additives, and subsequent inflammation, dysglycemia, dyslipidemia, microbiome dysbiosis, and renal or liver dysfunction."[4] Two recent systematic reviews have reported that consumption of UPFs across children and adults is associated with poor health outcomes, such as obesity, cardiovascular disease, and other diet-related diseases, as well as discrepancies across demographic groups that put certain Americans at an elevated risk of high intake and therefore chronic disease.[11,12] Additionally, several epidemiological studies have suggested that increased UPF intake increases the risk of developing chronic kidney disease and accelerates the disease progression.[5] A population based cohort study also found higher consumption of UPFs was associated with an increased risk of all-cause mortality, with greater consumption of certain food groups, such as processed meats and sugar sweetened beverages, demonstrating the strongest associations.[10,13]

Additionally, research has demonstrated an increased risk of certain cancers with increased UPF consumption. A meta-analysis and systematic review found that high UPF consumption, when compared to low UPF consumption, was associated with a significantly increased risk of certain site-specific cancers, particularly of the digestive tract and some hormone-related cancers, but there were differences in risks between genders.[14] More research is needed to better understand the potential causal pathways. Lastly, there is emerging research connecting greater UPF consumption to risks of cognitive decline and impairment as well as stroke.[15–17]

Research on UPFs has seen increased consistency in terms of defining UPFs since the introduction of the NOVA classification system in 2009, but challenges remain. Researchers have noted challenges with the NOVA classification system, including ambiguity, inconsistency in application, and the assignment of foods with nutritional value to the "ultra-processed" category.[18] For

example, a 2024 study found that higher intake of *certain* UPFs were consistently associated with higher all-cause mortality, particularly the UPF subgroups of meat/poultry/seafood based ready-to-eat products, sugar sweetened and artificially sweetened beverages, dairy based desserts, and ultra-processed breakfast foods.[13] However, there are foods, such as some yogurts made with fruit or granola, some milk alternatives, packaged whole grain bread, that are categorized as UPFs but still offer nutritional value.[19] This highlights that there may be important heterogeneity within different subgroups of foods categorized as UPFs in terms of their impact on health and some UPFs can s. Additionally, a recent review article noted the strength and credibility of evidence for many of UPF studies was either low and suggestive/weak.[10]

UPFs and the U.S. Dietary Guidelines

The 2025 Dietary Guidelines Advisory Committee's first print of their scientific report on the American Dietary Guidelines was the first time UPFs were included as a review topic and they stated there was limited evidence on the health impacts of UPFs to make definitive recommendations on its intake.[20] Instead, they recommended more research to inform future iterations of the guidelines. The new U.S. Dietary Guidelines for Americans, released in January 2026, makes a more definitive recommendation against eating highly processed foods, but avoids the term UPF. "Avoid highly processed packaged, prepared, ready-to-eat, or other foods that are salty or sweet, such as chips, cookies, and candy that have added sugars and sodium (salt)…Limit foods and beverages that include artificial flavors, petroleum-based dyes, artificial preservatives, and low-calorie non-nutritive sweeteners."[21] The U.S. Food and Drug Administration (FDA) and U.S. Department of Agriculture (USDA) released a Request for Information in the summer of 2025 to help develop a more unified and consistent definition of UPFs.[22]

Nutritional Literacy and Public Awareness of UPF Risks

In general, the U.S. population has low nutrition literacy, which is defined as "the degree to which individuals have the capacity to obtain, process, and understand nutrition information and skills needed in order to make appropriate nutrition decisions," with one estimate noting that just over one-third of adults have adequate nutrition literacy.[23,24] The Health Belief model suggests that the more people know about the risks of certain foods influences their eating behavior.[25] Having greater nutrition literacy has been correlated with better understanding of nutritional labels and healthier food decisions and thus improving nutritional literary in the general population has the potential to improve dietary choices and overall health.[24,26]

A literature search on U.S. public perceptions and knowledge on UPFs produced limited results. Outside of the U.S., studies on this issue have been largely limited to South American countries and more recently the United Kingdom (U.K.) and other countries in Europe. A study from the U.K. found that while most participants were aware of the term UPF, most could not accurately categorize whether foods were UPFs or not. There were important differences between participants with higher incomes and higher levels of education who were more likely to report both being aware of and avoid consuming UPFs.[27] A study on consumer perceptions and intake of UPFs found participants exposed to information on the negative health impacts of UPF reported increased concerns about consuming UPFs (relative to the control) but there was limited evidence that the acceptability of consuming UPFs was reduced.[26] In essence, while education on UPF increased concerns about UPFs, it didn't necessarily result in behavioral change in terms of UPF consumption. While public education on UPFs will likely affect consumer perceptions of UPFs, it may not impact immediate food intake.[26]

Additionally, physicians have historically lacked sufficient nutritional education or training to be able to provide high-quality, effective nutrition counseling despite recognition within the medical community about the importance of dietary behaviors for health.[28] However, awareness of the potential health risks associated with UPFs has grown and there has been increased attention from medical and public health organizations.[29,30] Additionally, the Make America Healthy Again 2025 report identifies poor diet and the growth of UPFs in the American diet as major concerns for childhood chronic disease.[31] The accompanying strategy document calls for the acceleration of federal efforts to address UPFs.[32] However, public awareness and understanding of UPFs may be exacerbated by the lack of clear labeling, regulatory standards, or educational resources to inform consumer choices with respect to UPFs.

Patient Information on UPFs

A scan of federal agency and health care organization websites as well as a search on PubMed for examples of educational materials on UPFs produced few results. While the USDA and the Department of Health and Human Services (HHS) both have repositories of nutrition-related printable materials and handouts, neither have resources specific to UPFs.[33] Most of these materials and handouts appear to only be available in English. While not specific to UPFs, the FDA has a social media toolkit for their Nutrition Facts Label Campaign, which is intended to help consumers make better informed decisions regarding food choices.[34] The FDA is also proposing to require a front-of-package nutrition label on most packaged foods to provide accessible, at-a-glance information on added sodium, sugar, and saturated fats to help consumers quickly and easily identify which foods are part of a healthy diet.[35] As UPFs generally contain a high amount of these three ingredients, this type of front-of-package label could be very helpful for consumers in identifying unhealthy UPFs.

One article addressed the development of UPF infographics for patients with chronic kidney disease, as UPFs can worsen blood pressure and glycemic control, and lead to constipation, hyperkalemia and hyperphosphatemia.[5] It is unknown whether the education materials referenced in this study have been widely distributed within or outside of this specific patient population. An example of one of the infographics from this paper is provided in Figure 1.

More commonly, health care systems and medical organizations have created dedicated webpages on UPFs. For example, the AMA, as part of their What Doctors Wish Patients Knew™ series, has published an informational page on UPFs.[36] Similarly, the American Heart Association has on their website, "Top Things to Know: Ultraprocessed Foods and Their Association with Cardiometabolic Health."[37] Health care organizations, like the Mayo Clinic and Massachusetts General Hospital (just to name a few), have also created webpages to improve patient education (See Figures 2 and 3).[38,39]

Physician Education and Resources on UPFs

Similar to patient resources, there are limited educational resources on UPFs for physicians. One of the leading organizations for physician education on nutrition is the Gaples Institute, an educational nonprofit dedicated to advancing the role of nutrition and lifestyle in medicine through education and advocacy.[40] While educational content from the Gaples Institute is featured and available on AMA's Ed Hub, they do not have educational content specifically on UPFs, even if some of their existing modules address them. As the Gaples Institute is a well-known provider of physician nutrition education, they could be an important organization to partner with on future clinician educational resources.

Although not specific to UPFs, available nutrition education on AMA's Ed Hub includes:

- Nutrition and Health – CME Course
- 2025 Update — Nutrition Science for Health and Longevity: What Every Physician Needs to Know from the Gaples Institute Nutrition and Lifestyle Education
- Heritage Diets: Adapting Nutrition Recommendations Across Cultures
- Talking to Patients About Using the Nutrition Facts Label to Make Healthy Food Choices (developed in collaboration with the FDA) – CME module

A scan of available nutrition education for physicians produced limited resources on UPFs but also included examples of 'Food is Medicine' courses or nutrition science courses. A few examples of nutritional education from other medical institutions and organizations are provided below:

- The Exam Room™ Podcast on processed foods featuring Dr. Neal Barnard, President of Physicians Committee for Responsible Medicine[41]
- The American Academy of Family Physicians has a publication entitled: Nutrition Myths and Healthy Dietary Advice in Clinical Practice[42]
- The American College of Lifestyle Medicine has multiple 'Food as Medicine' educational courses[43]
- The Stanford Center for Health Education has a Nutrition Science Online Short Course[44]

STATE AND FEDERAL LEGISLATION

Several states have adopted or are considering legislation that bans or prohibits UPFs, with California being the first to pass a law limiting UPFs from schools in October 2025.[45,46] As part of these efforts, the challenge of defining UPFs has been evident, and different states have taken different approaches to define unhealthy UPFs.[47] California's law is the first to create a statutory definition of UPFs, which is defined as:

An ultra-processed food contains one or more of the following:

- Surface-active agents
- Stabilizers and thickeners
- Propellents, aerating agents and gases
- Colors and coloring adjuncts
- Emulsifiers and emulsifier salts
- Flavoring agents and adjuvants
- Non-nutritive sweeteners [D-sorbitol, erythritol, hydrogenated starch hydrolysates, sucralose, isomal, lactitol, luo han fruit concentrate, maltitol, steviol glycosides, thaumatin, xylitol)

AND contains one or more of:

- Saturated fat at 10% or more of calories
- A ratio of mg sodium to calories of more than 1:1
- Sugars at 10% or more of calories[48]

There have also been a few pieces of legislation proposed at the federal level in 2025 and 2026. First introduced in December 2025 and reintroduced in January 2026, the Childhood Diabetes Reduction Act (H.R. 6294/S. 4195) is a bipartisan bill that would require the FDA to implement clear, front-of-package warning labels on foods high in sugar, salt, and saturated fat, or that are classified as a UPF.[49] The proposed bill also aims to restrict marketing of these products to children and directs the NIH to expand research on the harmful additives within them.[50] In the context of this bill, UPFs are defined as, "a food, including a beverage, containing one or more industrial

ingredients, including surface-active agents, stabilizers and thickeners, propellants, aerating agents and gases, color and coloring adjuncts, emulsifiers and emulsifier salts, flavoring agents and adjuvants, flavor enhancers, surface-finishing, non-sugar sweeteners, and other ingredients, as the Secretary [of HHS] determines appropriate."[50] Additionally, in April 2025, the Healthy Lunch for Healthy Kids Act (H.R. 2530) was introduced which aims to amend the National School Lunch Act to prohibit the serving of specific ultra-processed foods, including those containing artificial dyes, titanium dioxide, and other additives in school cafeterias.[51]

CURRENT AMA POLICY AND ACTIVITIES

In the past several years, the AMA has been actively engaged on the issue of UPFs. AMA Policy H-150.914, "Addressing the Health Impacts of Ultraprocessed Foods", directs the AMA to support and promote public health awareness and education about the differences between healthful and unhealthful UPFs, alluding to the existing tensions on defining UPF and whether all UPFs should be considered unhealthy and discouraged. In addition, AMA Policy G-630.140, "Lodging, Meeting Venues, and Social Functions," directed AMA to offer food options of minimally processed fiber-rich foods at AMA-sponsored receptions or meals.[52]

In a February 2025 letter commenting on the Scientific Report of the 2025 Dietary Guidelines Advisory Committee, the AMA urged the Agencies to include more concrete recommendations regarding UPFs.[53] In September 2025, the AMA sent a letter in response to an FDA Request for Information to help develop a uniform definition of UPFs for human food products in the U.S. food supply. In the letter, it was recommended that the definition of UPFs be developed with the primary goal of improving public health and reducing chronic disease.[54] Lastly, the AMA is in the process of organizing a four-part webinar series for 2026 that will engage physicians, residents and medical students in evidence-based education, aligned with HOD policy, on what constitutes a healthy diet, how different dietary patterns impact overall health and how to talk with patients about their dietary choices. As part of this series, at least one of the webinars will cover processed foods.

CONCLUSION

There is a dearth of available educational resources and materials on UPFs, for both patients and physicians. In some respects, this can be attributed to ongoing inconsistencies of how to define UPFs but there is growing evidence that increased UPF consumption has negative health outcomes. As there are current federal efforts underway to develop a more unified and consistent definition of UPFs, it may be prudent for the AMA to focus on lower cost educational options until there is more clarity on the UPF definition. However, as an organization, AMA should continue to support the development of patient materials that help them make healthier dietary choices and improve their health.

RECOMMENDATIONS

The Board of Trustees recommends:

(1) That the second resolve of Resolution 601-A-25 not be adopted; and

(2) That Policy H-150.914, "Addressing the Health Impacts of Ultraprocessed Foods" be amended by addition and deletion to read as follows:

1. Our AMA supports and promotes ~~public~~ awareness and education, among both the public and clinicians, about the differences between healthy~~ful~~ and unhealthy~~ful~~ ultraprocessed foods (UPF) and the benefits of minimally processed and unprocessed foods.

2. Our AMA supports the development of multi-lingual patient educational materials with regard to the health impact of UPFs and will help disseminate available materials through relevant AMA platforms.

~~2.~~ 3. Our AMA supports federal, state, and local policies that promote and incentivize the production and distribution of healthier, affordable, minimally-processed and unprocessed foods.

~~3.~~ 4. Our AMA encourages the integration of nutrition education into all levels of medical education to empower clinicians to best counsel patients efficiently and effectively on reducing unhealthful UPF consumption.

~~4.~~ 5. Our AMA supports increased funding ~~to the FDA~~ for research into the health impacts of ultraprocessed foods and strategies to mitigate their risks.

Fiscal Note: Between $1,000 - $5,000

APPENDIX

Table 1: NOVA Classification of Foods[1]

Category and Name	Definition
Group 1 – Unprocessed or minimally processed foods	Unprocessed foods or minimally processed foods that are altered by processes such as removal of inedible or unwanted parts, drying, crushing, grinding, fractioning, roasting, boiling, pasteurization, refrigeration, freezing, placing in containers, vacuum packaging or non-alcoholic fermentation. None of these processes add salt, sugar, oils or fats, or other food substances to the original food.
Group 2 – Processed culinary ingredients	These are ingredients obtained directly from group 1 foods or from nature, like oils and fats, sugar and salt. They are created by industrial processes such as pressing, centrifuging, refining, extracting or mining, and their use is in the preparation, seasoning and cooking of group 1 foods.
Group 3 – Processed foods	This category represents food products made by adding salt, sugar or other substance found in group 2 to group 1 foods, using preservation methods such as canning and bottling, and, in the case of breads and cheeses, using non-alcoholic fermentation. Food processing here aims to increase the durability of group 1 foods and make them more enjoyable by modifying or enhancing their sensory qualities.
Group 4 – Ultra-processed food and drink products	Food made from industrial formulations, typically with five or more and usually many ingredients. Such ingredients often include those also used in processed foods, such as sugar, oils, fats, salt, anti-oxidants, stabilizers, and preservatives. Ingredients only found in UPF products include substances not commonly used in culinary preparations, and additives whose purpose is to imitate sensory qualities of group 1 foods or of culinary preparations of these foods, or to disguise undesirable sensory qualities of the final product.

Figure 1 – Educational Materials Developed for Patients with Chronic Kidney Disease[5]

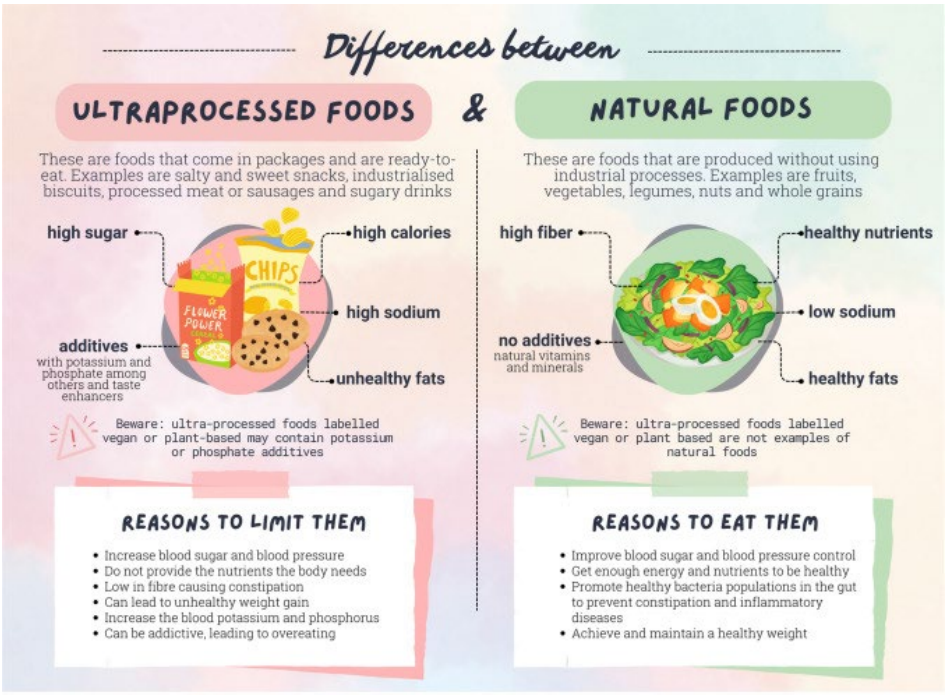

Figure 2 – Patient Education Webpage from Massachusetts General Hospital[39]

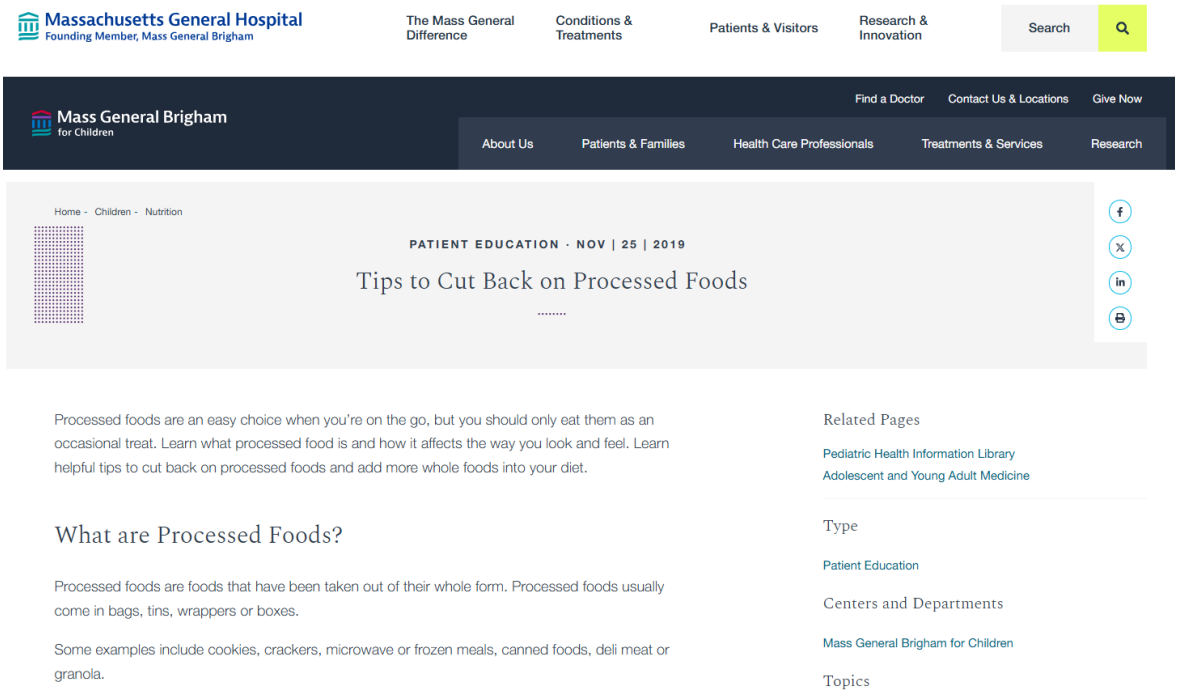

Figure 3 - Patient Education Webpage from the Mayo Clinic[38]

SPEAKING OF HEALTH | THURSDAY, JULY 25, 2024

What you should know about processed, ultra-processed foods

TOPICS IN THIS POST

Nutrition | Get Healthy Recipes And Tips

Processed, and especially ultra-processed, foods have been blamed for the national rise in obesity, high blood pressure and diabetes. But what exactly are these foods, and are they really all that bad for you?

Defining processed foods

According to the Department of Agriculture, processed foods are any raw agricultural commodities altered from their original state. This includes washing, cleaning, milling, cutting, chopping, heating, pasteurizing, blanching, cooking, canning, freezing, drying, dehydrating, mixing or packaging.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-A-26

Subject: Council on Science and Public Health Sunset Review of 2016 House Policies

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee D

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

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

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

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

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

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
6. Sunset policies will be retained in the AMA historical archives.

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RECOMMENDATION

The Council on Science and Public Health recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Minimal

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-120.936	Urine Drug Testing	Our AMA will, in conjunction with the AMA Opioid Task Force, develop practical guidance and educational materials to assist physicians with implementing urine drug testing as part of a risk mitigation strategy when opioid analgesics are prescribed for chronic use.	Rescind, accomplished. *The AMA hosted the Webinar "The Art of Urine Drug Testing: A Patient-Centered Approach." The AMA also promotes related education on the AMA Ed Hub™: Fundamentals of Urine Drug Testing and Crossing the Knowledge Gap in Drug Test Interpretation.*
D-120.937	Hormone Therapies: Off-Label Uses and Unapproved Formulations	Our AMA urges the United States Pharmacopeia to re-examine the validity of the current estriol monograph.	Retain, still relevant.
D-120.940	NPS Report Distribution to Practicing Physicians	Our AMA will distribute and promote the National Pain Strategy report to practicing physicians.	Rescind, accomplished.
D-120.969	Compounded Hormone Therapy Preparations	Our AMA: (1) recognizes the term "bioidentical hormone" as a marketing term not grounded in science; use of the term "compounded hormone therapy" is preferred; (2) will urge that renewed attention be devoted to the purity and potency of compounded hormone therapy formulations; (3) will urge continued attention to the reporting of adverse events related to the use of compounded hormone therapies; (4) recommends that physicians and other prescribers fully inform patients of the potential side effects and risks of the use of compounded hormone replacement therapy; (5) will request that when drug ingredients with black box warnings are used in compounded products, patients should be informed about the warnings and precautions associated with the use of such drug ingredients; and (6) supports that patients be informed that compounded products are not FDA-approved.	Retain, still relevant.

D-120.988	Inappropriate Actions by Pharmacies and Pharmacy Benefit Managers	Our AMA, in cooperation with pharmacy benefit managers, pharmacy companies, and other drug retailing organizations, shall develop model procedures that physicians may use when prescribing off-formulary pharmaceuticals that are medically indicated and that these procedures be in compliance with the Health Insurance and Portability and Accountability Act of 1996.	Retain, still relevant.
D-135.970	Coal-Tar Based Sealcoat Threat to Human Health and the Environment	Our AMA will advocate for legislation to ban the use of pavement sealcoats that contain polycyclic aromatic hydrocarbons (PAH) or require use of sealcoat products that contain minimal PAH.	Retain, still relevant.
D-135.986	Public Health Hazards Associated with Landscaping Services	Our AMA encourages the Occupational Safety and Health Administration to collaborate with the AMA, other appropriate medical societies, and other pertinent federal agencies to identify and recommend strategies to prevent and reduce the potential public health hazards created by various landscaping services (including lawn-mowing, fertilization, weed, insect & grub control, tree & bush care, debris removal, fence, driveway, rock garden & stone path construction requiring use of saws, and a full spectrum of motorized equipment).	Retain as amended to correct formatting errors. Our AMA encourages the Occupational Safety and Health Administration to collaborate with the AMA, other appropriate medical societies, and other pertinent federal agencies to identify and recommend strategies to prevent and reduce the potential public health hazards created by various landscaping services (including lawn-mowing, fertilization, weed, insect, and ~~&~~ grub control, tree ~~&~~ and bush care, debris removal, fence, driveway, rock garden and ~~&~~ stone path construction requiring use of saws, and a full spectrum of motorized equipment).
D-135.987	Modern Chemicals Policies	Our AMA: (1) will call upon the United States government to implement a national modern, comprehensive chemicals policy that is in line with current scientific knowledge on human and environmental health, and that	Retain, still relevant.

		requires a full evaluation of the health impacts of both newly developed and industrial chemicals now in use; and (2) encourages the training of medical students, physicians, and other health professionals about the human health effects of toxic chemical exposures.	
D-135.993	Contamination of Drinking Water by Pharmaceuticals and Personal Care Products	Our AMA supports the EPA and other federal agencies in engaging relevant stakeholders, which may include, but is not limited to the AMA, pharmaceutical companies, pharmaceutical retailers, state and specialty societies, and public health organizations in the development of guidelines for physicians and the public for the proper disposal of pharmaceuticals and personal care products to prevent contamination of drinking water systems.	Retain as amended and convert to an H-policy. Our AMA supports ~~the EPA and other federal agencies in engaging relevant stakeholders, which may include, but is not limited to the AMA, pharmaceutical companies, pharmaceutical retailers, state and specialty societies, and public health organizations in the development of guidelines for physicians and the public for~~ the proper disposal of pharmaceuticals and personal care products to prevent contamination of drinking water systems. *The EPA has developed resources and finalized a rule on managing pharmaceutical waste.*
D-30.994	Take Action to End Alcohol Ads on College Sports Telecasts	Our AMA will enhance its efforts to end alcohol advertising on sports broadcasts and particularly on college sports broadcasts; and to reach this goal, work with others to place special emphasis on college athletic conferences that are now or soon will be negotiating broadcast rights contracts, taking steps that include, but are not limited to: (1) Appealing directly to the NCAA, all college athletic conferences and member schools to end alcohol ads on their broadcasts; (2) Encouraging physicians, particularly those in or associated with college communities, to express their	Retain, still relevant.

		opposition to alcohol ads directly to top college administrators; (3) Urging state and local medical associations to contact colleges in their jurisdictions--particularly in the above conferences--and press them to end alcohol ads on their broadcasts; (4) Urging state and local medical associations to call on state legislatures to pass resolutions requesting colleges in their state to end alcohol ads on their broadcasts; and (5) Organizing a "sign-on" letter from medical societies to the NCAA President and Executive Committee urging an end to alcohol ads on NCAA broadcasts.	
D-440.997	Support for Public Health	1. 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." This shall be accomplished by AMA representation of the needs of its members? patients in public health-related areas, the promotion of the necessary funding and promulgation of appropriate legislation which will bring this to pass. 2. Our AMA: (A) will work with Congress and the Administration to prevent further cuts in the funds dedicated under the Patient Protection and Affordable Care Act to preserve state and local public health functions and activities to prevent disease; (B) recognizes a crisis of inadequate public health funding, most intense at the local and state health jurisdiction levels, and	Retain as amended. 1. 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." This shall be accomplished by AMA representation of the needs of its members~~?~~ and patients in public health-related areas, and the promotion of the necessary funding and promulgation of appropriate legislation which will bring this to pass.

		encourage all medical societies to work toward restoration of adequate local and state public health functions and resources; and (C) in concert with state and local medical societies, will continue to support the work of the Centers for Disease Control and Prevention, and the efforts of state and local health departments working to improve community health status, lower the risk of disease and protect the nation against epidemics and other catastrophes. 3. Our AMA 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.	
D-490.979	Banning Smoking in All Workplaces	Our AMA will (1) actively support national, state, and local legislation and actively pursue regulations banning smoking in all workplaces; and (2) work to ensure that federal legislation banning smoking in all workplaces does not prohibit or weaken more strict state or local regulations.	Retain, still relevant.
D-620.989	Promote Teen Health Week	1. Our AMA will actively promote Teen Health Week 2017 and encourage state medical associations and specialty medical associations across the nation to join the initial efforts as originated in Pennsylvania, and will encourage schools and other appropriate organizations to adopt, promote and participate in Teen Health Week. 2. Our AMA will actively advocate, through direct communication with the appropriate agencies and organizations,	Retain as amended and convert to an H-policy. 1. Our AMA will actively promote Teen Health Week ~~2017~~ and encourage state medical associations, ~~and~~ specialty medical associations, ~~across the nation to join the initial efforts as originated in Pennsylvania, and will encourage~~ schools and other appropriate organizations to adopt, promote and participate in Teen Health Week. ~~2. Our AMA will actively advocate, through direct communication with the~~

		for the development of an annually recognized Teen Health Week.	~~appropriate agencies and organizations, for the development of an annually recognized Teen Health Week~~ *The AMA promoted Teen Health Week via an article in 2017 and 2018. We also promoted the International Adolescent Health Week in 2021 (Facebook interview with founder of IAHW).*
H-10.961	Ocular Injuries from Air Guns	Our AMA: (1) encourages the use and provision of protective eyewear when using air guns; and (2) encourages education on the proper use of protective eyewear to avoid ocular injuries.	Retain, still relevant.
H-10.974	Assurance of the Public's Health Aboard Cruise Ships	The AMA, through federal legislation or international treaty as appropriate, urge the development of standards for the provision of medical care, including emergency medical care, for passengers aboard cruise ships entering or leaving United States ports.	Retain as amended. The AMA~~, through federal legislation or international treaty as appropriate, urge the development of~~ supports standards for the provision of medical care, including emergency medical care, for passengers aboard cruise ships entering or leaving United States ports. *The American College of Emergency Physicians published Cruise Ship Health Care Guidelines, which according to the CDC, most major cruise lines follow.*
H-115.985	Warning Labels on Over-The-Counter Iron Preparations and Dietary Supplements	The AMA (1) urges physicians to warn diagnosed patients with hereditary hemochromatosis against the use of over-the-counter iron preparations and dietary supplements containing iron; (2) believes that therapeutic doses of iron should be used only to treat iron-deficiency anemia; and (3) believes that the prophylactic use of iron preparations should be reserved for individuals at high risk of developing iron deficiency.	Retain, still relevant.

H-120.932	Pharmacy Review of First Dose Medication	It is AMA policy that a pharmacist should be available in person or by other means for consultation when medication is administered in a hospital setting.	Retain, still relevant.
H-120.943	Adequate Prescription Medication Supply	1. Our AMA urges health plans to: (a) define a month's supply as a minimum of 31 days and three month's supply as a minimum of 93 days, so that patients are not shorted on their one-month or three-month supply of prescription drugs; and (b) allow prescription refills to provide the appropriate number of doses for the time period specified by the physician. 2. Our AMA will advocate and support advocacy at the state and federal levels against arbitrary prescription limits that restrict access to medically necessary treatment by limiting the dose, amount or days of the first or subsequent prescription for patients with pain related to a cancer or terminal diagnosis.	Retain, still relevant.
H-120.945	Pharmacy Compounding	Our AMA: (1) recognizes that traditional compounding pharmacies must be subject to state board of pharmacy oversight and comply with current United States Pharmacopeia and National Formulary (USP-NF) compounding monographs, when available, and recommends that they be required to conform with USP-NF General Chapters on pharmaceutical compounding to ensure the uniformity, quality, and safety of compounded medications; (2) encourages all state boards of pharmacy to reference sterile compounding quality standards, including but not limited to those contained in United States Pharmacopeia Chapter 797, as the	Retain, still relevant.

		standard for sterile compounding in their state, and to satisfy other relevant standards that have been promulgated by the state in its laws and regulations governing pharmacy practice; (3) supports the view that facilities (other than pharmacies within a health system that serve only other entities within that health system) that compound sterile drug products without receiving a prescription order prior to beginning compounding and introduce such compounded drugs into interstate commerce be recognized as compounding manufacturers subject to FDA oversight and regulation; (4) supports the view that allowances must be made for the conduct of compounding practices that can realistically supply compounded products to meet anticipated clinical needs, including urgent and emergency care scenarios, in a safe manner; and (5) in the absence of new federal legislation affecting the oversight of compounding pharmacies, continues to encourage state boards of pharmacy and the National Association of Boards of Pharmacy to work with the United States Food and Drug Administration to identify and take appropriate enforcement action against entities that are illegally manufacturing medications under the guise of pharmacy compounding.	
H-120.963	Epidemiology of Drug Errors	The AMA will continue its collaborations with the Food and Drug Administration and the US Pharmacopoeial Convention, Inc., along with its own ongoing initiatives, to identify and eliminate causes of medication errors.	Retain as amended to update terminology and correct spelling. The AMA will continue its collaborations with the Food and Drug Administration and the US Pharmacop~~o~~eial Convention, ~~Inc.~~, along with its own ongoing

			initiatives, to identify and eliminate causes of medication errors.
H-125.985	Expanded Use of the AMA's Principles of a Sound Drug Formulary	Our AMA urges managed care organizations, pharmacy benefit managers, and others who design benefit packages and/or make pharmacy benefit decisions, to utilize the Principles of a Sound Drug Formulary System (as described in BOT Rep. 28, I-00) as they develop their pharmaceutical benefit plan(s) and that the Principles of a Sound Drug Formulary System be readily available on the AMA web site.	Retain as amended. Our AMA urges managed care organizations, pharmacy benefit managers, and others who design benefit packages and/or make pharmacy benefit decisions, to utilize the Principles of a Sound Drug Formulary System ~~(as described in BOT Rep. 28, I-00)~~ as they develop their pharmaceutical benefit plan(s) ~~and that the Principles of a Sound Drug Formulary System be readily available on the AMA web site.~~ *AMA does not have control over this resource and thus, would not showcase it on our website. The resource is readily available online.*
H-130.979	National Disaster Medical System	The AMA endorses the U.S. Department of Homeland Security's National Disaster Medical System, which was designed to fulfill three main objectives: (1) to provide medical assistance to a disaster area in the form of medical teams, supplies and equipment; (2) to evacuate patients who cannot be cared for in the affected area to designated locations elsewhere in the nation; and (3) to provide hospitalization in a national network of hospitals that have agreed to accept patients in the event of a national emergency.	Retain as amended. The AMA endorses the U.S. Administration for Strategic Preparedness and Response's ~~U.S. Department of Homeland Security's~~ National Disaster Medical System which was designed to fulfill three main objectives: (1) to provide medical assistance to a disaster area in the form of medical teams, supplies and equipment; (2) to evacuate patients who cannot be cared for in the affected area to designated locations elsewhere in the nation; and (3) to provide hospitalization in a national network of hospitals that have agreed to accept patients in the event of a national emergency. *The National Disaster Medical System is no longer managed under the Department of Homeland Security; it's under HHS's Administration for Strategic Preparedness and Response.*

H-135.924	Assurance and Accountability for EPA's State Level Agencies	Our AMA supports requiring that the United States Environmental Protection Agency (EPA) conduct regular quality assurance reviews of state agencies that are delegated to enforce EPA regulations.	Retain, still relevant.
H-135.925	Medications Return Program	1. Our AMA supports access to safe, convenient, and environmentally sound medication return for unwanted prescription medications 2. Our AMA supports such a medication disposal program be fully funded by the pharmaceutical industry, including costs for collection, transport and disposal of these materials as hazardous waste. 3. Our AMA supports changes in federal law or regulation that would allow a program for medication recycling and disposal to occur.	Retain, still relevant.
H-135.927	Human and Environmental Effects of Light Emitting Diode (LED) Community Lighting	1. Our AMA supports the proper conversion to community-based Light Emitting Diode (LED) lighting, which reduces energy consumption and decreases the use of fossil fuels. 2. Our AMA encourages minimizing and controlling blue-rich environmental lighting by using the lowest emission of blue light possible to reduce glare. 3. Our AMA encourages the use of 3000K or lower lighting for outdoor installations such as roadways. All LED lighting should be properly shielded to minimize glare and detrimental human and environmental effects, and consideration should be given to utilize the ability of LED lighting to be dimmed for off-peak time periods.	Retain, still relevant.
H-135.936	Proper Disposal of Unused Prescription and	1. Our AMA supports initiatives designed to promote and facilitate the	Retain as amended.

	Over-the-Counter (OTC) Drugs	safe and appropriate disposal of unused medications. 2. Our AMA will work with other national organizations and associations to inform, encourage, support and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in modifying their US Drug Enforcement Administration registrations to become authorized medication collectors and operate collection receptacles at their registered locations. 3. Our AMA will work with other appropriate organizations to develop a voluntary mechanism to accept non-controlled medication for appropriate disposal or recycling.	1. Our AMA supports initiatives designed to promote and facilitate the safe and appropriate disposal of unused medications. 2. Our AMA ~~will work with other~~ supports efforts by national organizations and associations to inform, encourage, ~~support~~ and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in modifying their US Drug Enforcement Administration registrations to become authorized medication collectors and operate collection receptacles at their registered locations. 3. Our AMA ~~will work with~~ supports other appropriate organizations ~~to~~ developing a voluntary mechanism to accept non-controlled medication for appropriate disposal or recycling. *Related AMA work includes the following: Keeping unused meds out of the wrong hands just got easier ; 2024 FDA Guidance ; 2025 FDA Guidance ; AMA 2019 Article – AMA urges participation in Prescription Drug Take Back Day*.
H-135.956	Human and Environmental Health Impacts of Chlorinated Chemicals	The AMA: (1) encourages the Environmental Protection Agency to base its evaluations of the potential public health and environmental risks posed by exposure to an individual chlorinated organic compound, other industrial compound, or manufacturing process on reliable data specific to that compound or process; (2) encourages the chemical industry to increase knowledge of the environmental behavior, bioaccumulation potential, and toxicology of their products and by-products; and (3) supports the implementation of risk reduction	Retain, still relevant.

		practices by the chemical and manufacturing industries.	
H-145.973	Firearm Related Injury and Death: Adopt a Call to Action	Our AMA endorses the specific recommendations made by an interdisciplinary, inter-professional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.	Retain, still relevant.
H-145.982	Prevention of Ocular Injuries from BB and Air Guns	The AMA encourages businesses that sell BB and air guns to make appropriate and safe protective eye wear available and encourages its use to their customers and to distribute educational materials on the safe use of non-powder guns.	Retain, still relevant.
H-15.978	Voluntary Highway Lights-On Campaign	The AMA advocates and encourages the institution of voluntary lights-on efforts during daylight hours for all motor vehicles not already automatically equipped with daytime running lights on American highways.	Retain, still relevant.
H-150.979	Fast Food	The AMA encourages fast food restaurants to reduce the saturated fat content of their foods, as well as to offer	Retain as amended to correct grammar. The AMA encourages fast food restaurants to reduce the saturated fat content of their foods, as well as to offer

		low fat alternatives to highly saturated fat foods.	low fat alternatives to foods high~~ly~~ in saturated fat ~~foods~~.
H-170.995	Healthful Lifestyles	The AMA believes that consumers should be encouraged and assisted to learn healthful practices by: (1) educating and motivating the consumers to adopt more healthful lifestyles; (2) exploring methods of utilizing public communication more effectively in health education efforts directed towards motivating consumers to adopt healthful lifestyles; (3) encouraging consumers, in appropriate risk groups, to utilize professional preventive health care services which would permit the early detection and treatment, or the prevention, of illness; and physicians demonstrating these practices through personal examples of health lifestyles.	Retain as amended to correct grammar. The AMA believes that consumers should be encouraged and assisted to learn healthful practices by: (1) educating and motivating the consumers to adopt more healthful lifestyles; (2) exploring methods of utilizing public communication more effectively in health education efforts directed towards motivating consumers to adopt healthful lifestyles; (3) encouraging consumers, in appropriate risk groups, to utilize professional preventive health care services which would permit the early detection and treatment, or the prevention, of illness; and physicians demonstrating these practices through personal examples of healthy lifestyles.
H-20.904	HIV/AIDS Education and Training	(1) Public Information and Awareness Campaigns Our AMA: a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection. b) Our AMA urges the communications industry, government officials, and the	Retain as amended to update terminology. …(3) Education and Training Initiatives for Practicing Physicians and Other Health Care ~~Workers~~ Personnel Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health ~~workers~~ personnel (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.

		health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection; c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies; d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities; e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve. (2) HIV/AIDS Education in Schools Our AMA: a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission,	

		and recommended risk reduction strategies; b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools. (3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies.	
H-215.961	Community Benefit Dollars for Diabetes Prevention	1. Our AMA supports allocating community benefit dollars to cover the cost of enrolling patients in an in-person or virtual diabetes prevention program that is part of the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program. 2. Our AMA will work with the American Hospital Association and other stakeholders to develop and disseminate a position paper with guidance for covering the costs of the Center for Disease Control and Prevention's Diabetes Prevention	Retain, still relevant.

		Recognition Program with community benefit dollars. 3. Our AMA encourages each state medical society to work with their respective hospitals and local Diabetes Prevention Program providers to offer the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program to patients. 4. Our AMA encourages that private and public payors offer the Centers for Disease Control and Prevention's Diabetes Prevention Recognition Program to patients as part of their suite of benefits.	
H-245.967	Prevention of Newborn Falls in Hospitals	Our AMA supports implementation of newborn fall prevention plans and post-fall procedures through clinically proven, high-quality, and cost-effective approaches.	Retain, still relevant.
H-25.991	Alzheimer's Disease	Our AMA: (1) encourages physicians to make appropriate use of guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias; (2) encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services; (3) encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders; (4) encourages studies to determine how best to provide stable funding for the	Retain, still relevant.

		long-term care of patients with Alzheimer's disease and other dementing disorders; (5) supports the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations; (6) supports increased awareness of the sex and gender differences in incidence and etiology of Alzheimer's disease and related dementias; and (7) encourages increased enrollment in clinical trials of appropriate patients with Alzheimer's disease and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer's disease and related dementias.	
H-280.946	Policies on Intimacy and Sexual Behavior in Residential Aged Care Facilities	Our AMA urges long-term care facilities and other appropriate organizations to: (1) adopt policies and procedures on intimacy and sexual behavior that preserve residents' rights to pursue sexual relationships, while protecting them from unsafe, unwanted, or abusive situations; and (2) provide staff with in-service training to develop a framework to address intimacy in their patient population.	Retain, still relevant.
H-30.935	Powdered Alcohol	Our AMA supports federal and state laws banning the manufacture, importation, distribution, and sale of	Retain, still relevant.

		powdered or crystalline alcohol intended for human consumption.	
H-30.948	Improving Nutritional State of Persons with Alcohol Use Disorder	The AMA encourages appropriate local, state and federal agencies to increase their efforts to: (a) improve the overall nutritional and health status of individuals with alcohol dependency and (b) reduce alcohol dependency.	Retain as amended to align the policy language with the title. The AMA encourages appropriate local, state and federal agencies to increase their efforts to: (a) improve the overall nutritional and health status of individuals with alcohol use disorder ~~dependency~~ and (b) reduce alcohol use disorder ~~dependency.~~
H-345.971	Faith and Mental Health	Our AMA supports: (1) mental health and faith community partnerships that foster improved education and understanding regarding culturally competent, medically accepted, and scientifically proven methods of care for psychiatric and substance use disorders; (2) better understanding on the part of mental health providers of the role of faith in mental health and addiction recovery for some individuals; and (3) efforts of mental health providers to create respectful, collaborative relationships with local religious leaders to improve access to scientifically sound mental health services.	Retain, still relevant.
H-345.974	Culturally, Linguistically Competent Mental Health Care and Outreach for At-Risk Communities	Our American Medical Association supports adequate attention and funds being directed towards culturally and linguistically competent mental health direct services for the diverse, multi-ethnic communities at greatest risk, and encourages greater cultural and linguistic-competent outreach to ethnic communities including partnerships with ethnic community organizations, health care advocates, and respected media outlets.	Retain, as amended to update language to be more inclusive. Our American Medical Association supports adequate attention and funds being directed towards culturally and linguistically competent mental health direct services for the diverse~~, multi-ethnic~~ communities at ~~greatest~~ risk, and encourages greater cultural and linguistic-competent outreach to ~~ethnic~~ communities including partnerships with ~~ethnic~~ community organizations

H-370.961	Umbilical Cord Blood Transplantation: The Current Scientific Understanding	Our AMA will: (1) encourage continued research into the scientific issues surrounding the use of umbilical cord blood-derived hematopoietic stem cells for transplantation, including the ex vivo expansion of umbilical cord blood-derived hematopoietic stem cells; the combination of multiple units of closely matched, unrelated umbilical cord blood cells for transplantation; and the improvement of umbilical cord blood cells collection techniques; and (2) support education for physicians and the public about the potential benefits of, and limitations to, umbilical cord blood transplantation as an alternative to bone marrow transplantation.	Retain, still relevant.
H-370.970	Umbilical Cord Blood Transplantation: The Current Scientific Understanding	Our AMA: (1) urges physicians to recognize that umbilical cord blood transplantation is a viable alternative to bone marrow transplantation in appropriately selected patients; (2) encourages the development of national standardized guidance to address the ethical, economic, and social issues surrounding umbilical cord blood transplantation; and (3) will continue to study cord blood banking in this country, and work with appropriate specialty societies and organizations, such as the National Marrow Donor Program, to develop and disseminate materials to educate physicians and the public about the issues of marketing cord blood banking services directly to patients, the informed consent process, and the existence of federally mandated regulatory oversight of these processes to ensure safety and compliance with specific uniform standards.	Retain, still relevant.

H-420.982	Standard Terminology for Reporting of Reproductive Health Statistics in the United States	The AMA supports attempts to standardize terminology for reproductive health statistics and, thus, to provide a uniform basis from which the collection and analysis of statistical data may proceed.	Retain, still relevant.
H-425.984	Clinical Preventive Services	Implications for Adolescent, Adult, and Geriatric Medicine: (1) Prevention should be a philosophy that is espoused and practiced as early as possible in undergraduate medical schools, residency training, and continuing medical education, with heightened emphasis on the theory, value, and implementation of both clinical preventive services and population-based preventive medicine. (2) Practicing physicians should become familiar with authoritative clinical preventive services guidelines and routinely implement them as appropriate to the age, gender, and individual risk/environmental factors applicable to the patients in the practice at every opportunity, including episodic/acute care visits. (3) Where appropriate, clinical preventive services recommendations should be based on outcomes-based research and effectiveness data. Federal and private funding should be increased for further investigations into outcomes, application, and public policy aspects of clinical preventive services.	Retain, still relevant.
H-440.824	Educating Clinicians and the Public About Amebic Meningoencephalitis	Our AMA supports: (1) CDC training and education efforts relating to Primary Amebic Meningoencephalitis (PAM); and (2) clinical guidelines and standards of care that promote rapid diagnosis and effective treatment of PAM.	Retain, still relevant. *Diagnosis of PAM is almost exclusively through CDC, which provides 24/7 support. CDC has a page on treatment options. With only 5 survivors and a survival rate of only 5%, it's hard to know what works. Delayed diagnosis is still*

			thought to be a common reason for bad outcomes with PAM.
H-440.825	Fund for Public Health Emergency Response	Our AMA supports the reauthorization and appropriation of sufficient funds to a public health emergency fund within the Department of Health and Human Services to facilitate adequate responses to public health emergencies without redistributing funds from established public health accounts.	Retain, still relevant.
H-440.826	Opposition to Quarantine for Zika Patients	Our AMA opposes quarantine measures for Zika-infected patients.	Retain, still relevant.
H-440.841	Permitting Sunscreen in Schools	1. Our AMA supports the exemption of sunscreen from over-the-counter medication possession bans in schools and encourages all schools to allow students to bring and possess sunscreen at school without restriction and without requiring physician authorization. 2. Our AMA will work with state and specialty medical societies and patient advocacy groups to provide advocacy resources and model legislation for use in state advocacy campaigns seeking the removal of sunscreen-related bans at schools and summer camp programs.	Retain, still relevant.
H-440.864	Noise Pollution	Our AMA recognizes noise pollution as a public health hazard, with respect to hearing loss, and supports initiatives to increase awareness of the health risks of loud noise exposure.	Retain, still relevant.
H-440.879	Expedited Partner Therapy (Patient-delivered Partner Therapy): An Update	Our AMA supports the Centers for Disease Control and Prevention's guidance on expedited partner therapy (EPT) that was published in its 2006 white paper, Expedited Partner Therapy in the Management of Sexually Transmitted Diseases.	Retain as amended. Our AMA supports the Centers for Disease Control and Prevention's guidance on expedited partner therapy (EPT) that was published in its ~~2006 white paper, Expedited Partner Therapy in the Management of Sexually Transmitted~~

			~~Diseases~~ Sexually Transmitted Infections (STI) Treatment Guidelines.
H-440.880	Definition of Health	The AMA officially adopts the following definition of health: "Health is a state of physical and mental well-being."	Retain, still relevant. *The Council notes that this definition should include social well-being, but the sunset report is not the appropriate mechanism for this change.*
H-440.897	Noise Induced Hearing Loss In Children And Adolescents	1. Our AMA: (a) encourages public education about the dangers of noise-induced hearing loss especially from toys and electronic devices; and (b) encourages the Consumer Product Safety Commission and other appropriate agencies to study the impact of toys and electronic devices on noise-induced hearing loss among children and adolescents. 2. Our AMA adopts pediatric noise exposure standards recommending that children avoid toys that produce greater than 85 dB of SPL, or greater than 90 dB SPL for more than one hour. 3. Our AMA will work with other stakeholders to ensure toy manufacturers' adherence to pediatric noise exposure standards that children avoid toys that produce 85 dB of SPL, or greater than 90 dB SPL. 4. Our AMA will work with other stakeholders to require that manufacturers label toys with the level of sound produced and/or a warning that sound production exceeds safety standards (85 dB of SPL) and may result in hearing loss.	Retain as amended. 1. Our AMA: (a) encourages public education about the dangers of noise-induced hearing loss especially from toys and electronic devices; and (b) encourages the Consumer Product Safety Commission and other appropriate agencies to study the impact of toys and electronic devices on noise-induced hearing loss among children and adolescents. 2. Our AMA adopts pediatric noise exposure standards recommending that children avoid toys that produce greater than 85 dB of SPL~~, or greater than 90 dB SPL for more than one hour~~. 3. Our AMA will work with other stakeholders to ensure toy manufacturers' adherence to pediatric noise exposure standards that children avoid toys that produce 85 dB of SPL~~, or greater than 90 dB SPL~~. 4. Our AMA will work with other stakeholders to require that manufacturers label toys with the level of sound produced and/or a warning that sound production exceeds safety standards (85 dB of SPL) and may result in hearing loss. *According to the National Institute on Deafness and Other Communication Disorder noises are more likely to damage*

			your hearing if they are: 85 dBA and last a few hours; 100 dBA and last at least 14 minutes; or 110 dBA and last at least 2 minutes. 85 dB is the level set by the National Institute of Occupational Health and Safety (NIOSH) for mandatory hearing protection.
H-440.948	Health Care Workers Infected with Hepatitis B Virus	All health care workers (i.e., any person involved in patient care in a paid capacity or as a volunteer and as a student, resident, trainee, or trained worker) who are at risk of infection with HBV should be fully immunized with HBV vaccine.	Retain as amended to update language with a change in title. Health Care ~~Workers~~ Personnel Infected with Hepatitis B Virus All health care personnel ~~workers~~ (i.e., any person involved in patient care in a paid capacity or as a volunteer and as a student, resident, trainee, or trained worker) who are at risk of infection with HBV should be fully immunized with a HBV vaccine.
H-455.986	Radon in Residential Dwellings and other Buildings	Our AMA (1) supports assuming a leadership role in educating physicians, others of the health care community, and the public concerning the significance of radon levels in residential dwellings and other buildings and the possible health effects of those levels; and (2) encourages the real estate community to increase transparency and disclosure of prior radon testing, and the most recent results of such testing.	Retain as amended. Our AMA (1) supports ~~assuming a leadership role in~~ educating physicians, others ~~of~~ in the health care community, and the public concerning the significance of radon levels in residential dwellings and other buildings and the possible health effects of those levels; and (2) encourages the real estate community to increase transparency and disclosure of prior radon testing, and the most recent results of such testing.
H-455.989	Involvement of Physician Expertise in Non-Military Radiation Emergencies	The AMA encourages physicians to provide expertise on the health aspects of radiation incidents, emergencies and accidents to the public, the media and responsible government agencies.	Retain, still relevant.
H-460.897	Tobacco Use or Exposure as a Variable in Clinical Research	Our AMA urges clinical investigators to carefully consider the need to include an assessment of smoking status, smoking history, and exposure to secondhand smoke in the design of	Retain, still relevant.

		clinical trial protocols and analysis of patient outcomes.	
H-460.929	Expanded Public Education Program in Support of Animal Research	The AMA opposes legislative limits placed on the appropriate and humane use of animals in research.	Retain, still relevant.
H-470.965	Ultimate and Extreme Fighting	Our AMA: (1) opposes ultimate fighting and extreme fighting events; and (2) encourages states which have not banned these events to pass a law doing so.	Retain, still relevant.
H-480.944	Improving Genetic Testing and Counseling Services	Our AMA supports: (1) appropriate utilization of genetic testing, pre- and post-test counseling for patients undergoing genetic testing, and physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) the development and dissemination of guidelines for best practice standards concerning pre- and post-test genetic counseling; and (3) research and open discourse concerning issues in medical genetics, including genetic specialist workforce levels, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic testing and counseling on patient care and outcomes.	Retain, still relevant.
H-480.945	Genome Editing and its Potential Clinical Use	Our AMA (1) encourages continued research into the therapeutic use of genome editing; and (2) urges continued development of consensus international principles, grounded in science and ethics, to determine permissible therapeutic applications of germline genome editing.	Retain, still relevant.
H-485.992	Support for Increased Educational	The AMA encourages independent television stations and network affiliates throughout the United States to	Retain, still relevant.

	Children's Television Programming	broadcast at least one hour per day, during regular viewing hours, of educational programming for children.	
H-495.977	Banning the Sale of Tobacco Products in Pharmacies and Health Care Facilities	Our AMA supports efforts to ban the sale of tobacco products meeting the definition of "tobacco product" under the Family Smoking Prevention and Tobacco Control Act, with the exception of medicinal nicotine products approved by the FDA, where health care is delivered or where prescriptions are filled, including retail outlets housing store-based health clinics.	Retain, still relevant.
H-50.972	Blood Donor Deferral Criteria Revisions	Our AMA will advocate for the elimination of current deferral policy and ask the Food and Drug Administration to develop recommendations for individual risk assessment during the public commentary period.	Rescind. *Current AMA policy "Blood and Tissue Donor Deferral Criteria H-50.973" is more comprehensive.*
H-505.961	Challenging the Pro-Tobacco Actions of the U.S. Chamber of Commerce	1. Our AMA strongly objects to any pro-tobacco efforts by the U.S. Chamber of Commerce and encourages the U.S. Chamber of Commerce to be transparent in all advocacy activity on behalf of tobacco companies. 2. Our AMA urges conscientious companies that are members of the U.S. Chamber of Commerce to call for an end to all pro-tobacco efforts within the organization.	Retain, still relevant. *The original policy was prompted by a multipart NYT investigation into how the U.S. Chamber of Commerce (U.S. Chamber) has helped the tobacco industry fight life-saving policies in more than a dozen countries.*
H-510.988	Supporting Awareness of Stress Disorders in Military Members and Their Families	Our AMA supports efforts to educate physicians and supports treatment and diagnosis of stress disorders in military members, veterans and affected families and continue to focus attention and raise awareness of this condition in partnership with the Department of	Retain, still relevant.

		Defense and the Department of Veterans Affairs.	
H-525.975	Heart Disease in Women	1. Our AMA supports increased awareness and education on preventive measures for heart disease in women and encourages comprehensive care of heart disease in women. 2. Our AMA urges research to address the gaps in knowledge related to coronary pathophysiology and diagnostic, treatment, and interventional strategies for heart disease in women; and to better understand the role of demographic, socioeconomic, and psychological factors in the onset of heart disease in women.	Retain, still relevant.
H-525.976	An Expanded Definition of Women's Health	Our AMA recognizes the term "women's health" as inclusive of all health conditions for which there is evidence that women's risks, presentations, and/or responses to treatments are different from those of men, and encourages that evidence-based information regarding the impact of sex and gender be incorporated into medical practice, research, and training.	Retain as amended to address formatting error. Our AMA recognizes the term "women's health" ~~—~~as inclusive of all health conditions for which there is evidence that women's risks, presentations, and/or responses to treatments are different from those of men, and encourages that evidence-based information regarding the impact of sex and gender be incorporated into medical practice, research, and training.
H-525.991	Inclusion of Women in Clinical Trials	Our AMA: (1) encourages the inclusion of women, including pregnant women when appropriate, in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women alike; (2) supports the National Institutes of Health policy requiring investigators to account for the possible role of sex as a biological variable in vertebrate animal and human studies; and (3) encourages	Retain, still relevant.

		translation of important research results into practice.	
H-60.916	Youth Incarceration in Adult Facilities	1. Our AMA supports, with respect to juveniles (under 18 years of age) detained or incarcerated in any criminal justice facility: (a) early intervention and rehabilitation services, (b) appropriate guidelines for parole, and (c) fairness in the expungement and sealing of records. 2. Our AMA opposes the detention and incarceration of juveniles (under 18 years of age) in adult criminal justice facilities.	Retain as amended. 1. Our AMA supports, with respect to juveniles (under 18 years of age) detained or incarcerated in any ~~criminal justice~~ correctional facility: (a) early intervention and rehabilitation services, (b) appropriate guidelines for parole, and (c) fairness in the expungement and sealing of records. 2. Our AMA opposes the detention and incarceration of juveniles (under 18 years of age) in adult ~~criminal justice~~ correctional facilities. *The term "criminal justice facility" is not commonly used, especially by NCCHC. The appropriate term is "correctional facility." Amendments reflect that change.*
H-60.922	Solitary Confinement of Juveniles in Legal Custody	Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.	Retain as amended to update language and change in title. Title Change: Solitary Confinement of Juveniles in ~~Legal Custody~~ Correctional Facilities Our AMA: (1) opposes the use of solitary confinement in juvenile correctional facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.
H-60.930	Insufficient Sleep in Adolescents	1. Our AMA identifies adolescent insufficient sleep and sleepiness as a public health issue and supports education about sleep health as a	Retain, still relevant.

		standard component of care for adolescent patients. 2. Our AMA: (a) encourages school districts to aim for the start of middle schools and high schools to be no earlier than 8:30 a.m., in order to allow adolescents time for adequate sleep; (b) encourages physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times to accommodate the biologic sleep needs of adolescents; and (c) encourages continued research on the impact of sleep on adolescent health and academic performance.	
H-60.986	Health Status of Detained and Incarcerated Youth	Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care; (2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children	Retain as amended to update language. (2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental health conditions ~~illness~~; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.

		and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior. (3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided. (4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system.	
H-65.974	Gender-Based Violence	Our AMA: (1) opposes inhumane treatment of people of both genders; and (2) encourages the development of programs to educate and alert all cultures to remaining practices of inhumane treatment based on gender and promote recognition of abusive practices and adequate health care for victims thereof.	Retain as amended to update language. Our AMA: (1) opposes inhumane treatment of people of ~~both~~ all genders; and (2) encourages the development of programs to educate and alert all cultures to remaining practices of inhumane treatment based on gender and promote recognition of abusive practices and adequate health care for ~~victims~~ survivors thereof.
H-75.987	Reducing Unintended Pregnancy	Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process; (2) supports reducing unintended pregnancies as a national goal; and (3) supports the	Retain as amended to update language. Our AMA: (1) urges health care professionals to provide care for ~~women~~ patients of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process;

		training of all primary care physicians and relevant allied health professionals in the area of preconception counseling, including the recognition of long-acting reversible contraceptives as efficacious and economical forms of contraception.	
H-75.996	Media Advertising and Public Service Announcements Regarding Contraception and Safe Sexual Practices	The AMA urges the print and broadcast media to permit advertising and public service announcements regarding contraception and safe sexual practices as a matter of public health awareness.	Retain, still relevant.
H-90.967	Support for Persons with Intellectual Disabilities	Our American Medical Association encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.	Retain, still relevant.
H-95.933	Action to Address Illegal Methamphetamine Production	Our AMA supports: (1) the widespread and proper use of the National Precursor Log Exchange (NPLEx) for pseudoephedrine-containing OTC products; (2) the replacement of current pseudoephedrine-containing OTC products with formulations that are resistant to methamphetamine production; and (3) initiatives that focus on prevention and treatment of methamphetamine abuse.	Retain as amended to update language. Our AMA supports: (1) the widespread and proper use of the National Precursor Log Exchange (NPLEx) for pseudoephedrine-containing OTC products; (2) the replacement of current pseudoephedrine-containing OTC products with formulations that are resistant to methamphetamine production; and (3) initiatives that focus on prevention and treatment of methamphetamine misuse and use disorder. ~~abuse~~
H-95.935	Increasing Awareness of Nootropic Use	1. Our AMA: (a) opposes the prescription of controlled substances, including stimulants and wakefulness-promoting agents, for the purpose of cognitive enhancement in otherwise normal, healthy individuals; and (b) discourages the nonmedical use of	Retain, still relevant.

		prescription drugs, including stimulants and wakefulness-promoting agents for cognitive enhancement at all levels of education and in the workplace. 2. Our AMA encourages continued research into the risks and benefits of drugs and other substances for improving function in patients undergoing cognitive decline or who are experiencing cognitive impairment. 3. Our AMA encourages more research into the patterns of use, as well as risks and benefits, of dietary supplements (including herbal remedies) being promoted for cognitive enhancement. 4. Our AMA urges the Federal Trade Commission to examine advertisements for dietary supplements and herbal remedies that claim cognitive enhancement to ensure that they are truthful and not misleading, and are substantiated.	
H-95.942	Safe Disposal of Used Syringes, Needles and Other Sharps in the Community	1. Our AMA recognizes that used sharps in the community pose a public health hazard in diverse ways to workers and to the public. 2. The AMA requests manufacturers of disposable hypodermic needles and syringes to adopt designs to prevent reuse, and to include in the packaging clear directions for their correct disposal. 3. Our AMA continues to support the mission of the Coalition for Safe Community Needle Disposal.	Retain as amended. 1. Our AMA recognizes that used sharps in the community pose a public health hazard in diverse ways to workers and to the public. 2. The AMA requests manufacturers of disposable hypodermic needles and syringes to adopt designs to prevent reuse, and to include in the packaging clear directions for their correct disposal. 3. Our AMA continues to support the mission of SafeNeedleDisposal.org ~~the Coalition for Safe Community Needle Disposal~~. *The Coalition was renamed in 2014 in accordance with new ownership.*

H-95.958	Syringe and Needle Exchange Programs	Our AMA: (1) encourages all communities to establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.	Retain as amended to update language. Our AMA: (1) encourages all communities to establish ~~needle~~ syringe exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for ~~needle~~ syringe exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that people who inject drugs ~~injection drug users~~ can purchase and possess needles and syringes without a prescription and ~~needle~~ syringe exchange program employees are protected from prosecution for disseminating syringes.

REPORT 2 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-26)
Setting Standards for Forensic Toxicology Laboratories Used in Litigation

EXECUTIVE SUMMARY

BACKGROUND. Resolution 212-A-25, referred by the House of Delegates (HOD), asked our American Medical Association (AMA) to pursue legislative or regulatory changes to require: 1. Forensic toxicology laboratories that analyze drugs in bodily fluids to follow the same protocols and obtain equivalent certifications as their clinical chemistry counterparts based in hospitals; 2. CLIA – exempt forensic toxicology laboratories to obtain relevant accreditations and certifications such as CAP Forensic Drug Testing accreditation program (CAP FDT, formerly FUDT or Forensic Urine Drug Testing Accreditation Program]) the American Board of Forensic Toxicology Laboratory Accreditation Program (ABFT LAP), the American Society of Crime Laboratory Directors Laboratory Accreditation Board (ASCLD/LAB) or other related certification program (as their clinical chemistry counterparts in hospitals are required) which are publicly displayed; 3. forensic toxicology laboratories to follow relevant state codes and regulations addressing testing of breath, blood, and urine for alcohol, other drugs, and intoxicating compounds; 4. a Laboratory Director and/or Certifying Scientist who reviews all protocols and laboratory manuals and signs off on each result electronically to be a licensed physician (with proper and current board certification) or a scientist with an appropriate advanced graduate degree and certification; and that results of laboratory proficiency testing and Quality Control Programs be available to the court and its litigants for review to assist in verifying forensic laboratory results.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms “CLIA-exempt toxicology labs”, “forensic labs”, “toxicology labs” AND “litigation”, and “forensic labs AND crime”. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and other applicable organizations were also reviewed for relevant information.

DISCUSSION. Forensic toxicology laboratories play a critical role in medicolegal decision-making, yet unlike CLIA-regulated clinical laboratories, CLIA-exempt forensic labs operate without a unified national oversight system, resulting in fragmented standards, inconsistent accreditation practices, and limited transparency. National scientific reviews have repeatedly documented deficiencies in method validation, quality assurance, independence, and access to underlying laboratory data, as well as instances of laboratory fraud and misconduct.

CONCLUSION. This report reviews the current oversight structure for forensic toxicology laboratories, outlines key differences between clinical and forensic laboratory regulation, and summarizes the extensive scientific literature documenting persistent challenges—such as inconsistent standards, insufficient method validation, limited access to underlying laboratory data, cognitive bias, and cases of laboratory fraud. It further examines the economic and operational pressures facing laboratories and the uneven adoption of accreditation and quality systems. Based on these findings, the recommendations support the development of consistent national baseline standards, a coordinated accreditation framework, increased transparency in laboratory practices, and nationally aligned expectations for scientific qualifications and oversight in CLIA-exempt forensic toxicology laboratories.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-A-26

Subject: Setting Standards for Forensic Toxicology Laboratories Used in Litigation

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee D

Resolution 212-A-25, "Setting Standards for Forensic Toxicology Laboratories Used in Litigation," was referred by the House of Delegates (HOD), and asked the following:

That our American Medical Association pursue legislative or regulatory changes to require:

1. Forensic toxicology laboratories that analyze drugs in bodily fluids to follow the same protocols and obtain equivalent certifications as their clinical chemistry counterparts based in hospitals; and
2. CLIA – exempt forensic toxicology laboratories to obtain relevant accreditations and certifications such as CAP Forensic Drug Testing accreditation program (CAP FDT, formerly FUDT or Forensic Urine Drug Testing Accreditation Program]) the American Board of Forensic Toxicology Laboratory Accreditation Program (ABFT LAP), the American Society of Crime Laboratory Directors Laboratory Accreditation Board (ASCLD/LAB) or other related certification program (as their clinical chemistry counterparts in hospitals are required) which are publicly displayed; and
3. forensic toxicology laboratories to follow relevant state codes and regulations addressing testing of breath, blood, and urine for alcohol, other drugs, and intoxicating compounds; and
4. a Laboratory Director and/or Certifying Scientist who reviews all protocols and laboratory manuals and signs off on each result electronically to be a licensed physician (with proper and current board certification) or a scientist with an appropriate advanced graduate degree and certification; and
5. that results of laboratory proficiency testing and Quality Control Programs be available to the court and its litigants for review to assist in verifying forensic laboratory results.

BACKGROUND

In the United States (U.S.), the type of laboratory accreditation required by a toxicology laboratory depends on the purpose of the laboratory's testing menu: clinical versus forensic. Like all clinical laboratories, clinical toxicology laboratories are subject to direct federal regulatory requirements for Clinical Laboratory Improvement Amendments of 1988 (CLIA) certification, classified as waived, moderate, or high-complexity testing operations.[1] CLIA requirements include on-site inspections and acceptable participation in proficiency testing, which may be met by achieving accreditation from an agency with CLIA-deemed status.[2,3] Forensic toxicology laboratories are CLIA-exempt under federal regulations but nonetheless subject to all applicable state and local regulatory requirements, which typically mandate independent laboratory accreditation.[4] Forensic science performed in toxicology labs has faced increasing scrutiny regarding these labs' methods and reliability.[5,6]

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A multi-year, Congressionally-mandated study released in 2009 by the National Research Council (NRC) was critical of weaknesses in the scientific underpinnings of the forensic disciplines routinely used in the criminal justice system.[6] The NRC outlined a comprehensive series of recommended reforms (see Table 2).[6] Reports have also highlighted concerns regarding the lack of standardization and oversight, the absence of independence of forensic laboratories from law enforcement, bias affecting the results and their interpretation, and the lack of reporting on measurement uncertainty.[6,7] In addition to calls for improvements in forensic science methods, there have been prominent cases of fraud by forensic scientists.[5,8] While toxicology is often perceived as one of the more objective forensic disciplines due to its reliance on analytical chemistry and quantitative measurements, it is not immune to bias, fraud, and error.[5,8,9] However, it is important to note that forensic toxicology laboratories face mounting pressures—including rising case volumes, staffing shortages, limited funding, and expanding testing demands—that contribute to persistent backlogs and hinder their capacity to maintain rigorous scientific practices.[6] These strains are intensified by the need to triage urgent requests, outdated equipment in some jurisdictions, and limited federal investment in toxicology research, leaving many labs without the resources needed for method validation, quality assurance, or modernization.[6]

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms “CLIA-exempt toxicology labs”, “forensic labs”, “toxicology labs” AND “litigation”, and “forensic labs AND crime”. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies and other applicable organizations were also reviewed for relevant information.

DISCUSSION

For the purposes of this report, forensic science refers to the application of scientific or technical practices to the recognition, collection, analysis, and interpretation of evidence for criminal, civil, or regulatory matters.[9] It encompasses a wide range of disciplines with distinct technologies and practices.[9] The National Institute of Justice (NIJ) categorizes these into multiple areas, including toxicology, firearms and toolmarks, questioned documents, trace evidence, controlled substances, DNA and serology screening, fire debris analysis, post-mortem analysis, impression and blood-pattern evidence, crime-scene investigation, medicolegal death investigation, and digital evidence.[10]

Because these disciplines vary widely in methods, error rates, research foundations, and levels of scientific acceptance, forensic science is not a uniform field.[6,7] Some areas rely on laboratory-based analytical techniques (i.e., DNA analysis, toxicology, drug chemistry), while others depend heavily on expert interpretation of observed patterns (i.e., fingerprints, handwriting, toolmarks, bite marks).[7,11] Forensic work is performed by individuals with diverse training backgrounds—from scientists such as chemists and biologists to law-enforcement personnel, crime-scene specialists, forensic pathologists, and laboratory technologists.[12] Importantly, Many forensic techniques are based on practical experience rather than fully validated scientific methods, and therefore may not fully account for the limitations inherent in their underlying methodologies.[6,7]

Forensic science has transformed litigation by introducing objective, empirically grounded evidence that helps courts resolve complex questions with far greater accuracy and confidence.[9] Advances such as DNA analysis have exonerated the innocent and identified perpetrators with unprecedented precision, fundamentally improving fairness and reliability in the justice system.[9] Across disciplines—including toxicology, digital forensics, and pattern evidence—scientific

methods now provide critical insights that strengthen fact-finding, support informed judicial decision-making, and enhance public trust in legal outcomes.[6,9]

What is the difference between clinical and forensic toxicology laboratories?

Both clinical and forensic toxicology laboratories aim to deliver accurate and timely analytical results, but they differ in purpose, end-users, and operational requirements.[13] Clinical laboratories perform rapid physiological testing to guide patient care, while forensic laboratories conduct one-time analyses intended for medicolegal proceedings.[6,14] Consequently, the two types of laboratories differ in how samples are collected and processed, the staffing and funding structures they rely on, and the technologies they employ.[6,14]

All U.S. clinical laboratories are regulated under CLIA, which applies to any facility performing tests on human specimens for diagnosis, treatment, prevention, or health assessment.[1,6,15] CLIA requires certification, biennial inspections, proficiency testing, quality control and quality assurance procedures.[6,15] Enforcement mechanisms include sanctions, certificate suspension or revocation, civil injunctions, fines, and publication of laboratory sanctions. Clinical labs must meet these standards to receive Medicare or Medicaid reimbursement.[1,6,15]

In contrast, toxicology laboratories performing only forensic testing are CLIA-exempt, because they test human specimens for purposes other than medical diagnosis or treatment—such as criminal, civil, workplace, or other medicolegal uses.[6,14] This category includes Substance Abuse and Mental Health Services Administration (SAMHSA)-certified workplace drug-testing laboratories.[16] Since CLIA does not apply, federal accreditation requirements do not govern these forensic laboratories.[16]

Clinical laboratory toxicology testing may still generate evidence with legal consequences, for example, in cases involving pregnant patients, newborns, children, or individuals involved in injury-producing incidents.[17] Unless requested by law enforcement or a court, such testing is treated as medical rather than forensic. Some clinical laboratories also conduct forensic drug testing, and in these circumstances, they are advised to maintain clear policies that separate clinical and forensic workflows, including specimen handling, processing, and documentation, to ensure appropriate regulatory compliance and evidentiary integrity.[17]

OVERSIGHT OF FORENSIC TOXICOLOGY LABS

Federal and State Oversight

Currently, there is no comprehensive federal regulatory system that oversees or governs forensic toxicology laboratories in the U.S.[18] Oversight is fragmented, largely voluntary, and dominated by private accreditation bodies, not federal regulation.[6,18] The only significant federal accreditation requirement applies to DNA labs participating in the Combined DNA Index System , via the DNA Identification Act.[19] Some federal entities operate forensic toxicology laboratories, but these labs follow internal standards and do not regulate state or local forensic toxicology labs.[20] As a result, voluntary accreditation is the closest thing to oversight of forensic toxicology labs.[21]

Given the lack of federal oversight, some states have established oversight bodies, including state forensic science commissions, task forces, oversight and advisory boards, or investigative councils with the goal of improving the field of forensic sciences through oversight and coordination of forensic science resources.[22] Twenty-one states and Washington, D.C. currently have statutorily

created or created by another means, such as through state legislation, forensic science state commissions or oversight bodies; however, all vary considerably with respect to which functions they fulfill (See Figure 1).[22]

Accreditation

Accreditation of toxicology laboratories relies on a multilayered system built around internationally recognized technical standards—primarily International Organization for Standardization (ISO) and the International Electrotechnical Commission (IEC) 17025—supported by national accrediting bodies and supplemented by state requirements that add discipline-specific controls.[23] These mechanisms aim to ensure that laboratories produce scientifically valid, reliable, and defensible results for criminal justice, medicolegal death investigation, and public safety.[23] Accreditation involves external experts who review documentation, perform on-site assessments, evaluate corrective actions, and verify ongoing compliance through surveillance audits.[23]

Two major accrediting bodies— ANSI National Accreditation Board (ANAB) and American Association for Laboratory Accreditation (A2LA)—currently accredit most forensic laboratories.[24,25] ANAB, which absorbed the former American Society of Crime Laboratory Directors (ASCLD/LAB), accredits labs to ISO/IEC 17025 and is the sole accreditor approved by several state forensic commissions.[26] It also evaluates laboratories using the American Board of Forensic Toxicology (ABFT) toxicology checklist, providing dual recognition for ISO/IEC 17025 with toxicology-specific criteria.[24,27] A2LA accredits laboratories under ISO/IEC 17025 for testing and calibration and ISO/IEC 17020 for inspection functions.[25] The College of American Pathologists (CAP), while best known for clinical laboratory accreditation, accredits clinical-toxicology laboratories and those operating in hybrid forensic-clinical environments.[28] It should be noted that there are various players involved in forensic toxicology laboratory practice that include laboratory accrediting bodies, standards-setting groups, professional societies, and oversight organizations (see Table 1).

However, accreditation is not guaranteed of error-free performance. Recent events continue to illustrate that accreditation alone does not consistently prevent fraud, deter misconduct, or ensure reliable scientific practices.[6–8] For example, an Injustice Watch investigation found that the accredited University of Illinois Chicago Analytical Forensic Testing Laboratory produced flawed and misleading THC test results used in cannabis DUI prosecutions across the state, with evidence that methodological problems were concealed for years despite accreditation audits.[6–8] This suggests that confidence in accredited labs may at times be misplaced. Because accreditation is not universally required, many unaccredited forensic laboratories continue operating without any substantial external oversight.

BRIEF SUMMARY OF ISSUES IN FORENSIC SCIENCE IN COURT PROCEEDINGS

Courts act as gatekeepers to ensure expert testimony is based on reliable science.[29,30] In practice, however, many courts admitted forensic toxicology and other forensic results with minimal scrutiny for decades.[5–7,31,32] Appellate analyses have found that judges are often more exacting with expert evidence in civil cases than in criminal cases.[6,33–37] Reports observed this disparity as well, noting appellate courts were "more willing to second-guess…scientific evidence in civil cases than in criminal cases."[6,33–38]

Relatedly, courts historically allowed certain forensic techniques to be presented by experts despite a lack of robust scientific validation.[6,39–41] Prior to the reforms of the last decade, it was not uncommon for a forensic toxicologist to testify about novel or less standard analyses (for instance,

using a new lab-derived method to identify a toxin) without the judge requiring proof of validation.[5–7,42] The consequence, as reports have reiterated, is that some evidence may not have met modern scientific standards of reliability.[6,41,43]

Validation and Research. Multiple studies have repeatedly found that many forensic disciplines rely on tradition and professional judgment rather than rigorous scientific testing.[5–7,40] Two concepts are central to evaluating reliability: foundational validity (whether a method has been empirically shown to work) and validity as applied (whether it was correctly used in a specific case).[7,44,45] Even scientifically sound methods can produce unreliable results without proper validation, consistent application, and clear documentation.[7,40,45,46] Forensic toxicology often uses instruments designed for clinical or research settings, but forensic samples may involve low drug concentrations, degraded materials, or complex mixtures.[7,40,45] Studies emphasize the need for validation that demonstrates repeatability, interlaboratory reproducibility, and known error rates.[6,7,40,45]

Practice Protocols and Standards. The lack of uniform standards across laboratories leads to differing protocols and inconsistent results.[6,31,32] A 2024 National Institute of Standards and Technology (NIST) analysis found that procedures "vary both within and across disciplines," producing variable outcomes that directly affect litigation.[31] For example, one lab may report a substance as present while another—using different thresholds or extraction methods—reports it as negative.[6,7,31] Such inconsistencies can result in different legal outcomes across jurisdictions and contribute to conflicting expert testimony.[6,7,31]

Substances and Technological Gaps. Toxicology laboratories struggle to keep pace with rapidly evolving drug markets, including synthetic opioids, novel psychoactive substances, and adulterants like xylazine.[7,31,47] These trends create significant measurement challenges and often outstrip laboratory method development.[31,47,48] As a result, some substances may go undetected or be mis-quantified, weakening evidentiary reliability in both criminal and civil cases.[7,47,48] Courts require toxicology findings to be valid, reliable, and consistent—standards difficult to achieve without ongoing scientific investment.[7,31,47,49]

Quality Assurance (QA) Programs. Strong quality assurance systems are essential, yet multiple investigations have found serious QA failures in forensic labs.[6,7,50] For example, an audit of the Houston Police Department Crime Lab revealed missing QA programs, insufficient training, poor documentation, analytical errors, and even falsified results.[51–53] Weak QA increases the risk of false positives, false negatives, and contamination, contributing to wrongful convictions; nearly one-quarter of DNA exonerations have involved misapplied forensic science.[6,52–54]

Exculpatory or Contradictory Result Disclosures. Some laboratories have withheld results inconsistent with prosecution theories. For example, a review of the North Carolina State Bureau of Investigation lab found analysts repeatedly omitted confirmatory tests that negated preliminary findings, violating discovery obligations.[7,55] Such nondisclosure can lead to wrongful convictions and undermines the expectation that forensic scientists serve as neutral, objective experts. [7,55–57]

Access to Underlying Data. Even without misconduct, defense teams may struggle to obtain raw data, quality control (QC) logs, or validation records due to proprietary software or restrictive policies.[6,7,58,59] Limited transparency hinders meaningful review of forensic evidence and can mask systemic issues until discovered through litigation or external audits—often years later.[6,7,60]

Cognitive and Contextual Bias. Toxicologists, like other experts, are vulnerable to biases influenced by case context or institutional pressures.[6,61,62] Bias can affect interpretation of marginal

results or QC anomalies.[63,64] Reports have warned of insufficient safeguards against cognitive bias, and few toxicology processes undergo black-box studies to measure examiner error and reliability.[6,7,65,66] These vulnerabilities risk introducing subjectivity into evidence presented as objective.

Overstatement and Over-Interpretation. Experts have historically overstated certainty, implying zero error or drawing unsupported conclusions.[7,67,68] Multiple reports have criticized such overstatement and emphasized that testimony must reflect actual scientific limitations.[6,7,67–69] In toxicology, this includes overstating impairment based on drug levels or failing to provide error rates and probabilities when reporting results.[6,7,67–69] Over-interpretation can mislead courts and juries, compromising fair outcomes.

SYSTEMIC PRESSURES IMPACTING FORENSIC TOXICOLOGY LABS

Forensic toxicology laboratories operate in a system burdened by compounding pressures and economic challenges including persistent backlogs driven by rising case submissions, limited staffing, inadequate funding, and expanding statutory testing requirements.[6,70,71] Studies show that forensic toxicology laboratories routinely process thousands of cases annually, with roughly 20 percent remaining backlogged delays that can prolong incarceration. [6,70,71] As a result, even highly skilled laboratories struggle to keep pace with scientific, operational, and legal expectations, despite their commitment to producing accurate and reliable results.

Law enforcement and prosecutors increasingly demand rapid laboratory results, often before charges are filed and again before trial.[70] At the same time, agencies continue expanding testing requests (i.e., DNA from guns or property crimes), forcing laboratories to triage between urgent new cases and older cold cases, exacerbating workflow bottlenecks.[6,70] DNA analysis—supported by extensive research, strong quality control, and validated statistical models—has become a benchmark for forensic reliability.[6,70,72] Its success highlights the comparative scientific gaps in other disciplines, including toxicology, which receive far less federal investment despite representing the majority of forensic casework.[6,70]

As a result, most forensic disciplines operate with limited research infrastructure, few funding sources, and foundational studies conducted largely within crime laboratories rather than independent academic institutions.[6,7,31,73] This shortage of high-quality research hinders method validation, new tool development, and evidence-based improvements, intensifying pressures on laboratories already operating under substantial resource constraints.[6,7,31,74] Further, accreditation, proficiency testing, and quality assurance programs—while essential to reliability—also impose meaningful financial burdens.[6,74] It should be noted that forensic toxicology labs are not fully supported by a single stable funding system. Instead, they rely on a patchwork of funding sources through a combination of state, county, and municipal appropriations, supplemented by federal grants and fee-for-service revenue for testing performed for law enforcement, courts, medical examiners, and other agencies.[74]

KEY FEDERAL ACTIONS TAKEN TO IMPROVE FORENSIC SCIENCE

Multiple reports have identified systemic deficiencies across forensic science, including fragmented laboratory systems, inconsistent training, limited research funding, and a lack of scientific validation for many commonly used methods.[6,7,31] Recommendations from those reports called for sustained national reform to improve scientific foundations, oversight, and practitioner standards (see Table 2-4).[6,7,31] In response, many national reforms were initiated.[7] These reforms are summarized in Table 4. Collectively, these efforts—national coordination initiatives, standards

development, expanded research funding, and accreditation and certification reforms—represent the most significant progress in the last decade.[75–82] Nonetheless, substantial work remains, particularly in establishing the scientific validity and reliability of many forensic methods still used in courts today.[81]

EXISTING AMA POLICY

The AMA has limited policy on the use of forensic toxicology tests in litigation. AMA Policy H-80.994, "Use of all Appropriate Medical Forensic Techniques in the Criminal Justice System" states that the AMA supports the availability and use of all appropriate medical forensic techniques in the criminal justice system. However, AMA does have policy regarding CLIA-certified labs. For example, AMA Policy H-480.933, "Regulation and Control of Self-Service Labs" states that the AMA will advocate for direct access testing, in which patients may order a diagnostic laboratory test on demand, should only be provided by teams which are physician-led, and performed in facilities that are CLIA-certified. Finally, the Code of Medical Ethics 4.1.4 "Forensic Genetics" states that physicians from whom genetic information is sought for purposes of criminal justice: may ethically carry out DNA analysis on stored tissue samples or release genetic information without the consent of a living or deceased patient (or the patient's authorized surrogate) in response to a warrant or court order; should release only the minimum information necessary for the specific purpose; and should decline to participate in the use of information from a genetic database created exclusively for criminal justice for any purpose other than identification.

CONCLUSION

Forensic toxicology laboratories play a critical role in both civil and criminal litigation, yet the U.S. lacks a unified regulatory framework to ensure their scientific reliability, transparency, and independence.[6,7,79,83] The current system functions largely on voluntary accreditation, variable state oversight, inconsistent methodological standards, and divergent admissibility practices. Although clinical laboratories operate within a comprehensive federal regulatory structure under CLIA, forensic toxicology laboratories remain largely exempt from these requirements.[1,6] This regulatory gap persists despite the scientific complexity and high-stakes consequences associated with toxicology findings in medicolegal settings.[1]

National reviews of forensic science over the past two decades consistently identify the same systemic deficiencies: lack of foundational validation, inadequate quality control systems, limited research infrastructure, vulnerability to cognitive and contextual bias, and insufficient transparency regarding laboratory practices and error rates.[6,7,31,79] Toxicology, though often perceived as an objective, instrument-driven discipline, is not exempt from these shortcomings—particularly when analytical limitations and interpretive errors intersect with the demands of litigation.[5,8] However, forensic toxicology laboratories face mounting pressures—including rising case volumes, staffing shortages, limited funding, and expanding testing demands—that contribute to persistent backlogs and hinder their capacity to maintain rigorous scientific practices.[6] As a result, even highly skilled laboratories struggle to keep pace with scientific, operational, and legal expectations, despite their commitment to producing accurate and reliable results.[6]

This report also highlights the ongoing consequences of fragmentation in forensic laboratory oversight. Inconsistent standards across jurisdictions, gaps in accreditation, and limited access to underlying laboratory data hinder courts' ability to evaluate evidence under modern scientific admissibility standards.[6,7,84] High-profile laboratory fraud cases further underscore the dangers of inadequate auditing, insufficient documentation practices, and the absence of independent oversight.[8,51,52] At the same time, toxicology laboratories face increasing workloads, rapid

proliferation of synthetic and emerging drugs, outdated instrumentation in some jurisdictions, and pressure to produce rapid results—all of which strain their capacity to maintain rigorous scientific practices.[6,70,71] Reports note that the pathway forward must therefore prioritize the core principles of scientific validity, transparency, and accountability.[6,7,31,81] They conclude that by embracing validated methods, standardized practices, and transparent quality systems, forensic toxicology laboratories can better fulfill their essential role in promoting justice, safeguarding due process, and upholding public confidence in the medicolegal system.[6,7,31,81]

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 212-A-25, and the remainder of the report be filed.

1. Our American Medical Association supports national efforts to establish a unified, science-based oversight framework for CLIA-exempt forensic toxicology laboratories, including the development of consistent baseline standards, a coordinated national accreditation structure, enhanced transparency requirements, and complementary oversight expectations for individual forensic toxicology practitioners to address the absence of mandatory accreditation and the current fragmentation of quality systems; and

2. Our American Medical Association encourages greater transparency in forensic toxicology laboratory operations, including publicly accessible information on personnel qualifications, accreditation status and scope, quality assurance practices, method validation documentation, and scientific oversight processes, and the key evidentiary materials needed for judicial evaluation such as raw data, validation records, quality-control logs, and proficiency testing results, to strengthen the reliability, interpretability, and accountability of medicolegal testing. (New HOD Policy)

Fiscal Note: Modest

Figure 1: Map of Forensic Science State Commissions or Oversight Bodies.[22]
States with a Commission include Texas, Oklahoma, Missouri, Illinois (also on the Task Force), Indiana, New York, Rhode Island, and Delaware. States with an Advisory/Oversight Board include Montana, Nebraska, Kansas, Arkansas, Alabama, North Carolina, South Carolina, and Massachusetts. States with a committee include Maryland, Wisconsin, and Arizona. States with a Council include Washington State and Washington, DC. States with a Task Force include Michigan. All other states have no commission.

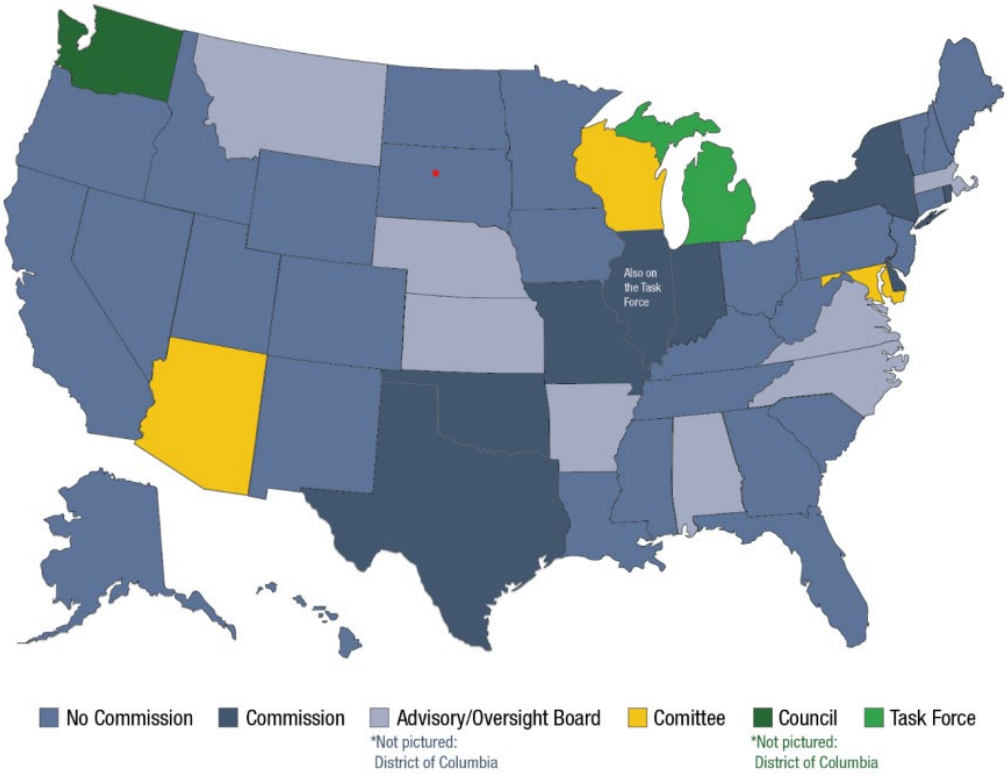

Table 1: Overview of Organizations Involved in Forensic Toxicology Practice and Oversight

Organization	Type	Primary Role in Forensic Toxicology Labs
ANSI National Accreditation Board (ANAB)[26]	Accrediting Body	Accredits forensic laboratories (including toxicology) to ISO/IEC 17025; often integrates ABFT toxicology criteria into scopes.
American Association for Laboratory Accreditation (A2LA)[25]	Accrediting Body	Accredits labs to ISO/IEC 17025 (testing/calibration) and, where applicable, ISO/IEC 17020 (inspection functions).
American Board of Forensic Toxicology (ABFT)[27]	Accrediting Body (Toxicology-Specific) & Individual Certifier	offers laboratory accreditation specifically for forensic toxicology and certification for individual forensic toxicologists.
College of American Pathologists – Forensic Drug Testing (CAP-FDT)[28]	Accrediting Body (Clinical/Forensic Workplace)	Accredits laboratories performing forensic drug testing (often workplace/model programs) and hospital/hybrid settings.
SAMHSA – National Laboratory Certification Program (NLCP)[16]	Federal Certification Program (Workplace Testing)	Certifies laboratories for federal workplace drug testing (urine/oral fluid) under NLCP.
Organization of Scientific Area Committees for Forensic Science (OSAC, NIST)[78]	Standards Development	Develops and promotes science-based forensic standards and posts them to the OSAC registry; informs what accrediting bodies/labs can adopt.
American Society of Crime Laboratory Directors (ASCLD)[26]	Professional Association	Supports lab leadership, quality improvement, and policy; networking/training for lab directors.
American Academy of Forensic Sciences (AAFS)[85]	Professional Society	Multidisciplinary professional home; advances ethics, education, and scientific exchange across forensic disciplines.
Society of Forensic Toxicologists (SOFT)[86]	Professional Society	Discipline-specific community for forensic toxicology; issues practice guidelines, supports training and research.
Consortium of Forensic Science Organizations (CFSO)[87]	Advocacy/Coordination	Represents multiple forensic organizations; advocates for funding, research, and policy reforms.
National Association of Medical Examiners (NAME)[88]	Office Accreditation (Medical Examiner/Coroner)	Accredits medicolegal death investigation offices and sets practice guidelines for me/coroner systems.
International Association of Coroners and Medical Examiners (IACME)[89]	Office Accreditation (Medical Examiner/Coroner)	Accredits coroner/medical examiners' offices; promotes standards for medicolegal death investigation operations.

Table 2: Summary of 13 recommendations made in the 2009 National Research Council report "Strengthening Forensic Science in the United States: A Path Forward.[6]

#	NRC Recommendation	Summary
1	**Create a National Institute of Forensic Science (NIFS)**	Establish an independent federal entity to lead standardization, research, accreditation, and policy.
2	**Standardize terminology and reporting**	Require consistent language, limits statements of certainty, and prevent overstated claims.
3	**Fund research to establish scientific foundations**	Support foundational and applied research in all forensic disciplines, particularly those lacking empirical validation.
4	**Develop and enforce standards for forensic practice**	Create mandatory, science-based standards for methods, training, reporting, and testimony.
5	**Require mandatory accreditation of laboratories**	All forensic laboratories must be accredited and demonstrate adherence to national quality standards.
6	**Require certification of forensic practitioners**	Practitioners should meet competency standards and undergo regular proficiency testing.
7	**Support independence of forensic laboratories**	Remove forensic labs from law-enforcement control to prevent bias and ensure neutrality.
8	**Strengthen quality assurance and quality control**	Implement rigorous QA/QC measures, including blind proficiency testing, to detect errors and misconduct.
9	**Improve forensic science education**	Develop standardized, science-based curricula for universities and training programs.
10	**Create national code of ethics**	Require ethical standards, reporting obligations, and consequences for misconduct or nondisclosure.
11	**Improve medicolegal death investigation systems**	Modernize and professionalize coroner/medical examiner systems nationwide.
12	**Strengthen interoperability and information sharing**	Coordinate forensic data standards and technology across agencies for improved nationwide use.

13	**Increase federal support for forensic science**	Substantially increase sustained funding for research, standards development, and laboratory improvement.

Table 3: Summary of 8 recommendations made in the 2016 Report to the President "Forensic Science in Criminal Courts: Ensuring Scientific Validity."[7]

#	PCAST Recommendation	Summary
1	**Establish clear scientific criteria for "foundational validity"**	Define standards requiring empirical testing, reproducible results, known error rates, and peer-reviewed studies before a forensic method is deemed scientifically valid.
2	**Require empirical "black-box" studies for subjective methods**	Subjective feature-comparison disciplines (e.g., firearms, footwear, bite marks, hair microscopy) must demonstrate accuracy and reliability through properly designed, large-scale black-box studies.
3	**Require empirical testing of "validity as applied"**	Examiners must demonstrate they can reliably apply validated methods in casework through proficiency testing that simulates real forensic conditions.
4	**DOJ/NIST should ensure foundational validity before admitting forensic methods in court**	Federal agencies should evaluate forensic disciplines and clearly identify which methods meet scientific standards for validity. Methods lacking foundational validity should not be presented as reliable evidence.
5	**Develop and fund large-scale independent research programs**	Calls for substantial federal funding (NIJ, NIST, NSF) for foundational and applied research, especially for subjective pattern-comparison methods.
6	**Create national scientific oversight for forensic methods**	Establish bodies (independent of law enforcement) responsible for scientific review, research priorities, and setting validity standards for forensic techniques.
7	**Ensure forensic testimony is scientifically accurate and limited in scope**	Examiners must not overstate conclusions. Testimony should reflect actual empirical support, known error rates, and limitations, avoiding claims of individualization unless scientifically justified.
8	**Strengthen proficiency testing, certification, and accreditation**	Improve examiner certification and lab accreditation by requiring rigorous, scientifically meaningful proficiency tests and transparent reporting of results.

Table 4: Summary of 4 recommendations made in the 2024 National Institute of Standards and Technology report "Strategic Opportunities to Advance Forensic Science in the United States A Path Forward Through Research and Standards."[31]

#	NIST Recommendation	Summary
1	**Accuracy & Reliability of Forensic Methods**	Quantify and establish statistically rigorous measures of accuracy, repeatability, reproducibility, and uncertainty for complex forensic methods
2	**New Methods & Technology Development**	Develop new and improved methods for rapid, robust, and scientifically validated analysis of complex forensic evidence
3	**Science Based Standards & Guidelines**	Develop rigorous, consensus-based documentary standards, conformity assessment schemes, and guidelines across forensic disciplines
4	**Adoption & Implementation of Advances**	Promote widespread adoption of improved methods, standards, technologies, and training across the forensic ecosystem

Table 5: Brief timeline of recent U.S. efforts to strengthen forensic science.[6,7,31,32,78,90]

Date	Event
November 2005	Congress authorizes the NAS to conduct a national study of forensic science.
February 2009	NAS issues *Strengthening Forensic Science in the United States: A Path Forward*, a landmark report proposing 13 major reforms.
February 2013	DOJ and NIST announce formation of NCFS and NIST-administered scientific guidance groups.
Sept 2013 – Apr 2014	OSTP establishes a research strategy working group (DOJ–NIST–NSF).
February 2014	NIST announces creation of OSAC (Organization of Scientific Area Committees) at first NCFS meeting.
February 2014	OSTP issues *Strengthening Forensic Science: A Progress Report*.
September 2016	PCAST releases *Forensic Science in Criminal Courts: Ensuring Scientific Validity of Feature-Comparison Methods*, calling for empirical validation, black-box studies, and federal action.
April 2017	DOJ discontinues NCFS as federal advisory body, ending formal DOJ–NIST joint forensic policy leadership.
2021–2022	Several states (e.g., Texas, New York) incorporate OSAC standards by reference or require labs to consider OSAC Registry standards in accreditation.

2022–2026	NIJ releases and implements its *Forensic Science Strategic Research Plan 2022–2026*, outlining national priorities: foundational research, applied methods, workforce development, and coordinated community practice.
September 2024	NIST issues *Strategic Opportunities to Advance Forensic Science in the United States: A Path Forward Through Research and Standards* (NIST SP-1319).
2025	NIJ publishes *Forensic Science Strategic Research Plan 2022–2026*, reaffirming federal investment priorities and partnerships.
2026 (Ongoing)	NIST continues scientific foundation reviews; NIJ continues research funding aligned with the 2022–2026 plan.

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REPORT 3 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-26)
Public Health Implications of Food Subsidies

EXECUTIVE SUMMARY

BACKGROUND. Policy H-150.915, "Public Health Implications of US Food Subsidies," adopted at the 2025 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD) asked that our AMA study the public health implications of United States food subsidies, focusing on: (1) How these subsidies influence the affordability, availability, and consumption of various food types across different demographics. (2) Potential for restructuring food subsidies to support the production and consumption of more healthful foods, thereby contributing to better health outcomes and reduced healthcare costs related to diet-related diseases. (3) Avenues to advocate for policies that align food subsidies with the nutritional needs and health of the American public, ensuring that all segments of the population benefit from equitable access to healthful, affordable food.

METHODS. English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: "food/farm/agricultural subsidies" AND "public health", "food/farm/agricultural subsidies" AND "diet," and "food/farm/agricultural subsidies" AND "nutrition." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies, such as the United States (U.S.) Department of Agriculture and applicable professional and advocacy organizations were also reviewed for relevant information.

DISCUSSION. Poor diet is a leading cause of morbidity and mortality, both in the U.S. and globally. Poor dietary habits include low intake of fruits, vegetables, and whole grains as well as excessive consumption of added sugars, saturated fats, and sodium, often via ultra-processed foods. Farm subsidies are monetary payments and other types of financial support provided by the federal government to farmers or agribusinesses. Agricultural subsidies in the U.S. primarily support the production of just a few commodity crops, namely corn, soybeans, cotton, and wheat, which are used heavily in ultra-processed foods, biofuels such as ethanol, and food for livestock. Additionally, a majority of agricultural subsidies go to large agrobusinesses and very wealthy individuals/corporations, while many smaller and independent, family-run farms receive comparatively little government assistance. One outcome of our current agricultural subsidy system is that many food groups recommended as part of a healthy diet, such as fresh fruits and vegetables, tend to be more expensive per unit of energy relative to less healthy and highly processed foods that rely on cheap commodity crops such as corn, soybeans, and wheat. There are limited studies that directly evaluate the impact of farm subsidies on health, but current evidence shows that individuals in the highest quartile of subsidized food consumption had higher probabilities of obesity, abdominal adiposity, and dysglycemia compared to the lowest quartile of consumption. Additionally, agricultural practices have direct and indirect impacts on the environment through a myriad of pathways, which in turn impact public health. These primarily include environmental contaminants/pollutants, climate change, and depletion of natural resources and areas.

CONCLUSION. Current farm subsidies support an agricultural system focused on commodity crops, such as corn, which fosters increased consumption of unhealthy foods and negatively impacts health. Agricultural practices incentivized by farm subsidies also have direct and indirect adverse impacts on the environment through a myriad of pathways. Strategies to improve the current system should prioritize the production and consumption of more fruits, vegetables, and whole grains.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-A-26

Subject: Public Health Implications of Food Subsidies

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee D

AMA Policy H-150.915, "Public Health Implications of US Food Subsidies," was adopted at the 2025 Annual Meeting of the American Medical Association (AMA) House of the Delegates (HOD) and states the following:

> Our AMA will study the public health implications of United States food subsidies, focusing on:
> 1. How these subsidies influence the affordability, availability, and consumption of various food types across different demographics.
> 2. Potential for restructuring food subsidies to support the production and consumption of more healthful foods, thereby contributing to better health outcomes and reduced healthcare costs related to diet-related diseases.
> 3. Avenues to advocate for policies that align food subsidies with the nutritional needs and health of the American public, ensuring that all segments of the population benefit from equitable access to healthful, affordable food.

METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: "food/farm/agricultural subsidies" AND "public health", "food/farm/agricultural subsidies" AND "diet," and "food/farm/agricultural subsidies" AND "nutrition." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies, such as the United States (U.S.) Department of Agriculture and applicable professional and advocacy organizations were also reviewed for relevant information.

BACKGROUND

Poor diet is a leading cause of morbidity and mortality, both in the U.S. and globally.[1] In the U.S., it has been estimated that about one million people die annually from diet-related chronic diseases, such as type 2 diabetes, cardiovascular disease, obesity, and some cancers.[2] Globally, noncommunicable diseases account for more than 70 percent of deaths and an estimated 40 percent are attributed to dietary factors.[3] Poor dietary habits include low intake of fruits, vegetables, and whole grains as well as excessive consumption of added sugars, saturated fats, and sodium, often via ultra-processed foods.[3] For example, the average adult in the U.S. only consumes two of the five recommended daily servings of fruits and vegetables while consumption of ultra-processed foods has steadily increased.[4,5] Additionally, according to the Centers for Disease Control and Prevention (CDC), Americans consume too many added sugars as part of their diet, which contributes to a number of health concerns, including excessive weight gain, type 2 diabetes, and

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heart disease.[6] High-fructose corn syrup is particularly concerning, as overall consumption increased by more than 1000 percent between 1970 and 1990 and it has little to no nutritional value as an additive.[7]

The health consequences of poor diet are inequitably distributed, with individuals from marginalized, communities of color and indigenous populations experiencing the worst diet-associated health outcomes.[8–10] Additionally, people with lower incomes generally have lower dietary quality and consume fewer fruits, vegetables and whole grains, but consume more refined grains, added sugars, and saturated fats compared to those with higher incomes.[11] Access to healthy, nutritious, and affordable foods is an important social determinant of health that is influenced by several upstream environmental, community and policy factors.[11] Agricultural policies, and specifically the U.S. Farm Bill and its associated food and farm subsidies, represent a critical component of the federal policy landscape impacting the U.S. food system. In the broadest sense, food subsidies are financial aid provided by the government to producers or consumers to make food more affordable or to support agricultural industries. On the consumer side, food subsidies in the U.S. most notably include the Supplemental Nutrition Assistance Program (SNAP), child nutrition programs, and emergency food assistance.[12] On the producer side, agricultural or farm subsidies (used interchangeably here) are monetary payments and other types of direct financial support provided by the federal government to farmers or agribusinesses.[13] Based on the whereas clauses included in the original resolution (Res 428-A-25) which prompted this report, the primary focus of this report will be on farm subsidies but will also briefly touch on consumer subsidies.

DISCUSSION

Farm subsidies were first institutionalized in the 1930s during the Great Depression and U.S. dust bowl, a time where crop prices had fallen considerably, rural areas were experiencing extreme poverty, and nearly a fifth of the U.S. population was still employed in the farm sector.[14] Food and farm subsidies are generally controlled by the U.S. Farm Bill, an omnibus piece of legislation that is normally reauthorized every five to six years and forms the basis of all or most of the agricultural policy in the U.S. A visual breakdown of how money is distributed under the U.S. Farm Bill as of 2018 can be seen in Figure 1. As of 2018, about three-quarters of the $428 billion allocated to the farm bill was intended for nutrition programs – namely SNAP.[15] Nine percent of funds were earmarked for crop insurance programs, seven percent for commodities, seven percent for conservation programs, and about one percent for miscellaneous programs.[15]

Farm subsidies, in particular the crop insurance program and commodity payments, are intended to help farmers deal with natural disasters and risk management while also incentivizing the development of specific farming practices and conservation efforts.[16] There are five general categories of agricultural subsidies, which include:

1. Direct payments, which are paid at a set rate every year regardless of sales or weather conditions.
2. Counter-cyclical payments are triggered when commodity market prices fall below certain thresholds.
3. A revenue assurance program provides for overall profitability for a given crop.
4. Marketing loans, which offer favorable terms whereby farmers can realize gains through loan deficiency payments and commodity certificates.
5. Disaster payments and crop insurance subsidies; disaster payments allow farmers to recoup large losses due to natural disasters or other ecological factors, and the government also subsidizes crop insurance to further insulate farmers from risk.[17,18]

Agricultural subsidies, historically and currently, primarily support the production of just a few commodity crops, namely corn, soybeans, cotton, and wheat. These crops are used heavily in ultra-processed foods, biofuels such as ethanol, and food for livestock.[19] For example, the U.S is the largest producer of corn in the world but a majority of corn produced is not used for direct human consumption. Corn is a major component of livestock feed, which accounts for nearly 40 percent of total domestic corn use, and another 35 to 40 percent of corn is used for biofuel production (see Figure 2).[20] Corn farms alone received approximately 30.5 percent of all federal farm subsidies, equaling $3.2 billion in 2024.[16] A very small percentage of U.S. farm subsidies are used to produce other fresh fruits and vegetables.

Additionally, a majority of agricultural subsidies go to large agribusinesses and wealthy individuals/corporations, while many smaller and independent, family-run farms receive comparatively little government assistance.[21] For example, one report found that between 2012 to 2020, the top 10 percent of farms (in terms of size), which also tend to be owned and operated by wealthier individuals, received 56.4 percent of all crop insurance subsidies, with the top 5 percent receiving 36.4 percent.[22] A Government Accountability Office report found that a recipient of agricultural subsidies in the form of insurance premium subsidies, whose annual gross income exceeded $900,000, received an average of $1.2 million annually in premium subsidies during the years 2009 to 2013, while participants whose annual gross incomes were less than $900,000 received an average of about $7,480 annually in premium subsidies during the same period.[23] Thus, current agricultural subsidies policy accumulates more benefits to wealthier farmers and does much less to support middle- and lower-income farms.[24] There are also important racial and ethnic disparities in the distribution of farm subsidies. U.S. farm subsidies have historically favored large, white-owned farms and have systematically marginalized African American and Indigenous farmers. These groups have and continue to face barriers in accessing government subsidies, such as United States Department of Agriculture (USDA) denying or delaying loans to African American and Indigenous farmers, resulting in substantial land loss and a widening racial wealth gap in agriculture.[19,25–27]

The downstream impacts of U.S. farm subsidies result from a complex system that is largely driven by the financial incentives provided for large-scale production of commodity crops, which both fuels the widespread availability of unhealthy foods while simultaneously promoting farming practices that contribute to environmental degradation. Figure 3 depicts a high-level conceptual causal pathway diagram that traces how U.S. farm subsidies impact agricultural production decisions which then influence both the consumer food environment and several environmental outcomes, all of which have public health impacts. The following two sections summarize the health and environmental impacts of farm subsidies.

Health Impacts of Farm and Food Subsidies

Public health proponents of reforms to farm subsidies have argued that subsidization of commodity crops, such as corn, fosters increased consumption of ultra-processed foods, sugar-sweetened beverages, and more meat and dairy products than were historically recommended by the U.S. Dietary Guidelines, as unhealthy foods are more widely available and cheaper than healthy alternatives as a result of farm subsidies.[7,28,29] Food groups recommended as part of a healthy diet, such as fresh fruits and vegetables, tend to be more expensive per unit of energy compared to many highly processed goods that rely on cheap commodity crops such as corn, soybeans, and wheat. For example, one study found the purchase price of ultra-processed foods was $0.55 versus $1.45 for unprocessed foods per 100 kcal.[30] This trend is not limited to the U.S. A report by the United Nation's Food and Agriculture Organization found that vegetables were on average nine times more expensive than starchy food staples worldwide.[31] See Figure 4 for a helpful visual comparing the

global prices of different food categories per kilocalorie. Additionally, the availability of vegetables for consumption in the U.S. has been steadily declining for the last two decades while the domestic availability of meat has increased.[32,33]

The 2017 AMA Council on Science and Public Health report on sugar-sweetened beverages referenced a 2016 study that found individuals consuming the highest amounts of foods made from subsidized commodities have a 14 to 41 percent higher probability of cardiometabolic risk as measured by BMI, abdominal adiposity, C-reactive protein, and lipid levels.[34] An updated version of this study published in 2020 using more recently available data found consistent results. Namely, those in the highest quartile of subsidized food consumption had higher probabilities of obesity, abdominal adiposity, and dysglycemia compared to the lowest quartile of consumption, although some associations were significantly weakened from the previous years of study.[35] However, the authors note that U.S. consumption of foods created with subsidized crops has declined since the previously published study, from 56 percent to 51 percent.[35] This finding aligns with steady a decline of corn being used to create high fructose corn syrup in recent years, from around five percent in 2016 to three percent in 2024, which can be attributed to several factors, including changes to consumer preferences and the increasing proportion of corn being used as biofuel.[29,36,37]

Beyond sugar-sweetened beverages, another pathway through which agricultural subsidies impact the American diet is the consumption of meat. In general, grain-fed animals gain weight faster and become fatter than pasture-fed animals with diets lower in grains. Thus, the lower cost of feed makes it faster and cheaper to raise poultry, hogs, and cattle, which translates to relatively low costs for meat products.[7] As of 2025, the USDA estimates that the average American will consume about 60 pounds of beef and about 100 pounds of poultry per capita each year.[33] Americans are among the top per capita meat consumers in the world and are estimated to eat more than 1.5 times the average daily protein requirement due to high meat consumption.[38] Diets with higher meat consumption, particularly of red and processed meat, are correlated with the occurrence of several chronic diseases and acute health conditions, including high cholesterol, heart disease, stroke, obesity, certain cancers, type 2 diabetes, and premature death.[7,38,39] Additionally, there is some evidence that pasture-raised animals are better for consumers' health than heavily grain-fed animals since pasture-raised animals tend to have lower calories and total fat, higher levels of vitamins and good fatty acids, and a healthier balance of omega-3 and omega-6 fats.[40,41]

There are limited studies, beyond the ones referenced above, that quantify the impact of agricultural subsidies in their current form on dietary shifts and their resulting health outcomes. However, several studies have used modeling approaches to estimate impacts from taxes on certain food (e.g., sugar sweetened beverage taxes) and subsidizing the *purchase* of fresh fruit and vegetables. There is an important distinction between subsidies for consumers to purchase fruit and vegetables versus subsidies for farmers to grow produce beyond the few commodity crops mentioned above. The following studies address subsidized purchases, not subsidized production.

A modeling study published in 2020 compared the effects in New Zealand of a 20 percent fruit and vegetable subsidy, taxes on foods high in saturated fat, sugar, and salt, and an 8 percent junk food tax.[42] Models estimated a positive impact on health-adjusted life years per 1000 people for all the policies, ranging from 127 for the junk food tax, 212 for the fruit and vegetable subsidy, to 581 for the sugar tax. The study also reported significant health expenditure savings across the remaining lifespan per capita ranging from nearly $500 to over $2100 depending on the policy.[42] A similar study was done to simulate the effects of these types of food policies in the Australian population. In this study, taxes on sugar, salt, saturated fat, and sugar-sweetened beverages were estimated to have strong net positive health gains. The authors note that while fruit and vegetable purchasing

subsidies are a cost-effective addition to taxes, they do not lead to significant health benefits when modeled as a standalone intervention.[43]

SNAP is the largest food subsidy and nutrition assistance program in the U.S. which provides roughly 40 million low-income Americans with monthly benefits to purchase groceries.[12] SNAP has been demonstrated to reduce health care costs, improve health outcomes, and has been referred to as the nation's most important anti-hunger program.[44] SNAP functions as a prevention strategy against food insecurity, which is associated with several negative health outcomes across the lifespan. SNAP health benefits include better self-reported health, lower risk of heart disease and obesity among adults who had access to SNAP earlier in life, higher likelihood of periodic medical check-ups for infants and children in participating families, and greater medication adherence among older participants.[44]

Environmental Impacts of Farm Subsidies

Agricultural practices have direct and indirect impacts on the environment through a myriad of pathways, which in turn impact public health. Due to the nature of our current agricultural subsidy system and its incentives, the production of just a few commodity crops by large companies represent an overwhelming amount of agricultural production, and these therefore play a large role in the environmental impact of agriculture.[45] There are a few broad categories of environmental impact tied to the food system; these primarily include environmental contaminants/pollutants, climate change, and depletion of natural resources and areas.[45]

Environmental contaminants and pollutants. Agricultural production, at nearly every stage of the process, is associated with the release of environmental contaminants and pollutants, which include nutrients, such as nitrogen and phosphorous; pesticides; pharmaceuticals; pathogens; and air pollutants/gases (e.g., ammonia, methane, and fine particulate matter).[45] What follows is a high level summary of these issues and their impacts to the environment and public health.

Nutrients such as nitrogen, phosphorous, and potassium are essential for plant growth. Fertilizers, both organic and synthetic, are commonly applied during agriculture to provide these nutrients and promote higher crop yields. Organic fertilizers are derived from natural resources, such as decomposed plant matter or animal waste, while synthetic fertilizers are manufactured with blends of chemical compounds, with generally higher concentrations of nutrients.[46] Global agricultural use of synthetic fertilizers has increased fivefold since the 1960s, which increases the amount of nitrogen entering the environment. Synthetic fertilizers greatly increase the nutrient load in soil within a short amount of time, which impacts water quality through runoff. This includes nitrates entering groundwater systems as well as rivers and coastal areas. Nitrogen oxides and nitrous oxide are also released as an air pollutant into the atmosphere.[47] Nitrogen oxides contribute to air pollution, irritate the respiratory system, and can react with other chemicals and water in the atmosphere to create acid rain.[48] Acute, low levels of exposure to nitrous oxides can irritate the eyes, nose, throat, and lungs and cause coughing, shortness of breath, tiredness, and nausea.[49] Nitrogen, phosphorus, and other plant nutrients in surface water contribute to algae blooms that can foul drinking and recreational water systems and sometimes poison pets or wild animals.[50]

Another well-studied environmental concern from agriculture is pesticides. Pesticides are commonly and extensively used in agriculture to increase crop yields and to protect crops from pests that could reduce yield production. Types of pesticides include herbicides, insecticides, fungicides, and rodenticides. An estimated two million tons of pesticides are used globally each year.[51] The move towards large scale monoculture agriculture is associated with an increase in the use of pesticides in order to compensate for each crop's susceptibility to disease from specific

pathogens.[52] The level of toxicity for any pesticide depends on the type of pesticide and its chemical structure, its mode of entry, the dose, and the exposure period.[53]

Due to the relatively low cost of subsidized grains, another outcome from the current industrial agricultural system supported is the growth in Concentrated Animal Feeding Operations (CAFOs). CAFOs are a specific type of large-scale industrial agricultural facility that raises animals, usually at high density, for the consumption of meat, eggs, or milk. CAFOs are reflective of a major shift that has occurred within the U.S. agricultural system in the past 60 years, from one previously characterized by small and medium-sized farms to one that is now dominated by much larger operations that concentrate large numbers of animals in relatively small geographic areas. The primary environmental and public health concern from CAFOs is the large volume of manure produced by animals, which contain potential contaminants and can negatively impact local air quality and water systems.[45] Local communities around CAFOs suffer from lower quality of life due to the intensity of odors, gaseous emissions, insect vectors, and diseases spreading from the farms. There is an important environmental justice aspect to these exposures, as swine CAFOs have been found to be disproportionately located near rural, low-income African American communities in some parts of the country.[54]

As noted above, one major concern with CAFOs is the large amount of animal waste that is produced which then needs proper disposal. This creates another agricultural pollutant: pathogens. Pathogens from animal waste can infect other animals, can infiltrate local water supplies, and can be spread onto other agricultural products through the application of fertilizer in the form of animal waste. Despite vast improvements in food safety over the last century, there are still millions of human foodborne illnesses that occur every year.[55,56] There are also distinct risks from cross-species pathogens from the raising of livestock, particularly with CAFOs, and the potential risk of disease in other animals and humans. One recent example came from the highly pathogenic avian influenza A (H5N1), which spread quickly among poultry farms and then to dairy cows and subsequently infected a small number of farm workers, who were primarily Latino migrant workers.[57,58] One study found that agricultural intensification over the past several decades is associated with an increased risk of zoonotic disease emergence and that the future of zoonotic diseases will be closely linked to the evolution of our agricultural systems.[59]

As a protective measure, many farms will proactively give animals antibiotics to mitigate the risk of infection and quick spread of pathogens in CAFOs. As a result, CAFOs have also been implicated in concerns over growing antibiotic resistance and the contamination of natural systems with pharmaceutical byproducts, as the animals being held in CAFOs often must consume large amounts of antibiotics to survive within the cramped and compact conditions. The growing evidence of the environmental and public health harm caused by CAFOs has resulted in major public health and medical organizations adopting policies on them. Farm workers and nearby communities are exposed to numerous air pollutants from CAFOs, including particulate matter, ammonia, hydrogen sulfide, volatile organic compounds, noxious fumes, microorganisms, and endotoxins.[60–62] In 2019, the American Public Health Association approved the policy, "Precautionary Moratorium on New and Expanding Concentrated Animal Feeding Operations," and in 2023, the AMA adopted policy H-135.908, "Public health implications of industrialized farms," which recognizes CAFOs as a public health hazard.[63,64]

Climate Change. Agriculture is a major contributor to U.S. greenhouse gas (GHG) emissions and accounts for almost 11 percent of U.S. GHG emissions.[19] GHG emissions associated with agriculture are heavily concentrated in a few commodities, namely those having to do with cattle (e.g., beef and dairy), as cows produce substantial methane emissions with their ruminant digestive process, and from nitrous oxide emissions from activities like fertilizer application and storage of

manure.[65,66] In fact, nitrous oxide generated by agriculture is estimated to be responsible for about eight percent of total global anthropogenic GHG warming as of 2021.[47] Subsidies can play an important role in impacting GHG emissions associated with agriculture, as they influence how much is produced, what is produced, where it is produced, and how goods are produced.[67] One modeling study analyzing data from countries that participate in the Organisation for Economic Co-operation and Development (OECD) found that agricultural subsidies had the effect of increasing production of crops and GHG emissions, but results were variable across countries and were highly dependent on the commodities grown and technology used.[65]

While current agricultural practices exacerbate climate change, climate change itself impacts agricultural production through a variety of pathways. For example, climate change threatens food supplies by increasing the risk of flooding and extreme rain events, which can lead to contamination of food and water and destroy crops. At the same time, climate change can lead to increased drought and hotter temperatures in other parts of the country that could damage crops and harm livestock.[19,47] This current dynamic and negatively reinforcing relationship between agriculture and climate change is one that could be used as a powerful lever for positive change and climate change mitigation if subsidies were redesigned to promote more sustainable practices across the industry

Depletion of natural resources and areas. Our current agricultural system contributes to the depletion of natural resources, most importantly, healthy soil, freshwater, and natural areas, which is also tied to biodiversity. The critical importance of soil health for the future of agriculture cannot be understated. While soil erosion is a natural process, it has been identified as one of the most important land degradation processes that occurs with agriculture. Soil creation is a long-term geological process and one that is unable to keep up with current rates of erosion from agriculture. Erosion processes deplete organic matter within the soil and reduce its overall fertility and water holding capacity.[45] This last point creates a positive feedback loop – as soil continues to erode, it has less water holding capacity and therefore is more likely to have increased runoff, which furthers the process of erosion.[45] Agricultural runoff is a leading cause of pollution to rivers and streams, lakes, and impairments to wetlands.[68] While crop yields have generally increased over the past century, this has largely been from technological advances, including more intensive use of fertilizers, which for the time being has been able to mask potential effects of continuous soil degradation.[45] While monoculture farming increases productivity of single crops, it contributes to faster degradation of soil and its fertility, and requires a higher use of fertilizers.[52]

Fresh water is crucial for agriculture. In the U.S., agriculture is a major user of ground and surface water. Irrigation accounts for 47 percent of our nation's total freshwater withdrawals from both sources between 2010 and 2020.[69] Irrigation for cropland is highly geographically dependent, with a large majority of the irrigated land concentrated in western states where the production of many crops requires irrigation due to a more arid climate.[69] Irrigation for agriculture is a primary culprit for groundwater depletion – defined as long-term water-level declines caused by sustained groundwater pumping – which is a major sustainability issue and being felt acutely in the High Plains region of the U.S. (including the Ogallala aquifer) and other aquifers in the Mountain West and Southwest.[70,71] Corn and soybeans, which are also the most subsidized commodity crops in the U.S., are a few of the crops with the highest water consumption demands.[71,72] Reduced groundwater levels are not just a threat to the sustainability of our current food production system, but also have other adverse impacts, including land subsidence, increased costs for users as it becomes increasingly difficult to pump water from underground aquifers, and reduced water quality primarily due to saltwater intrusion.[71]

The intensification of agricultural production over the last 50 years has led to the expansion of agricultural lands into previously natural areas, which has put pressure on existing wild habitats and species and negatively impacted biodiversity.[47] According to the U.S. Environmental Protection Agency, nearly 1.2 billion acres of the nation's 2.3 billion acres are devoted to agriculture.[68] Due to changes in the U.S. Farm Bill in 1990, annual acres planted for both corn and soybeans crops, the two biggest U.S. crops in terms of total production, have increased by 14 and 26 million, respectively, over the last 35 years.[73] Ironically, declines in biodiversity caused by the expansion of agriculture and the increased use of fertilizers and pesticides, has resulted in a reduction in the number and variety of pollinators as well as natural predators for common agricultural pests, which has an overall net negative impact on current agriculture and creates a positive feedback loop in terms of necessitating increased use of synthetic inputs in the future.[74] The loss of biodiversity has also been found to increase the risk of human exposure to both new and established zoonotic pathogens.[75] Agricultural ecosystems have also become less diverse as monoculture farming has expanded, which has the effect of reducing national food security and stability.[76]

Agricultural Sustainability. While sustainability has many facets, agricultural sustainability aims to meet current food and resource needs without compromising the ability of future generations to do the same.[77] Pillars of sustainable agriculture include building healthy soil and preventing erosion, effective water management, minimizing air and water pollution, reducing climate warming emissions, increasing climate resilience, and promoting biodiversity.[77,78] There are many types of sustainable agricultural practices, and they tend to be most effective when used in combination. A few examples include:

- Rotating crops on a regular basis and planting a variety of crops, which creates healthier soil and improves pest control.
- To help reduce soil erosion, planting cover crops during the off-season and perennial plants to maintain living roots in the soil year-round.
- Creating nutrient management and targeted irrigation strategies to help reduce the application of excessive nutrients and water runoff.
- Integrated pest management approaches to help reduce the use of chemical pesticides.
- Agroforestry, a practice in which trees and shrubs are incorporated into fields, which provide shade and shelter for plants and animals that may be beneficial in controlling pests.
- Developing a systems approach to farmland management that treats uncultivated or less intensively cultivated areas as integral to the farm ecosystem.[78]

Improving the Farm Bill for Health

Multiple health and medical organizations agree that a diet aimed at achieving optimal human and planetary health should prioritize a wide variety of whole and minimally processed plant foods including vegetables, fruits, whole grains, and legumes, with moderate inclusion of animal-sources foods, while minimizing red and processed meats, foods high in saturated fat, and ultra-processed foods.[79–81] Aligned with this dietary guidance, several health-related associations have developed recommendations for future reauthorizations of the U.S Farm Bill to improve health and sustainability. Recommendations include increased subsidies for fruit and vegetable production, creating incentives for sustainable agricultural practices, conservation efforts, and more equitable distribution of subsidies that help diversify crops and improve equity within rural farming communities that have been historically excluded from federal agricultural assistance programs.[19,82] For example, the Society for Behavioral Medicine has recommended the inclusion of fruits and vegetables in commodity programs, providing additional insurance subsidies for producing fruits

and vegetables, and developing new insurance programs geared towards fruit and vegetable production.[82] Another recommendation is to establish financial incentives that increase funding for organic agriculture practices and prioritize sustainable agricultural practices in government-funded farm-to-table institution programs.[83] Other important focus areas for increased research and funding would be restorative agriculture, precision farming techniques, improving resilience in the face of climate change, and agricultural practices that take a broader ecological approach that considers its role within the larger environmental context.[19,45]

Many of the other recommendations for the U.S. Farm Bill focus on nutritional assistance and improving accessibility of healthy foods for consumers. A common theme in these recommendations is that the U.S. Farm Bill should incorporate a 'food is medicine' framework.[83] The 'food is medicine' framework is defined as the provision of healthy food resources or interventions in coordination with the healthcare sector to prevent, manage, or treat specific clinical conditions.[84] Specific interventions within a food is medicine approach includes medically tailored meals, produce prescriptions, medically tailored groceries, and nutrition counseling. So, for example, the Society for Behavioral Medicine has recommended that a reauthorization of the Farm Bill should increase the amount of funding available for produce prescription programs through the Gus Schumacher Nutrition Incentive Program.[83]

The other major theme of recommendations from medical professionals and associations includes continued and increased federal spending to support nutritional assistance programs, namely the Women, Infants and Children (WIC) program and SNAP. Continued and increased federal funding to support the WIC program and SNAP benefits is crucial for improving accessibility to healthful and nutritious food and reducing insecurity among low-income individuals and families in the U.S.[19,83,85] Other initiatives aimed at consumers to assist in purchasing healthy foods funded by the U.S. Farm Bill include the Food Insecurity Nutrition Incentive program and the Healthy Food Financing Initiative. The Food Insecurity Nutrition Incentive program is a grant-based program which provides financial incentives for families to purchase healthy foods while the Healthy Food Financing Initiative is designed to stimulate economic development and job creation by supporting farmers and healthy food retailers in low-income communities, underserved communities, and communities of color.[85] There is strong evidence that incentive programs like these can have positive impacts on health. The Community Preventive Services Task Force has recommended fruit and vegetable incentive programs as an important community-based program based on strong evidence of effectiveness in reducing household food insecurity and increasing household fruit and vegetable consumption.[86]

Other recommendations to update the Farm Bill to improve health include increased consumer education and increased nutritional research funding. Specifically, the Academy of Nutrition and Dietetics recommended increased funding for nutrition education programs that empower communities to develop skills to choose healthful diets and reduce the risks of developing chronic disease that are done in conjunction with nutrition assistance or delivery programs.[85] Research funding should also be increased to improve our understanding of the connections between nutrition, our food system, and accessibility by supporting existing initiatives and centers, for example the Agricultural and Food Research Initiative and the Agricultural Research Service's Human Nutrition Research Centers.[85]

Current Regulatory Landscape

The last time the U.S. Farm Bill was officially reauthorized was in 2018. However, there were important components normally considered in the Farm Bill that were included in H.R.1, dubbed by its proponents as the "One Big Beautiful Bill Act." Passed in July 2025 through budget

reconciliation, H.R. 1 covers several major farm bill provisions and funds them through 2031. However, the funds allocated for SNAP in H.R. 1 represent one of the largest cuts to SNAP funding in its history, equaling approximately $187 billion in cuts through 2030. Additionally the bill created new cost-sharing requirements for states and stricter work requirements for recipients.[87] These funding cuts and changes are estimated to reduce or eliminate SNAP benefits for nearly four million Americans.[87]

H.R. 1 also included provisions related to agriculture subsidies for commodities and crop insurance. The bill increased reference prices for covered commodities like wheat, corn, and soybeans and payment limits were increased for commodity programs. Funding for important crop insurance programs were extended and expanded. Affordability issues were partially addressed through expansion of premium assistance for beginning farmers and ranchers and a new pilot program for poultry insurance was created. The bill also made permanent certain 2017 tax provisions beneficial to family farms and ranches, including increased estate tax exemptions and enhanced business expensing options.[88–90]

H.R. 1 also restructured funding that had been obligated for climate-specific conservation funds under the Inflation Reduction Act into a permanent farm bill baseline funding pool.[89] The high level summary from one organization, the National Sustainable Agriculture Coalition, notes that the agricultural provisions in H.R. 1 increased subsidies for large commodity growers (even though they already primarily benefit from that program), included little to no support for smaller farmers and those that grow diversified crops, made drastic cuts to nutrition assistance programs, preserved some conservation efforts, and ultimately delayed the passage of a comprehensive farm bill that is overdue.[88] However, in November 2025, Congress passed an omnibus appropriations package that extended the remaining 2018 Farm Bill provisions until September 30, 2026, including the Conservation Reserve Program, that were left out of H.R. 1.[92]

EXISTING AMA POLICY

AMA has several existing policies that recognize the unhealthy contribution of excessive sugars in the American diet and encourages healthier food option availability.[34,93–95] Additionally, AMA Policy H-150.932, "Reform the U.S. Farm Bill to Improve U.S. Public Health and Food Sustainability," supports the creation of a new advisory board to review and recommend U.S. Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders.[96] Policy D-150.978, "Sustainable Foods," supports practices and policies in medical schools, hospitals, and other health care facilities that model a healthy and ecologically sustainable food system… [and] evidence-based policies and programs to eliminate disparities in healthy food access…such as tax incentive programs, community-level initiatives and federal legislation.[97] Policy D-150.944, "Combating Obesity and Health Disparities," supports the provision of vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs as well as federal subsidies that encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol.[98] Policy H-135.908, "Public health implications of industrialized farms," recognizes CAFOs as a public health hazard.[64] In a related report, CSAPH published a 2017 report on sugar sweetened beverages that included a section on the role of U.S. farm subsidies in the American diet and related health impacts.[34] AMA also has several policies on SNAP that support continued and increased funding for the program to improve diet and nutrition for all Americans.[99,100] Lastly, in March 2024, AMA joined the Medical Society Consortium on Climate and Health and 78 other health care organizations in sending a letter to the House of Representatives Agriculture Committee on the U.S. Farm Bill reauthorization, emphasizing the

importance of supporting a farm bill that prioritizes affordable and nutritious food as well as clean air and water.[101]

CONCLUSION

While U.S. farm subsidies were historically intended to stabilize the agricultural sector and produce enough food for Americans during challenging times, the nature of the U.S. food and agricultural system has changed drastically over the past 100 years. Currently, farm subsidies disproportionately benefit large, corporate farm operations and support an agricultural system focused on commodity crops, such as corn. This system fosters increased or excessive consumption of less healthy foods, such as unhealthy ultraprocessed foods, which are often more widely available and cheaper than healthy alternatives partly because of farm subsidies. Despite improvements in production efficiencies, agricultural practices have direct and indirect impacts on the environment through a myriad of pathways, which in turn impact public health. These include environmental contaminants and pollutants, climate change, and depletion of natural resources and areas. Strategies to improve the current food subsidy system should include increased subsidies for fruit and vegetable production, incentives for sustainable agricultural practices and conservation efforts, and more equitable distribution of subsidies that help diversify crops and improve equity for small producers that have been historically excluded from federal agricultural assistance programs.

RECOMMENDATIONS

The Council on Science and Public Health recommends that AMA Policy H-150.932, "Reform the US Farm Bill to Improve US Public Health and Food Sustainability," be amended by addition and deletion to read as follows and the remainder of the report be filed.

~~Reform the US Farm Bill to Improve US Public Health and~~ Food ~~Sustainability:~~ Our American Medical Association will advocate for ~~supports~~:

- Increased subsidies for the production of a diversity of health-promoting, whole foods, including fruits and vegetables;
- Reallocation of existing subsidies to improve equity for farmers that have been historically excluded from or underfunded by federal agricultural assistance programs;
- Increased funding for financial incentives, programs, and research initiatives to support sustainable agricultural practices, restorative agriculture, conservation efforts, and other projects that improve ecological diversity and resilience to climate change;
- Strengthen funding for U.S. Farm Bill initiatives which incorporate a 'food is medicine' approach and support interventions such as medically tailored meals, produce prescriptions, medically tailored groceries, nutrition counseling, and evidence-based education on preparation of healthy food; and
- the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders. (Modify Current HOD Policy)

Fiscal Note: Minimal

APPENDIX

Figure 1: Breakdown of U.S. Farm Bill allocations as of 2018[15]

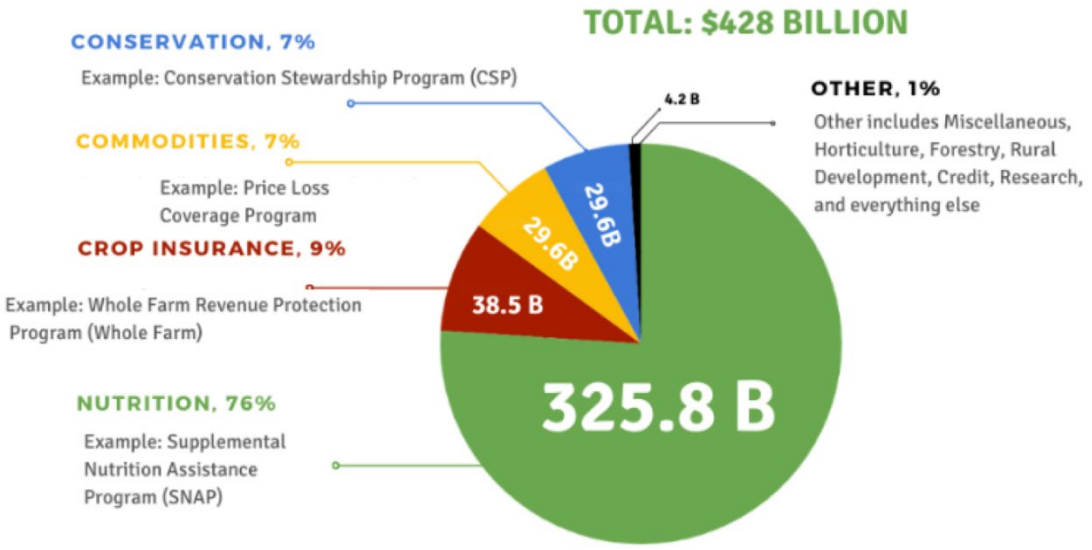


Figure 2: Historial data on U.S. Domestic Corn Use[20]

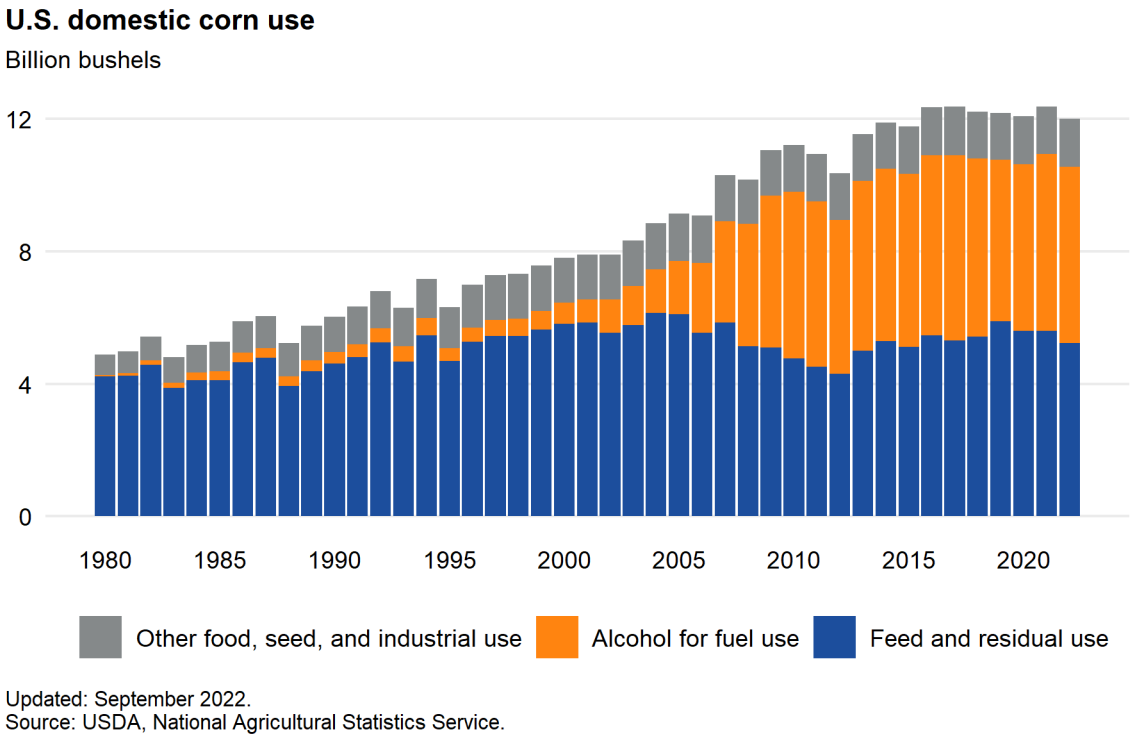


Figure 3: Conceptual pathway diagram illustrating the relationship between U.S. Farm Subsidies and downstream public health impacts

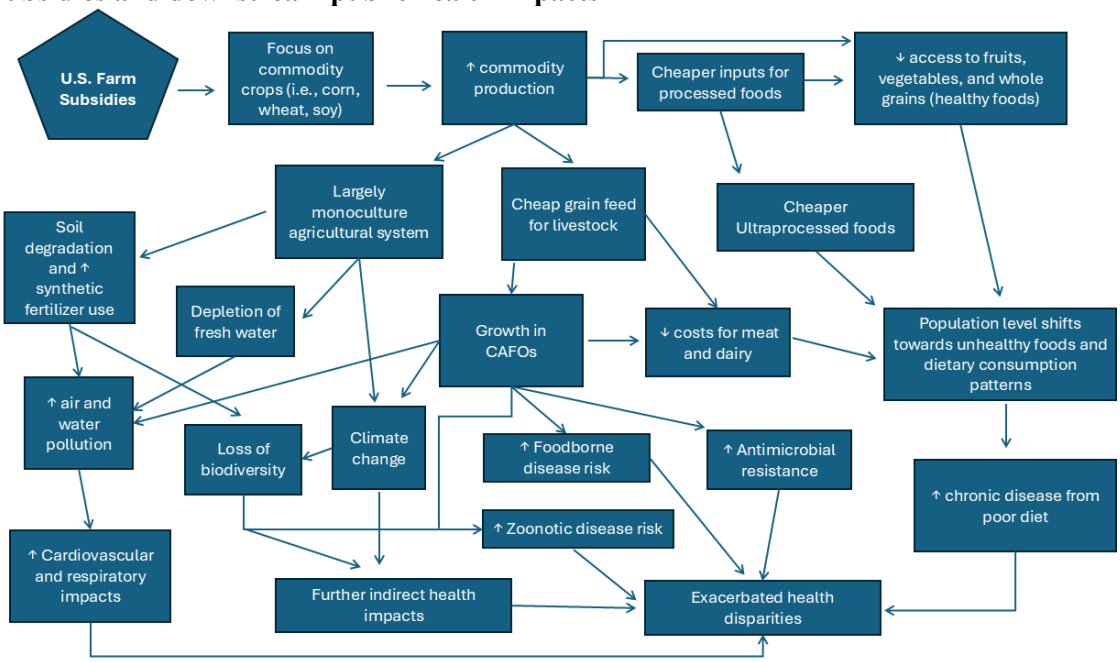
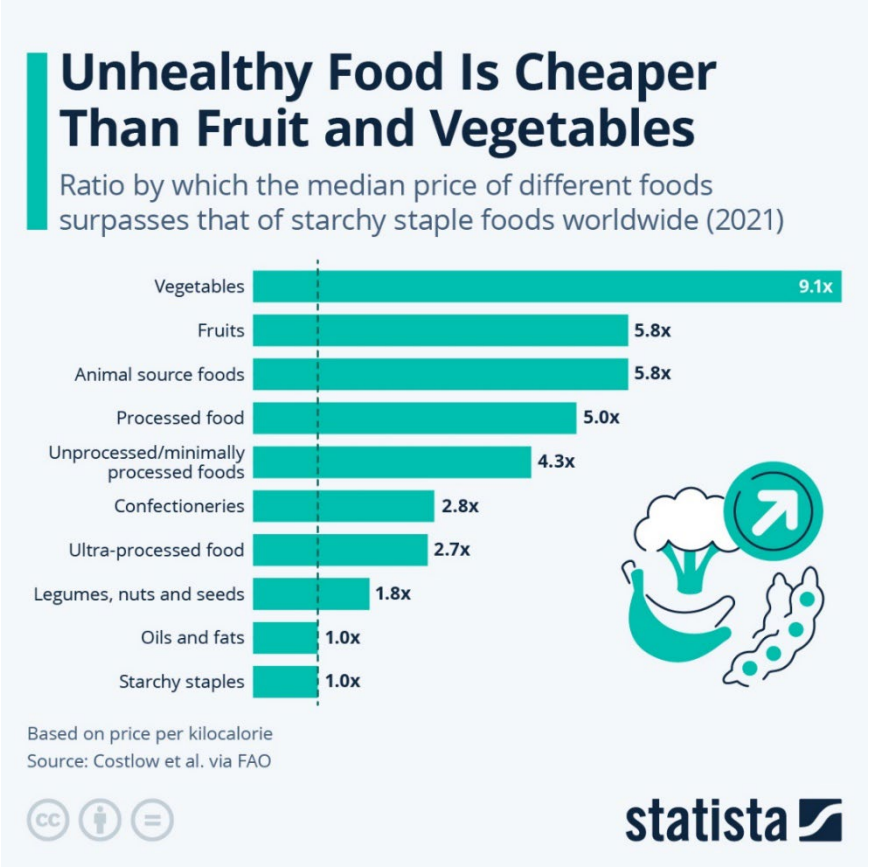


Figure 4: Comparative prices of different food groups based on total kilocalories[31]



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REPORT 4 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-26)
Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers

EXECUTIVE SUMMARY

BACKGROUND: Resolution 404-A-25, "Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers" was referred for study. This report outlines the current state of low-dose computed tomography (LDCT) for lung cancer screening (LCS) including: (1) disease prevalence, screening rates, and high-risk populations, (2) risks, benefits, and evidence of effectiveness and potential future applications (3) barriers to and disparities in screening, and (4) current efforts to promote awareness among physicians and the public.

METHODS: English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: "lung cancer screening" AND "low dose CT." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies and applicable professional and advocacy organizations were also reviewed for relevant information.

DISCUSSION: Lung cancer has significant health and economic impacts in the U.S. It is the second most common cancer, is generally diagnosed at late stages, and consequently comes with a poor prognosis. Moreover, these effects are often more prevalent among marginalized individuals. Fortunately, there is evidence that LDCT has a high sensitivity and specificity for detecting lung cancer. Targeted screening can result in earlier diagnosis and better health outcomes like reduced lung cancer-specific mortality, yet screening rates remain low. Consequently, significant research efforts evaluate the barriers to and disparities in LDCT for LCS as well as efforts to address those barriers and improve LDCT LCS rates. Most of the current interventions to improve LDCT LCS focus on either improving education or addressing structural barriers. There is some evidence that educational interventions, particularly those that use shared decision-making (SDM), improve knowledge and awareness for both patients and clinicians. However, even with increased use of SDM screening, screening rates remain low, suggesting greater emphasis should be put on evaluating ways to improve SDM or on interventions that address structural barriers. Early efforts to bring LDCT to underserved areas (e.g., mobile LDCT and telehealth) or facilitate patient navigation (e.g., centralized programs, scheduling support, reminders, transportation) may improve screening rates but there is a clear need for more research to confirm the evidence of effectiveness, feasibility, and scalability.

CONCLUSION: There have been substantial efforts to better understand low LDCT LCS rates and disparities. Evidence supports continued efforts to improve knowledge and awareness with educational interventions, particularly those that use SDM. However, persistent low screening rates despite SDM efforts demonstrate the need for continued research into optimal methods of implementation as well as into interventions that address logistical and structural barriers. Currently, efforts to bring LDCT to underserved areas or facilitation of patient navigation have shown promise, but ultimately more research is needed to confirm the evidence of effectiveness, feasibility, and scalability.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 4-A-26

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

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee D

Resolution 404-A-25, "Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers," was referred for study and asked the following:

> That our American Medical Association will partner with other professional and public health organizations as well as key stakeholders in cardiology, pulmonology, oncology, and imaging specialties to increase awareness amongst chronic smokers (who would benefit from appropriate lung cancer screening) regarding their risk for both lung cancer and coronary artery disease and encourage their participation in screening programs through a joint public campaign effort; and be it further
>
> That our AMA promote physician education and awareness regarding the value of chest CT in detecting both lung cancer and calcified atherosclerotic plaque and encourage reporting the extent of coronary artery calcification in non-contrast chest CT studies performed as a part of lung cancer screening program.

METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: "lung cancer screening" AND "low dose CT." Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies and applicable professional and advocacy organizations were also reviewed for relevant information.

BACKGROUND

Lung cancer is the second most commonly diagnosed cancer in the United States (U.S.), is generally detected at late stages, and consequently comes with a poor prognosis.[1–3] Early-stage lung cancer is more amenable to treatment and has a better prognosis; however, it requires early detection. Fortunately, there is evidence that low-dose computed tomography (LDCT) has a high sensitivity and specificity for detecting lung cancer.[4–12] Moreover, targeted screening can reduce lung cancer-specific mortality.[5,8–16] Despite the benefits of LDCT for lung cancer screening (LCS), rates of screening remain low.[17–22] This report outlines the current state of LDCT for LCS including: (1) the evidence of effectiveness, (2) disease prevalence, screening rates and high-risk populations, (3) barriers to and disparities in screening, and (4) current efforts to promote awareness among physicians and the public.

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DISCUSSION

The Lung Cancer Landscape: Prevalence, Mortality, Risk Factors, and Disparities

The 2026 Cancer Statistics report estimates 229,410 new cases of lung cancer will be diagnosed in the U.S. this year.[23] Although lung cancer incidence is falling, it remains the leading cause of cancer deaths in U.S. men and women (19 percent and 21 percent respectively).[23,24] Most patients diagnosed with lung cancer present with distant or metastatic disease which is harder to treat and associated with higher mortality.[25,26] Notably the five-year relative survival for lung cancer has improved steadily, rising from 12 percent in 1975–1977, to 15 percent in 1995–1997, and reaching 28 percent in 2015–2021.[23] In addition to loss of life, lung cancer caused approximately $13 billion in lost earnings in the U.S. in 2019, not to mention the $1.35 billion in patient out-of-pocket costs associated with lung cancer treatment and caregiving.[27–29] Furthermore, there is evidence that cancer costs increased by stage with statistically significant and economically meaningful differences between the lower cost of early-stage cancer compared to higher cost late-stage cancer.[30,31] The risk of developing lung cancer is primarily driven by smoking status, with 80 to 90 percent of lung cancer deaths linked to smoking.[3,32,33] Although, smoking prevalence dropped from 42 percent in 1964 to 11 percent in 2023, it continues to be the leading cause of preventable death in the U.S.[23,34] Other risk factors for lung cancer include environmental exposures (e.g., radon, heavy metals, asbestos, arsenic), radiation therapy, other noncancer lung diseases, race/ethnicity, and family history.[3,25]

Factors that impact smoking behaviors have a significant impact on lung cancer rates. Historically, men had higher rates of smoking and a higher incidence of lung cancer. However, recently men have shown steeper reductions in lung cancer incidence compared with women, who took up cigarette smoking later and were slower to quit.[23,27,35] Age also increases lung cancer risk as more than half of diagnoses occur at age 70 years or older, and 83 percent occur at age 65 years or older.[36]

Notably, tobacco marketing efforts have historically targeted members of marginalized and underserved communities, who often have the highest incidence and mortality from the disease.[27,37–41] Native American people have the highest lung cancer mortality at 38.7 per 100,000 compared with 34.5 per 100,000 in White people, who rank second, and 33.1 per 100,000 in Black people, who rank third.[23] There is also evidence that Black males have the highest rates of age-adjusted lung cancer incidence and lung cancer mortality of all U.S. racial/ethnic groups.[39,41] Generally, Black individuals tend to develop lung cancer at an earlier age and are diagnosed at a later stage than white individuals.[39,42,43] Trends are also less favorable for Asian American, Native Hawaiian, and Pacific Islander women, among whom lung cancer incidence is increasing.[27] Evidence also shows that American Indian/Alaskan Natives have the highest overall prevalence of cigarette smoking and the slowest decline in lung cancer incidence of any group.[27,34,39,41,44] Incidence rates declined fastest in Black individuals in the last 10 years.[27] There is also evidence that lung cancer disproportionately affects people of low socioeconomic status, who experience more environmental exposures, higher lung cancer mortality, and have fewer resources and are less able to manage the economic burden of screening and treatment.[27,39,45–47]

Geography also impacts lung cancer rates and mortality. Rural populations experience particularly stark disparities in lung cancer outcomes including higher rates of smoking, a higher incidence of lung cancer, greater late-stage diagnosis, and have higher lung cancer mortality.[48–51] This is particularly true for Black individuals in rural areas when compared than those in urban areas.[39,52] State to state differences are notable and often tied to historical smoking trends.[27]

Recommendations for Lung Cancer Screening with LDCT

LDCT converts a series of x-ray images to create 3-D views of tissues and organs, but uses significantly less radiation than regular CT, thereby decreasing the radiation exposure risk.[53] Lung cancer screening guidelines recommend annual screening with LDCT as it has a moderate net benefit in persons at high risk of lung cancer based on age, total cumulative exposure to tobacco smoke, and years since quitting smoking.[54] However, there is slight variability in the screening guidelines regarding age and pack year cutoffs. (See Table 1).

Benefits of LDCT: screening efficacy, lung cancer mortality, incidental findings, and future applications

There is strong evidence from multiple systematic reviews, meta-analyses, and other studies that LDCT has high sensitivity and specificity to detect lung cancer.[4–12] There is also a well-defined high-risk population that may benefit from LCS with LDCT as LDCT is associated with increased diagnosis of early-stage non-small cell lung cancer (NSCLC), increased rates of resection, and a significant reduction in lung cancer-related mortality.[5,8–15,38,55–62]

Furthermore, some researchers and clinicians suggest that LDCT for LCS may be a useful tool to diagnose other cardiovascular and pulmonary conditions (e.g., ischemic heart disease, COPD, coronary artery disease) in otherwise asymptomatic patients.[63–71] LDCT for LCS provides images of the entire chest and upper abdomen and using a single scan to evaluate multiple conditions could reduce radiation exposure, save time, and decrease costs.[63,64] Cardiovascular conditions like coronary artery calcification (CAC), increase with age, are more common in smokers, and are frequently noted on LCS LDCT scans.[55,65,72,73] Additionally, although the clinical standard for evaluating CVD risk via CAC requires a dedicated ECG-synchronized cardiac CT, it can also be measured on any standard protocol CT image that includes complete imaging of the heart such as routine noncontrast-enhanced, non-ECG gated chest CT (NCT) scans.[63,64]

Current evidence suggests that CAC, particularly general grading of CAC volume, can be feasibly and reliably assessed using visual or software quantitative analysis methods on LDCT for LCS, which is reinforced by the fact that CAC is one of the most common incidental findings on LDCT for LCS.[63,66,69,74–79] Simultaneously, some evidence suggests that using LDCT from LCS to assess CAC and specifically for the assessment of Agatston calcium scoring may be less accurate.[63] There is also substantial variability in CAC detection on LDCT scans for LCS.[55,67,68,80] Therefore, while using LDCT for LCS to evaluate CAD and CAC is possible, there is no consensus regarding specific approaches or guidelines for using LDCT images for CVD risk assessment.[63,64] Technological innovation utilizing machine learning and artificial intelligence has been proposed as a tool to help diagnose CAC on LDCT for LCS; however, more research is needed to determine the evidence of effectiveness and ensure that the tools are both ethical and equitable.[6,64,71,81–83]

While there is potential benefit in using LDCT for LCS to diagnose CAD and CAC and facilitate earlier clinical intervention, it is important to avoid unnecessary workup – particularly when diagnosis does not necessarily engender clinical action or intervention.[66,69,74] For instance, the Nederlands-Leuvens Longkanker Screenings Onderzoek (NELSON) study found that only 1 percent of incidental findings had significant clinical implications and current data is unclear regarding whether knowledge of the presence of CAC on LDCT for LCS translates to intervention or decreased CV mortality.[70,80] Ultimately, further studies are needed to determine whether CAC could enhance uptake and adherence to primary prevention strategies.[67,70]

Finally, it is important to note that most studies of LDCT for LCS lack diversity, thereby limiting generalizability of the findings to marginalized groups who face higher incidence of lung cancer, lower rates of screening and treatment, more advanced lung cancer disease at diagnosis, and higher lung cancer mortality.[38,84–91] Much of the evidence for LDCT comes primarily from two large clinical trials: The National Lung Screening Trial (NLST) and NELSON; however, 89.6 percent of participants in the NLST were White and of higher socioeconomic status than the general population, while the NELSON study did not report these demographic factors.[38,92–95]

Risks of LDCT: overdiagnosis, false positives, psychological harm, etc.

Although there is strong evidence supporting the use of LDCT for LCS in high-risk groups, it is important to acknowledge that potential psychological harms, overdiagnosis, false positives, and consequent unnecessary treatments and health care costs remain challenges.[11,25,96–99] Overdiagnosis occurs when malignancies that would have remained asymptomatic or progressed too slowly to impact a patient's health are discovered, whereas false positives occur when the LDCT picks up an abnormal finding (e.g., cyst, calcification), but follow-up scans or inquiry are unconcerning.[98–101] Both overdiagnosis and false positives are risks associated with LDCT for LCS that can have negative psychological impacts (e.g., increased anxiety and stress), result in unnecessary diagnostic procedures (e.g., follow-up imaging, biopsies), overtreatment (e.g., surgery, radiation, chemotherapy), and extended patient monitoring.[97,100,102] There is some evidence that false-positives and misdiagnosis are more common among people who are screened using LDCT than x-ray.[12,97] However, there is also evidence that false positive and misdiagnosis rates may be reduced by factors like extending the length of post-screening follow-up, assessing the volume doubling time of detected nodules, and implementing Lung Imaging Reporting and Data System (Lung-RADS) criteria.[9,13,100,103,104] Lung-RADS is a classification system to aid interpretation of findings in LDCT for LCS and standardize follow-up and management decisions. There is no consensus on the optimal cut-off size for nodules classified as positive.[9,10]

Psychological harms like anxiety and distress are commonly associated with cancer screening and LDCT for LCS is no different.[105] False-positive results, overdiagnosis and detection of incidental findings in asymptomatic people are risks that can reduce screening participation.[106] Short-term adverse psychological burden has been reported, particularly after a false-positive result, but this was found to diminish over time.[107–109] Multiple reviews have shown that are no long-term psychological harms from screening.[12,104] Also, there are interventions which have been regularly shown to reduce psychosocial burden in cancer screening including patient-centered communication, psychological preparation for different types of outcome, the use of decision aids in shared decision making (SDM), and multi-faceted interventions incorporating emotional support and patient education can reduce negative experiences.[80,105,110,111] Finally, evidence suggests rates of false positives and overdiagnosis of lung cancer using LDCT are not very different from the overdiagnosis rate of breast cancer, and therefore might be reasonable.[62]

General Lung Cancer Screening Rates

Despite the strong evidence that LDCT is effective for LCS, support from professional organizations and advocacy groups, and increased prevalence of LCS programs (e.g., in community, cancer centers, academic health systems, and Veterans Health Care Administration (VHA)), actual rates of screening remain very low.[20,21] A 2024 study found that roughly 12.7 million adults were eligible for lung cancer screening with LDCT, but only 18.3 percent were screened.[22] This mirrors studies from 2017, 2020, and 2022 that found similarly low screening rates at 14.4 percent, 6.5 percent, and 18.1 percent respectively.[17–19] Importantly, there is significant state to state variability in screening rates -- Florida has a 18.1 percent screening rate, whereas Nevada is

much lower at 6.5 percent.[20,27,39,112] In contrast, one study found county-level breast, cervical, and colorectal cancer screening rates ranging from 39.8 to 89.7 percent.[113] Another study found that among those eligible for LCS, breast and colorectal cancer screening rates were nearly 4 times higher than the LCS rates.[114]

Disparities in Lung Cancer Screening

Lung cancer screening is one of the most observed topics in the health disparities literature.[91] Evidence of disparities in LCDT use for LCS are notable among racial and ethnic minoritized adults, uninsured individuals, and residents of specific regions.[21,38,91,115–118] Evidence also suggests that education level, income, and veteran status also impact lung cancer screening decisions and rates.[21,38,91,115–118] A number of studies and systematic reviews found that Black or Hispanic adults had lower rates of LCS than White adults.[38,116–119] However, the most recent data shows that Native American people have some of the lowest screening rates (14 percent) compared to Black people and White people (20 and 18 percent respectively).[23]

Access to LDCT is a major factor in screening rates, and lack of access is especially pronounced in rural and socioeconomically disadvantaged areas and populations.[120–123] One study found that unscreened patients had a lower annual household income than those who were screened.[116] Individuals with low socioeconomic status also face financial, social, and geographic barriers to accessing LCS and essential follow-up.[124] LCS utilization is also influenced by health insurance access, coverage, and costs as evidence by the fact that individuals with higher total out-of-pocket medical costs are less likely to adhere to annual LCS.[125,126] Similarly, there is evidence that a greater proportion of screened non-Hispanic Black respondents were of Medicare age and gaining access to Medicare coverage increased LCS in screening-eligible men.[127,128]

Patterns of LCS accessibility and utilization vary with geographical factors like total distance from screening facilities, regional differences tied to historical trends and priorities, and rural-urban environment differences that impact resources. One study found that five percent of the population eligible for LDCT does not have access to screening facilities within 40 miles and this is markedly higher among individuals living in micropolitan and rural counties at 17.1 percent and 24.5 percent.[123] Evidence generally indicates that a larger percentage of the rural population lacks access; however, some studies found that urban residents were less likely to be screened and less likely to be aware of screening.[38,123,129–132] LDCT screening rates also vary widely across states.[119,133] Several southern states with a high lung-cancer burden (e.g., Mississippi, West Virginia, and Arkansas) have relatively low rates of screening, whereas several northeastern states with lower lung cancer burden (e.g., Massachusetts, Vermont, and New Hampshire) had the some of the highest rates of LDCT screening. Kentucky is a notable exception as they have high lung cancer mortality and also one of the highest screening rates.[119,133]

Finally, veteran status is associated with increased odds of screening.[131] Veterans have higher smoking rates than their nonveteran peers, but there is also evidence that efforts by the Veterans Health Administration (VHA) hospitals have resulted in good LCS uptake with more than half of eligible VHA patients agree to undergo screening at eight demonstrations sites between 2013 and 2015.[134,135] Notably, VA-Partnerships to Increase Access to Lung Screening (VA-PALS), a multidisciplinary collaboration between clinicians and computer scientists within and outside the VA to increase access to high quality LCS, might contribute to higher rates of screening among vets.[131,136]

BARRIERS TO LDCT LCS UTILIZATION AND EFFORTS TO ADDRESS THEM

The most common barriers to utilization of LDCT for LCS are patient and clinician knowledge, perceived high false-positive rate leading to unnecessary procedures, patient refusal, time constraints, lack of transportation, concerns about cost or lack of insurance coverage, and difficulty using the electronic medical record (EMR) to determine and notify clinicians of eligible patients.[137] These barriers fall into two conceptual groups: (1) knowledge, attitudes, and beliefs; and (2) structural barriers to access.

Clinician and patient knowledge, attitudes, and beliefs

There is evidence that physicians support LDCT for LCS and that they believe the benefits outweigh the potential harms for high-risk patients.[138] Yet evidence also suggests that physicians' lack of knowledge about eligibility, screening guidelines, and CMS insurance coverage is an obstacle to referral of LDCT.[38,88,116,138–146] Several studies illustrate the mistaken belief among physicians that the USPSTF recommends screening with chest x-ray.[139,140,142] There is also evidence that many clinicians struggle to accurately identify all CMS eligibility criteria or correctly state the current guidelines.[21,137,138,147] One study found that the majority of physicians were unsure whether Medicare/Medicaid covered LDCT LCS, despite the fact that CMS had already issued their coverage determination.[138] This is concerning since a majority of physicians in that study also reported that they would recommend LDCT screening for high-risk patients if cost were not an issue.[138]

There is also evidence that clinicians' perceived patient barriers (e.g., lack of awareness, stress, anxiety, cost, and lack of insurance coverage) and concern about the potential for false positives are significant obstacles to lung cancer screening referrals.[138,140–144,147,148] Clinician knowledge levels may also be impacted by setting. One study found that academic-based clinicians achieved similar knowledge scores to community-based clinicians, both of which were significantly higher than the knowledge scores of health care professionals in safety net-based settings.[137] Similarly, another study found that almost all physicians reported that a computed tomography machine was available at a facility within 20 minutes of their practice, but nearly half were unsure of whether LDCT screening was offered at those facilities.[138] Finally, controlling for clinician characteristics (hospital affiliation, specialty, title, employment) and CMS eligibility provider knowledge scores, a higher provider knowledge score was associated with a higher likelihood of ordering a LDCT scan.[137]

Lack of knowledge or awareness about LDCT for LCS is also commonly reported by patients.[149–153] Multiple studies found that most eligible smokers had little or no knowledge about lung cancer screening and had never had a health care professional recommend it to them.[38,144,152,154,155] This is important as lack of knowledge can contribute to feelings of fear, fatalism, and stigma, which are also reported by patients as barriers to utilizing LDCT for LCS.[144,152,153,155–157] Findings from one review show that screening attendance is affected by fear of both diagnosis and screening procedure.[158] Similarly, one study found that the primary barrier to returning for subsequent annual screenings was receiving a negative or false-positive screening result.[151] Moreover, a generational history of discrimination and mistrust contributes to perceptions of stigma and challenges with patient–clinician communication.[39] As a result, underrepresented racial/ethnic populations and individuals with low socioeconomic status exhibit greater feelings of fatalism, nihilism, and futility associated with medical intervention, which may reduce pursuit of lung cancer screening.[155–157,159] Furthermore, there is some evidence of differences in total knowledge scores associated with race, with White participants having slightly higher total knowledge about screening when compared to Black participants.[148] In a separate study, Latinx patients were more likely to believe that lung cancer can be prevented, were less worried about developing lung cancer, and had a greater

willingness to be screened when educated about screening when compared with non-Latinx patients.[160]

Intervention to improve knowledge and awareness: Education, public awareness, and shared-decision-making

There is some evidence that educational efforts can increase both clinician and patient knowledge and awareness.[112,161–164] Some studies have demonstrated that group based learning, targeted education programs, and educational lectures can increase clinician knowledge about LCS, improve their ability to identify eligible patients, and increase referrals to LDCT; however, most interventions to increase LDCT LSC rates have targeted patient education with SDM.[112,161,162,164] This is likely because SDM counseling is required for reimbursement and recommended by federal agencies and national specialty societies to help patients in making informed decisions about LCS.[165,166]

There is significant variability in studies of and approaches to SDM for LCS; however, evidence from multiple reviews and studies demonstrate that decision aids, tools, and processes for SDM improve patient knowledge, reduce decisional conflict and regret, show acceptability to patients and clinicians, and increase LCS uptake and adherence.[96,110,167–172] Moreover, when effectively tailored to populations at higher risk for lung cancer, SDM can further promote health equity.[172,173] At the same time screening rates remain low and many clinicians cite major barriers to utilizing SDM, including time constraints, competing clinical demands and priorities, limited awareness about LCS guidelines, lack of skilled training in SDM, and insufficient resources to implement SDM.[164,174–176] One study found that clinicians were concerned about the feasibility of integrating yet another recommendation into routine practice, let alone the capacity to provide the high-volume, high-quality lung cancer screening and treatment centers required to support screening programs.[140] There are also concerns that SDM conversations are often too brief, prioritize exchanging information over patient preferences, focus on benefits over harms, and lack sufficient use of decision aids.[176,177] This underscores the need to both explore alternative methods of SDM which can minimize hands-on clinician time and expand beyond a sole focus on education interventions to incorporate multilevel targets when designing LCS interventions.[110,164]

Proposed approaches include integrating SDM and telehealth for LCS, prediction-augmented SDM tools, developing adaptable SDM training programs, developing novel SDM decision aids and tools, and establishing key SDM process and training quality measures.[172,178] For example, one study found that conducting SDM over the telephone could be a way to address logistical barriers, improve patient knowledge, and reduce fatalistic beliefs and distrust in the medical system.[179] Implementation should consider feasibility and that delivery should include patient-facing print, web, in-person, and video options.[96] Moreover SDM content and presentation methods should be developed collaboratively with screening-eligible adults.[180]

Structural Barriers: Time Constraints, Insurance Coverage, and Electronic Health Records (EHR)

Even when patients and clinicians are well informed about the risks and benefits of LDCT there are several structural barriers that may prevent them from pursuing or accessing LDCT. For instance, the EHR can be a useful tool to cue physicians to patients who are eligible for LDCT; however, that requires that the EHR contains detailed and accurate smoking history calculation and age.[21] Eligible individuals may be missed if they do not have a clinical encounter or if the EHR fails to capture and retain accurate cumulative pack-year calculations.[181] For example, one cross-sectional study found that imprecise smoking history data in the EHR resulted in identifying only 30 percent of potentially LCS eligible study respondents when searching for screen-eligible beneficiaries for

LCS.[182] Reliance on EHRs for referrals is complicated by the patchwork nature of the current health care system in the U.S. and by the underuse of health care services and cancer screening among people who smoke.[183,184]

Many physicians also referenced patient barriers like insurance coverage and cost as rational for why they did not bring up or recommend LDCT for LCS with the patients who might be eligible.[140] One study found that the most reported barriers to ordering screening included prior authorization requirements, lack of insurance coverage, and coverage denials.[175] Since 2015, LCS with LDCT has been covered under Medicaid; however, to qualify for reimbursement several criteria, including SDM counseling, must be met. This creates two interconnected barriers. First, the SDM requirement has been interpreted by some to be a time-consuming barrier to uptake.[179,185] Second, individual state-based decision-making rules and rejection of Medicaid expansion have limited access to LCS using LDCT, and in some cases, continues to leave eligible LCS candidates without a route to screening.[19,39,186,187] There is evidence that screening implementation is higher among individuals with insurance compared with uninsured subjects.[188] Yet, underrepresented racial/ethnic populations are more likely to be uninsured or ineligible because of foreign-born nativity or citizenship status.[39] More than half of those who qualify for lung cancer screening on the basis of USPSTF recommendations are estimated to have Medicaid or be uninsured.[146]

Structural barriers like lack of transportation, cost of screening, and time constraints (e.g., inability to get time off of work, inability to find child care, and other pressing issues) also limit access or a patient's reported willingness and/or ability to pursue LDCT for LCS.[144,149–152,158] For example, one study found decreased intention to screen when patients were required to pay for the test.[157]

Structural Interventions: Mobile LDCT, digital interventions, and patient navigation

Logistical barriers to access are some of the most reported by patients, particularly by marginalized individuals who often have higher rates of lung cancer and worse lung cancer mortality. The two primary approaches that have been used to address logistical barriers are those that either focus on bringing LDCT to underserved areas (e.g., mobile LDCT and telehealth) or on facilitating patient navigation (e.g., scheduling support, reminders, transportation).

For instance, mobile screening services might offer a potential solution to narrow healthcare disparities for marginalized populations.[125,189] There are some studies that show that mobile LDCT LCS platforms can lead to higher rates of LCS and early lung cancer detection, particularly in underserved populations. However, more research is needed to confirm the evidence and determine scalability.[190] Similarly, digital interventions, particularly decision aids and telehealth, have shown promise in improving knowledge and the quality of decision-making around LCS, but there are very few studies and the effects are small.[191] Ultimately, further research is needed to determine the evidence of effectiveness, feasibility, and scalability of mobile LDCT, digital decision aids, and telehealth interventions.

There is also evidence that centralized programs are more effective regarding screening rates, adherence to guidelines, and follow-up care, than decentralized programs.[192–195] However, centralized programs require considerably more investment and resources.[178,196] There is also substantial variation in practices utilized across centralized LCS program models, including the specific structures and practices that enhance LCS quality and effectiveness, which has not been sufficiently explored.[119,192,193,195,196] Often centralized programs employ processes that improve screening among underserved populations, including clinical reminders to identify eligible patients, providing educational materials, addressing barriers to accessing care such as insurance coverage and transportation, and patient navigation.[196,197] There is also some evidence that patient navigation

practices, including scheduling support, reminders, and transportation may improve LCS uptake and adherence, particularly in vulnerable populations.[198–201] Furthermore, the few interventions addressing social determinants of health in LCS have favorably resulted in increased screening rates.[202] While more evidence is still needed, it is likely that effective, equitable screening requires addressing barriers along several steps of the LCS continuum.[195,203]

CURRENT AMA POLICY

AMA Policy, H-185.936 "Lung Cancer Screening to be Considered Standard Care" addresses LDCT for LCS. It highlights the importance of insurance coverage, improving access, and the need to promote education and awareness about LDCT for LCS to patients and clinicians.

CONCLUSION

Lung cancer has significant health and economic impacts in the U.S., particularly since it is often diagnosed late when prognosis is poor.[1–3] Moreover, these effects are often more prevalent among marginalized individuals. However, there is strong evidence that LDCT LCS can result in earlier diagnosis and better health outcomes as well as emerging evidence of the potential to use LDCT for LCS to diagnosis CAC.[4–12] Despite the benefits of LDCT for LCS, rates remain low.[17–22] Most of the current interventions to improve LDCT LCS focus on either: (1) improving education or (2) addressing structural barriers. There is some evidence that education improves knowledge and awareness for both patients and clinicians, particularly through SDM. However, even with increased use of SDM, screening rates remain low, suggesting greater emphasis should be put on evaluating ways to improve SDM or on interventions that address structural barriers. Early efforts to bring LDCT to underserved areas (e.g., mobile LDCT and telehealth) or to facilitate patient navigation (e.g., scheduling support, reminders, transportation) are promising but there is a clear need for more research to confirm the evidence of effectiveness, feasibility, and scalability.

RECOMMENDATIONS

Your Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 404-A-25 and the remainder of the report be filed.

That Policy H-185.936 "Lung Cancer Screening to be Considered Standard Care," be amended by addition to read as follows:

1. Our American Medical Association recommends that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit.
2. Our AMA will empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States.
3. Our AMA will work with interested national medical specialty societies and state medical associations to urge the Centers for Medicare & Medicaid Services and state Medicaid programs to increase access to low-dose CT screening for Medicaid patients at high risk for lung cancer by including it as a covered benefit, without cost-sharing or prior authorization requirements, and increasing funding for research and education to improve awareness and utilization of the screening among eligible enrollees.
4. Our AMA, in conjunction with other interested national specialty societies of expertise (e.g., ACP, AAFP, ACR), will create and share educational resources and training to help

physicians efficiently discuss and document low-dose computed tomography (LDCT) lung cancer screening during shared decision-making visits for high-risk populations.

5. Our AMA will promote physician education and awareness regarding the value of low-dose CT in detecting lung cancer, and will encourage education, technological innovation, and continued research around the detection of coronary artery calcification on low-dose CT performed as a part of a lung cancer screening program.
6. Our AMA will support efforts by key stakeholders in cardiology, pulmonology, oncology, and imaging specialties to research interventions to improve access to and utilization of lung cancer screening with low-dose CT scans in high-risk patients.

(Modify Current HOD Policy)

Fiscal note: Minimal

APPENDIX

Table 1. Lung Cancer Screening Guidelines

Organization (Year)	**Age**	**Pack years**	**Other**
American Academy of Thoracic Surgeons (2012)[204]	55-79	30	Currently smoke or quit <15 years ago
US Preventive Services Task Force – B Recommendation (2021)[166]	50-80	20	Currently smoke or quit <15 years ago
American Academy of Family Physicians (2021)[205]	50-80	20	Currently smoke or quit <15 years ago
American Cancer Society (2023)[206]	50-80	20	Currently smoke or previously smoked
American College of Chest Physicians (2021)[207]*	55-77	30	Currently smoke or quit <15 years ago
American College of Chest Physicians (2021)[207]**	50-80	20	Currently smoke or quit <15 years ago
National Comprehensive Cancer Network (2024)[208]	50 ≥	20	History of smoking
Medicare & Medicaid Coverage[186]	50-77	20	Currently smoke or quit <15 years ago

*Offered with a strong recommendation
**Offered with a weak recommendation

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 5-A-26

Subject: Removing Artificial Turf in Schools, Parks, and Public Places

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee D

Resolution 408-A-25, "Removing Artificial Turf in Schools, Parks and Public Places," was referred for study and asked the following:

> That our American Medical Association (AMA) recommend replacing artificial turf with natural, drought-tolerant and hardiness zone appropriate turfgrass in parks, sports fields and lawns when it is to be replaced; and be it further
>
> That our AMA support natural, drought-tolerant and hardiness zone appropriate turfgrass as the preferred choice on sports fields or lawns, in all public and private schools and colleges, as well as in city parks.

This report provides a summary of the available evidence on the positive and negative health impacts of artificial turf fields, the current landscape of legislative activity to limit artificial turf, and available evidence for disproportionate impacts on specific populations.

METHODS

English language reports were selected from searches of PubMed and Google Scholar databases using the search terms: "artificial turf" AND "health impacts", "artificial turf" AND "injury," and "artificial turf" AND "accessibility." Legal websites, such as LexisNexis, and Google were utilized to search for state and local legislation on artificial turf. Search terms included "[State name] ban or regulations on artificial turf" and "cities or counties in [State name] that have bans or regulations on artificial turf". Additional articles and sources were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies, such as the U.S. Environmental Protection Agency, and applicable professional and advocacy organizations were reviewed for relevant information.

BACKGROUND

Artificial turf is made by heating plastic resin (generally polyethylene and polypropylene) so it can be reshaped into a yarn-like substance to produce grass-like threads that sit on several layers that provide cushioning. Artificial turf was first introduced in the 1960s and was originally intended to provide cushioned recreational surfaces for urban schools that did not have natural grass play areas or found them difficult to maintain.[1] Artificial turf has gone through several technological phases since then. First generation artificial turf, commonly known as AstroTurf, gained notoriety when it was installed in the Houston Astrodome in 1966.[1] AstroTurf was composed of short, stiff nylon fibers layered over a compacted soil base, sometimes with a closed-cell foam cushion added beneath the carpet.

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AstroTurf had significant technical limitations, aesthetic shortcomings, and was criticized for its abrasive textures, resulting in concerns about injuries. The second generation of artificial turf was developed in the late 1970s and included a shock-absorbing pad beneath the first-generation carpet with longer fibers compared to the first-generation turf. Additionally, in this evolution of artificial turf, infill materials were added, such as silica sand, which filled the spaces between the turf fibers, allowing them to stand upright. While the introduction of infill materials improved shock absorption, it caused painful abrasion injuries.[1,2]

For the current, or third generation, of artificial or synthetic turf, introduced in the late 1990s, the composition of artificial threads changed from polypropylene to polyethylene which increased the fiber length and decreased the risk of skin abrasion.[1] The artificial grass sits on several layers, including an infill layer made of rubber (generally recycled tire crumb), coconut fibers, cork, nutshells and sand, a backing layer to which the blades are sewn, a drainage layer, and sometimes additional padding layers.[2] Technological advances within the last five years in artificial turf aim to address existing issues with heat retention, environmental concerns, and injury risk, with the development of environmentally friendly materials, improved drainage, recyclability, and antimicrobial treatments, but these are very recent advances and most installations of artificial turf are using third generation synthetic turf as described above.[1,2]

Since its introduction in the 1960s, the use of artificial turf across the country has grown, with nearly 19,000 turf fields currently estimated to be in use across North America.[3] Proponents of artificial turf argue that it can be used in all weather conditions, it provides multi-use opportunities, that it can save water, reduce the need for toxic pesticides and fertilizers, uses recycled materials (i.e., rubber tires), and is less expensive.[4] Despite these purported advantages, many communities are concerned about the potential health impacts of artificial turf, leading some cities to ban them or reject installation of new fields.[5] The following summarizes the known health risks and environmental concerns of artificial turf versus natural turf as well as an overview of legislative activity on this subject. For easy reference, a comparison table summarizing the advantages and disadvantages between artificial turf and natural turf grass is provided in Table 1.

DISCUSSION

Environmental Health Concerns

Many chemicals found in synthetic turf fields have known health risks, including benzene, arsenic, volatile organic compounds, phthalates, and per- and polyfluoroalkyl substances (PFAS). A 2016 Environmental Protection Agency (EPA) literature review on recycled tire crumb used in artificial turf identified 350 unique chemical compounds, some of which have known adverse health impacts.[6] This EPA report stated that studies had not shown an elevated health risk from playing on artificial turf fields but acknowledged study limitations that did not allow for a comprehensive evaluation.[6] A 2024 follow-up report by the EPA, Centers for Disease Control and Prevention (CDC), and the Agency for Toxic Substances and Disease Registry (ATSDR) included pre- and post-activity biomonitoring data on polycyclic aromatic hydrocarbon (PAH) concentrations in approximately 160 study participants. PAHs represent a group of chemicals naturally found in fossil fuel-based products.[7] The 2024 EPA/CDC/ATSDR study did not report any significant differences in PAH concentrations based on turf type (i.e., synthetic versus natural).[7] This indicates that while there may be chemicals present in the artificial turf, that does not necessarily equate to increased exposure risk for users of artificial turf fields. However, beyond point of contact exposure, artificial turf has the potential to pollute local water systems, such as groundwater and nearby streams and water bodies.[3,8,9]

Artificial turf is also of concern as plastics break down into smaller pieces called microplastics. Microplastics are pieces of plastic that range in size but are less than 5 millimeters.[10] Microplastics have been found throughout the human body, including a recent finding of microplastics in the olfactory bulb of the brain.[11,12] While research on the health impacts of microplastics themselves in our body is still nascent, recent research found a four-fold increase in the risk of poor cardiovascular outcomes in patients with microplastics present in their carotid artery plaque.[13] Microplastics can also be viewed as "trojan horses" as they carry with them a complex array of chemicals which separate from the plastic and spread throughout our bodies via the circulatory system.[14] While health and safety information are lacking for most chemicals in plastic, at least four major categories of chemicals found in plastics have been more extensively studied in terms of health impacts. These include phthalates, bisphenols, PFAS, and flame-retardant additives.[15] The effects of these chemical additives are known to affect nearly every organ system in the body of people of all ages, but particularly young children.[16] More detailed information on the health and environmental impacts of plastics and microplastics can be found in the AMA Council on Science and Public Health Report, *Plastic Pollution Reduction*, adopted at the AMA House of Delegates 2025 Interim meeting.[17]

In comparison, the primary environmental concerns for natural turf fields include exposure to and environmental contamination from pesticides and water usage. Pesticide pollution negatively impacts water, soil, and the surrounding environment and has negative health impacts, particularly for workers regularly exposed via occupational applications (e.g., groundskeepers, landscapers, and farm workers).[18] Depending on the frequency and level of exposure, pesticides can result in both acute and long-term health consequences, including cancer, neurological disorders, and endocrine disruptions.[19] Pesticide exposure can also increase the incidence of respiratory issues and neurodegenerative diseases.[19] However, agricultural uses account for nearly 90 percent of total pesticide applications in the U.S. and thus the contribution of pesticides from use on recreational fields likely constitutes a relatively small portion of human and environmental exposure.[20]

In terms of water usage, natural grass turf is water-intensive and depending on the size of the field and local climate, may require substantial water resources per year. On the other hand, natural grass helps reduce runoff and mitigate flooding as it both stores water and slows down groundwater infiltration, although fields can flood with heavy rainfall.[18] Flooding has been demonstrated to be a challenge for artificial turf fields as well, sometimes requiring intensive repairs or total replacement after a flood event.[3] In a risk-benefit analysis of natural grass versus artificial turf, it was noted that the creation of the plastic used in artificial turf is so water intensive and because artificial turf may require water to cool it during hot weather, the purported water savings over the course of its useful life might be overstated.[2] Natural grass fields also offer several environmental benefits, including reducing surface temperatures, supporting biodiversity (depending on pesticide usage), reducing soil erosion, and acting as a carbon sink.[18]

Another important environmental consideration in the debate between artificial and natural turf is the disposal of artificial turf at the end of its useful life. One factor that proponents of third generation artificial turf market is that the infill uses recycled rubber tire crumb.[4] There are many challenges with disposing of rubber tire crumb, including that it contains a range of metals, semivolatile organic compounds, volatile organic compounds and bacteria that can leach into surrounding soil and water, contaminating local ecosystems.[21] Additionally, large concentrations of rubber tires in landfills pose a fire hazard as they are highly flammable and create toxic smoke when burned.[21] However, while artificial turf has been positively marketed as a way to help with the issue of rubber tire waste, the turf itself has a limited lifespan and poses its own waste management challenges. Artificial turf has an average life span of eight to ten years and disposal of turf is difficult, as it cannot be easily recycled.[22] Communities have struggled to find ways to

dispose of it, as in some cases municipal collection systems will not accept it and existing methods create additional environmental challenges.[2,22]

Heat-related Illness

In addition to the chemical exposure risk, artificial turf fields also retain more heat than natural grass as the synthetic materials absorb solar energy, creating localized 'heat islands.'[23] Artificial turf fields have been documented to reach temperatures between 160- 200 degrees Fahrenheit on warm, sunny days (over 90 degrees).[23] These extreme temperatures increase the risk of skin burns (first to third degree) and heat-related illness, such as heat stress, heat exhaustion, and heat stroke. These issues are increasingly of concern with warmer temperatures caused by climate change and have important implications for urban climate resilience. For example, the average number of heat waves experienced by U.S urban areas has increased from two per year in the 1960s to six per year in the 2010s.[24] Higher temperatures have resulted in higher rates of heat-related illness, particularly for young athletes; the prevalence of heat illnesses and heat-related deaths occurring in organized sports has increased among high school athletes.[18]

Injury Risk

Many different factors influence the risk of sports injury, including the type of activity, level of competition, weather conditions, individual characteristics, and playing surface. Even among synthetic turf fields, there is a range of turf surfaces and there have been changes to synthetic turf products over time, which make attribution of risk challenging. In terms of comparing lower extremity injury risk between natural and synthetic turf fields, a systematic review found similar overall injury rates in a majority of articles evaluating newer synthetic turf fields, but football players, particularly those at high levels of competition, were more likely to sustain a knee injury on artificial turf than on natural grass.[25] Another systematic review comparing injury rates between female and male soccer players on artificial turf versus natural turf found female soccer players had a significantly higher risk of anterior cruciate ligament injuries on artificial turf compared to natural turf.[26] Concerns over increased risk of knee injuries led the National Football League Players Association to call for the elimination of artificial turf fields in 2023.[27]

Other common injuries for competitive contact sports include head injuries and concussions. A systematic review on comparative risk of these types of injuries based on the type of playing field found rate ratios for head injury and concussion were less on artificial turf compared to natural grass fields, though the analysis was based on limited publications.[28] In subgroup analyses by sport type, effects were significant among rugby and American football but not significant for soccer.[28] These mixed findings indicate that the potential risk of sport injuries on artificial turf versus natural turf is complicated by many factors, including the type of sport, the type of injury studied, and the age (and likely maintenance) of the fields.

User Preferences and Recreational Opportunities

Anecdotally, artificial turf fields are believed to promote more physical activity as they provide consistent, year-around, and needed recreational fields to meet the needs of many competing community interests. Additionally, media accounts of local decision-making processes regarding the installation of turf fields reflect a high demand for recreational playing fields in communities with high levels of youth and adult sports leagues, hence why the durability and year-round ability to play on artificial turf fields is a compelling advantage for these communities.[3] However, research among a broad array of park users, including athletes, have demonstrated an overall preference for natural turf fields over artificial turf, with respondents to surveys on the issue indicating

environmental, aesthetic, heat, and perceived injury risk concerns associated with artificial turf in comparison to natural turf.[29–31]

Equity considerations

While underserved urban areas may have a lack of greenspace available for recreational uses, installing artificial turf in these same areas may inadvertently increase the urban heat island effect. Urban heat islands are a phenomenon where urban areas experience significantly warmer temperatures as compared to surrounding suburban and rural areas, due to a lack of greenspace, a higher proportion of concrete and asphalt surfaces, and radiative heating from buildings and cars.[32] Urban heat islands disproportionally impact communities that have been historically marginalized, especially Black communities, due to historical discriminatory practices like redlining and racialized zoning.[33] Urban heat islands can be exacerbated by artificial turf fields as they also retain and radiate heat.[2,23] Thus, installing artificial turf in communities that already are at greater risk of heat-related illnesses from exposure to urban heat may exacerbate existing inequities.

During testimony at the reference committee hearing on Resolution 408-A-25, delegates raised the question of whether the removal of artificial turf fields would have negative repercussions for users and athletes with disabilities, in particular those who use wheelchairs. There was no peer-reviewed evidence on differences in accessibility for users with disabilities between artificial turf and natural turf fields. While it is assumed artificial turf can provide good accessibility for those using wheelchairs due to its relatively smooth and even surface, it is critical that it meet the Americans with Disabilities Act requirements, be well installed, and consistently maintained to improve accessibility for all users.[34]

LEGISLATION

A few states have passed legislation that bans or restricts the installation of artificial turf and many of them are explicitly focused on banning artificial turf that contains PFAS chemicals. Colorado, for example, beginning January 1, 2026, bans the installation of artificial turf "that contains intentionally added PFAS chemicals" though it does not prohibit maintaining existing artificial turf that is installed before January 1, 2026.[35] Similarly, as of July 1, 2024, Vermont banned manufacturers from selling or distributing artificial turfs that have PFAS intentionally added or entered the product from the manufacturing or processing of the product that the manufacturer knew or should have been aware about.[36] As of January 1, 2025, Minnesota prohibited PFAS in a variety of products.[37] While artificial turf is not explicitly mentioned in that state statute, the Minnesota Pollution Control Agency noted that artificial turf falls under one of the explicitly mentioned categories.[38] Nevada has required "nonfunctional turf" to be removed before December 31, 2026.[39] Beginning January 1, 2029, artificial turf that contains intentionally added PFAS is not allowed to be sold in Rhode Island.[40] Maryland has required the Department of the Environment, in collaboration with several other groups and representatives, to conduct a study on the synthetic turf industry and report its findings to committees within the General Assembly by July 1, 2026.[41] Based on that report and the Department's findings, regulations and restrictions on artificial turf may be adopted.

In the absence of state-wide regulations, some cities have passed ordinances or rules regulating artificial turf.[42–45] Regulations can include a complete ban on the installation of new artificial turf, a ban on artificial turf in only some areas or lot types, requiring existing artificial turf to be replaced with natural grass by a certain year or once repairs cost a certain amount, or be a temporary ban. Temporary bans, typically referred to as moratoriums, often act as a pause on the installation of artificial turf so the community can further study the effects and possible alternatives to artificial

turf. An example of this was a proposed in Maine, but it was not enacted.[46] In locations without legislative activity, municipalities are educating residents about potential health risks. For example, the Board of Health in Amherst town, Massachusetts created advisements related to the health risks of artificial turf and hosted webinars about the issue even though they have no law or ordinance regulating the use or installation of artificial turf.[47,48] Table 2 highlights the types of regulations related to artificial turf, but this should not be considered a comprehensive list.

EXISTING AMA POLICY

AMA does not have existing policy on artificial turf but does have policy on the health harms of microplastics, supporting the use of ecologically sustainable products, as well as several policies on a few chemical additives common in artificial turf, including PFAS, and phthalates.[49–52] Additionally, AMA policy supports the creation and maintenance of existing public land and outdoor spaces for recreation and policy that aims to reduce the risk of concussion and other injuries in youth sports.[53,54]

CONCLUSION

While artificial turf has the potential to provide more reliable and consistent recreational fields for year-round activities, there are risks and disadvantages that communities should consider prior to its installation. These disadvantages include high costs of installation, increased human and environmental exposure to a wide array of chemicals, heat absorption and increased risk of heat-related illnesses for users during the summer, injury risks, and disposal challenges at the end of its useful life. While artificial turf may ease mobility constraints compared to natural grass, true accessibility remains broader in scope.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 408-A-25, and the remainder of the report be filed.

1. The American Medical Association (AMA) recommends well maintained, natural, drought-tolerant and hardiness zone appropriate turfgrass, with the use of integrated pest management to reduce potential chemical exposures, as the preferred choice on sports fields or lawns, in public and private schools and colleges, as well as in city parks.

2. Our AMA recommends municipalities conduct comprehensive risk-benefit analyses when deciding whether to replace natural turfgrass with artificial turf (or vice versa) to best meet the needs and concerns of their communities, including those with accessibility concerns.

3. The AMA encourages more research to address evidence gaps on the potential health risks of artificial turf fields. In particular, more research is needed on the release of chemicals from artificial turf, the level of exposure to turf users, and potential health impacts, as well as the differences in risk from heat-related illnesses and physical injuries on artificial turf versus natural turf.

(New HOD Policy)

Fiscal note: Minimal

Table 1. Natural Grass Fields vs. Synthetic Turf - A Summary of Advantages and Disadvantages

Natural Grass	Artificial Turf
Environmental impacts	
Advantages • Climate benefits. Natural grass contributes to carbon sequestration, reduces stormwater surface runoff, and helps maintain a healthier ecosystem by supplying oxygen, filtering stormwater, and absorbing heat. • No waste. Natural grass fields do not have an end of life and, therefore, do not create waste that must be recycled or disposed of. **Disadvantages** • Chemical Exposures. Natural grass athletic fields often require the use of pesticides to ensure playability. • Water Dependency. Natural grass athletic fields require consistent irrigation, particularly in drier climates.	**Advantages** • Water Conservation. Although water is used occasionally for cooling and cleaning synthetic turf, limited evidence is available for quantifying the amount of water used for these purposes. **Disadvantages** • Chemical Exposures. Synthetic turf fields can contain chemicals that may be harmful to human health and the environment. Chemicals can leach from the synthetic components of the turf into local water systems and research shows that some synthetic turf fields contain microplastics and potentially toxic chemicals, such as PFAS chemicals. • Waste. Currently, recyclability of the components of synthetic turf fields at the end of their usable life (~8 to 10 years) is questionable both due to limited information provided by companies that supply and maintain synthetic turf fields and because the complex construction of synthetic turf makes it challenging and costly to recycle. • Drainage. Synthetic turf does not pull water out of soil and release it into the air nor does it filter pollution to protect water quality of nearby waterways like natural grass can.
Maintenance and Costs	
Maintenance. Keeping natural grass up to the highest playing standards requires more consistent upkeep compared to a synthetic turf field. Natural grass requires regular mowing, watering, fertilizing, and pest control, which requires labor and incurs costs. This is especially true in climates that are not conducive to growing and maintaining grass. **Cost-Efficiency for Installation and Renovation**. The installation and renovation	**Maintenance.** Synthetic turf fields typically require less maintenance than natural grass fields as it does not require mowing, watering or fertilizing. Thus, required labor and maintenance costs are typically lower for synthetic turf fields. **Initial Cost.** The initial cost of installing synthetic turf can be relatively high, with costs varying depending on the type and quality of turf chosen. The replacement cost of synthetic turf can also be high.

cost of natural grass is typically lower than that of synthetic turf.	
Accessibility and Playability	
Advantages • Potential for Less Injuries. There are some studies that show that natural grass is a safer playing surface with fewer injuries to players compared to synthetic turf fields, however studies are inconclusive and limited. • Cooler Surface. Natural grass remains cooler than synthetic turf during hot weather, reducing the risk of heat-related injuries and making it more comfortable for athletes. **Disadvantages** • The overuse of a natural grass field can result in uneven and damaged playing surfaces, affecting the quality of gameplay and increasing the risk of injuries to players. Further, rainfall or moisture on natural grass fields can create a slick surface. • Weather Dependency. Use of natural grass fields can be heavily influenced by weather conditions. Fields are typically closed for use due to rain or extreme weather, which can disrupt scheduled events. Fields often cannot be used for several days after a big rainfall because use can significantly damage wet fields. • Limited Hours. Often, natural grass fields are not available for play during winter months because the field needs to "rest." In addition, hours of use must be limited throughout the rest of the year to maintain fields in playable condition.	**Advantages** • Year-Round and Consistent Usage. Synthetic turf fields are typically available for use year-round except when the ground is frozen. Additionally, turf provides more predictable play for athletes such as consistent player footing. • Durability/More Hours of Play. Synthetic turf can withstand heavy use and is less susceptible to wear and tear compared to natural grass. Fields are not susceptible to bald spots or other damage from overuse like natural grass fields, allowing for longer hours of play on synthetic turf field. However, more use can reduce its useful life. • Limited space: Synthetic turf fields are useful in environments with limited recreational fields as they can be used consistently throughout the year. • Permanent Marking. Field lines and markings for multiple sports can be permanently inlaid on synthetic turf fields, eliminating the need for continual re-striping with paint required for natural grass fields. **Disadvantages** • Potentially More Injuries. While more research is needed, data from several studies show that injuries are more prevalent for athletes on synthetic turf compared with natural grass. An increased risk of "turf burn" also increases players' susceptibility to antibiotic-resistant staph infections (i.e., MRSA). • Heat Issues. Synthetic turf can reach significantly greater temperatures than natural grass under the same weather conditions, which can increase the risk of heat-related illnesses for players, create

	uncomfortable play conditions, and result in skin burns if direct contact is made. • Limited Lifespan. Synthetic turf has a lifespan of typically eight to ten years. Lifespan can be impacted by local climate, maintenance, and use. • Movement of Infill. Synthetic turf infill requires proper depth and weight or it can move throughout the seasons, causing bulges and wrinkles in the surface that can be a hazard to players.

Table 2. Examples of artificial turf legislative/regulatory actions

California	A handful of cities in California have banned artificial turf and added restrictions on existing ones. In 2024, Millbrae prohibited the installation of synthetic grass and artificial turf.[43] Additionally, if existing synthetic grass or artificial turf is damaged or destroyed to a prescribed level, it must be replaced with "water-efficient natural landscaping." Similarly, San Marino recently banned installation of synthetic grass and artificial turf in most cases.[55] Exceptions are that the ban does not apply to facilities that are owned and used by schools and rear yards of residences under 100 square feet. Any existing artificial turf or synthetic grass that is damaged to the extent of 35 percent of its replacement cost must be removed and replaced with water-efficient natural landscaping. Additionally, all existing artificial turf, synthetic grass, artificial plants or artificial vegetation must be removed no later than October 31, 2030.
Connecticut	Westport has banned the creation of any new or replacement of playing fields using synthetic infill material (means ambient and cryogenic crumb rubber, coated crumb rubber, ethylene propylene diene monomer granules, and recycled footwear).[56]
Louisiana	In the historic districts of Louisiana, many preservation commissions have prohibited synthetic turf in front yards and have issued removal orders and fines for homeowners that have installed artificial turf without permission.[57]
Massachusetts	In 2022, Boston's mayor directed that no new artificial turfs are to be installed in the city of Boston.[42] Some other cities, such as Wayland and Concord, have passed a temporary ban on installing new artificial turf.[58,59]
New Jersey	The city of Belmar has a list of districts and locations where artificial turf is banned and has requirements that locations must meet before being allowed to install artificial turf.[60] This does not apply to designated sports fields on public property where the installation of artificial turf has been approved by the Borough's Governing Body.
Texas	Murphy city has banned homeowners from installing synthetic turf if it is visible from the street. However, if artificial turf was installed before August 1, 2014, it is not affected by this ban as it was grandfathered in.[44]
Utah	In Salt Lake City, artificial turf is not allowed in "areas that require landscaping" and any artificial turf that was installed before March 5, 2024

	must be removed by September 18, 2025. Previously, as early as 1995, Salt Lake City banned artificial turf in other specific areas.[45]

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REPORT 6 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-26)
Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities

EXECUTIVE SUMMARY

BACKGROUND. Resolution 421-A-25 was referred by the American Medical Association (AMA) House of Delegates (HOD). The resolution asked that our AMA seek a study and report back providing recommendations at the federal level to reduce the adverse impact of air and noise pollution in disproportionately impacted and vulnerable communities from aviation. The resolution included specific recommendations for areas to study.

METHODS. English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: “aviation” AND “air pollution”, “aviation” AND “noise pollution,” and “aviation” AND “health equity.” Additional articles and relevant reports were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies, such as the Federal Aviation Administration (FAA) and United States (U.S.) Environmental Protection Agency (EPA), and websites for airport administration authorities were also reviewed for relevant information, particularly regarding current mitigation strategies utilized to reduce the adverse impacts of air and noise pollution form aviation.

DISCUSSION. Communities near airports and aviation corridors often face higher pollution exposure, compounded risks, and fewer resources for mitigation and therefore, aviation-related air and noise pollution contributes disproportionately to poor health outcomes in these communities. Evidence shows that aviation emissions contribute to adverse health outcomes, including respiratory and cardiovascular diseases, cognitive impairment, and cancer, while associated noise pollution increases risks for sleep disruption, mental health issues, and cardiovascular conditions. Despite technological advances and existing mitigation strategies, disparities in exposure persist, especially among low-income and minority neighborhoods near airports.

Both the EPA and the FAA play important roles in setting and enforcing standards around air and noise pollution from aircraft. The International Civil Aviation Organization, a United Nations agency serves as the global forum on issues related to international civil aviation. Aside from baseline federal standards, noise and air pollution management in the U.S. is largely dependent on the policies and regulations of local airports and municipalities. For example, airports develop their own noise compatibility programs to meet FAA requirements, which include land use strategies, operational procedures, and sometimes flight curfews. In general, as air pollution standards are set at the federal level, local airport policies and regulations focus more on noise pollution than air pollution, though some noise pollution reduction policies may also help reduce air pollution as well.

CONCLUSION. The expansion of commercial aviation continues to raise important concerns about air and noise pollution, particularly for communities near airports and other vulnerable groups. Ongoing policy, research, and legislative efforts are needed to address health and environmental concerns and to ensure strong protections are adopted for both affected communities and airport workers exposed to elevated levels of aviation pollution.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 6-A-26

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

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee D

Resolution 421-A-25 was referred by the American Medical Association (AMA) House of Delegates (HOD) and asked the following:

> That our AMA seek a study and report back providing recommendations at the federal level to reduce the adverse impact of air and noise pollution in disproportionately impacted and vulnerable communities from aviation, including the following areas:
>
> 1. Promotion of Sustainable Aviation Fuels: Advocate for the adoption of sustainable alternative jet fuels, which have been shown to decrease premature death rates in communities near airports and downwind.
> 2. Implementation of Noise Abatement Procedures: Encourage the use of flight paths and operational procedures that minimize noise impact on residential areas, particularly those inhabited by minority populations disproportionately impacted communities.
> 3. Investment in Noise Mitigation Infrastructure: Support the installation of soundproofing materials in homes, schools, and healthcare facilities located in high-noise areas to reduce the adverse health effects of noise pollution as well as non-combustion engines (i.e. solar or electric).
> 4. Community Engagement and Education: Foster partnerships with affected communities to raise awareness about the health impacts of air and noise pollution and involve them in decision-making processes regarding aviation operations.
> 5. Research and Monitoring: Advocate for ongoing research to monitor air and noise pollution levels in minority populations disproportionately impacted communities and study the effectiveness of implemented interventions.

METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: “aviation” AND “air pollution”, “aviation” AND “noise pollution,” and “aviation” AND “health equity.” Additional articles and relevant reports were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies, such as the Federal Aviation Administration (FAA) and United States (U.S.) Environmental Protection Agency (EPA), and websites for airport administration authorities were also reviewed for relevant information, particularly in regard to current mitigation strategies utilized to reduce the adverse impacts of air and noise pollution form aviation.

BACKGROUND

Over the last fifty years, commercial air travel in the U.S. has seen substantial growth in both the number of flights and the expansion of airport facilities. The number of flights performed by U.S.

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carriers has grown from roughly five million annual departures in the mid-1970s to well over nine million by 2025.[1,2] From a global perspective, airplane traffic has grown at an annual average rate of roughly five percent over the last 30 years.[3] Private jet travel has also increased, with 2025 seeing a record-setting number of private jet flights globally at nearly four million.[4] The Federal Aviation Administration (FAA) is the primary federal agency responsible for regulating airport and airplane activities in the U.S.

While the increase in commercial aviation has made it much easier and cheaper for individuals to travel both domestically and internationally, there are concerns from communities who live around airports or along major flight paths about both air and noise pollution. Aside from baseline federal standards, noise pollution management is largely dependent on local airport policies and regulations. This report primarily focuses on public health concerns regarding air and noise pollution from commercial aviation, as opposed to military aviation. There are important differences in terms of the type of jet fuel used for commercial and military aircraft and noise levels are highly dependent on the size and type of aircraft, with military aircraft (e.g., fighter jets) having significantly different noise profiles and fuel needs compared to commercial airplanes.

DISCUSSION

Air Pollution

As compared to the gasoline used in everyday vehicles, airplanes use different formulations of fossil fuels, enabling airplanes to travel at high speeds, for great distances, and at high elevations without freezing the fuel. There are two main categories of commercial aviation fuels: jet fuel and aviation gasoline (AVGAS).[5] Jet fuel is a kerosine-based fuel aviation fuel that tends to be heavier with a higher flash point and freezing point than standard kerosene and is used for most commercial aviation. AVGAS, as the name suggests, is a gasoline-based aviation fuel that is typically used on smaller aircraft.[5] Unlike gasoline used in motor vehicles which has been unleaded for many decades, AVGAS still contains some amount of lead as it is helpful to meet high octane performance requirements in jet engines.[6]

The combustion of fuel in airplanes releases particulate matter, nitrogen oxides, sulfur oxides, volatile organic compounds, and other air toxics.[7,8] Ultrafine particulate matter (UFP), a term to describe particles smaller than 100 nanometers, is particularly concerning as airplane engines release large amounts of UFP and particulates of this size are able to penetrate deep into lung tissue.[9] A 2021 systematic review on the impacts of commercial airplane activity on air quality near airports found consistent evidence that UFP matter is elevated in and around airports while other studies found elevated levels of black carbon (otherwise known as soot), polycyclic aromatic hydrocarbons, and other criteria pollutants regulated by the EPA (e.g., sulfur dioxide, lead, and nitrogen dioxide).[8,9] As a result of growing private jet travel, private jet flights are also a growing source of air pollution, particularly in the U.S., which is where an overwhelming majority of private flights occur.[10] There are numerous factors that impact actual exposure to aviation air pollution, including the size of the airport and volume of air traffic, distance from the source, the prevailing meteorological conditions - which include wind speed and direction, humidity, and temperature – as well as the type, age and size of operational aircraft.[9] However, it has been demonstrated that the highest concentrations of UFP are generally measured downwind of the aircraft, but more research is needed to understand dispersion processes and other environmental factors that affect emissions and exposure levels.[9]

Differentiating air pollution from aviation versus other mobile pollution sources can be challenging. The EPA uses tools such as the Air Toxics Screening Assessment, which provides a

snapshot of outdoor air quality and estimates air pollutant concentrations, to measure health risks at the census tract level, estimating both cancer and non-cancer hazards from aviation and other mobile sources.[11] Aviation-related air pollution has been demonstrated to be associated with significant adverse health impacts, particularly in nearby communities. Air pollutants from aviation elevate risks for respiratory diseases (e.g., asthma and chronic obstructive pulmonary disorder), cardiovascular disease, cancer, cognitive impairment, and premature mortality.[9,12,13] Another study found exposure to UFP from aircraft emissions *in Utero* was positively associated with preterm birth among pregnant mothers.[14] A 2015 study assessing the global health impacts of civil aviation emissions attributed about 16,000 premature deaths per year globally to aviation emissions.[15]

Noise pollution

Noise pollution from aviation operations is another public health concern, which was raised as early as the late 1960s and early 1970s.[16] The EPA defines noise pollution as unwanted or disturbing sounds that interfere with normal activities, such as conversation or sleep, and/or diminish one's quality of life.[17] Normal decibel (dBA) levels generally range between about 35 to 70, with 60 dBA benchmarked as the noise level of a typical conversation. Prolonged exposure to noises at 85 dBA or over can lead to potential hearing loss.[18] The noise of a jet engine taking off is somewhere in the range of 120 to 130 dBA (depending on your proximity to the sound) and is considered unsafe.[18] The European Environment Agency classifies environmental noise—including aircraft noise—as the third most significant environmental cause of ill health in Europe after air pollution and temperature-related factors, emphasizing the scale and seriousness of the issue for policy makers and public health authorities.[19]

Noise created from aviation operations is different and unique in a few ways from noise created by everyday transportation and traffic patterns. First, the frequency of aircraft noise is different from traffic noise as it is dominated by low-frequency engine hums, high-frequency jet whine, and the sound of propellers moving depending on the speed of the aircraft. Second, the temporal pattern of aircraft noise – isolated with quick onset and decay (i.e., a plane flying over) – is distinct from traffic noise which tends to create a continuous, persistent background noise.[20] There are several tools airports can use to understand aviation noise. Many airports monitor noise levels through the placement of monitors at strategic places across the airports.[20] Additionally, sound level contour maps use a combination of sound measurements and sound mapping software to better predict where the highest levels of sound will occur, which can help with mitigation planning.[20]

A 2022 Australian report based on survey data of nearly 2000 residents found that airplane noise was associated with negative impacts to sleep, mental distress, and that aircraft noise interfered with daily activities in their homes.[21] A consensus paper on the health impacts from aviation noise pollution reported similar detrimental effects, including mental health impacts, sleep disruption, adverse effects on academic performance of children, and increases the risk for cardiovascular disease of people living in the vicinity of airports.[20] Increased rates of anxiety, depression, and general feelings of annoyance have been reported in communities exposed to persistent aircraft noise.[22] Aircraft noise is a major cause of sleep disruption, leading to fatigue, cognitive impairment, reduced productivity, and long-term mental health effects.[23] Studies highlight impaired learning, memory, and reading comprehension among children attending schools located near airports with high noise exposure.[24–26] Lastly, chronic exposure to aviation noise has been found to increase the risk for hypertension, heart attacks, and stroke.[27–29] In their most recent report, published in 2025, the European Environment Agency estimated that chronic exposure to transport-related noise (of which aviation is included) in Europe contributes to 66,000 premature deaths annually in Europe, around 50,000 new cardiovascular disease cases, and over half a million children experience reading difficulties and about 63,000 experience behavioral issues.[19]

Equity considerations

Communities near airports and aviation corridors, which tend to be lower-income, minority communities, often face higher pollution exposure, compounded risks, and fewer resources for mitigation and therefore aviation-related air and noise pollution contributes disproportionately to poor health outcomes in these communities.[30] For example, communities living near airports may have less access to mitigation resources (e.g., air purifiers or home soundproofing) and live close to other emission sources such as major roads and highways.[31] With the U.S., research has highlighted that integrating socioeconomic factors with pollution data is critical for identifying and addressing disparities with air pollution exposure.[32–35]

The FAA had previously created guidance for environmental justice analyses that required consideration disproportion and adverse effects on low-income or minority populations for any airport development action or any airport action subject to FAA approval.[36] However, due to executive order and identified priorities under the current administration, environmental justice and climate impacts are no longer required as part of FAA environmental analyses.[37] The FAA must still comply with the National Environmental Policy Act, which requires appropriate environmental impact assessments for relevant actions directly undertaken by the FAA.[37]

Airport workers, in particular those working on the ground in the airport tarmac (i.e., where airplanes approach and leave the airport terminal), represent another vulnerable population as they are exposed to significantly higher levels of aviation-related air and noise pollution for longer periods of time. Aviation workers are often exposed to noise levels that exceed safe noise thresholds and chronic exposure to high noise levels can cause permanent hearing loss, sleep disturbances, and heightened stress, potentially leading to cardiovascular problems.[38–40] The Occupational Safety and Health Administration (OSHA) sets protection standards for airport workers and requires hearing protection, such as ear plugs, muffs, or both, when noise exposure exceeds the action levels, which is 85 decibels, and mandates proper ventilation and personal protective equipment to mitigate air quality hazards.[41] OSHA also requires employers to provide hearing conservation programs and training, medical surveillance, and access to resources to reduce exposure levels and safeguard worker health. However, airport workers are a largely understudied population and more research is needed.[42]

Strategies to mitigate air and noise pollution

Both the EPA and the FAA play important roles in setting and enforcing standards around air and noise pollution from aircraft. Under the Clean Air Act, the EPA sets national standards limiting emissions of pollutants such as hydrocarbons, carbon monoxide, nitrogen oxides, particulate matter, and lead which apply to aircraft engines used in commercial aviation.[7] While the EPA sets air pollution standards, the FAA administers compliance and certification requirements. States and local authorities cannot set independent aircraft emissions standards. For noise pollution regulation, originally the EPA was responsible for aviation noise standards under the Noise Control Act of 1972, which also established the EPA's Office of Noise Abatement and Control, but since the early 1980s, direct regulatory authority for aircraft noise standards has been under the FAA.[17,43] However, the EPA still provides technical input and coordinates with federal partners and the public on relevant studies and recommended practices.[17] As part of their responsibilities, the FAA regulates the maximum noise level that an aircraft can emit through requiring aircraft to meet noise certification standards.

The International Civil Aviation Organization (ICAO), a United Nations agency that serves as the global forum on issues related to international civil aviation, has studied various noise abatement

strategies and developed a 'balanced approach' system that identifies 18 policy measures aimed at reducing noise, which are categorized into four pillars: (1) reduction of noise a the source (i.e., aircraft design and technical requirements), (2) land-use planning and management (e.g., reduce noise-sensitive land use around airports, such as residential areas), (2) operational procedures that focus on noise abatement (e.g., preferential runways and flight paths away from residential areas), and (4) aircraft operating restrictions (e.g., airport curfews).[16,44] The most common policy measures implemented were noise abatement procedures, engine run-up restrictions, preferential runways, and airport curfews.[16] Fifty percent of airports in North America use one to four of these policy measures, and nearly forty percent use five to nine of these policy measures.[16]

Modern aircraft technology has achieved significant improvements in noise levels through technological advances and lighter materials, with current jet aircraft being much quieter than first models released in the 1960s and 1970s.[45,46] ICAO's Chapter 14 standard, introduced in 2013 and effective in 2024, requires new aircraft models to be at least seven decibels quieter than previous standards.[47,48] Additionally, the aviation industry has set ambitious targets, including the Advisory Council for Aviation Research and Innovation in Europe's FlightPath 2050 vision of a 65 percent reduction in noise emissions by 2050 compared to 2000 levels.[49]

Aside from baseline federal standards, in the U.S. noise and air pollution management is largely dependent on the policies and regulations of local airports and municipalities. For example, airports develop their own noise compatibility programs to meet FAA requirements, which include land use strategies, operational procedures, and sometimes flight curfews. In general, as air pollution standards are set at the federal level, local airport policies and regulations focus more on noise pollution than air pollution, though some noise pollution reduction policies may also help reduce air pollution as well. A table is provided in the Appendix outlining the policies and programs of several major U.S. airports. It is also worth noting that many of these airports, in addition to the programs and specifics listed in the chart, implement some form of voluntary curfew where planes are not allowed to enter or leave between late hours of the night and early hours of the morning.

The regulatory approach for airport noise mitigation in the U.S. is noticeably different from the European Union (EU), which is more centralized and requires uniform reporting and standardized mitigation efforts across EU member countries. The European Noise Directive, the primary regulatory framework for airport noise management, requires major airports (over 50,000 movements per year) to regularly assess and report noise levels.[50] These assessments are used to create noise maps and action plans for mitigation involving stakeholders that include airports, airlines, local authorities, and communities. Additionally, EU noise exposure thresholds are generally 55 dBA during the day and 50 dBA during the night, while the FAA applies a Day-Night Average Sound Level threshold of 65 dBA.[19,43] In summary, Europe has a centralized regulatory structure with lower noise threshold limits and more proactive land-use planning as part of their noise mitigation efforts. On the other hand, the U.S. has a more decentralized approach, higher federal noise thresholds, and mitigation measures that often depend on local airport initiatives that focus on operational procedures and operating restrictions.

From an air pollution perspective, one promising solution is the integration of and eventual transition to sustainable aviation fuel. Sustainable Aviation Fuel (SAF) refers to a class of liquid fuels produced from renewable or waste-derived sources—such as used cooking oil, non-food crops, agricultural residues, municipal solid waste, and even CO_2 direct air capture.[51] Studies show that SAF produces less PM, sulfur oxides, and aromatics compared to conventional jet fuel, especially during the landing and take-off cycle at airports.[52,53] Thus, shifting toward SAF could lower emissions of these pollutants and improve local air quality, particularly for airport-adjacent

communities and airport workers. While SAF generally produces fewer soot particles and less NOx, the specific reduction of different air pollutants will vary by fuel type and process pathway.

Lastly, another benefit of SAF is its lower greenhouse gas (GHG) emission profile. Currently, the EPA estimates that commercial airplanes and large business jets contribute 10 percent of U.S. transportation emissions, and account for three percent of the nation's total GHG emissions.[54] SAF has the potential to reduce lifecycle GHG emissions by up to 80 percent (and potentially more), but it depends on the feedstock and production process of the SAF.[55–57] The U.S., EU, and other regions have implemented policy supports like the SAF Grand Challenge and FEETS (Fuels Eligible for ETS Support) to close cost gaps and scale up SAF production, aiming for large-scale deployment by 2030 and 2050 for meaningful climate and health impact.[58] The European Union Aviation Safety Agency has a set a minimum supply mandate for sustainable aviation fuels in Europe, starting with two percent in 2025 and increasing to 70 percent by 2050.[55]

LEGISLATION

There were two proposed bills in the 2025-2026 Congressional legislative session that are relevant to mitigation of air and noise pollution from airplanes. The first, entitled the 'Aviation Noise and Emissions Mitigation Act' proposed to develop pilot grant programs through the EPA to research and collect data on aircraft, airport noise, and emissions in order to develop mitigation strategies.[59] The second, the 'Sound Insulation Treatment Repair and Replacement Program Act', which passed as part of the National Defense Authorization Act for Fiscal Year 2026 on December 18, 2025, established a pilot program at up to four large airports to fund projects to repair or replace failing sound insulation systems in nearby residential homes.[60,61]

CURRENT AMA POLICY

While AMA does not have specific policy on aviation related pollution, it has several existing policies, supporting federal regulation and action on air pollution, including policy H-135.998, "AMA Position on Air Pollution" and D-135.985, "Air Pollution and Public Health."[62,63] AMA also has policy, D-135.996, "Reducing Sources of Diesel Exhaust, " which has a similar threat profile to airplane jet fuel.[64] Additionally, AMA has policy recognizing noise pollution as a public health issue, supporting ongoing federal environmental justice initiative, and the importance of environmental determinants of disease.[65,66]

CONCLUSIONS

The expansion of commercial aviation continues to raise important concerns about air and noise pollution, particularly for communities near airports and other vulnerable groups. Evidence shows that aviation emissions contribute to adverse health outcomes, including respiratory and cardiovascular diseases, cognitive impairment, and cancer, while associated noise pollution increases risks for sleep disruption, mental health issues, and cardiovascular conditions. Despite technological advances and existing mitigation strategies, disparities in exposure persist, especially among low-income and minority neighborhoods near airports. Ongoing policy, research, and legislative efforts are needed to address health and environmental concerns and to ensure strong protections are adopted for both affected communities and airport workers exposed to elevated levels of aviation pollution.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 421-A-25, and the remainder of the report be filed.

Our American Medical Association:

1. Supports increased surveillance, monitoring and research of air and noise pollution exposure from aviation, specifically for vulnerable populations, airport workers and nearby communities.
2. Encourages studies on the effectiveness of different interventions to mitigate air and noise pollution exposure from aviation.
3. Encourages airports to implement policy measures identified under the 'balanced approach' system to minimize noise exposure in surrounding communities, which could include changes to common flight paths, flight curfews, land use planning and community engagement, sound-proof insulation projects in nearby communities, and further technological advances to reduce jet engine noise.
4. Supports the phase-in of sustainable aviation fuels to reduce air pollution and climate impacts associated with aviation. (New HOD Policy)

Fiscal note: Minimal

APPENDIX

San Francisco International Airport (SFO)	SFO was the first airport in the US to implement an extensive noise insulation program. They provide acoustic improvements to single family residential properties, at no cost to the homeowner, that are inside a specific noise contour based on noise mapping. Additionally, in 2020, the SFO Noise Office launched its Noise Action Plan that have five objectives: promote quieter planes, introduce and prioritize quieter procedures, maintain and encourage active community engagement, expand and improve our noise monitoring program, and active land-use planning and mitigation.[67,68]
Los Angeles International Airport (LAX)	LAX has in place a Preferential Runway Use Policy that, when applicable and safe, has planes depart and land on the ocean side (west) instead of over neighborhoods (east side). It also has a LAX Residential Sound Insulation Program to treat homes, free of cost to the homeowner, close to LAX and reduce the noise level by at least 5 decibels.[69,70]
Westchester County Airport (HPN)	HPN has a noise abatement program, with several sub-programs that are each designed to reduce the noise levels created by aircraft operations. As part of these efforts, they have noise monitoring systems and adopted special programs for helicopters and large aircrafts.[71]
Long Beach Airport (LGB)	In collaboration with city efforts, Long Beach has one of the strictest noise-controlled airports in the US. With its Noise Ordinance, it lays out maximum single event and cumulative noise exposure limits and the ability to fine aircrafts owners/operators for multiple violations of their noise ordinance.[72]
Santa Monica Airport (SMO)	The airport's Fly Neighborly Program has several features that help reduce noise pollution. Such features include departure paths to be over the Penmar Golf Course instead of neighborhoods and special procedures for helicopters. There is also an imposed maximum noise exposure limit of 95 decibels for any single noise event.[73]
Tweed New Haven Airport (HVN)	HVN has distributed nearly $12 million dollars in federal funding to soundproof nearby homes, with the most recent phase being completed in 2023. They also have an online platform that the community can access to see aircraft activity and noise levels.[74]
Seattle-Tacoma (SEA-TAC) International Airport	SEA-TAC International Airport operates one of the most comprehensive aircraft noise reduction programs, including a sound insulation program dating back to 1985 that has insulated over 9,400 single-family homes. Their SEA Stakeholder Advisory Round Table serves as a forum for discussion and practical aircraft noise reduction initiatives.[75]
Chicago O'Hare International Airport	Chicago O'Hare International Airport operates the Airport Noise Management System, a comprehensive system providing actual measurement of aircraft noise levels in neighborhoods and suburban communities around O'Hare and Midway airports. The system includes permanent noise monitors and connects directly to FAA air traffic control radar to collect aircraft flight tracks, recording more than 5 million data points daily.[76]

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REPORT 10 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-26)
Standardizing Safety Requirements for Traditional and Rideshare Based Non-Emergency Medical Transportation

EXECUTIVE SUMMARY

INTRODUCTION. Resolution 508-A-25, referred by the House of Delegates (HOD), asked that our American Medical Association (AMA) study and report back with recommendations on appropriate minimum safety requirements/certifications (i.e., vehicle, Basic Life Support, Health Insurance Portability and Accountability Act) for non-emergency medical transportation (NEMT) and rideshare-based non-emergency medical transportation (RB-NEMT).

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms “non-emergency medical transport”, “rideshare-based non-emergency medical transport”, “Uber Health”, “Lyft Healthcare”, and “rideshare-based medical transportation AND HIPAA”. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies; applicable organizations were also reviewed for relevant information.

BACKGROUND. NEMT enables millions of patients, especially Medicaid beneficiaries, older adults, people with disabilities, and rural residents—to reach medical care when no other options exist. As a mandatory Medicaid benefit, it supports preventive services, chronic disease management, and continuity of care, but long-standing challenges such as missed pickups, variable service quality, uneven safety practices across states, and persistent program-integrity issues continue to affect reliability and outcomes. RB-NEMT has emerged as a flexible, on-demand supplement that can improve responsiveness and reduce delays for ambulatory riders, particularly for discharges and last-minute or recovery rides. However, RB-NEMT operates under a very different regulatory structure: drivers are independent contractors without medical or mobility-assistance training, and vehicles lack the accessibility features needed for higher-acuity riders. As a result, RB-NEMT is appropriate only for riders requiring minimal assistance and for select trip types. Traditional NEMT is guided by federal and state safety expectations—Medicaid rules, ADA accessibility standards, HIPAA privacy requirements, and state-level driver, vehicle, and insurance regulations—but these are applied inconsistently nationwide. In contrast, RB-NEMT currently has no evidence-based minimum safety standards, highlighting an important gap in oversight and the need for further research.

CONCLUSION. This report discusses traditional NEMT and emerging rideshare-based NEMT (RB-NEMT) and the distinctive roles they play within the health care transportation system. The report also outlines how traditional NEMT is governed by longstanding federal and state safety expectations but continues to experience variability in implementation and operational challenges that affect reliability and quality. Although, RB-NEMT offers flexibility and responsiveness for certain riders and trip types, it operates within a different regulatory framework and lacks evidence-based minimum safety standards, with existing studies providing only limited guidance—primarily related to appropriate rider matching. Because of these differences and the gaps identified, the recommendations focus on three overarching needs: recognizing transportation as essential to equitable access to care; promoting greater consistency in the application of existing NEMT safety standards across states; and supporting further research to evaluate RB-NEMT safety risks and develop evidence-based minimum safety requirements before prescriptive operational standards can be responsibly established.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 10-A-26

Subject: Standardizing Safety Requirements for Traditional and Rideshare Based Non-Emergency Medical Transportation

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee D

Resolution 508-A-25, "Standardizing Safety Requirements for Traditional and Rideshare-Based Non-Emergency Medical Transportation," was introduced by the Medical Student Section and was referred. It asked the following:

> That our American Medical Association (AMA) study and report back with recommendations on appropriate minimum safety requirements/certifications (i.e., vehicle, Basic Life Support, Health Insurance Portability and Accountability Act) for non-emergency medical transportation (NEMT) and rideshare-based non-emergency medical transportation (RB-NEMT).

This report provides a review of the topic and makes policy recommendations.

BACKGROUND

Transportation is critical for access to medical care, with nearly six million Americans annually having transportation barriers impacting timely access to care including missed appointments.[1] Traditional non-emergency medical transport (NEMT) programs, typically funded through Medicare or Medicaid, provide essential transportation for vulnerable populations, including the elderly, disabled, and rural residents, via taxis, vans, or buses.[2] However, these services often suffer from reliability issues such as late arrivals and no-shows, which can disrupt continuity of care and increase health care costs.[3] In response to these limitations, rideshare-based NEMT (RB-NEMT) programs have emerged, leveraging platforms like Uber and Lyft to expand access.[4] These services have demonstrated improvements in appointment attendance, reduced wait times, and lower costs, while also enhancing patient satisfaction.[4] Despite these benefits, RB-NEMT drivers are typically independent contractors with minimal training in patient confidentiality, basic life support (BLS), or medical liability protocols.[4,5] This lack of standardized training and credentialing raises concerns about patient safety and quality of care.[4,5]

RB-NEMT proponents note that it is appealing because it may provide more flexibility for passengers; it is well suited for last-minute rides, like hospital discharges; and may reduce waiting times and cost.[6] Additionally, RB-EMT can better track rides and collect data, potentially addressing quality, fraud, waste, and abuse.[7] Conversely, critics of RB-NEMT note that issues include lower pay for drivers, lack of access in rural areas, inadequate driver screening, and safety issues for drivers and riders.[8] Because the NEMT population is more likely to be low-income, older adults, and individuals with disabilities, additional specialized training for drivers is needed.[9]

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METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms “non-emergency medical transport”, “rideshare-based non-emergency medical transport”, “Uber Health”, “Lyft Healthcare”, and “rideshare-based medical transportation AND HIPAA”. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by government agencies; applicable organizations were also reviewed for relevant information.

DISCUSSION

Transportation is a fundamental component of accessing routine, nonemergency medical care.[10] Transportation challenges to health care are disproportionately experienced by individuals who are low-income, older adults, non-White, women, and less educated, many of whom are Medicaid enrollees.[11] An estimated 25 percent to 55 percent of Medicaid enrollees missed, arrived late to, or did not try to go to a health care appointment because of transportation issues.[10] Adults and children who missed medical appointments due to transportation issues had extensive comorbidities and a significantly higher prevalence of health conditions compared with those who missed care for other reasons.[12] Inconsistent care due to transportation challenges can negatively affect health and increase preventable emergency department visits, particularly for individuals with chronic conditions.[10] Missed appointments do not just cause delays in medical care. They also cost the U.S. health care system $150 billion annually.[13]

BACKGROUND ON NONEMERGENCY MEDICAL TRANSPORATION (NEMT)

What is NEMT?

NEMT is a system that provides individuals with transportation to medical and health-care services when they lack other means of transport.[14] As a mandatory Medicaid benefit, NEMT plays a central role in reducing transportation-related barriers and ensuring that beneficiaries, particularly those who are older, disabled, or managing chronic conditions, can reliably access needed care.[15,16] Although all states must offer NEMT, the scope of what is covered, how services are delivered, and the overall quality of transportation vary considerably across state programs.[4] States may differ in the number of trips they authorize, whether prior approval is required, and whether small copayments are allowed, reflecting differences in beneficiary needs, delivery systems, and geographic context.[17]

Medicaid has covered NEMT since the program’s creation in 1966, with federal authority grounded in 42 CFR § 440.170.[18,19] Congress later reinforced this requirement in the Consolidated Appropriations Act of 2021, explicitly recognizing transportation network companies (TNCs) as allowable NEMT providers.[20,21] Over time, states have adopted three primary approaches to administering NEMT: state-run fee-for-service systems, managed care arrangements in which health plans coordinate transportation directly or through subcontractors, and broker-based models where states contract with a dedicated transportation broker to manage the benefit.[4,19] States most commonly rely on the brokerage model, which research suggests may improve oversight, reduce fraud and abuse, and help contain costs, particularly in capitated arrangements where brokers have fewer incentives to oversupply trips.[22]

Because states retain significant flexibility in implementing NEMT, program structure and operational practices vary widely.[4,6,19] Some states impose extensive credentialing, documentation, or quality-assurance requirements, while others take a lighter regulatory approach. These

differences shape the beneficiary experience and influence program integrity, cost management, and access to care.[4,19,22] The federal requirement to provide transportation remains consistent across the country, but how NEMT is delivered, and how effectively it meets patients' needs, ultimately depends on state choices regarding administration, contracting, and service design.[4,21]

Types of NEMT services

People who rely on NEMT have a wide range of physical, cognitive, and functional abilities. To ensure that each individual receives transportation that matches their needs, NEMT services are commonly organized into four broadly recognized levels of assistance.[4] These levels reflect how much support a rider requires before, during, and after the trip.[4]

Hand-to-Hand (H2H). H2H service is intended for individuals who require continuous assistance throughout the transportation process or who must maintain a formal chain of custody.[4,23] This includes riders unable to travel independently whether due to cognitive, sensory, or significant physical impairments, and individuals who must be transferred directly between responsible adults.[4,23] Children, for example, typically fall under H2H because they require a parent, guardian, or caregiver to accompany them for the full duration of the trip.[4,23] The driver or attendant plays an active support role, ensuring the rider is safely handed off at both pickup and drop-off locations.[4,23]

Door-to-Door (D2D). D2D service is appropriate for individuals who can ambulate with some independence but still require light physical assistance from the driver.[4,23] This support may include walking with the rider from their front door to the vehicle, assisting with entering and exiting the vehicle, opening doors, fastening seatbelts, or helping stow mobility devices and belongings.[4,23] Assistance in this category does not involve lifting, securement, or continuous monitoring but instead provides the modest, task-specific help some riders need to safely complete the trip.[4,23]

Curb-to-Curb (C2C). C2C is suitable for riders who can reach the curb independently and enter the vehicle with little or no driver assistance.[4,23] The driver remains responsible for operating the vehicle safely and verifying the passenger's identity but does not accompany the rider to or from their residence or destination doors.[4,23] This service level is widely used for riders who remain ambulatory and do not require support beyond the immediate boarding process.[4,23]

Area-to-Area (A2A). A2A serves individuals who are fully ambulatory and can walk longer distances—for example, from their residence to a designated pickup point, such as a bus stop or centralized meeting area.[4,23] Unlike C2C riders, who may only be comfortable walking a short distance to the curb, A2A riders can travel farther and access transportation from non-residential pickup sites.[4,23] This service is frequently used in transit-rich or campus-style settings where stops are located away from individual homes.[4,23]

Assigning a rider to the correct service level requires considering functional ability, cognitive status, environmental factors, and safety needs.[4,23] These categories help transportation providers, care coordinators, and health plans determine the most appropriate and safe mode of travel.[4,23] However, no national dataset currently captures the number of individuals who fall into each service level, and the true distribution likely varies by state, geography, and beneficiary population.[4]

How are NEMT rides scheduled?

NEMT rides may be scheduled either by the individual or by a care provider, depending on the state, the beneficiary's insurance program, and the administrative model used for NEMT.[4,6] In most states, scheduling occurs through a broker or managed care organization that operates a call center

or dispatch system.[4,6] When a request is made, the broker first verifies the individual's eligibility for NEMT and determines whether the ride meets coverage criteria.[4,24] If approved, the broker then assigns the trip to an appropriate transportation provider within its network. The selection of a transportation mode is guided by several factors, including the rider's functional needs, the availability of transportation options (such as proximity to a bus stop), and environmental conditions like extreme heat or cold, which may influence safety or accessibility.[4,24] Scheduling decisions also consider whether the ride is planned in advance or a last-minute request, as well as system-level constraints such as cost or vehicle availability.[4,24] Once assigned, a trip may be direct, transporting a single passenger from pickup to drop-off, similar to rideshare or taxi service, or shared, with multiple passengers boarding and disembarking along the route, similar to paratransit operations.[4,15,24]

Benefits of NEMT

Access to NEMT plays a critical role in reducing barriers to care for Medicaid beneficiaries and other transportation-vulnerable populations.[25] Studies consistently demonstrate that providing reliable transportation is associated with increased use of preventive and primary care, reduced reliance on emergency departments and inpatient services, and more timely access to treatment for individuals with chronic health conditions.[1,26,27] Evidence also indicates that NEMT can generate meaningful cost savings for the health system.[4,8,28] Even when accounting for transportation costs, NEMT has been linked to reductions in avoidable hospitalizations and improved management of chronic diseases.[4,8,28] National estimates suggest that Medicaid finances approximately 103 million NEMT trips annually, at an average cost of $26–$29 per trip, underscoring the scale and relatively low per-ride expense of the benefit.[4,29]

Common issues with NEMT

NEMT has long faced operational and oversight challenges that affect both the reliability and integrity of the benefit. A 2016 Government Accountability Office (GAO) review identified persistent concerns about late or missed pickups, and such delays often resulted from complex routing patterns. For example, traditional NEMT trips may involve multiple passengers and numerous stops which can significantly lengthen travel times and reduce patient satisfaction.[30] The report also highlighted broader program-integrity vulnerabilities, including fraud, waste, inefficiencies, and insufficient oversight.[30] States reported difficulty verifying eligibility, confirming that the transportation mode matched patient needs, and ensuring that trip destinations were appropriate for covered services.[30] Investigations by the HHS Office of Inspector General (OIG) further revealed substantial improper payments: between 2005 and 2011, five states collectively paid an estimated $63 million for rides that did not meet NEMT requirements.[31] Additional issues included billing for multiple trips when only one was needed, billing for deceased beneficiaries, and inappropriate up-charging—for example, assigning a costly ambulance trip for routine dialysis transport when a lower-acuity mode would have sufficed.[30,31]

Together, these findings underscore the complexity of administering NEMT across multiple delivery models, each with different data systems, credentialing requirements, and oversight capabilities.[28,30,31] Variability across states and contractors can make it difficult to consistently ensure that drivers, vehicles, and trips meet program standards.[4,28,30,31] These well-documented challenges continue to shape federal and state efforts to strengthen screening, monitoring, and trip-validation processes across both traditional and emerging NEMT modalities.[28,30,31]

What safety standards exist for NEMT?

Current minimum safety standards for NEMT are shaped primarily by federal Medicaid requirements, the American Disabilities Act (ADA) accessibility regulations, and Health Insurance Portability and Accountability Act (HIPAA) privacy rules.[18,32–35] At the federal level, Medicaid's "transportation assurance" obligates states to ensure necessary transportation and describe how they will provide it, which forms the structural foundation for safety oversight in all NEMT programs.[36] Federal rules for managed care and Prepaid Ambulatory Health Plans (PAHPs) require states and contracted NEMT entities to meet selected standards related to enrollee rights, information disclosure, and operational capacity.[37–40] The ADA further establishes technical minimums for accessible transportation, such as lift specifications, securement systems, and equipment maintenance, which apply whenever NEMT providers transport riders with mobility disabilities.[33] HIPAA compliance is required when protected health information is transmitted for scheduling or coordinating NEMT, which increasingly affects rideshare-integrated NEMT programs.[32]

At the state level, minimum safety standards become more detailed and prescriptive, especially regarding driver qualifications, vehicle conditions, and insurance requirements.[41,42] Most states require criminal background checks, motor-vehicle-record screenings, exclusion (LEIE) checks, drug testing, and periodic re-credentialing.[42–44] Vehicle standards commonly include documented safety inspections, compliance with state transportation codes, adherence to ADA equipment requirements (for accessible vehicles), and routine preventive maintenance.[33,36,43] Insurance requirements typically mandate commercial auto liability, general liability, and workers' compensation, with specific minimum coverage levels defined by state Medicaid contracts or broker agreements.[43,45] These standards serve as the baseline for ensuring safety and provider accountability in traditional NEMT settings.[18,32,33,36–40,43–45]

However, reports have identified recurring vulnerabilities, such as use of unqualified drivers, improperly documented trips, and unsafe or uninspected vehicles, prompting states and brokers to require pre-trip eligibility verification, real-time GPS validation, incident reporting, and strict record-keeping.[30,31] Voluntary accreditation bodies such as the Non-Emergency Medical Transportation Accreditation Commission (NEMTAC) have also emerged, offering consensus standards for driver training, securement practices, quality assurance, and organizational safety culture, which states, brokers, and plans increasingly treat as benchmarks for high-quality NEMT.[46] It should be noted that the 2002-2025 NEMTAC Provider Standard draft is currently open for public comment.[47] The NEMTAC Provider Standard is a comprehensive, American National Standards Institute aligned draft framework designed to establish national, consensus-based safety and operational expectations for NEMT providers.[47] It outlines structured requirements across organizational management, operations, staffing, and compliance, with the goal of elevating service quality, improving safety, and supporting uniformity across diverse state Medicaid environments.[47]

BACKGROUND ON RIDESHARE BASED NONEMERGENCY MEDICAL TRANSPORATION (RB-NEMT)

What is RB-NEMT?

Rideshare-based non-emergency medical transportation (RB-NEMT) refers to the use of transportation network companies (TNCs), such as Uber and Lyft, to provide medical transportation for riders.[4,48,49] Over the past decade, rideshare platforms have expanded rapidly nationwide, creating new opportunities to supplement traditional NEMT services.[50] Their entry into the NEMT market was driven by several converging trends: the growing availability of TNC

services, increases in the Medicaid and Medicare Advantage populations, rising demand for transportation among older adults, and capacity constraints within traditional NEMT provider networks.[51,52] Lyft first entered the NEMT space in 2016, followed by Uber in 2018, integrating their platforms with brokers and health plans to deliver curb-to-curb transportation for eligible beneficiaries.[51,52]

In an RB-NEMT model, brokers or health plans schedule rides through dedicated TNC health-care platforms rather than through the consumer-facing app.[4] Riders do not need a smartphone to participate, and TNC drivers generally do not know they are transporting a Medicaid or medically referred passenger, only that the ride was pre-arranged through a third party.[4,53] Early evaluations, including pilot programs and industry analyses, suggest that RB-NEMT may reduce missed pickups, improve punctuality, and lower transportation costs, particularly for ambulatory riders.[4,54,55] For example, one health system reported substantial reductions in rider complaints and no-show rates, along with notable cost savings when compared with taxi-voucher programs.[4,56] While these findings draw from industry-sponsored work and may not be generalizable, they highlight the potential operational advantages of rideshare integration.[4,56]

State and federal policy around RB-NEMT continues to evolve, and important gaps remain between NEMT regulatory expectations and what TNCs are structurally designed to provide. For example, state NEMT rules often require driver training in CPR or first aid, routine drug testing, specific insurance coverage, or specialized vehicle licensing, requirements that do not align with the independent-contractor model used by TNCs.[4,42] Vehicles used in RB-NEMT may also lack features required for certain NEMT trips, such as wheelchair securement systems or state-mandated license plates.[4,9]

What types of NEMT services and rider are best for RB-NEMT?

Studies have found that RB-NEMT is most appropriate for individuals who require minimal to no physical assistance and can safely use curb-to-curb (C2C) or area-to-area (A2A) services.[4,54,55,57] While RB-NEMT is primarily suited for riders needing low-assistance service, studies have noted that it can also be effective for specific trip types that benefit from flexibility and rapid deployment. RB-NEMT is a strong option for inpatient and outpatient discharges, where timing is unpredictable and traditional NEMT often requires advance scheduling.[4,54,55,57] It is also well suited for last-minute appointments, recovery rides following a missed pickup, and off-hour or high-volume periods, when traditional fleets may be limited.[4,57] In rural areas, where NEMT access is often sparse, RB-NEMT can expand transportation availability when rideshare networks operate locally.[58] By assigning ambulatory riders and flexible trip types to RB-NEMT, health plans and brokers can preserve traditional NEMT's specialized vehicles and trained personnel for riders who require D2D or H2H support.[4,59] This targeted assignment improves overall system efficiency, helps address capacity constraints, and ensures that higher-acuity riders retain access to appropriately equipped and staffed transportation.[4,59]

What safety standards exist for RB-NEMT?

Current minimum safety standards for RB-NEMT are far less formalized than those governing traditional NEMT, but several expectations have emerged through multiple studies.[4] At present, the only widely supported minimum standard is rider-service matching, meaning RB-NEMT should be used exclusively for low-assistance riders (i.e., those who can safely use C2C or A2A transportation) and do not require physical assistance, medical monitoring, or specialized mobility equipment.[4,54,59] Evidence consistently shows that rideshare vehicles cannot safely accommodate motorized wheelchairs, scooters, or securement-dependent devices, and drivers lack required

training in passenger assistance or medical support.[4,54,55,59] In addition, states and brokers implementing RB-NEMT generally rely on platform-level safety controls (i.e., identity verification, GPS tracking, and basic background checks already required of rideshare drivers) rather than NEMT-specific safety certifications.[4,60]

Beyond rider suitability, the most consistent minimum safety expectations relate to privacy and data handling, not clinical or operational safety. Because arranging RB-NEMT requires the transmission of pickup and destination details that may constitute protected health information (PHI), RB-NEMT platforms must operate through HIPAA-aligned scheduling dashboards, with Business Associate Agreements (BAAs) executed between the rideshare intermediary and the covered entity.[4,61–63] For example, Uber Health notes that platforms restrict driver-visible information to the "minimum necessary" (i.e., name and pickup point) and maintain encrypted PHI storage separate from consumer rideshare systems.[64] However, there are no federally defined driver-training requirements, no RB-NEMT-specific vehicle standards, and no validated safety benchmarks for transporting medically vulnerable individuals through TNCs.[4] As multiple studies have emphasized, RB-NEMT safety standards remain largely undeveloped, with the current minimums driven by platform safeguards, state-level rider selection criteria, and HIPAA compliance.[4,33,57]

EXISTING AMA POLICY

The AMA has limited policy on non-emergency medical transportation. AMA Policy H-130.954, "Non-Emergency Patient Transportation Systems," states our AMA supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems, and encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

CONCLUSION

NEMT plays a vital role in enabling timely access to health care, particularly for Medicaid beneficiaries, older adults, people with disabilities, and individuals living in rural or underserved communities.[1,12,28] For these populations, transportation is not simply a logistical need, but a foundational determinant of whether patients can obtain preventive services, maintain continuity of care, and effectively manage chronic conditions.[65] Traditional NEMT systems, delivered through state programs, brokers, and managed care plans, continue to serve riders who require specialized vehicles, trained personnel, or hands-on support.[4,19,22] However, despite their longstanding role in supporting access, these systems face persistent challenges in reliability, oversight, and operational consistency that can undermine their effectiveness.[30,31] In recent years, RB-NEMT has emerged as a flexible and on-demand complement to traditional models.[51,52] RB-NEMT may offer advantages such as rapid response times, broad geographic availability, and improved scheduling capacity for ambulatory riders and last-minute needs.[54,55] Yet this model operates within a fundamentally different regulatory structure. Rideshare vehicles are not equipped for mobility-device securement, and drivers, who function as independent contractors, are not trained to provide physical assistance or medical oversight.[4] As a result, RB-NEMT is appropriate only for certain riders and specific types of trips, and its safe integration requires careful matching of riders to service levels that align with vehicle capabilities and driver competencies.[4,54,55,59]

While traditional NEMT is guided by long-standing safety expectations grounded in federal Medicaid requirements, ADA accessibility standards, HIPAA privacy protections, and state-level driver, vehicle, and insurance regulations, these expectations are applied unevenly across states and

delivery models.[18,32,33,36–40,42,44,45,61–63] This variability underscores the need for greater consistency and coordination in how minimum safety standards are implemented for traditional NEMT. In contrast, RB-NEMT lacks comparable, evidence-based safety standards altogether. Existing studies provide clear guidance only on the importance of appropriate rider selection for RB-NEMT; beyond this, current research is insufficient to define validated safety requirements for driver training, vehicle specifications, or operational procedures.[4,60,64] Moreover, differences between state NEMT rules and TNC operating frameworks further complicate the development of uniform RB-NEMT safety expectations.[4,41,42]

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 508-A-25 and the remainder of the report be filed.

1. Our AMA acknowledges that transportation is a foundational component of health care access and supports policies that ensure vulnerable populations can obtain necessary medical care.
2. Our AMA supports efforts to promote greater consistency and coordination in the minimum safety standards that guide traditional non-emergency medical transportation across states and delivery models and encourages ongoing evaluation of these standards as transportation systems and patient needs evolve.
3. Our AMA acknowledges that rideshare-based non-emergency medical transportation (RB-NEMT) is an expanding component of medical transportation and supports continued research to assess safety risks and establish evidence-based minimum safety requirements to help ensure RB-NEMT can be integrated safely and appropriately into patient care. (New HOD Policy)

Fiscal Note: Modest

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(A-26)

Introduced by: Organized Medical Staff Section

Subject: Partnership with the Administration to Reduce Harmful Chemicals in Food and Align with European Safety Standards

Referred to: Reference Committee D

Whereas, the American Medical Association recognizes that food safety and the reduction of harmful chemical additives in the food supply represents a critical public health priority affecting millions of Americans; and

Whereas, the European Union has implemented more stringent regulations regarding food additives, artificial colors, preservatives, and other chemical substances, resulting in significantly lower exposure rates to potentially harmful compounds compared to the United States; and

Whereas, numerous peer-reviewed studies have linked certain food additives commonly used in the United States—including artificial food dyes, certain preservatives, and flavor enhancers—to adverse health outcomes including hyperactivity in children, allergic reactions, and potential carcinogenic effects; and

Whereas, the current U.S. food regulatory framework allows the use of over 3,000 food additives, many of which are prohibited or restricted in European markets due to safety concerns; and

Whereas, American families deserve access to food products that meet the same safety standards enjoyed by consumers in Europe and other developed nations; and

Whereas, the Trump Administration has expressed commitment to improving American health outcomes and reducing regulatory barriers that may impede food safety improvements; and

Whereas, collaboration between medical professionals and government agencies is essential to develop evidence-based policies that protect public health while supporting American food producers and manufacturers; therefore be it

RESOLVED, that our American Medical Association advocates for the establishment of a joint task force comprising AMA representatives, FDA officials, USDA personnel, and relevant administration appointees to:

1. Conduct a systematic review of food additives currently approved in the U.S. but banned or restricted in Europe
2. Evaluate the scientific evidence regarding health impacts of these substances
3. Develop a prioritized timeline for regulatory action on the most concerning additives
4. Create transition pathways for food manufacturers to adopt safer alternatives

(Directive to Take Action); and be it further

RESOLVED, that our AMA will monitor the implementation of any resulting food additive regulation policies and provide ongoing medical and scientific guidance to ensure reforms achieve meaningful public health improvements. (Directive to Take Action)

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

Received: 3/25/26

RELEVANT AMA POLICY

Food Safety - Federal Inspection Programs H-150.967
Our American Medical Association encourages the FDA and the U.S. Department of Agriculture to continue their efforts to assure the safety of the food supply. Inspection of meat, poultry, and seafood should be viewed as one component of an overall program for improving food safety.
Citation: CSA Rep. L, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21

FDA Drug Safety Policies D-100.978
Our American Medical Association will monitor and respond, as appropriate, to the implementation of the drug safety provisions of the Food and Drug Administration Amendments Act of 2007 (FDAAA; P.L. 110-85) so that the Food and Drug Administration can more effectively ensure the safety of drug products for our patients.
Citation: Sub. Res. 505, A-08; Reaffirmed: CSAPH Rep. 1, A-21

Addressing the Health Impacts of Ultraprocessed Foods H-150.914
1. Our AMA supports and promotes public awareness and education about the differences between healthful foods and unhealthful ultraprocessed foods (UPF) and the benefits of minimally processed and unprocessed foods.
2. Our AMA supports federal, state, and local policies that promote and incentivize the production and distribution of healthier, affordable, minimally-processed and unprocessed foods.
3. Our AMA encourages the integration of nutrition education into all levels of medical education to empower clinicians to best counsel patients efficiently and effectively on reducing unhealthful UPF consumption.
4. Our AMA supports increased funding to the FDA for research into the health impacts of ultraprocessed foods and strategies to mitigate their risks.

Citation: Res. 430, A-25

Reform the US Farm Bill to Improve US Public Health and Food Sustainability H-150.932
Reform the US Farm Bill to Improve US Public Health and Food Sustainability: Our American Medical Association supports the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders.
Citation: Res. 215, A-13; Reaffirmed: BOT Rep. 09, A-23

Strategies to Reduce the Consumption of Food and Beverages with Added Sweeteners H-150.927
1. Our American Medical Association acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption and food products with added sugars, and support evidence-based strategies to reduce the consumption of SSBs and food products with added sugars, including but not limited to, excise taxes on SSBs and food products with added sugars, removing options to purchase SSBs and food products with added sugars in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption and food products with added sugars, and the use of plain packaging.
2. Our AMA encourages continued research into strategies that may be effective in limiting SSB consumption and food products with added sugars, such as controlling portion sizes; limiting

options to purchase or access SSBs and food products with added sugars in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs and food products with added sugars to children; and changes to the agricultural subsidies system.

3. Our AMA encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price.
4. Our AMA encourages physicians to
    a. counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with healthier beverage and food choices, as recommended by professional society clinical guidelines.
    b. work with local school districts to promote healthy beverage and food choices for students.
5. Our AMA recommends that taxes on food and beverage products with added sugars be enacted in such a way that the economic burden is borne by companies and not by individuals and families with limited access to food alternatives.
6. Our AMA supports that any excise taxes are reinvested in community programs promoting health.
7. Our AMA will advocate for the end of tax subsidies for advertisements that promote among children the consumption of food and drink of poor nutritional quality, as defined by appropriate nutritional guiding principles.

Citation: CSAPH Rep. 03, A-17; Modified: Res. 429, A-22

Fast Food H-150.979
The AMA encourages fast food restaurants to reduce the saturated fat content of their foods, as well as to offer low fat alternatives to highly saturated fat foods.
Citation: Sub. Res. 123, A-86; Amended by Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16

Increasing Awareness of Nutrition Information and Ingredient Lists H-150.948
Our American Medical Association supports legislation or rules requiring restaurants, retail food establishments, and vending machine operators that have menu items common to multiple locations, as well as all school and workplace cafeterias, especially those located in health care facilities, to have available for public viewing ingredient lists, nutritional information, and standard nutrition labels for all menu items.
Citation: Sub. Res. 411, A-04; Reaffirmed: A-07; Reaffirmed in lieu of Res. 413, A-09 and Res. 418, A-09; Modified: BOT Rep. 1, A-14; Modified: CSAPH Rep. 01, A-24

The Health Effects of High Fructose Syrup H-150.919

1. Our American Medical Association recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS.
2. Our AMA encourages independent research (including epidemiological studies) on the health effects of HFCS and other added sugars, and evaluation of the mechanism of action and relationship between fructose dose and response.
3. Our AMA in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added sugars in their diet.

Citation: CSAPH Rep. 8, A-23

Food Additives H-150.998
Our American Medical Association supports the passage of legislation that would amend the Food Additive Act to require evidence based upon scientifically reproducible studies of the association of food additives with an increased incidence of cancer in animals or humans at dosage levels related to the amounts calculated as normal daily consumption for humans before removal of an additive from the market.
Citation: Sub. Res. 4, A-776; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 6, A-10; Reaffirmed; BOT Rep. 7, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(A-26)

Introduced by: Oklahoma, American Association of Public Health Physicians, Mississippi, Tennessee

Subject: Strengthening Public Health Protections Against Raw Milk–Associated Illness

Referred to: Reference Committee D

Whereas, raw unpasteurized milk poses significant risks of foodborne illness from pathogens such as Campylobacter, Shiga toxin-producing E. coli, Salmonella, Listeria, avian influenza, Brucella, Tuberculosis, and others, even from herds appearing healthy[1,5,6]; and

Whereas, from 1998-2018, raw milk caused at least 202 U.S. outbreaks resulting in 2,645 illnesses, 228 hospitalizations, and severe complications including hemolytic uremic syndrome, Guillain-Barré syndrome, sepsis, and death[1,5]; and

Whereas, children under 5 years are at highest risk for severe outcomes, including long-term kidney damage and neurological harm, yet cannot advocate for themselves against parental or caregiver choices exposing them to these preventable dangers[2,5]; and

Whereas, pregnant individuals consuming raw milk risk transmitting Listeria to fetuses, leading to miscarriage, stillbirth, preterm birth, or neonatal sepsis, disproportionately affecting the most vulnerable pediatric populations[1,2,5]; and

Whereas, the New Mexico Department of Health warned New Mexicans to avoid raw dairy products following the death of a newborn from Listeria infection in February of 2026 [9]; and

Whereas, claims of nutritional superiority or health benefits from raw milk lack high-quality evidence, while pasteurization eliminates pathogens without reducing essential nutrients[4,6,7,8]; and

Whereas, major public health authorities including the FDA, CDC, and AAP strongly advise against raw milk consumption, particularly for children, pregnant people, and immuno-compromised individuals[1,2,5]; and

Whereas, our AMA policy H-150.980, Milk and Human Health, reaffirms the policy that all milk sold for human consumption should be required to be pasteurized; therefore be it

RESOLVED, that our American Medical Association oppose the consumption and distribution of raw unpasteurized milk and dairy products, for protection of everyone, including but not limited to those at risk for Listeria complications (New HOD Policy); and be it further

RESOLVED, that our AMA urge congress and state legislatures to prohibit interstate sale of raw unpasteurized milk, strengthening current FDA regulation (New HOD Policy); and be it further

RESOLVED, that our AMA collaborate with like-minded organizations, possibly the AAP, to jointly develop and disseminate cost-efficient public education initiatives on the risks of raw,

unpasteurized milk and dairy products for children, targeting parents, schools, and childcare providers (Directive to Take Action); and be it further

RESOLVED, that our AMA support and advocate for, in jurisdictions where the sale or distribution of unpasteurized raw milk products cannot be prohibited, the implementation of labeling requirements that clearly warn consumers of the specific health risks associated with consumption of raw milk products, for general public and for members of vulnerable populations (Directive to Take Action); and be it further

RESOLVED, that our AMA support banning raw milk in settings accessible to children, such as schools and daycare facilities. (New HOD Policy)

Fiscal Note: Major – $69,695. Joint development and dissemination of education initiatives.

Received: 4/7/26

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RELEVANT AMA POLICY

Milk and Human Health H-150.980
The AMA reaffirms its policy that all milk sold for human consumption should be required to be pasteurized.

Food-Borne Illness H-440.904
Our AMA will work with appropriate federal agencies, medical specialty societies, and public health organizations to (1) educate physicians and the public on measures to prevent food-borne illness; and (2) ensure enforcement of existing regulations for the safe production, handling, and transportation of food items.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(A-26)

Introduced by: New Jersey

Subject: AMA's continued support for COVID-19 vaccination in pregnant individuals and children

Referred to: Reference Committee D

Whereas, on May 27, 2025, the CDC removed its recommendation for COVID-19 vaccination in healthy pregnant individuals and children aged 6 months–17 years (1); and

Whereas, pregnancy is a recognized high-risk condition for severe COVID-19 illness and infants born to unvaccinated mothers are more vulnerable in the first six months of life (2); and

Whereas, the AMA has previously demonstrated that the COVID-19 vaccination during pregnancy is safe for both mother and infant with no increase in miscarriage, preterm birth, or adverse fetal outcomes (3); and

Whereas, existing AMA policy D-440.921 ("An Urgent Initiative to Support COVID-19 Vaccination and Information Programs") emphasizes the necessity to promote the integrity of COVID-19 vaccine information; and

Whereas, the AMA does not have existing policy explicitly recommending ongoing Covid-19 vaccination for healthy pregnant individuals and children aged 6 months through 17 years old; therefore be it

RESOLVED, that our American Medical Association calls on the U.S. Centers for Disease Control and Prevention, Health and Human Services, and the Department of Health and Human Services to restore explicit recommendations for COVID-19 vaccination of pregnant individuals and young children aged 6 months to 17 years. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/9/2026

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RELEVANT AMA POLICY

An Urgent Initiative to Support COVID-19 Vaccination and Information Programs D-440.921
Our AMA will institute a program to promote the integrity of a COVID-19 vaccination information program by: (1) educating physicians on speaking with patients about COVID-19 infection and vaccination, bearing in mind the historical context of "experimentation" with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about up-to-date, evidence-based information regarding COVID-19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations; (5) educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online; and (6) supporting the public purchase and cost-free distribution and administration of COVID-19 booster vaccine doses.

Education and Public Awareness on Vaccine Safety and Efficacy H-440.830
1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; (f) supports state policies allowing minors to override their parent's refusal for vaccinations; and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.
2. Our AMA: (a) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (b) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.

[1]AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(A-26)

Introduced by: New Jersey

Subject: Develop Climate-Conscious Resources for Physicians

Referred to: Reference Committee D

Whereas, climate change poses a significant and immediate threat to public health, with impacts that include increased heat-related illnesses, respiratory conditions, vector-borne diseases, and disruptions to healthcare delivery; and

Whereas, the healthcare sector, including the U.S. healthcare system, is both affected by climate change and a significant contributor to greenhouse gas emissions; and

Whereas, physicians and other healthcare professionals play a vital role in advocating for environmentally sustainable practices within the healthcare system and in educating patients about the health impacts of climate change; and

Whereas, initiatives developed by a national foundation has been very successful at decreasing unnecessary tests, treatments, and procedures; and

Whereas, a national foundation has developed a comprehensive resource, broken down by specialty, focused on the intersection of climate change and healthcare, providing guidance, educational materials, and actionable recommendations to reduce the environmental impact of clinical practices; therefore be it

RESOLVED, that our American Medical Association support compiling and maintaining a resource for U.S. physicians, focused on education physicians and other healthcare professionals about the health impacts of climate change and the role of the healthcare sector in contributing to greenhouse gas emissions (New HOD Policy); and be it further

RESOLVED, that our AMA support providing practical, evidence-based recommendations for reducing the environmental footprint of clinical practices and healthcare systems (New HOD Policy); and be it further

RESOLVED, that our AMA support offering resources and tools to support physicians in advocating for environmentally sustainable policies and practices within their organization and communities (New HOD Policy); and be it further

RESOLVED, that our AMA facilitates collaboration and sharing of best practices among healthcare professionals and institutions committed to addressing climate change and promoting sustainability. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 4/9/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(A-26)

Introduced by: New Jersey

Subject: Studying the Environmental Impact of Ambient Clinical Intelligence Use

Referred to: Reference Committee D

Whereas, ambient clinical intelligence is proving to be an important technology tool for strengthening the physician-patient relationship and reducing physician burnout; and

Whereas, the demand for ambient clinical intelligence tools is significantly increasing and has a projected growth of by 38.62% from 2025 to 2030; and

Whereas, the growth of data centers to support ambient clinical intelligence is also being built to accommodate demand and place a significant strain on the electrical grid with potential public health implications; and

Whereas, data centers, as part of their routine operation, account for 1% of global electricity usage and this percentage is predicted to grow to 21% by 2030; and

Whereas, training a single AI model can emit over 284,000 kg of carbon dioxide; and

Whereas, built data centers come with an additional environmental cost of soil damage in areas where mineral extraction is done, pollution from the manufacturing of data center components and electronic waste from retired hardware, which have grown to more than 50 pounds annually with only about 20% of it is recycled; and

Whereas the direct impact on public health and infrastructure caused by data centers have been quantified to be as high as $5.4 billion dollars in a 5-year period; therefore be it

RESOLVED, that our American Medical Association in collaboration with state medical societies, develop a framework to study the public health impact and ecological challenges posed by the growth of ambient clinical intelligence (Directive to Take Action); and be it further

RESOLVED, that our AMA support efforts to voluntarily report emissions, water use, and e-waste from data centers to allow for public health entities to anticipate care and coverage costs to affected populations (New HOD Policy); and be it further

RESOLVED, our AMA works with stakeholders to encourage state and federal legislatures to offer specific tax incentives to ambient clinical intelligence vendors to work toward using 100% sustainable energy sources (Directive to Take Action); and be it further

RESOLVED, our AMA works with other industry healthcare associations to help establish clear guidelines on the responsible disposal of AI-enabled medical devices as well as AI purposed hardware. (Directive to Take Action)

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

Received: 4/9/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(A-26)

Introduced by: Medical Society of New Jersey

Subject: Reduce Environmental Impact of Medical Journals

Referred to: Reference Committee D

Whereas, the U.S. healthcare system generates a tremendous amount of waste, contributing 8.5% of greenhouse gas emissions and producing 4 billion pounds of waste annually; and

Whereas, there are over 1 million physicians in the United States, each of whom receives, on average, multiple medical journals monthly; and

Whereas, these journals are commonly wrapped in low-density polyethylene (LDPE), a material that, according to the Environmental Protection Agency (EPA), contributed 500,000 tons to U.S. landfills in 2015; and

Whereas, plastics, including LDPE, have been found in human blood, stool, and urine, and are known to cause cell death, allergic reactions, and inflammation; and

Whereas, a majority of physicians in a recent study expressed a preference for digital formats over print versions of medical journals; therefore be it

RESOLVED, that our American Medical Association's medical journals be provided via electronic-only means by default, and that physicians and other recipients be required to opt in to receive print versions (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage specialty societies to require physicians to opt in to receive print versions of journals, with the default option being to receive electronic-only versions. (New HOD Policy)

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

Received: 4/9/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(A-26)

Introduced by: American Association of Public Health Physicians

Subject: Colorectal Cancer in Alaskan Native Patients

Referred to: Reference Committee D

Whereas, colorectal cancer is on the rise among Americans younger than age 50[1]; and

Whereas, the United States (U.S.) Preventive Services Task Force (USPSTF) currently recommends that colorectal cancer screening begin at age 45 for average-risk adults[2]; and

Whereas, while incidence and mortality attributable to colorectal cancer has decreased among Americans, disparities have worsened among Alaskan Natives, with incidence exceeding 60 to 90 cases per 100,000 persons in this population–the highest worldwide[3,4]; and

Whereas, the age-adjusted incidence of colorectal cancer among Alaskan Natives exceeds that of the non-Hispanic white population across the entire adult lifecourse[5]; and

Whereas, from 2014–2018, the colorectal cancer incidence rate among the Alaska Native population (67.1/100,000) was over twice as high as the rate for the White population in Alaska (26.4/100,000), and over three times higher than the rate among Asian/Pacific Islander persons and Black persons in Alaska (20.3/100,000 and 17.1/100,000, respectively)[5]; and

Whereas, investigations of the troubling increase in colorectal cancer incidence and mortality among Alaskan Natives suggests contributions from genetic, environmental, social, and structural factors as key drivers of this disparity[5,6]; and

Whereas, in 2013, the Alaska Tribal Health System and Alaska Native Epidemiology Center (a federally-designated public health authority) recommended that persons with Alaska Native ancestry begin screening colonoscopies at age 40, which was driven by robust, powered epidemiological evidence in the Alaskan Native population[3,4,5-,8]; and

Whereas, uptake of this recommendation may be limited among physicians due to the USPSTF declining to implement a population-specific recommendation for this group due to low representation of Alaskan Natives in general population studies investigating colorectal cancer and supporting USPSTF recommendations[9]; and

Whereas, the Affordable Care Act links USPSTF recommendations, which currently conflict with those of the Alaska Tribal Health System and Alaska Native Epidemiology Center), and insurance coverage requirements, which may lead to denial of medically appropriate colorectal cancer screening in Alaskan Native patients[10]; and

Whereas, intensified efforts at the local, state, tribal, and federal level will be necessary to reduce the burden of early-onset colorectal cancer among Alaskan Natives, both living in and relocated out of Alaska, and the greater American public; and

Whereas, recommendations focused specifically on the Alaskan Native population with regards to colorectal cancer screening are not in conflict with the USPSTF position on colorectal screening in average-risk adults; and

Whereas, a quality evaluation of all rural and urban-setting colonoscopies conducted as part of the Alaska Native Tribal Health Center Colorectal Cancer Control Program funded by the U.S. Centers for Disease Control and Prevention from 2009 to 2015 (n = 6,704) reported comparable complication rates to the general U.S. population (0.5%)[7]; and

Whereas, colonoscopy is the preferred modality for colorectal cancer screening due to a high number of false-positive results associated with a high prevalence of Helicobacter pylori-associated hemorrhagic gastritis in the Alaskan Native population[7]; and

Whereas, greater investment in colorectal cancer prevention and control efforts may eventually lead to reduced mortality and population-level cancer stage migration; therefore be it

RESOLVED, that our American Medical Association advocates that the National Cancer Institute dedicate resources to the investigation of early-onset colorectal cancer in Americans younger than age 45 (Directive to Take Action); and be it further

RESOLVED, that our AMA will coordinate with interested national medical specialty societies, state medical associations, Alaska Native Corporations, and tribal governments to enhance physician education and awareness of the tribal public health authority recommendation to initiate preventive screening for colorectal cancer at age 40 in individuals with Alaska Native ancestry and advocate that these screenings be covered by all public and private payers, including the Indian Health Service and U.S. Centers for Medicare and Medicaid Services. These patients should also be counseled that the U.S. Preventive Services Task Force does not have a position on initiating colorectal cancer screening at age 40 in the Alaska Native population, and thus should be presented the risks and benefits associated with colonoscopy and medically appropriate screening alternatives. (Directive to Take Action)

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

Received: 4/13/26

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10. O'Brien MJ, Kirley KA, Ackermann RT. Reducing Health Disparities Through Prevention: Role of the U.S. Preventive Services Task Force. Am J Prev Med. 2020;58(5):724-727. doi:10.1016/j.amepre.2019.11.022

RELEVANT AMA POLICY

Advocating for the Implementation of Updated U.S. Preventive Services Task Force Recommendations for Colorectal Cancer Screening Among Primary Care Physicians and Major Payors by the AMA D-425.990

Our American Medical Association will coordinate with interested national medical specialty societies and state medical associations to enhance physician education and awareness of the US Preventive Services Task Force (USPSTF) guidelines to initiate preventive screening for colorectal cancer at age 45.

Clinical Preventive Services H-410.967

1. Our American Medical Association recommends the USPSTF guidelines to clinicians and medical educators as one resource for guiding the delivery of clinical preventive services. USPSTF recommendations should not be construed as AMA policy on screening procedures and should not take the place of clinical judgment and the need for individualizing care with patients; physicians should weigh the utility of individual recommendations within the context of their scope of practice and the situation presented by each clinical encounter.
2. Our AMA will continue to encourage the adoption of practice guidelines as they are developed based on the best scientific evidence and methodology available.
3. Our AMA will continue to promote discussion, collaboration, and consensus among expert groups and medical specialty societies involved in preparation of practice guidelines.

Improving Health Care of American Indians and Alaska Natives H-350.976

1. Our American Medical Association recommends that all individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens.
2. Our AMA recommends that the federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives.
3. Our AMA recommends that state and local governments give special attention to the health and health-related needs of non-reservation American Indians and Alaska Natives in an effort to improve their quality of life.
4. Our AMA recommends that American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
5. Our AMA recognizes practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives.
6. Our AMA monitors Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care.
7. Our AMA supports consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs.
8. Our AMA recommends strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
9. Our AMA recommends a team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
10. Our AMA will continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

11. Our AMA recommends that state and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside.
12. Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian and Alaska Native health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians and Alaska Natives.
13. Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(A-26)

Introduced by: American College of Obstetricians and Gynecologists, The American Association of Gynecologic Laparoscopists

Subject: Addressing Rural Maternal Morbidity and Mortality through Collaboration and Intersectionality

Referred to: Reference Committee D

Whereas, since 2020 there has been a 12% decrease in labor and delivery units in rural hospitals, with fewer than half of United States counties offering labor and delivery services and more than two closures per month over the last four years, according to the Center for Healthcare Quality and Payment Reform (CHQPR)[1]; and

Whereas, many additional rural hospitals are at risk of losing maternity care services due to financial losses associated with maintaining 24/7 staffing compared to reimbursement, with CHQPR estimating that more than 100 additional closures may occur in 2026[1]; and

Whereas, rural hospitals are at even greater risk of closure due to reductions in Medicaid and Affordable Care Act funding following enactment of H.R.1 in 2025; and

Whereas, birthing individuals in maternity care deserts, rural counties, and communities predominantly composed of American Indian and Alaska Native individuals experience extended travel distances and times to obtain maternity services, increasing the risk of preterm birth and out-of-hospital delivery; and

Whereas, closure of labor and delivery units places systemic strain on emergency medical services, medical transport services, and emergency rooms in hospitals without maternity care physicians, and life-threatening obstetric complications may occur in these settings; and

Whereas, over 80% of maternal deaths are preventable with appropriate prenatal, labor and delivery, and postpartum care;[3] and

Whereas, 60% of maternal deaths occur in the postpartum period (up to 12 months after birth,) the majority related to cardiovascular disease or behavioral health;[3] and

Whereas, there is a parallel between states with abortion restrictions and states with poor maternal health outcomes;[4] and

Whereas, rural communities experience significantly higher maternal mortality rates overall, and more than 70% of these deaths occur during the postpartum period;[5] and

Whereas, a 2023 study in the American Journal of Public Health reported that pregnant individuals residing in rural areas experience higher risk of ICU admission, and nearly twice the maternal mortality of those in urban areas;[6] therefore be it

RESOLVED, that our American Medical Association publish a focused report examining the intersection of maternal mortality disparities, access to rural pregnancy care, workforce shortages, and reproductive health policy variability, with recommendations to reduce preventable maternal deaths, including during the postpartum period (Directive to Take Action); and be it further

RESOLVED, that our AMA ensure that this report includes evidence-based recommendations to reduce preventable maternal mortality through the postpartum year, including strategies for optimized allocation of federal and state funding (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with specialty societies and public health stakeholders to promote and disseminate innovative practice models—such as regional call-sharing systems, tele–maternal-fetal medicine support, and hospital–physician partnership structures—designed to reduce rural maternal morbidity and mortality, including during the postpartum period. (Directive to Take Action)

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

Received: 4/13/26

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RELEVANT AMA POLICY

H-420.946 (2024) Advocating for Evidence-Based Strategies to Improve Rural Obstetric Health Care and Access

D-420.993 (2021) Disparities in Maternal Mortality

H 420.993 (2024) Improving Mental Health Services During Pregnancy and Postpartum

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(A-26)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Eliminate PFAS and Glyphosate in our Food and Environment

Referred to: Reference Committee D

Whereas, the EPA in 2025 has allowed PFAS insecticides for use on US food crops (e.g. isocycloseram (insecticide) and cyclobutrifluram (fungicide), and these compounds are linked to serious health issues, including liver toxicity, cancer, and reproductive harm[1]; and

Whereas, PFAS do not break down easily, remain on the food crops, and contaminate both the soil and the water supply indefinitely endangering both human and environmental health[2]; and

Whereas, recently the US by presidential order is expanding and allowing glyphosate to be used on our food supply despite health warnings[3]; and

Whereas, Glyphosate has serious health risks including non-Hodgkin lymphoma, liver disease, metabolic disorders, and hormone disruption, with studies indicating neurotoxicity, developmental effects, and increased cancer risk by up to 41%[4, 5]; and

Whereas, the AMA has policy for PFAS danger to human health[6]; therefore be it

RESOLVED, that our American Medical Association promote a safe and healthy food supply and environment by advocating for removal of PFAS and Glyphosate chemicals from our food supply and environment. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

REFERENCES

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2. https://pmc.ncbi.nlm.nih.gov/articles/PMC7906952/#R261
3. https://www.whitehouse.gov/presidential-actions/2026/02/promoting-the-national-defense-by-ensuring-an-adequate-supply-of-elemental-phosphorus-and-glyphosate-based-herbicides/
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6. H-135.916

RELEVANT AMA POLICY

H-135.916 Per- and Polyfluoroalkyl Substances (PFAS) and Human Health

1. Our American Medical Association supports continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health.
2. Our AMA supports legislation and regulation seeking to address contamination, exposure, classification, and clean-up of PFAS substances.
3. Our AMA will advocate for states, at minimum, to follow guidelines presented in the Environmental Protection Agency's Drinking Water Health Advisories for perfluorooctanoic acid (PFOA) and perfluorooctane sulfonic acid (PFOS), with consideration of the appropriate use of Minimal Risk Levels (MRLs) presented in the CDC/ATSDR Toxicological Profile for PFAS.
4. Our AMA will amplify physician and public education around the adverse health effects of PFAS chemicals and potential mitigation and prevention efforts. [Res. 901, I-19 Modified: Res. 428, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(A-26)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Light Pollution

Referred to: Reference Committee D

Whereas, the current AMA policy on adverse human health effects and environmental damage of light pollution and high blue wavelength is based on a Council on Science and Public Health (CSPH) report from 2012: (Report 4 of the CSPH (a-12) Light Pollution: Adverse Health Effects of Nighttime Lighting[1]; and

Whereas, AMA policy on disability glare remains intact and widely adopted from Resolution 516, A-09[2]; and

Whereas, the AMA policy on LED outdoor lighting is based on a CSPH report from 2016 CSAPH Report 2-A-16: Human and Environmental Effects of Light Emitting Diode (LED) Community Lighting[3]; and

Whereas, these documents remain as the AMA advice for nighttime lighting for communities and cities worldwide, and are frequently downloaded and used as expert opinion for many local towns and cities worldwide[4]; and

Whereas, significant new research and evidence have been reported over the past 10 years, we should now update our AMA policy on light at night and excess blue light night time emission[0]; and

Whereas, the suppression of melatonin from excess blue light wavelength especially at 479 nm as reported by Martin Moore-ede in “The Light Doctor” 2024 leads to numerous adverse human health effects well documented by many and numerous scientific publications, including in JAMA[5, 6, 9, 10]; and

Whereas, our current AMA policy from 2016 states outdoor lighting should be 3000K or less, that recommendation is outdated now, and many lighting companies continue to recommend 3000K outdoor lighting or even still 4000K in some cases[3]; and

Whereas, night street light dimming capabilities are now readily available and should be encouraged for minimal added cost per light fixture, for dimming streetlights late at night a time of a towns choosing that will further limit glare, further save energy usage during late night and early morning lighting times[7]; and

Whereas, significant advances in LED technology has been made, with 2700K lighting now readily available, and even 2200K or 2400K lighting now offered, with significantly lower blue light emission[8]; therefore be it

RESOLVED, that our American Medical Association update its outdoor lighting recommendations to be:

1. Most outdoor lighting including street lighting should be 2700K or lower
2. Exceptions for inner city high traffic regions could be made for 3000K when deemed necessary for public safety
3. For rural and residential areas, or locations with interest in environmentally friendly policy, strong considerations be given to use 2200K to 2400K outdoor lighting
4. AMA policy on shielding to prevent disability glare should remain unchanged and should have fully shielded light fixtures to limit emission to 10 degrees below the horizontal to limit glare
5. Consideration should be given for streetlight dimming technology on most streetlights for further energy savings at low traffic times and further glare reduction. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

REFERENCES

1. H-135.932
   CSAPH Rep. 4, A-12, reaffirmation CSPH Rep 1, A-22, Reaffirmation: BOT Rep 30, A-24
2. H-135.937
   Res. 516, A-09, Reaffirmed: CSAPH Rep. 4, A-12, Reaffirmed: CSAPH Rep. 1, A-22
3. CSAPH Rep. 02, A-16
4. Multiple citations in journals worldwide
5. AMA Journal of ethics, Oct 2024, Vol 26, N10: E804-810, "We're all Healthier Under a Starry Sky", Mario Motta, MD
6. *The Light Doctor: Using Light to Boost Health, Improve Sleep, and Live Longer, Martin Moore-ede, Circadian books 2024*
7. https://www.microchip.com/en-us/solutions/sustainability/street-lighting
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9. New Insights on Circadian Health and Cardiometabolic Disease-Light, Sleep, Food, Exercise, and More, JAMA 2025;334;(23):2055-2057. doi:10.1001/jama.2025.22365
10. Role of Circadian Health in Cardiometabolic Health and Disease Risk: A Scientific Statement From the American Heart Association, Circulation
    Volume 152, Number 21

RELEVANT AMA POLICY

H-135.932 Light Pollution: Adverse Health Effects of Nighttime Lighting

1. Our American Medical Association supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency.
2. Our AMA recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment.
3. Our AMA supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night.
4. Our AMA supports work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place. [CSAPH Rep. 4, A-12Reaffirmation: A-22Reaffirmed: CSAPH Rep. 1, A-22Reaffirmed: BOT Rep. 30, A-24]

H-135.937 Advocating and Support for Light Pollution Control Efforts and Glare Reduction for Both Public Safety and Energy Savings

1. Our American Medical Association will advocate that all future outdoor lighting be of energy efficient designs to reduce waste of energy and production of greenhouse gases that result from this wasted energy use.
2. Our AMA supports light pollution reduction efforts and glare reduction efforts at both the national and state levels.
3. Our AMA supports efforts to ensure all future streetlights be of a fully shielded design or similar non-glare design to improve the safety of our roadways for all, but especially vision impaired and older drivers. [Res. 516, A-09 Reaffirmed: CSAPH Rep. 4, A-12 Reaffirmed: CSAPH Rep. 1, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(A-26)

Introduced by: American Academy of Ophthalmology

Subject: Addressing the Myopia Epidemic, Public Education, and Insurance Coverage for Evidence-Based Myopia Control

Referred to: Reference Committee D

Whereas, uncorrected myopia (nearsightedness) is the leading cause of distance vision impairment globally; and

Whereas, myopia continues to increase among children worldwide and is projected to affect up to 50% of the world's population by 2050 with high myopia in 10%; and

Whereas, myopia and especially high myopia is associated with increased risk of serious ocular complications such as retinal detachment, myopic maculopathy, glaucoma, and choroidal neovascularization, which represent avoidable causes of visual impairment if myopia progression can be slowed; and

Whereas, peer-reviewed evidence demonstrates that interventions such as environmental/behavioral changes (e.g., increased outdoor time, reducing near work/excessive screen time), optical interventions (e.g., highly aspherical lenses, peripheral defocus contact lenses), and pharmacological treatment (e.g., low dose atropine drops) can slow the progression of myopia in children and adolescents, with other promising treatments under evaluation; and

Whereas, public awareness of myopia as a progressive condition and of the availability of these evidence-based interventions to reduce myopia progression remains limited, contributing to underutilization and preventable long-term morbidity; and

Whereas, despite its significant impact on health and morbidity, myopia is not consistently classified as a disease, including by the Centers for Medicare and Medicaid Services; and

Whereas, inconsistent insurance coverage for these evidence-based myopia-control treatments creates financial barriers for patients seeking early intervention, disproportionately affecting underserved populations; therefore be it

RESOLVED, that our American Medical Association recognize that myopia is a significant and increasing public health concern warranting public health outreach, improved screening in children, and prevention efforts (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for public education initiatives to increase awareness among patients, caregivers, educators, and policymakers about the risks of progressive myopia and the availability of evidence-based interventions shown to slow myopia progression (Directive to Take Action); and be it further

RESOLVED, that our AMA support efforts to formally classify myopia as a disease to ensure that patients can receive appropriate treatment and insurance coverage for the treatment of this medical condition (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts to ensure comprehensive insurance coverage and reimbursement for evidence-based treatments demonstrated to slow myopia progression in pediatric and adolescent patients. (New HOD Policy)

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

Received: 4/14/26

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4. National Academies of Sciences, Engineering, and Medicine; Division of Behavioral and Social Sciences and Education; Board on Behavioral, Cognitive, and Sensory Sciences; Committee on Focus on Myopia: Pathogenesis and Rising Incidence. Myopia: Causes, Prevention, and Treatment of an Increasingly Common Disease. Washington (DC): National Academies Press (US); 2024 Sep 17. PMID: 39348479.
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RELEVANT AMA POLICY

H-60.913 Increasing Outdoor Activity to Prevent Myopia Onset and Progression in School Children
Our AMA supports efforts to increase outdoor time and promote other activities that have been demonstrated to reduce the progression of myopia in children. [Res. 405, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(A-26)

Introduced by: New York

Subject: Guiding Principles of Pandemic Prevention, Preparedness and Response; Support for the World Health Organization Pandemic Agreement

Referred to: Reference Committee D

Whereas, Resolution WHA78.1, the “WHO Pandemic Agreement” was adopted at the Seventy-eighth World Health Assembly on May 20th, 2025; and

Whereas, the WHO Pandemic Agreement was negotiated, and subsequently adopted by 193 out of the 194 member states, with the sole exception being the United States of America; and

Whereas, on January 22nd, 2026, the United States of America withdrew its membership from the World Health Organization; and

Whereas, New York State and many other states were gravely affected by the COVID-19 Pandemic, and should uphold the highest level of scientific, medical and intergovernmental evidence and cooperation for the prevention, preparedness and response to future pandemics; and

Whereas, State level policies such as Medical Society of the State of New York’s “MSSNY Principles of Public Health During an Infectious Disease Outbreak” (260.875) have been a useful initial resource for guiding Pandemic Prevention, Preparedness and Response, but are not as extensive as the principles stated in the WHO Pandemic Agreement; and

Whereas, National level policies such as the American Medical Association’s “Pandemic Preparedness” (H-440.847), “Pandemic Ethics and the Duty of Care” (D-130.960), “AMA Role in Addressing Epidemics and Pandemics” (H-440.835)722, “Low Cost Drugs to Economically Disadvantaged Countries During Times of Pandemic Health Crises” (H-250.988) and “Pandemic Ethics and the Duty of Care” (H-140.821), speak to federal level guidance and limited international guidance, they do not speak to several more in-depth principles of pandemic preparedness regarding intergovernmental and international cooperation that is called for in the WHO Pandemic Agreement; and

Whereas, the American Medical Association is a member of the World Medical Association, and specific policy supporting the below guiding principles from the World Health Organization Pandemic Agreement would allow the American Medical Association to participate in debate and policy making in a more evidence-based way, given the present lack of commitment to these principles from the United States Federal Government; therefore be it

RESOLVED, that our American Medical Association support and adopt the following Articles of the World Health Organization Pandemic Agreement as our framework for Pandemic Prevention, Preparedness and Response:

Article 4, Pandemic prevention and surveillance;

- Article 5, One Health approach for Pandemic Prevention, Preparedness and Response;
- Article 6, Preparedness, readiness and health system resilience;
- Article 7, Health and care workforce;
- Article 8, Regulatory systems strengthening;
- Article 9, Research and development;
- Article 10, Sustainable and geographically diversified local production;
- Article 11, Transfer of technology and cooperation on related know-how for the production of pandemic-related health products;
- Article 12, Pathogen Access and Benefit-Sharing Systems;
- Article 13, Supply chain and logistics;
- Article 14, Procurement and distribution;
- Article 15, Whole-of-government and whole-of-society approaches;
- Article 16, Communication and public awareness;
- Article 17, International cooperation and support for implementation;
- Article 18, Sustainable financing; and be it further.

(Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(A-26)

Introduced by: American Association of Public Health Physicians

Subject: Erosion of the Public Evidence Base for Health Policy

Referred to: Reference Committee D

Whereas, for many decades, the U.S. Centers for Disease Control and Prevention (CDC) have maintained surveillance systems for a wide range of diseases and other conditions to help guide public and private efforts to protect the health of all Americans and, in some cases, global health; and

Whereas, for almost all such diseases and conditions, the decision to monitor each one is based on the professional judgment of experts in the field and committees of outside experts and approved at an annual meeting where each states epidemiologist is represented; and

Whereas, for each of the diseases and conditions in this surveillance system, a decision for surveillance is based on consideration of the condition's public health importance, the utility of a surveillance system to guide disease control efforts, and – in some cases – the prospects for eliminating the disease or condition permanently; and

Whereas, experts predict that declining vaccination rates and other risk factors will lead to dramatic increases in vaccine-preventable disease morbidity, which must be promptly tracked, analyzed, and controlled in order to prevent further morbidity and mortality; and

Whereas, we are seeing the resurgence of vaccine-preventable disease such as pertussis[1], Haemophilus influenzae[2], and Neisseria meningitisi[3] in the United States; and

Whereas, CDC surveillance data from the 2024–2025 influenza season documented at least 43 million symptomatic illnesses, 560,000 hospitalizations, and 38,000 deaths, making it the most severe influenza season since 2017–2018 and underscoring the necessity of uninterrupted national surveillance systems to guide timely response[4]; and

Whereas, an audit published in Annals of Internal Medicine found that 46% of CDC databases previously updated at least monthly had halted updates by October 2025, with most pauses exceeding six months[5,6]; and

Whereas, the same audit found that paused databases disproportionately involved vaccination-related surveillance, including influenza, COVID-19, and RSV, while none of the currently updated databases covered vaccination topics[7]; and

Whereas, these pauses were unexplained, with no public notices, banners, or press releases provided by the CDC to justify or contextualize the interruptions[8]; and

Whereas, the Annals investigation warns that these widespread interruptions undermine evidence-based medicine, impede outbreak readiness, and erode public trust in federal public health leadership at a time when accurate information is crucial; and

Whereas, this pause appears to have been initiated solely at the federal level, without consultation with state, city, territorial, or other entities who also have responsibility for communicable and chronic disease control; and

Whereas, as of April 2026, the United States faces a prolonged respiratory syncytial virus (RSV) season[9]; and

Whereas, the convergence of paused surveillance, budget reductions, political interference, and declining childhood vaccination rates significantly endangers national health security; therefore be it

RESOLVED, that our American Medical Association urges the U.S. federal government to publicly disclose the causes of federal disease surveillance interruptions; to provide expeditious timelines for restoration of surveillance databases and analyses for all nationally notifiable diseases, including hiring and re-hiring of scientifically qualified and appropriately funded staff; and to adopt an adequate mandatory public notification protocol for any future pauses (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate Congressional oversight, including an annual report, assessing CDC surveillance performance; staffing adequacy; data transparency; and the impact of funding levels collectively on public health readiness and national security. (Directive to Take Action)

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

Received: 4/15/26

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2. https://pauloffit.substack.com/p/the-return-of-hib?utm_source=post-email-title&publication_id=1530624&post_id=190095908&utm_campaign=email-post-title&isFreemail=true&r=4d9qd&triedRedirect=true&utm_medium=email
3. https://www.cdc.gov/meningococcal/php/surveillance/index.html
4. CDC Releases 2024-2025 Flu Report, With Suggestions for Upcoming Season | Infectious Diseases | JAMA | JAMA Network
5. Unexplained Pauses in Centers for Disease Control and Prevention Surveillance: Erosion of the Public Evidence Base for Health Policy | Annals of Internal Medicine
6. Nearly half of CDC surveillance databases have halted updates, raising concerns about health data gaps
7. Unexplained Pauses in Centers for Disease Control and Prevention Surveillance: Erosion of the Public Evidence Base for Health Policy | Annals of Internal Medicine
8. Unexplained Pauses in Centers for Disease Control and Prevention Surveillance: Erosion of the Public Evidence Base for Health Policy | Annals of Internal Medicine
9. RSV is still spreading, prompting states to extend the immunization period | CNN

RELEVANT AMA POLICY

Public Health Surveillance H-440.813
Bolstering Public Health Preparedness H-440.892
Vector-Borne Diseases H-440.820
Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems D-440.922
Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research D-440.905

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(A-26)

Introduced by: American Association of Public Health Physicians

Subject: Restoring Balanced Scientific Perspective within the ACIP

Referred to: Reference Committee D

Whereas, in June 2025, our AMA adopted an emergency resolution, now codified as AMA Policy D-440.902, expressing alarm about then-recent developments in United States vaccine policy; and

Whereas, in July 2025, multiple medical specialty associations and public health organizations filed a lawsuit that among other issues argued that the voting members appointed in 2025 to the Advisory Committee on Immunization Practices (ACIP) panelists lacked the qualifications to recommend vaccinations and that their decisions endangered the health of Americans; and

Whereas, the undermining of United States vaccine and public health policy by Health and Human Services Secretary Robert F. Kennedy Jr. has continued and worsened since June 2025; and

Whereas, lapses in vaccine coverage for many vaccines result in preventable harm to vulnerable persons who cannot be vaccinated or in whom vaccines are less effective, to persons in whom these vaccines are less effective than in others, and to people both near and far who deserve protection from preventable diseases; and

Whereas, in a factually rich and carefully balanced Memorandum and Order issued on March 16, 2026, Federal Judge Brian Murphy reversed the appointment of the new, largely unqualified ACIP members; stayed the decisions purportedly made by this panel; and stayed other vaccine-related decisions made by the U.S. Department of Health and Human Services (HHS) and the U.S. Centers for Disease Control and Prevention (CDC) without consulting any version of the ACIP[1]; and

Whereas, Federal law specifies that, “Advisory committees requiring technical expertise should include persons with demonstrated professional or personal qualifications and experience relevant to the functions and tasks to be performed by the Committee[2]; and

Whereas, on April 6, 2026, HHS published in the federal register and published on CDC webpages changes to the ACIP Charter on membership of the voting members of the ACIP, moving from topical coverage to specialty area and geographical coverage, and changing the purpose and composition of ACIP[3]; and

Whereas, geographic representation cannot improve decision-making because the vaccine recommendations should apply nationwide to all individuals in similar circumstances, because Americans and their infections travel frequently and migrate from one region to another, and because regional population-level variations in the immunization schedule would complicate vaccine compliance determinations without any corresponding benefit; and

Whereas, this new charter appears intended to thwart physicians' claims for organizational-level relief from counterproductive and burdensome changes to physicians' counseling workload and to the difficulty of achieving community vaccine coverage; and

Whereas, this new charter eliminates the prior specification for experience in preventive medicine and health economics, among others[4]; and

Whereas, the proposed new ACIP charter, published on April 6, 2026, was not available for public comment as of April 10, 2026; therefore be it

RESOLVED that our American Medical Association amend Policy D-440.902 by addition and deletion to read as follows:

1. Our American Medical Association will continue~~initiate~~ sustained public advocacy in support of the ~~current~~previous Advisory Committee on Immunization Practices (ACIP) structure, including the liaison representative program, as outlined in ACIP's 2024 Charter and practiced until Spring 2025.
2. Our AMA will ~~immediately send a letter to the Secretary of Health and Human Services calling for an immediate reversal of the recent changes to the Advisory Committee on Immunization Practices~~ pursue all appropriate channels to reverse the 2025-2026 changes to ACIP's structure, membership, and operations.
3. Our AMA will ~~immediately send a letter to the Senate Committee on Health, Education, Labor, and Pensions (HELP) and~~ request an investigation into the actions of the U.S. Secretary of Health and Human Services regarding his administration of the Centers for Disease Control and Prevention and Advisory Committee on Immunization Practices.
4. Our AMA will continue to identify and evaluate alternative evidence-based vaccine advisory structures and invest resources in such initiatives, as necessary.

(Modify Current HOD Policy); and be it further

RESOLVED, that our AMA condemns the arbitrary and unilateral 2026 alterations to the ACIP charter, which appear to have been designed to subvert the authority of relevant Federal judges and to allow the appointment of unqualified committee members and liaisons to the Advisory Committee on Immunization Practices (ACIP) (New HOD Policy); and be it further

RESOLVED, that our AMA will collaborate with interested state and specialty societies to support litigation against changes to the ACIP charter, budget, operating principles and staffing which produce ongoing harm to the public's health, and many of which were adopted without adequate and meaningful opportunity for public comment (Directive to Take Action); and be it further

RESOLVED, that our AMA specifically notes the importance of representation from health economics experts, and from the medical specialty of Preventive Medicine, in vaccine policy development as was recognized in the original charter, but was eliminated in the most recent update of the charter. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

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2. 41 CFR 102-3 60(b)(1)
3. https://www.federalregister.gov/documents/2026/04/06/2026-06577/advisory-committee-on-immunization-practices-acip-notice-of-charter-renewal, accessed April 14, 2026
4. https://perma.cc/WVL8-XJWH

RELEVANT AMA POLICY

Advisory Committee on Immunization Practices D-440.902
Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems D-440.922
Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research D-440.905

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(A-26)

Introduced by: Colorado, Washington, Utah, American College of Physicians

Subject: Advocacy for Restoration of the Endangerment Finding Regarding Greenhouse Gas Emissions

Referred to: Reference Committee D

Whereas, our American Medical Association supports the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people; and

Whereas, our American Medical Association declares climate change a public health crisis that threatens the health and well-being of all individuals; and

Whereas, our American Medical Association supports initiatives to promote environmental sustainability and other efforts to halt global climate change; and

Whereas, the AMA's Declaration of Professional Responsibility identifies among physician "duties and responsibilities", to "Educate the public and polity about present and future threats to the health of humanity" and to "Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being"; and

Whereas, the endangerment finding is a conclusion by the U.S. Environmental Protection Agency (EPA) that certain greenhouse gases, such as carbon dioxide and methane, pose a threat to public health and welfare, allowing for federal regulation of these emissions under the Clean Air Act and has been a key legal basis for regulating greenhouse gas emissions; and

Whereas, on 2/12/2026, the EPA announced it had repealed the endangerment finding; and

Whereas, it is likely that multiple lawsuits to restore the endangerment finding will be filed; therefore be it

RESOLVED, that our American Medical Association encourage the Litigation Center to monitor lawsuits against the rescinding of the endangerment finding and to consider submitting amicus curiae briefs in those with a likelihood of success on behalf of the HOD (New HOD Policy); and be it further

RESOLVED, that our AMA advocate against the repeal of the endangerment finding and support its restoration (Directive to Take Action); and be it further

RESOLVED, that our AMA publicly state that repeal of the endangerment finding is a threat to public health and take appropriate action, to include collaboration with relevant associations and stakeholders, to ensure that the public is adequately educated. (Directive to Take Action)

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

Received: 4/15/26

REFERENCES

1. https://www.ama-assn.org/public-health/prevention-wellness/ama-declaration-professional-responsibility
2. https://www.epa.gov/newsreleases/president-trump-and-administrator-zeldin-deliver-single-largest-deregulatory-action-us
3. https://www.scientificamerican.com/article/what-repealing-the-endangerment-finding-means-for-public-health/
4. https://www.nytimes.com/2026/02/12/climate/what-to-know-epa-endangerment-finding.html
5. https://woods.stanford.edu/news/epa-endangerment-finding-explained-5-facts-about-science-and-health-risks

RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938
AMA Advocacy for Environmental Sustainability and Climate H-135.923
Declaring Climate Change a Public Health Crisis D-135.966

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(A-26)

Introduced by: American Society for Clinical Pathology, American Society of Cytopathology, American Society of Dermatopathology, College of American Pathologists, National Association of Medical Examiners

Subject: Clinical Laboratory Workforce Shortage and Sustainability

Referred to: Reference Committee D

Whereas, medical laboratory professionals working in multiple disciplines throughout clinical, anatomic, and public health laboratories are indispensable, highly trained, and specialized members of the physician-medical director led health care team which generates critical diagnostic information that drives the majority of medical decisions across all clinical specialties; and

Whereas, the United States is experiencing a critical and worsening shortage of qualified clinical laboratory personnel due to workforce attrition, retirements, limited training program capacity, and insufficient recruitment, training only one third to one half of needed positions annually; and

Whereas, inadequate staffing in clinical laboratories can lead to delays in results, increased diagnostic errors, reduced access to specialized testing, and degraded quality of care, ultimately resulting in significant negative impacts on patient outcomes; and

Whereas, barriers to entering and remaining in the clinical laboratory workforce include limited awareness of the profession, insufficient compensation relative to educational requirements, lack of career advancement opportunities, and regulatory and reimbursement challenges; therefore be it

RESOLVED, that our American Medical Association recognize the unique and critical role of medical laboratory professionals in patient care and public health and the urgent need to address workforce shortages (New HOD Policy); and be it further

RESOLVED, that our AMA support advocacy efforts to sustain and strengthen clinical laboratory training and education programs, including assistance for faculty development and infrastructure, to address capacity and recruitment needs (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with relevant stakeholders, including accrediting bodies, educational institutions, health care organizations, and professional societies, to promote awareness of clinical laboratory careers, as members of the physician-led health care team, among students and the public. (Directive to Take Action)

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

Received: 4/15/26

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2. The United States is facing a critical, long-term shortage of medical laboratory professionals, with the Bureau of Labor Statistics (.gov) projecting a need for roughly 10,000–24,000 new professionals annually to fill vacancies, far exceeding the ~5,000–7,400 annual graduates. Bureau of Labor Statistics, US Department of Labor, https://www.bls.gov/ooh/healthcare/clinical-laboratory-technologists-and-technicians.htm
3. AACC Whitepaper on Overcoming Lab Staffing Shortages, Erika Deaton-Mohney MT(ASCP), CPP; Sharon Ehrmeyer, PhD, MT(ASCP); Christopher Farnsworth, PhD, DABCC; Theresa Kunzler, MS, MT(ASCP); Frederick Strathmann, PhD, DABCC; & Monica Thomas, MPA, CLS(ASCP); https://myadlm.org/advocacy-and-outreach/adlm-policy-reports/2023/adlm-whitepaper-on-overcoming-lab-staffing-shortages#:~:text=The%20mechanism%20by%20which%20many,to%20reference%20laboratories%20(25)
4. Edna Garcia, Jenny Diaz, Iman Kundu, Melissa Kelly, Ryan Soles, The American Society for Clinical Pathology 2024 Vacancy Survey of medical laboratories in the United States, American Journal of Clinical Pathology, Volume 164, Issue 5, November 2025, Pages 759–777, https://doi.org/10.1093/ajcp/aqaf101

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 417
(A-26)

Introduced by: American College of Occupational & Environmental Medicine

Subject: Respiratory Protection for Wildland Firefighters

Referred to: Reference Committee D

Whereas, wildland firefighters are exposed to wildfire smoke containing fine particulate matter (PM2.5), carbon monoxide, aldehydes, benzene, acrolein, dioxins, and polycyclic aromatic hydrocarbons at levels linked to acute and chronic cardiopulmonary harm and cancer, yet most wildland fire suppression operations do not require respiratory protection; and

Whereas, federal interagency guidance has historically excluded mandatory respirator use during suppression, citing concerns related to heat burden and performance, despite evidence supporting the effectiveness of National Institute for Occupational Safety and Health (NIOSH)-approved filtering facepiece respirators, air-purifying respirators (APRs), and powered air-purifying respirators (PAPRs); and

Whereas, bandannas and non-certified masks provide no meaningful protection, while properly selected, fit-tested, and medically cleared respirator use can significantly reduce toxic inhalation risks in both wildland and wildland–urban interface (WUI) operations; and

Whereas, federal wildland firefighters now receive enhanced workers' compensation under the Federal Employees' Compensation Act (FECA) for certain cancers, chronic obstructive pulmonary disease, and sudden cardiac events, while many state, county, municipal, and volunteer firefighters face inconsistent presumptive coverage that may exclude smoke-related injuries; and

Whereas, NIOSH and peer-reviewed research confirm health risks from recurrent wildfire smoke exposure and emphasize the value of systematic health monitoring and respiratory protection for firefighters; and

Whereas, the most current edition of the National Fire Protection Association (NFPA) 1984 standard, developed with direct NIOSH participation, establishes performance standards for wildland firefighter respirators that address particulate, carbon monoxide, and toxic gas exposures while requiring heat resistance, storage integrity, and IP65 protection for powered units; therefore be it

RESOLVED, that our American Medical Association advocate for the adoption of evidence-based respiratory protection standards for wildland firefighting, including triggers based on PM2.5 or other exposure metrics, easy access to NFPA 1984-compliant, NIOSH-approved Class 2 or Class 3 respirators, and protocols that balance respiratory protection with heat and exertion demands (Directive to Take Action); and be it further

RESOLVED, that our AMA join the American College of Occupational and Environmental Medicine (ACOEM) in advocating for relevant federal and state fire agencies, forestry departments, and occupational safety organizations to research, develop, and field-test

lightweight, low-breathing-resistance (<=80 mm H_2O at 150 L/min) respirators and related controls better suited for prolonged wildland use (8 or more hours) (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the creation of surveillance and longitudinal medical monitoring programs for wildland firefighters to support registries and studies evaluating respiratory protection effectiveness, acute and chronic health risks, and mitigation strategies. (Directive to Take Action)

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

Received: 4/15/26

REFERENCES

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2. Burgess, J., P.I., University of Arizona. Fire Fighter Cancer Cohort Study (FFCCS). As of January 2025, over 700 wildland firefighters are enrolled across California, Colorado, Utah, and Wyoming. https://www.ffccs.org/wildland21-26
3. CDC NIOSH Science Bulletin: 23 Mar 2026 - Highlights from NIOSH Contributions to Private Sector Standards Development and Activities: https://www.cdc.gov/niosh/bulletin/2026/standards.html?ACSTrackingID=DM154233&ACSTrackingLabel=New%20NIOSH%20Science%20Bulletins%20(April%207%2C%202026)&deliveryName=DM154233
4. NFPA 1984: Standard on Respirators for Wildland Fire-Fighting Operations and Wildland Urban Interface Operations – 2022 Edition: https://www.nfpa.org/codes-and-standards/nfpa-1984-standard-development/1984

RELEVANT AMA POLICY

H-440.810: Availability of Personal Protective Equipment (PPE)

1. Our American Medical Association affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises.
2. Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions.
3. Our AMA will advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff, as well as trainees and contractors working in such facilities, in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need.
4. Our AMA supports physicians and health care professionals and other workers in health care facilities in being permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty.
5. Our AMA supports the rights of physicians and trainees to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster.
6. Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies.
7. Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel.

[Res. 412, I20: Appended: Res. 414, A21: Modified: Res. 401, I-21]

H-440.813 Public Health Surveillance

1. Our American Medical Association recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats.

2. Our AMA recognizes the important role that physicians play in public health surveillance through reporting diseases and conditions to public health authorities.
3. Our AMA encourages state legislatures to engage relevant state and national medical specialty societies as well as public health agencies when proposing mandatory reporting requirements to ensure they are based on scientific evidence and meet the needs of population health.
4. Our AMA recognizes the need for increased federal, state, and local funding to modernize our nation's public health data systems to improve the quality and timeliness of data.
5. Our AMA supports the CDC's data modernization initiative, including electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from electronic health records to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws.
6. Our AMA will advocate for incentives for physicians to upgrade their EHR systems to support electronic case reporting as well as incentives to submit case reports that are timely and complete.
7. Our AMA will share updates with physicians and medical societies on public health surveillance and the progress made toward implementing electronic case reporting.
8. Our AMA will advocate for increased federal coordination and funding to support the modernization and standardization of public health surveillance systems data collection by the Centers for Disease Control and Prevention and state and local health departments.
9. Our AMA supports data standardization that provides for minimum national standards, while preserving the ability of states and other entities to exceed national standards based on local needs and/or the presence of unexpected urgent situations.

[CSAPH Rep. 1, I-19: Reaffirmed: Res. 219, A-21: Appended: Alt. Res. 402, A-21: Modified: CSAPH Rep. 2, I-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 418
(A-26)

Introduced by: Women Physicians Section

Subject: Ensuring Access to Full HIV Post-Exposure Prophylaxis (PEP) Courses for Survivors of Sexual Assault

Referred to: Reference Committee D

Whereas, it is estimated that 1.2 million people in the United States are living with HIV, yet about 1 in 8 people do not know they have the disease[1]; and

Whereas, the CDC reported that 56% of new HIV diagnoses in 2022 were amongst people aged 13-24 years old[2]; and

Whereas, post-exposure prophylaxis (PEP) uses antiretroviral (ARV) medications to reduce the risk of human immunodeficiency virus (HIV) transmission when initiated within 72 hours of exposure[3]; and

Whereas, completion of a full 28-day HIV post-exposure prophylaxis (PEP) regimen is recommended to maximize effectiveness in preventing HIV infection[3]; and

Whereas, individual studies demonstrate variable uptake and completion rates, including acceptance rates near 59–62% in some settings and completion rates ranging from approximately 29% to 66% across cohorts[4,5,6,7]; and

Whereas, strategies such as dispensing medication before discharge, providing trauma-informed counseling, and ensuring coverage of the full PEP regimen have been identified as mechanisms to improve adherence and reduce barriers[3]; and

Whereas, financial barriers, insurance status, trauma-related decision-making challenges, and logistical barriers contribute to failure to initiate or complete prescribed PEP regimens[1,4,5,6]; and

Whereas, up to 69% of sexual assault survivors are between the ages of 12-34 years of age[10]; and

Whereas, survivors of sexual assault may be exposed to HIV, with estimated per-act transmission risks of approximately 0.1–0.2% for vaginal assault and 1–3% for anal assault when assailant HIV status is unknown, and trauma or concurrent sexually transmitted infections may increase transmission risk[8,9]; and

Whereas, sexual assault survivors experience some of the lowest PEP completion rates among exposure groups, with approximately 40% completing a full regimen in meta-analysis studies and substantially lower completion documented in some U.S. cohorts[3,4]; and

Whereas, sexual contact through unprotected intercourse with an infected partner remains the most common method of HIV spread[11]; and

Whereas, although HIV transmission after sexual assault is relatively uncommon, documented seroconversions have occurred and longitudinal studies demonstrate increased HIV acquisition risk among sexual assault survivors compared with unexposed populations[9,12,13]; and

Whereas, women account for approximately 18–19% of new HIV diagnoses in the United States, with persistent racial disparities disproportionately affecting Black women, underscoring the importance of equitable access to HIV prevention strategies following sexual assault[14]; and

Whereas, some jurisdictions, including New York State, now require hospitals to provide a full 28-day HIV PEP regimen to sexual assault survivors to reduce structural barriers to completion[15]; therefore be it

RESOLVED, that our American Medical Association encourages hospitals, health systems, and affiliated payers to consider policies ensuring provision of the full recommended course of HIV post-exposure prophylaxis for survivors of sexual assault (New HOD Policy); and be it further

RESOLVED, that our AMA amend H-20.900 “HIV, Sexual Assault, and Violence” as follows:

> Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested ~~in six months~~ at recommended intervals consistent with current clinical guidelines if the initial test is negative, and that strict confidentiality of test results be maintained; and
>
> (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, ~~and~~ (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use, and (c) encourages hospitals, health systems, and affiliated payers to consider policies ensuring provision of the full recommended course of HIV post-exposure prophylaxis for survivors of sexual assault

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

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RELEVANT AMA POLICY

8.1 Routine Universal Screening for HIV

Physicians' primary ethical obligation is to their individual patients. However, physicians also have a long-recognized responsibility to participate in activities to protect and promote the health of the public. Routine universal screening of adult patients for HIV helps promote the welfare of individual patients, avoid injury to third parties, and protect public health.

Medical and social advances have enhanced the benefits of knowing one's HIV status and at the same time have minimized the need for specific written informed consent prior to HIV testing. Nonetheless, the ethical tenets of respect for autonomy and informed consent require that physicians continue to seek patients' informed consent, including informed refusal of HIV testing.

To protect the welfare and interests of individual patients and fulfill their public health obligations in the context of HIV, physicians should:

(a) Support routine, universal screening of adult patients for HIV with opt-out provisions.

(b) Make efforts to persuade reluctant patients to be screened, including explaining potential benefits to the patient and to the patient's close contacts.

(c) Continue to uphold respect for autonomy by respecting a patient's informed decision to opt out.

(d) Test patients without prior consent only in limited cases in which the harms to individual autonomy are offset by significant benefits to known third parties, such as testing to protect occupationally exposed health care professionals or patients.

(e) Work to ensure that patients who are identified as HIV positive receive appropriate follow-up care and counseling.

(f) Attempt to persuade patients who are identified as HIV positive to cease endangering others.

(g) Be aware of and adhere to state and local guidelines regarding public health reporting and disclosure of HIV status when a patient who is identified as HIV positive poses significant risk of infecting an identifiable third party. The doctor may, if permitted, notify the endangered third party without revealing the identity of the source person.

(h) Safeguard the confidentiality of patient information to the greatest extent possible when required to report HIV status.

[Issued: 2016]

H-20.920 HIV Testing

(1) General Considerations

a) Persons who suspect that they have been exposed to HIV should be tested so that appropriate treatment and counseling can begin for those who are seropositive;

b) HIV testing should be consistent with testing for other infections and communicable diseases;

c) HIV testing should be readily available to all who wish to be tested, including having available sites for confidential testing;

d) The physician's office and other medical settings are the preferred settings in which to provide HIV testing;

e) Physicians should work to make HIV counseling and testing more readily available in medical settings.

(2) Informed Consent Before HIV Testing

a) Our AMA supports the standard that individuals should knowingly and willingly give consent before a

voluntary HIV test is conducted, in a manner that is the least burdensome to the individual and to those administering the test. Physicians must be aware that most states have enacted laws requiring informed consent before HIV testing;
b) Informed consent should include the following information: (i) patient option to receive more information and/or counseling before deciding whether or not to be tested and (ii) the patient should not be denied treatment if they refuse HIV testing, unless knowledge of HIV status is vital to provide appropriate treatment; in this instance, the physician may refer the patient to another physician for care;
c) It is the policy of our AMA to review the federal laws including the Veteran's Benefits and Services Act, which currently mandates prior written informed consent for HIV testing within the Veterans Administration hospital system, and subsequently to initiate and support amendments allowing for HIVtesting without prior consent in the event that a health care provider is involved in accidental puncture injury or mucosal contact by fluids potentially infected with HIV in federally operated health care facilities;
d) Our AMA supports working with various state societies to delete legal requirements for consent to medically indicated HIV testing that are more extensive than requirements generally imposed for informed consent to medical care.
(3) HIV Testing Without Explicit Consent
a) Explicit consent should not always be required prior to HIV testing. Physicians should be allowed, without explicit informed consent, and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;
b) General consent for treatment of patients in the hospital should be accepted as adequate consent for the performance of HIV testing;
c) Model state and federal legislation should be developed to permit physicians, without explicit informed consent and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;
d) Our AMA will work with the Centers for Disease Control and Prevention, the American Hospital Association, the Federation, and other appropriate groups to draft and promote the adoption of model state legislation and hospital staff guidelines to allow HIV testing of a patient maintaining privacy, but without explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids; and to allow HIV testing, without any consent, where a health care worker has been placed at risk by exposure to body fluids of a deceased patient.
(4) HIV Testing Procedures
a) Appropriate medical organizations should establish rigorous proficiency testing and quality control procedures for HIV testing laboratories on a frequent and regular basis;
b) Physicians and laboratories should review their procedures to assure that HIV testing conforms to standards that will produce the highest level of accuracy;
c) Appropriate medical organizations should establish a policy that results from a single unconfirmed positive ELISA test never be reported to the patient as a valid indication of HIV infection;
d) Appropriate medical organizations should establish a policy that laboratories specify the HIV tests performed and the criteria used for positive, negative, and indeterminate test results;
e) Our AMA recommends that training for HIV blood test counselors encourage patients with an indeterminate Western blot to be advised that three-to-six-month follow-up specimens may need to be submitted to resolve their immune status. Because of the uncertain status of their contagiousness, it is prudent to counsel such patients as though they were seropositive until such time as the findings can be resolved.
(5) Routine HIV Testing
a) Routine HIV testing should include appropriate informed consent and pre-test and post-test counseling procedures;
b) State medical associations should work to create state laws that encourage hospitals and other medical facilities to initiate routine HIV testing programs; and
c) Supports coverage of and appropriate reimbursement for routine HIV testing by all public and private payers.
(6) Opt-out HIV Testing
a) Opt-out HIV testing should be provided with informed consent for individuals who may have come into contact with the blood, semen, or vaginal secretions of an infected person in a manner that has been shown to transmit HIV infection. Such testing should be encouraged for patients for whom the physician's knowledge of the patient's serostatus would improve treatment. Opt-out HIV testing should be regularly provided for the following types of individuals who give an informed consent: (i) patients at sexually

transmissible disease clinics; (ii) patients at drug abuse clinics; (iii) individuals who are from areas with a high incidence of AIDS or who engage in high-risk behavior and are seeking family planning services; and (iv) patients who are from areas with a high incidence of AIDS or who engage in high-risk behavior requiring surgical or other invasive procedures;
b) The prevalence of HIV infection in the community should be considered in determining the likelihood of infection. If opt-out HIV testing is not sufficiently accepted, the hospital and medical staff may consider requiring HIV testing.
(7) Mandatory HIV Testing
a) Our AMA opposes mandatory HIV testing of the general population;
b) Mandatory testing for HIV infection is recommended for (i) military personnel; (ii) donors of blood and blood fractions; breast milk; organs and other tissues intended for transplantation; and semen or ova for artificial conception;
c) All entrants into federal and state prisons should be offered HIV screening, but it should only be mandatory when risk factors are present;
d) Our AMA will review its policy on mandatory testing periodically to incorporate information from studies of the unintended consequences or unexpected benefits of HIV testing in special settings and circumstances.
(8) HIV Test Counseling
a) Pre-test and post-test voluntary counseling should be considered an integral and essential component of HIV testing. Full pre-test and post-test counseling procedures must be utilized for patients when HIV is the focus of the medical attention, when an individual presents to a physician with concerns about possible exposure to HIV, or when a history of high-risk behavior is present;
b) Post-test information and interpretation must be given for negative HIV test results. All negative results should be provided in a confidential manner accompanied by information in the form of a simple verbal or written report on the meaning of the results and the offer, directly or by referral, of appropriate counseling and potentially pre-exposure prophylaxis treatment;
c) Post-test counseling is required when HIV test results are positive. All positive results should be provided in a confidential face-to-face session by a professional properly trained in HIV post-test counseling and with sufficient time to address the patient's concerns about medical, social, and other consequences of HIV infection.
(9) HIV Testing of Health Care Workers
a) Our AMA supports routine voluntary HIV testing of physicians, health care workers, and students in appropriate situations;
b) Employers of health care workers should provide, at the employer's expense, serologic testing for HIV infection to all health care workers who have documented occupational exposure to HIV;
c) Our AMA opposes HIV testing as a condition of hospital medical staff privileges;
d) Physicians and other health care workers who perform exposure-prone patient care procedures should know their immune or infection status with respect to HIV.
(10) Counseling and Testing of Pregnant People for HIV
Our AMA supports the position that there should be universal HIV testing of all pregnant people, with patient notification of the right of refusal, as a routine component of perinatal care, and that such testing should be accompanied by basic counseling and awareness of appropriate treatment, if necessary. Patient notification should be consistent with the principles of informed consent.
(11) HIV Home Test Kits
a) Our AMA does not oppose HIV home collection test kits that are linked with proper laboratory testing and counseling services, provided their use does not impede public health efforts to control HIV disease;
b) Standardized data should be collected by HIV home collection test kit manufacturers and reported to public health agencies.
(12) College Students
Our AMA encourages undergraduate campuses to conduct confidential, free HIV testing with qualified staff and counselors.
[CSA Rep. 4, A-03; Appended: Res. 515, A-06; Reaffirmed: BOT Rep. 1, A-07; Appended: Res. 506, A-10; Modified: CSAPH Rep. 01, A-20; Modified: Speakers Rep. 02, I-24]

H-20.918 Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission
In view of the significance of the finding that treatment of HIV-infected pregnant people with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their infants, our AMA recommends the following statements:

(1) Given the prevalence and distribution of HIV infection among individuals in the United States, the potential for effective early treatment of HIV infection, and the significant reduction in perinatal HIV transmission with treatment of pregnant people with appropriate antiretroviral therapy, routine education about HIV infection and testing should be part of a comprehensive health care program for all individuals. The ideal would be for all people to know their HIV status before considering pregnancy.

(2) Universal HIV testing of all pregnant people, with patient notification of the right of refusal, should be a routine component of perinatal care. Basic counseling on HIV prevention and treatment should also be provided to the patient, consistent with the principles of informed consent.

(3) The final decision about accepting HIV testing is the responsibility of the patient. The decision to consent to or refuse an HIV test should be voluntary. When the choice is to reject testing, the patient's refusal should be recorded. Test results should be confidential within the limits of existing law and the need to provide appropriate medical care for patients and their infant.

(4) To assure that the intended results are being achieved, the proportion of pregnant people who have accepted or rejected HIV testing and follow-up care should be monitored and reviewed periodically at the appropriate practice, program or institutional level. Programs in which the proportion of patients accepting HIV testing is low should evaluate their methods to determine how they can achieve greater success.

(5) Pregnant people who are not seen by a health care professional for prenatal care until late in pregnancy or after the onset of labor should be offered HIV testing at the earliest practical time, but not later than during the immediate postpartum period.

(6) When HIV infection is documented in a pregnant person, proper post-test counseling should be provided. The patient should be given an appropriate medical evaluation of the stage of infection and full information about the recommended management plan for their own health. Information should be provided about the potential for reducing the risk of perinatal transmission of HIV infection to the infant through the use of antiretroviral therapy, and about the potential but unknown long-term risks to the patient and the infant from the treatment course. The final decision to accept or reject antiretroviral treatment recommended for the patient and their infant is the right and responsibility of the patient. When the serostatus is either unknown or known to be positive, appropriate counseling should also be given regarding the risks associated with breastfeeding for both her own disease progression and disease transmission to the infant.

(7) Appropriate medical treatment for HIV-infected pregnant people should be determined on an individual basis using the latest published Centers for Disease Control and Prevention recommendations. The most appropriate care should be available regardless of the stage of HIV infection or the time during gestation at which the patient presents for prenatal or intrapartum care.

(8) To facilitate optimal medical care for pregnant people and their infants, HIV test results (both positive and negative) and associated management information should be available to the physicians taking care of both individuals. Ideally, this information will be included in the confidential medical records. Physicians providing care for a pregnant person or their infant should obtain the appropriate consent and should notify the other involved physicians of the HIV status of and management information about the pregnant patient and their infant, consistent with applicable state law.

(9) Continued research into new interventions is essential to further reduce the perinatal transmission of HIV, particularly the use of rapid HIV testing for patients presenting in labor and those presenting in the prenatal setting who may not return for test results. The long-term effects of antiretroviral therapy during pregnancy and the intrapartum period for both pregnant patients and their infants also must be evaluated. For both infected and uninfected infants exposed to perinatal antiretroviral treatment, long-term follow-up

studies are needed to assess potential complications such as organ system toxicity, neurodevelopmental problems, pubertal development problems, reproductive capacity, and development of neoplasms.

(10) Health care professionals should be educated about the benefits of universal HIV testing, with patient notification of the right of refusal, as a routine component of prenatal care, and barriers that may prevent implementation of universal HIV testing as a routine component of prenatal care should be addressed and removed. Federal funding for efforts to prevent perinatal HIV transmission, including both prenatal testing and appropriate care of HIV-infected pregnant people, should be maintained.
[CSA Rep. 4, A-03; Reaffirmed: CEJA Rep. 3, A-10; Reaffirmed: CSAPH Rep. 01, A-20; Modified: Speakers Rep. 02, I-24]

H-80.998 Sexual Assault Survivor Services
Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.
[Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: Res. 202, I-17]

H-80.991 Coverage for Care for Sexual Assault Survivors
Our American Medical Association advocates for federal and state efforts to reduce financial barriers that limit sexual assault survivors' ability to seek physical and mental health care and social services after sexual assault, including funds to cover emergency, acute inpatient, and follow up services including testing, medications, and counseling without out-of-pocket costs for any patient.
[Res. 805, I-24]

H-20.900 HIV, Sexual Assault, and Violence
Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained; and (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, and (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use.
[CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Res. 905, I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 419
(A-26)

Introduced by: Women Physicians Section, American College of Lifestyle Medicine

Subject: Examining the Impact of Circadian Disruption from Shift Work During Pregnancy

Referred to: Reference Committee D

Whereas, circadian rhythm is centrally regulated by the suprachiasmatic nucleus of the hypothalamus and entrained by environmental light-dark cyclic inputs, enabling coordination of hormonal secretion, metabolic function, and physiologic homeostasis;[1] and

Whereas, light exposure during nighttime hours can desynchronize timing signals between the suprachiasmatic nucleus and peripheral cellular circadian rhythms;[2] and

Whereas, emerging evidence in occupational health, sleep medicine, and obstetrics suggests associations between circadian disruption and resulting perturbed melatonin cycles during pregnancy and adverse maternal and fetal outcomes, although existing evidence remains heterogeneous;[3] and

Whereas, a meta-analysis published under American Journal of Obstetrics and Gynecology reported "very low" certainty evidence suggesting higher rates of miscarriage among pregnant women with fixed night shifts in comparison to pregnant women who worked day shifts;[4] and

Whereas, rotating shifts have an association with preterm delivery and gestational hypertension;[4] and

Whereas, studies have demonstrated associations between maternal shift work and adverse neonatal outcomes, including psychological and behavioral problems;[3] and

Whereas, the timing of labor onset is determined by multifactorial physiologic processes, including sleep disruption and synchronicity between circadian rhythms and light exposure in pregnant physicians, which warrants further study;[2] and

Whereas, there is currently limited consensus guidance on scheduling accommodations for pregnant physicians and other health care workers exposed to shift work, leading to variability in institutional policies; and

Whereas, evidence-informed guidance may help support physician well-being, maternal health, and workforce sustainability while maintaining continuity of patient care; therefore be it

RESOLVED, that our American Medical Association supports the study of the impact of circadian disruption from shift work during pregnancy, including implications for maternal and fetal health (New HOD Policy); and be it further

RESOLVED, that our AMA encourages dissemination of evidence-informed approaches to scheduling and workplace accommodations for pregnant individuals as appropriate based on the findings of a report on circadian disruption from shift work during pregnancy. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/2026

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RELEVANT AMA POLICY

H-420.960 Effects of Work on Pregnancy
Our American Medical Association supports the right of employees to work in safe workplaces that do not endanger their reproductive health or that of their unborn children.

1. Our AMA supports workplace policies that minimize the risk of excessive exposure to toxins with known reproductive hazards irrespective of gender or age.
2. Our AMA encourages physicians to consider the potential benefits and risks of occupational activities and exposures on an individual basis and work with patients and employers to define a healthy working environment for pregnant people.
3. Our AMA encourages employers to accommodate increased physical requirements of pregnant people; recommended accommodations include varied work positions, adequate rest and meal breaks, access to regular hydration, and minimizing heavy lifting.
4. Our AMA acknowledges that future research done by interdisciplinary study groups composed of obstetricians/gynecologists, occupational medicine specialists, pediatricians, and representatives from industry can best identify adverse reproductive exposures and appropriate accommodations.

[CSA Rep. 9, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation, A-12; Modified: CSAPH Rep. 1, A-22]

H-405.947 Compassionate Leave for Physicians, Medical Students, Medical Trainees, and Physician Residents and Fellows
Our American Medical Association urges:
a. medical schools, and the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation to incorporate and/or encourage development of compassionate leave policies. Such compassionate leave policies should consider inclusion of extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to complete a medical degree.
b. residency and fellowship training programs, their sponsoring institutions, and Accreditation Council for Graduate Medical Education to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning,

pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should also include whether the leave is paid or unpaid, outline what obligations and absences must be made up, and determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to achieve independent practice and board eligibility for their specialty.

c. medical group practices to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should also include whether the leave is paid or unpaid and what obligations and absences must be made up.

Our AMA encourages medical schools, residency and fellowship programs, specialty boards, specialty societies and medical group practices to incorporate into their compassionate leave policies a three-day minimum leave, with the understanding that no medical student or physician should be required to take a minimum leave.

Medical students and physicians who are unable to work beyond the defined compassionate leave period because of physical or psychological stress, medical complications of pregnancy loss, or another related reason should refer to their institution’s sick leave policy, family and medical leave policy, and other benefits on the same basis as other physicians who are temporarily unable to work for other reasons.

Our AMA supports the concept of equal compassionate leave for bereavement due to death or loss (e.g., pregnancy loss and other such events impacting fertility in a physician or their partner) as a benefit for physicians, medical students, medical trainees, and physician residents and fellows, regardless of gender or gender identity.

Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

These guidelines as above should be freely available online and in writing to all applicants to medical school, residency, or fellowship.

[Res. 309, I-22; Modified: CME Rep. 01, I-23]

H-135.932 Light Pollution: Adverse Health Effects of Nighttime Lighting

1. Our American Medical Association supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency.
2. Our AMA recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment.
3. Our AMA supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night.
4. Our AMA supports work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place.

[CSAPH Rep. 4, A-12; Reaffirmation: A-22; Reaffirmed: CSAPH Rep. 1, A-22; Reaffirmed: BOT Rep. 30, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 420
(A-26)

Introduced by: Women Physicians Section

Subject: Expanding Support for Women Experiencing Homelessness

Referred to: Reference Committee D

Whereas, the rate of unsheltered homelessness among women has increased significantly more than men in recent years, especially among unhoused veterans, and over three-quarters of unhoused families are headed by women[1,2]; and

Whereas, women experiencing homelessness have higher rates of mortality, poor health, mental illness, substance use, victimization, and adverse birth outcomes, yet face reduced access to preventive, reproductive, specialty, and ongoing healthcare services[1-3,9]; and

Whereas, homelessness and associated distress is disproportionately experienced by people of color as well as LGBTQ+ populations, and nearly two-thirds of unhoused gay and transgender youth will attempt suicide[2-4]; and

Whereas, domestic violence is a leading cause of homelessness among women and families, with over half of LGBTQ survivors reporting homelessness as a result, yet referral rates to support services after positive screening remains low[2,6,7,8]; and

Whereas, homeless women who have experienced intimate partner violence are more likely to have medical and psychiatric conditions and less likely to access primary care compared to those who did not[2,6,7,8]; and

Whereas, the Violence Against Women Act, first enacted in 1994 and reauthorized in 2022 to protect survivors' access to safe housing and prevent housing discrimination, will be up for reauthorization again in 2027[11,12,13]; and

Whereas, women experiencing homelessness have high rates of chronic physical conditions, including asthma, anemia, bronchitis, hypertension, and ulcers, as well as mental health conditions, particularly substance use and depression[5,10]; and

Whereas, unhoused patients report provider bias, stigma, and disrespect as major barriers to care, often leading them to forgo needed services, compounded by insurance gaps, medication access challenges, and limited knowledge about where to seek care[2,3,5,10]; and

Whereas, programs such as Boston Healthcare for the Homeless, are establishing systems for trauma-informed, low-barrier care specifically for women at shelters and at female-only drop-in times, encompassing services from behavioral health to reproductive health to cancer screening, while providing a safe space to access therapeutic activities[14], therefore be it

RESOLVED, that our American Medical Association amend H-160.903 "Eradicating Homelessness" by addition and deletion as follows:

1. Our American Medical Association supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost-effective approaches which recognize the positive impact of stable and affordable housing coupled with social services.
2. Our AMA recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless and recognizes that women experiencing homelessness may face distinct health and safety risks that warrant tailored approaches.
3. Our AMA recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis.
4. Our AMA supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance, and encourages attention to gender-specific health needs within such programs when feasible.
5. Our AMA recognizes the need for an effective, evidence-based national plan to eradicate homelessness.
6. Our AMA encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.
7. Our AMA will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of ~~homeless patients~~ individuals experiencing homelessness, including gender-specific health needs and the impact of domestic and intimate partner violence on housing instability, and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs.
8. Our AMA encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital.
9. Our AMA encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients, including support for research to better understand health needs, barriers to care, and effective interventions among populations disproportionately affected by housing instability.
10. Our AMA:
    a. supports laws protecting the civil and human rights of individuals experiencing homelessness, and
    b. opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available.
11. Our AMA recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.
12. Our AMA:
    a. supports training to understand the needs of housing-insecure individuals for those who encounter this vulnerable population through their

professional duties, including trauma-informed approaches and awareness of domestic violence as a contributor to housing instability;

b. supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and

c. will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.

13. Our AMA encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

H-160.903 Eradicating Homelessness

1. Our American Medical Association supports improving the health outcomes and decreasing the health care costs of treating the chronically **homeless** through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services.

2. Our AMA recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-**homeless**.
3. Our AMA recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis.
4. Our AMA supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance.
5. Our AMA recognizes the need for an effective, evidence-based national plan to eradicate homelessness.
6. Our AMA encourages the National Health Care for the **Homeless** Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for **homeless** persons.
7. Our AMA will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of **homeless** patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs.
8. Our AMA encourages the development of holistic, cost-effective, evidence-based discharge plans for **homeless** patients who present to the emergency department but are not admitted to the hospital.
9. Our AMA encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of **homeless** patients.
10. Our AMA:
    a. supports laws protecting the civil and human rights of individuals experiencing homelessness, and
    b. opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available.
11. Our AMA recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.
12. Our AMA:
    a. supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties;
    b. supports the establishment of multidisciplinary mobile **homeless** outreach teams trained in issues specific to housing insecure individuals; and
    c. will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.
13. Our AMA encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.

[Res. 401, A-15 Appended: Res. 416, A-18 Modified: BOT Rep. 11, A-18 Appended: BOT Rep. 16, A-19 Appended: BOT Rep. 28, A-19 Appended: Res. 414, A-22 Appended: Res. 931, I-22 Reaffirmed in lieu of: Res. 205, A-23]

H-295.912 Education of Medical Students and Residents about Domestic Violence Screening
Our American Medical Association will continue its support for the education of medical students and residents on **domestic violence** by advocating that medical schools and graduate medical education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient. [Res. 303, I-96 Reaffirmed: CME Rep. 2, A-06 Reaffirmed: CME Rep. 01, A-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 421
(A-26)

Introduced by: Georgia

Subject: Improving Access to Care and Support for Patients with Inflammatory Bowel Disease in the United States

Referred to: Reference Committee D

Whereas, inflammatory bowel disease (IBD), encompassing Crohn's disease and ulcerative colitis, is a chronic, relapsing condition that requires early and accurate diagnosis as well as ongoing disease monitoring, including colonoscopy, to assess inflammation, guide therapy, and prevent complications[1]; and

Whereas, patients with long-standing IBD represent a high-risk population compared to the general colorectal cancer screening population, given their increased risk of colorectal cancer and need for more frequent surveillance colonoscopies[2],[3]; and

Whereas, a nationwide cohort study analyzing over 1.7 million IBD-related hospitalizations (2016–2021) demonstrated significant racial and ethnic disparities in IBD outcomes, with Black patients experiencing higher hospitalization rates and increased risks of complications such as perianal abscess and rectal bleeding compared to White patients[4]; and

Whereas, these disparities persist after adjusting for socioeconomic and hospital-related factors, suggesting that systemic inequities in access to timely diagnosis, specialist care, and advanced therapies contribute to worse outcomes and increased healthcare utilization[4]; and

Whereas, minority and uninsured patients with IBD, particularly Black and Hispanic individuals, are less likely to receive advanced biologic or novel therapies and are more likely to be treated with corticosteroids and opioids, which are associated with increased complications and poorer long-term outcomes[5],[6]; and

Whereas, interruptions in biologic therapy, often due to insurance instability or delays in prior authorization, can lead to loss of response through development of antidrug antibodies, necessitating therapy changes and increasing the risk of disease flares, hospitalizations, and complications[4]; and

Whereas, the high cost of biologic therapies represents a major component of IBD-related healthcare expenditures, while restrictive payer practices such as step therapy and prior authorization further delay access to effective treatment[7]; and

Whereas, colonoscopy is essential for both diagnosis and colorectal cancer surveillance in patients with long-standing IBD, as recommended by the American College of Gastroenterology and American Gastroenterological Association[2],[3]; and

Whereas, increasing public and provider awareness of low-cost or no-cost colonoscopy programs and expanding access for uninsured patients with IBD may improve early detection, reduce disease progression, and decrease long-term healthcare costs[4]; therefore be it

RESOLVED, that our American Medical Association support the development and implementation of standardized, scalable referral and patient navigation pathways for each state — through collaboration with the American Gastroenterological Association, the American College of Gastroenterology, the American Society for Gastrointestinal Endoscopy, the Crohn's & Colitis Foundation, state and local Departments of Public Health, Federally Qualified Health Centers, safety-net health systems, and community-based organizations — to connect patients with inflammatory bowel disease to timely and affordable colonoscopy services for diagnosis and surveillance, leveraging existing colorectal cancer screening and navigation models (New HOD Policy); and be it further

RESOLVED, that our AMA support educational initiatives and resource dissemination, developed in collaboration with appropriate partners—including patient advocacy organizations, professional societies, and health systems—to increase awareness among physicians regarding documentation requirements for Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) eligibility in patients with severe inflammatory bowel disease, in order to improve access to financial support and insurance coverage (New HOD Policy); and be it further

RESOLVED, that our AMA support policies that support nationwide efforts to expand equitable access to colonoscopy services for patients with inflammatory bowel disease and increase physician awareness of disability benefit eligibility as a mechanism to improve continuity of care and access to necessary medical services. (New HOD Policy)

Fiscal Note Minimal – less than $5,000

Received: 4/15/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 422
(A-26)

Introduced by: LGBTQ+ Section, Washington State Medical Association, California Medical Association

Subject: Expanding Access to High Resolution Anoscopy

Referred to: Reference Committee D

Whereas, Anal cancer incidence is markedly elevated among people living with HIV and other high-risk populations, including men who have sex with men, transgender women, individuals with prior vulvar high-grade squamous intraepithelial lesions (HSIL) or vulvar cancer, and solid organ transplant recipients, with incidence among men who have sex with men living with HIV approaching 89 per 100,000 person-years—more than tenfold higher than the general U.S. population[1]; and

Whereas, the ANCHOR trial demonstrated that treatment of anal HSIL reduces progression to anal cancer by 57%, establishing high-resolution anoscopy (HRA) with treatment as an evidence-based cancer prevention strategy[1]; and

Whereas, access to HRA in the United States is severely limited and geographically concentrated, with fewer than 200 HRA sites nationwide, nearly half located in five states (California, New York, Florida, Maryland, and Massachusetts), 17 states without any HRA site, several states with only a single site, and most services clustered in urban academic centers[2]; and

Whereas, national estimates indicate that more than 120,000 people living with HIV with abnormal screening results lack access to follow-up HRA through their HIV care facility, creating substantial disparities in cancer prevention access for rural, low-income, and marginalized populations[3]; and

Whereas, HRA services in the United States are variably housed across multiple specialties—including infectious diseases, colorectal surgery, obstetrics/gynecology, and others—and there is no uniformly standardized graduate medical education pathway or accreditation requirement for competency in HRA; international practice standards have emphasized the need for defined minimum competencies and formalized training evaluation, and existing certification programs reflect the substantial procedural experience required for proficiency, contributing to workforce variability and limited capacity to expand services rapidly[4–6]; and

Whereas, expanding equitable access to HRA requires coordinated efforts addressing reimbursement, workforce development, referral infrastructure, and integration into HIV and other high-risk care settings; therefore be it

RESOLVED, that our American Medical Association collaborate with relevant national medical specialty societies to promote development and dissemination of evidence-based and practical guidance, referral pathways, and implementation strategies to integrate anal cancer screening and HRA access into routine care for high-risk populations (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage and promote educational resources, training opportunities, and competency guidance related to high-resolution anoscopy developed by relevant medical specialty societies and other expert organizations in order to support expansion of patient access and an appropriately trained workforce (New HOD Policy); and be it further

RESOLVED, that our American Medical Association advocate at the federal and state levels for policies that expand equitable access to high-resolution anoscopy (HRA) for high-risk populations, including ensuring adequate reimbursement, reducing geographic disparities, and supporting workforce development (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage federal agencies, including the Health Resources and Services Administration (HRSA) and Centers for Medicare and Medicaid Services (CMS), to support funding mechanisms and demonstration programs that expand HRA capacity in HIV care settings, federally qualified health centers, and underserved communities. (New HOD Policy)

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

Received: 4/15/26

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RELEVANT AMA POLICY

H-440.872 HPV Associated Cancer Prevention

1. Our American Medical Association;
a. strongly urges physicians and other health care professionals to educate themselves, appropriate patients, and patients' parents or caregivers when applicable, about HPV and associated diseases, the importance of initiating and completing HPV vaccination, as well as routine HPV related cancer screening; and
b. encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.
2. Our AMA will work with interested parties to intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.
3. Our AMA supports legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers.
4. Our AMA;
a. encourages the integration of HPV vaccination and appropriate HPV-related cancer screening into all appropriate health care settings and visits;
b. supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups , including but not limited to low-income and pre-sexually active populations; and

c. recommends HPV vaccination for all groups for whom national medical specialty societies or the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
5. Our AMA supports efforts by states to increase HPV vaccine availability and accessibility, and HPV vaccination rates through a combination of policies such as facilitating administration of HPV vaccinations in community-based settings including local health departments and schools, reminder-based interventions, school-entry requirements, and requirements for comprehensive and evidence-based sexual education.
6. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination, according to ACIP recommendations as of May 1, 2025, and subsequent vaccine recommendations developed by national medical specialty societies, to people who are incarcerated for the prevention of HPV-associated cancers.
7. Our AMA advocate that racial, ethnic, socioeconomic, and geographic differences in high-risk HPV subtype prevalence be taken into account during the development, clinical testing, and strategic distribution of next-generation HPV vaccines.
8. Our AMA will encourage continued research into (a) interventions that equitably increase initiation of HPV vaccination and completion of the HPV vaccine series; (b) the impact of broad opt-out provisions on HPV vaccine uptake; and (c) the impact of the COVID-19 pandemic and vaccine misinformation on HPV vaccine uptake.
[Res. 503, A-07 Appended: Res. 6, A-12 Reaffirmed: CSAPH Rep. 1, A-22 Reaffirmation: A-22 Modified: Res. 916, I-22 BOT Action Sept. 2023 Modified: CSAPH Rep. 03, I-24 Appended: BOT Rep. 24, I-25]

H-460.913 Screening for HPV-Related Anal Cancer
1. Our American Medical Association supports continued research on the diagnosis and treatment of anal cancer and its precursor lesions, including the evaluation of the anal pap smear as a screening tool for anal cancer.
2. Our AMA's advocacy efforts to implement screening for anal cancer for high-risk populations.
3. Our AMA's national medical specialty organizations and other stakeholders in developing guidelines for interpretation, follow up, and management of anal cancer screening results.
[Res. 512, A-04 Reaffirmed: CSAPH Rep. 1, A-14 Appended: Res. 421, A-22]

H-465.994 Improving Rural Health
1. Our American Medical Association:
a. supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health,
b. urges physicians practicing in rural areas to be actively involved in these efforts, and
c. advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:
a. Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
b. Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
c. Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
d. Advocate for adequate and sustained funding for public health staffing and programs
3. Our American Medical Association will work with relevant stakeholders to develop a national strategy to eliminate rural cancer disparities in screening, treatment, and outcomes and achieve health equity in cancer outcomes across all geographic regions.
4. Our AMA calls for increased federal and state funding to support research on rural cancer disparities and equity in care, access, and outcomes and development of interventions to address those disparities.
5. Our AMA advocates for evidence-based collaborative models for innovative telementoring/ teleconsultation between health care systems, academic medical centers, and community physicians to improve access to cancer screening, diagnosis, treatment, rehabilitation, and patient services in rural areas.
[Sub. Res. 72, I-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: CLRPD Rep. 1, A-08 Reaffirmed: CEJA

Rep. 06, A-18 Appended: Res. 433, A-19 Modified: CSAPH Rep. 2, A-22 Reaffirmed: CMS Rep. 09, A-23 Reaffirmed: Res. 724, A-23 Appended: Res. 919, I-24 Reaffirmed: Res. 237, I-25 Reaffirmed: CMS Rep. 03, I-25]

H-160.991 Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
5. Our AMA supports preservation and maintenance of federal and state public funding for physicians and institutions engaged in clinical care, research, and medical education regarding LGBTQ+ populations.
[CSA Rep. C, I-81 Reaffirmed: CLRPD Rep. F, I-91 CSA Rep. 8 - I-94 Appended: Res. 506, A-00 Modified and Reaffirmed: Res. 501, A-07 Modified: CSAPH Rep. 9, A-08 Reaffirmation A-12 Modified: Res. 08, A-16 Modified: Res. 903, I-17 Modified: Res. 904, I-17 Res. 16, A-18 Reaffirmed: CSAPH Rep. 01, I-18 Reaffirmed: CSAPH Rep. 08, A-24 Appended: Res. 413, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 423
(A-26)

Introduced by: LGBTQ+ Section

Subject: Expanding Access to HIV Pre-Exposure Prophylaxis (PrEP)

Referred to: Reference Committee D

Whereas, HIV pre-exposure prophylaxis (PrEP) is a highly effective biomedical intervention which, when taken as prescribed, can reduce the risk of sexual HIV acquisition by about 99% and has become a cornerstone of national HIV-prevention strategies [1-2]; and

Whereas, existing AMA policy (H-20.895, H-20.894, H-165.821) already supports education about PrEP, coverage of all approved PrEP regimens, removal of insurance barriers, inclusion of PrEP as a preventive essential health benefit, and expanded access through physician-led collaborative practice models but lack policy regarding ways to improve access and uptake in target populations [3]; and

Whereas, recent federal and state budget proposals, litigation targeting the preventive-services mandate, and the patchwork nature of federal, state, and private assistance programs have introduced substantial uncertainty and instability in PrEP medication and service funding, threatening continuity of care and jeopardizing progress toward ending the HIV epidemic [4-12]; and

Whereas, although overall PrEP use has increased in the United States, national surveillance repeatedly shows that only a minority of people with PrEP indications actually receive it, with particularly low uptake among cisgender women and people living in the Southern United States [13-14]; and

Whereas, profound disparities in PrEP awareness, access, and adherence persist among populations disproportionately affected by HIV - including women (particularly Black, Latina, Indigenous, transgender, and Southern women), as well as Black, Latino, Indigenous, and rural communities - despite overall growth in PrEP use nationally [13, 15-17] ; and

Whereas, transgender women face a disproportionate burden of HIV and, despite high levels of interest in PrEP, experience multiple barriers - including discrimination, lack of gender-affirming care, and limited provider knowledge - underscoring the need for tailored, affirming PrEP delivery models [17-18]; and

Whereas, women account for a substantial proportion of new HIV diagnoses globally and in the United States, and gendered power dynamics, reproductive coercion, intimate partner violence, economic dependence, and stigma can limit women's ability to negotiate condom use or disclose PrEP use, making PrEP access and autonomy over HIV prevention a critical reproductive health and bodily autonomy issue [19-20]; and

Whereas, many clinicians report limited training, time, or comfort in discussing sexual health and PrEP with patients - especially women, transgender and gender-diverse people, and people

in rural areas - highlighting the importance of integrating PrEP education into medical school curricula, graduate medical education, and continuing medical education [1,2, 21]; and

Whereas, the NIH Office of AIDS Research and the Office of Research on Women's Health have highlighted persistent HIV disparities among women and gender-diverse people, calling for women-centered prevention and care strategies across the lifespan—including improved access to PrEP, trauma-informed services, and integration of HIV prevention with sexual and reproductive health care [22]; and

Whereas, innovative PrEP delivery models - including telePrEP, same-day or rapid-start initiation, community-based and mobile services, pharmacy-based and home-based PrEP monitoring, and integration of PrEP into primary care, sexual-health clinics, substance-use-disorder treatment programs, and services for survivors of sexual assault - have been shown to reduce barriers, improve uptake, and reach populations underserved by traditional clinic-based models [21, 23]; and

Whereas, social determinants of health such as housing instability, lack of transportation, childcare responsibilities, limited paid leave, medical mistrust, and intersectional stigma (including racism, sexism, homophobia, and transphobia) continue to impede PrEP uptake and persistence, particularly for women and marginalized communities, and require coordinated policy and systems-level responses [4-13]; and

Whereas, legal and policy threats to coverage for preventive services, including PrEP, create confusion among payers, providers, and patients, and may have a chilling effect on prescribing or seeking PrEP unless strong medical and public health voices advocate for continued, reliable access [4-12]; and

Whereas, aligning AMA policy with evolving evidence and best practices to emphasize funding stability, equity-focused implementation, innovative delivery models, and attention to social determinants of health will strengthen ongoing AMA efforts to end the HIV epidemic and advance gender and racial health equity [1-3, 22]; therefore be it

RESOLVED, that our American Medical Association supports advocacy, research funding, and targeted programmatic support to address disparities in PrEP access among populations disproportionately affected by HIV, ensuring that strategies are tailored to the unique needs of these communities (New HOD Policy); and be it further

RESOLVED, that our AMA supports efforts to expand PrEP access to all individuals in alignment with evidence-based guidelines and shared decision making, including but not limited to innovative delivery models across various care settings and strategies to address social determinants of health that impede PrEP uptake such as housing instability, transportation barriers, and stigma. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

H-20.914 Discrimination and Criminalization Based on HIV Seropositivity

Our AMA:

(1) Remains cognizant of and concerned about society's perception of, and discrimination against, HIV-positive people;

(2) Condemns any act, and opposes any legislation of categorical discrimination based on an individual's actual or imagined disease, including HIV infection; this includes Congressional mandates calling for the discharge of otherwise qualified individuals from the armed services solely because of their HIV seropositivity;

(3) Encourages vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate against persons based on disease;
(4) Encourages medical staff to work closely with hospital administration and governing bodies to establish appropriate policies regarding HIV-positive patients;
(5) Supports consistency of federal and/or state laws with current medical and scientific knowledge including avoidance of any imposition of punishment based on health and disability status;
(6) Encourages public education and understanding of the stigma created by HIV criminalization statutes and subsequent negative clinical and public health consequences; and
(7) will: (a) advocate for repeal of legislation that criminalizes non-disclosure of Human Immunodeficiency Virus (HIV) status for people living with HIV; and (b) work with other stakeholders to develop a program whose primary goal is to destigmatize HIV infection through educating the public, physicians, and other health care professionals on current medical advances in HIV treatment that minimize the risk of transmission due to viral load suppression and the availability of PrEP.

PrEP is an Essential Health Benefit H-165.821

1. Our American Medical Association supports the continued inclusion of Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) as a Preventive Essential Health Benefit under the Patient Protection and Affordable Care Act.

2. Our AMA will support and join legal efforts to overturn the judgment rendered in Braidwood v. Becerra in the U.S. District Court for the Northern District of Texas.

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895

1. Our American Medical Association will educate physicians, physicians-in-training, and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of all approved PrEP regimens in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for all approved PrEP regimens, such as prior authorization, mandatory consultation with an infectious disease specialist, and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
5. Our AMA encourages the discussion of and education about PrEP during routine sexual health counseling.

HIV, Sexual Assault, and Violence H-20.900

Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained; and (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, and (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use.

Improving PrEP & PEP Access H-20.894

Our American Medical Association supports efforts to increase access to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) through the establishment of collaborative practice agreements between pharmacists and physicians, based on AMA's model legislation related to collaborative drug therapy management.
1. Our AMA supports a requirement that any pharmacy-associated prescription of PREP/PEP needs to be in accordance with the current CDC PREP/PEP clinical practice guidelines within the physician-led team.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:424
(A-26)

Introduced by: LGBTQ+ Section

Subject: Supporting Education and Access to Postexposure Doxycycline (DoxyPEP)

Referred to: Reference Committee D

Whereas, more than 2.2–2.4 million cases of chlamydia, gonorrhea, and syphilis are reported annually in the United States, with overall sexually transmitted infection (STI) morbidity remaining substantially higher than a decade ago and congenital syphilis increasing nearly 700% over ten years [1-3]; and

Whereas, these infections disproportionately affect adolescents and young adults, men who have sex with men (MSM), transgender women, and racial and ethnic minority populations, contributing to persistent health inequities [1-3]; and

Whereas, cisgender women and people who were assigned female at birth (transgender and gender diverse individuals) bear the highest global burden of STIs [4]; and

Whereas, bacterial STIs are associated with serious complications including pelvic inflammatory disease, infertility, chronic pelvic pain, increased HIV acquisition risk, and severe adverse fetal and neonatal outcomes from congenital syphilis [1, 3-6]; and

Whereas, traditional prevention strategies (abstinence, reduction in number of sexual partners, barrier protection, and routine testing) are not sufficient alone to address the current STI burden, particularly in populations facing structural and social barriers to care [7]; and

Whereas, randomized clinical trials among MSM and transgender women with recent bacterial STIs have demonstrated that doxycycline postexposure prophylaxis (DoxyPEP), dosed as 200 mg within 72 hours after condomless sex, reduces the combined incidence of gonorrhea, chlamydia, and syphilis by approximately two-thirds compared with standard care [8-10]; and

Whereas, in 2024, the Centers for Disease Control and Prevention issued clinical guidelines recommending that MSM and transgender women with a bacterial STI diagnosed in the past 12 months be counseled about and, after shared decision-making, be offered DoxyPEP as an ongoing, patient-managed STI prevention strategy [11]; and

Whereas, while cisgender women and people who were assigned female at birth are not explicitly listed in current clinical guidelines, guidelines could specifically address strategies for clinicians to discuss DoxyPEP with cisgender women and people who were assigned female at birth within the existing list of user education and support recommendations, or produce a shared decision-making toolkit as an appendix to guidelines to minimise this gap while awaiting further efficacy data [3, 12-14]; and

Whereas, existing AMA policies strongly support HIV pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) through physician and trainee education, insurance coverage, and removal of access barriers, and support comprehensive, evidence-based sexual health education [15]; and

Whereas, AMA currently lacks explicit policy on the use, education, and coverage of DoxyPEP for bacterial STI prevention, despite emerging evidence and clinical guidance [15]; therefore be it

RESOLVED, that our AMA supports physician and trainee education on Postexposure Doxycycline (DoxyPEP) and other anti-microbial postexposure treatments (New HOD Policy); and be it further

RESOLVED, that our AMA supports prescribing and insurance coverage of Postexposure Doxycycline (DoxyPEP) for sexually transmitted infection (STI) prevention. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/15/26

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RELEVANT AMA POLICY

PrEP is an Essential Health Benefit H-165.821

1. Our American Medical Association supports the continued inclusion of Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) as a Preventive Essential Health Benefit under the Patient Protection and Affordable Care Act.
2. Our AMA will support and join legal efforts to overturn the judgment rendered in Braidwood v. Becerra in the U.S. District Court for the Northern District of Texas.

Discrimination and Criminalization Based on HIV Seropositivity H-20.914

H-20.914 Discrimination and Criminalization Based on HIV Seropositivity
Our AMA:
(1) Remains cognizant of and concerned about society's perception of, and discrimination against, HIV-positive people;

(2) Condemns any act, and opposes any legislation of categorical discrimination based on an individual's actual or imagined disease, including HIV infection; this includes Congressional mandates calling for the discharge of otherwise qualified individuals from the armed services solely because of their HIV seropositivity;
(3) Encourages vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate against persons based on disease;
(4) Encourages medical staff to work closely with hospital administration and governing bodies to establish appropriate policies regarding HIV-positive patients;
(5) Supports consistency of federal and/or state laws with current medical and scientific knowledge including avoidance of any imposition of punishment based on health and disability status;
(6) Encourages public education and understanding of the stigma created by HIV criminalization statutes and subsequent negative clinical and public health consequences; and
(7) will: (a) advocate for repeal of legislation that criminalizes non-disclosure of Human Immunodeficiency Virus (HIV) status for people living with HIV; and (b) work with other stakeholders to develop a program whose primary goal is to destigmatize HIV infection through educating the public, physicians, and other health care professionals on current medical advances in HIV treatment that minimize the risk of transmission due to viral load suppression and the availability of PrEP.

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895
1. Our American Medical Association will educate physicians, physicians-in-training, and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of all approved PrEP regimens in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for all approved PrEP regimens, such as prior authorization, mandatory consultation with an infectious disease specialist, and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
5. Our AMA encourages the discussion of and education about PrEP during routine sexual health counseling.

HIV, Sexual Assault, and Violence H-20.900
Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained; and (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, and (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use.

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968
1. Our American Medical Association supports the concept of sexuality education in the home, when possible, as well as developmentally appropriate sexuality education programming in the schools at all levels, at local option and direction.
2. Our AMA urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that:
    a. are based on rigorous, peer reviewed science;
    b. incorporate sexual violence prevention;
    c. show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant;
    d. include an integrated strategy for making condoms and other effective barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases;

e. utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ+ youth;
f. appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities;
g. include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program;
h. are part of an overall health education program; and
i. include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;

3. Our AMA will continue to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate.
4. Our AMA will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program.
5. Our AMA opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems.
6. Our AMA endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes.
7. Our AMA supports federal funding of comprehensive sex education programs that stress the importance of preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, including contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits.
8. Our AMA extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy.
9. Our AMA supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent.
10. Our AMA encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

Improving PrEP & PEP Access H-20.894

1. Our American Medical Association supports efforts to increase access to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) through the establishment of collaborative practice agreements between pharmacists and physicians, based on AMA's model legislation related to collaborative drug therapy management.
2. Our AMA supports a requirement that any pharmacy-associated prescription of PREP/PEP needs to be in accordance with the current CDC PREP/PEP clinical practice guidelines within the physician-led team.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 425
(A-26)

Introduced by: American College of Emergency Physicians

Subject: Prioritizing, Measuring, and Preventing Workplace Violence in Health Care

Referred to: Reference Committee D

Whereas, nearly 75% of all workplace assaults in the United States occur in health care and social service settings, reflecting a disproportionate burden of violence in these environments; and

Whereas, emergency departments are particularly vulnerable settings, with 91% of emergency physicians reporting that they or a colleague experienced workplace violence in the past year, 47% reporting physical assault, and 71% witnessing assaults against colleagues; and

Whereas, workplace violence threatens the physical and psychological safety of health care professionals and undermines the delivery of safe, effective patient care; and

Whereas, unsafe work environments contribute to workforce instability, with nearly one in five physicians reporting symptoms of depression and approximately 29% of health care workers intending to leave their jobs within two years; and

Whereas, current efforts to collect and report workplace violence data remain inconsistent across jurisdictions, limiting the ability to understand national trends and implement effective interventions; and

Whereas, health care workers may be dissuaded from reporting workplace violence due to concerns about institutional liability, reputational harm to health care organizations, normalization of violence (e.g., attribution to intoxication or illness), and fear of retaliation or lack of meaningful follow-up; and

Whereas, existing policy of our American Medical Association encourages the development of workplace violence prevention standards, supports research and funding to evaluate effective interventions, and promotes dissemination of best practices (H-515.957, D-515.983); and

Whereas, existing policy of our AMA encourages health care facilities to implement reporting tools, training programs, and institutional policies to reduce workplace violence (H-515.966); and

Whereas, current AMA policy addressing workplace violence is distributed across multiple policies and directives, creating fragmentation that may limit clarity, coordination, and effectiveness of advocacy efforts; therefore be it

RESOLVED, that our American Medical Association recognize workplace violence in health care as a national advocacy priority and expand existing AMA policy to support standardized reporting and data-driven prevention strategies (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the development and implementation of standardized, mandatory reporting mechanisms for workplace violence incidents across all health care settings, with appropriate protections for patient and worker privacy (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for policies that remove barriers to reporting workplace violence, including protections against retaliation, reduction of disincentives related to institutional liability or reputational concerns, and the establishment of a culture in which all acts of violence against health care workers are recognized as unacceptable and reportable regardless of patient condition (Directive to Take Action); and be it further

RESOLVED, that our AMA support the aggregation and analysis of workplace violence data to inform research, benchmarking, and the development of national policies aimed at reducing violence in health care settings (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the development, funding, and implementation of evidence-based, trauma-informed strategies to prevent workplace violence and protect the health care workforce (Directive to Take Action); and be it further

RESOLVED, that our AMA rescind existing policies H-515.957 (Preventing Violent Acts Against Health Care Providers), D-515.983 (Preventing Violent Acts Against Health Care Providers), and H-515.966 (Violence and Abuse Prevention in the Health Care Workplace). (Rescind HOD Policy)

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

Received: 4/15/26

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6. American Medical Association. Preventing Violent Acts Against Health Care Providers D-515.983.
7. American Medical Association. Violence and Abuse Prevention in the Health Care Workplace H-515.966.

RELEVANT AMA POLICY

American Medical Association. Preventing Violent Acts Against Health Care Providers H-515.957.
American Medical Association. Preventing Violent Acts Against Health Care Providers D-515.983.
American Medical Association. Violence and Abuse Prevention in the Health Care Workplace H-515.966.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 426
(A-26)

Introduced by: American College of Cardiology

Subject: Integrating Nutrition into Health Care Delivery to Reduce Cardiovascular Risk and Food Insecurity ("Food is Medicine")

Referred to: Reference Committee D

Whereas, diet-related chronic diseases—including cardiovascular disease, diabetes, and obesity—remain leading causes of morbidity, mortality, and health care expenditures in the United States; and

Whereas, food insecurity and poor diet quality disproportionately affect individuals with lower socioeconomic status and contribute to adverse cardiovascular outcomes and widening disparities; and

Whereas, "Food is Medicine" interventions—including medically tailored meals, medically tailored groceries, and produce prescription programs—have demonstrated improvements in health outcomes, reductions in hospitalizations, and lower health care costs; and

Whereas, the bipartisan Medically Tailored Home-Delivered Meals Demonstration Pilot Act (H.R. 5439 / S. 2834) would establish a Medicare pilot program to deliver medically tailored meals to patients with diet-related chronic disease and evaluate impacts on outcomes and costs; and

Whereas, bipartisan Congressional efforts, including a Fiscal Year 2027 Labor–HHS appropriations letter led by Jim McGovern (D-MA-02), Vern Buchanan (R-FL-16), Chellie Pingree (D-ME-01), and Emilia Sykes (D-OH-13), call for strengthening and expanding Food is Medicine initiatives and integrating nutrition into the U.S. health care system; and

Whereas, the American Medical Association has affirmed that "food is medicine" and is committed to advancing nutrition education, research, and policy efforts to improve chronic disease outcomes; and

Whereas, current clinical practice guidelines, including Section 4.1.2.1 of the recently published 2026 American College of Cardiology/American Heart Association lipid management guidelines, support plant-based dietary patterns across the lifespan for primary and secondary prevention of atherosclerotic cardiovascular disease; and

Whereas, despite strong evidence and guideline support, access to health-promoting foods remains limited for many patients due to cost, availability, and structural barriers; therefore be it

RESOLVED, that our American Medical Association recognizes Food is Medicine interventions—including medically tailored meals—as evidence-based strategies to improve health outcomes, reduce diet-related chronic disease, and address food insecurity (New HOD Policy); and be it further

RESOLVED, that our AMA supports federal efforts to integrate nutrition services into health care delivery as well as funding for Food is Medicine initiatives through the yearly Labor–HHS appropriations process (New HOD Policy); and be it further

RESOLVED, that our AMA encourages collaboration with relevant specialty societies, including the American College of Cardiology, and supports research, education, and implementation efforts to advance Food is Medicine interventions in clinical practice, with emphasis on improving cardiovascular outcomes, reducing health disparities, and lowering health care costs. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/20/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 427
(A-26)

Introduced by: Medical Student Section

Subject: Infant Feeding Options for HIV-Seropositive Individuals

Referred to: Reference Committee D

Whereas, human milk's composition of nutrients, along with its antimicrobial, anti-inflammatory, and immunoregulatory agents makes it uniquely ideal for human infants and has been associated with decreased incidence of lower respiratory infections, otitis media, SIDs, and overall neonatal and infant mortality [1-5]; and

Whereas, human milk also has proven decreased incidence of other later-onset diseases including but not limited to, obesity, Type 1 and Type 2 diabetes, and inflammatory bowel disease[6–9]; and

Whereas, breastfeeding has many health benefits for the lactating person, such as decreased incidence of several types of cancer, type 2 diabetes, and hypertension[10–12]; and

Whereas, despite its extensive proven benefits, there are extensive disparities in breastfeeding rates, particularly as the rates in non-Hispanic White and Hispanic populations are significantly higher than in non-Hispanic Black populations[13]; and

Whereas, evidence, including the multi-country PROMISE trial, places the transmission rate of HIV from parent to breastfeeding infants as less than 5%, and less than 1% for parents that have a suppressed viral load[16]; and

Whereas, due to the extensive benefits of breastfeeding for infants and the lactating parent, the newer evidence of low rates of transmission by parents adequately virally suppressed by ART has prompted greater discussion of infant feeding options; and

Whereas, the National Institutes of Health (NIH) recommends clinicians support the choice of HIV seropositive individuals to breastfeed if they are virally suppressed, or to formula/replacement feed[17]; and

Whereas, the American Academy of Pediatrics (AAP) supports breastfeeding among HIV seropositive individuals who desire to do so if criteria are met, including early ART initiation, sustained viral suppression, adherence to ART and infant prophylaxis, and reliable ART access[18]; and

Whereas, our AMA has adopted multiple policies supporting breastfeeding, including H-245.982 ("AMA Support for Breastfeeding") and D-310.950 ("Protecting Trainee's Breastfeeding Rights"); and

Whereas, AMA Policy H-20.916 currently advises clinicians to unequivocally counsel HIV seropositive patients against breastfeeding where alternative nutrition is available, which is inconsistent with evidence and recommendations; therefore be it

RESOLVED, that the American Medical Association amend Policy H-20.916, "Breastfeeding and HIV Seropositive People," by addition and deletion as follows:

Breastfeeding and HIV Seropositive People, H-20.916

Our American Medical Association believes that, where safe and alternative nutrition is widely available, HIV seropositive people should receive evidence-based, patient-centered counseling to support shared decision-making about infant feeding. Patients living with HIV who are using antiretroviral therapy (ART) and have a sustained undetectable viral load and who choose to breastfeed should be supported in this decision. ~~be counseled not to breastfeed and not to donate breast milk.~~ HIV testing of all human milk donors should be mandatory, and milk from HIV-infected donors should not be used for human consumption.

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

H-20.916 Breastfeeding and HIV Seropositive Individuals
Our American Medical Association believes that, where safe and alternative nutrition is widely available, HIV seropositive people should be counseled not to breastfeed and not to donate breast milk. HIV testing of all human milk donors should be mandatory, and milk from HIV-infected donors should not be used for human consumption. [CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Reaffirmed: CSAPH Rep. 8, A-23]

H-20.918 Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission
In view of the significance of the finding that treatment of HIV-infected pregnant people with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their infants, our AMA recommends the following statements:
(1) Given the prevalence and distribution of HIV infection among individuals in the United States, the potential for effective early treatment of HIV infection, and the significant reduction in perinatal HIV transmission with treatment of pregnant people with appropriate antiretroviral therapy, routine education about HIV infection and testing should be part of a comprehensive health care program for all individuals. The ideal would be for all people to know their HIV status before considering pregnancy.
(2) Universal HIV testing of all pregnant people, with patient notification of the right of refusal, should be a routine component of perinatal care. Basic counseling on HIV prevention and treatment should also be provided to the patient, consistent with the principles of informed consent.
(3) The final decision about accepting HIV testing is the responsibility of the patient. The decision to consent to or refuse an HIV test should be voluntary. When the choice is to reject testing, the patient's refusal should be recorded. Test results should be confidential within the limits of existing law and the need to provide appropriate medical care for patients and their infant.
(4) To assure that the intended results are being achieved, the proportion of pregnant people who have accepted or rejected HIV testing and follow-up care should be monitored and reviewed periodically at the appropriate practice, program or institutional level. Programs in which the proportion of patients accepting HIV testing is low should evaluate their methods to determine how they can achieve greater success.
(5) Pregnant people who are not seen by a health care professional for prenatal care until late in pregnancy or after the onset of labor should be offered HIV testing at the earliest practical time, but not later than during the immediate postpartum period.
(6) When HIV infection is documented in a pregnant person, proper post-test counseling should be provided. The patient should be given an appropriate medical evaluation of the stage of infection and full information about the recommended management plan for their own health. Information should be provided about the potential for reducing the risk of perinatal transmission of HIV infection to the infant through the use of antiretroviral therapy, and about the potential but unknown long-term risks to the patient and the infant from the treatment course. The final decision to accept or reject antiretroviral treatment recommended for the patient and their infant is the right and responsibility of the patient. When the serostatus is either unknown or known to be positive, appropriate counseling should also be given regarding the risks associated with breastfeeding for both her own disease progression and disease transmission to the infant.
(7) Appropriate medical treatment for HIV-infected pregnant people should be determined on an individual basis using the latest published Centers for Disease Control and Prevention recommendations. The most appropriate care should be available regardless of the stage of HIV infection or the time during gestation at which the patient presents for prenatal or intrapartum care.
(8) To facilitate optimal medical care for pregnant people and their infants, HIV test results (both positive and negative) and associated management information should be available to the physicians taking care of both individuals. Ideally, this information will be included in the confidential medical records. Physicians providing care for a pregnant person or their infant should obtain the appropriate consent and should notify the other involved physicians of the HIV status of and management information about the pregnant patient and their infant, consistent with applicable state law.
(9) Continued research into new interventions is essential to further reduce the perinatal transmission of HIV, particularly the use of rapid HIV testing for patients presenting in labor and those presenting in the prenatal setting who may not return for test results. The long-term effects of antiretroviral therapy during pregnancy and the intrapartum period for both pregnant patients and their infants also must be evaluated. For both infected and uninfected infants exposed to perinatal antiretroviral treatment, long-term follow-up

studies are needed to assess potential complications such as organ system toxicity, neurodevelopmental problems, pubertal development problems, reproductive capacity, and development of neoplasms.
(10) Health care professionals should be educated about the benefits of universal HIV testing, with patient notification of the right of refusal, as a routine component of prenatal care, and barriers that may prevent implementation of universal HIV testing as a routine component of prenatal care should be addressed and removed. Federal funding for efforts to prevent perinatal HIV transmission, including both prenatal testing and appropriate care of HIV-infected pregnant people, should be maintained. [CSA Rep. 4, A-03; Reaffirmed: CEJA Rep. 3, A-10; Reaffirmed: CSAPH Rep. 01, A-20; Modified: Speakers Rep. 02, I-24]

H-245.982 AMA Support for Breastfeeding
(1) Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.
(2) Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.
(3) Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.
(4) Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).
(5) Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines. [CSA Rep. 2, A-05Res. 325, A-05Reaffirmation A-07Reaffirmation A-12Modified in lieu of Res. 409, A-12 and Res. 410, A-12Appended: Res. 410, A-16Appended: Res. 906, I-17Reaffirmation: I-18]

D-310.950 Protecting Trainees' Breastfeeding Rights
(1) Our American Medical Association will work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME), to

include language in housestaff manuals or similar policy references of all training programs regarding protected times and locations for milk expression and secure storage of breast milk.
(2)Our AMA will work with appropriate bodies, such as the LCME, ACGME, and Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for breastfeeding people in regular program reviews. [Res. 302, I-16Modified: Speakers Rep. 02, I-24].

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 428
(A-26)

Introduced by: Medical Student Section

Subject: Protecting Environmental Health Before, During, and After War

Referred to: Reference Committee D

Whereas, according to the World Health Organization (WHO), healthier environments could prevent almost one-quarter of the global burden of disease, as clean air, a stable climate, safe water, sanitation, and hygiene (WASH), safe use of chemicals, protection from radiation, healthy workplaces, sustainable agriculture, health-supportive cities, and preserved natural ecosystems are all prerequisites for good health;[1] and

Whereas, according to the UN Environment Programme (UNEP), heavy bombardment of populated areas contaminates soil, air, and groundwater from the munitions and the release of hazardous materials such as asbestos, industrial chemicals, and fuel, creating long-term environmental and health hazards;[2] and

Whereas, explosives use destroys water supplies and sanitation facilities, leading to pollution from sewage; in rural areas, bombing decreases soil quality and agricultural productivity by disrupting topography and altering drainage patterns; and unexploded remnants of war left behind continue to injure and kill civilians for years;[3] and

Whereas, the sinking of military vehicles during conflicts has caused long-term oil spills, including wrecks off of the Iraqi coast that release hydrocarbons into the Persian Gulf linked to cancer, anemia, organ damage, and neurological harm, contaminating Kuwaiti desalination plants that supply the majority of regional drinking water;[4] and

Whereas, the U.S. Department of Defense is the world's largest institutional consumer of oil and among the world's top greenhouse gas emitters, adding significantly to climate change;[3] and

Whereas, between 1961 and 1971, more than 91 million liters of Agent Orange, containing persistent environmental pollutants (POPs) that accumulate in food sources, were applied across 3.1 million hectares of Vietnam, exposing over 4 million people to toxic dioxins, leading to cancers, congenital disabilities, and intergenerational harm;[5,6] and

Whereas, more than 600 U.S. military sites have been designated as Superfund sites, reflecting widespread contamination of air, soil, and water by hazardous substances associated with defense activities;[7] and

Whereas, proximity to toxic waste and Superfund sites has been linked to increased risks of cancer, congenital anomalies, and other adverse health outcomes, with disproportionate impacts on low-income and minority communities;[8] and

Whereas, supporting evidence from the U.S. Environmental Protection Agency (EPA) Discharge Monitoring Reports documents releases of arsenic, cyanide, and lead by the Atlantic Fleet Weapons Training Facility on Vieques Island, Puerto Rico, into surrounding waters of the live

impact area, demonstrating that environmental pollution can lead to adverse neonatal outcomes;[9] and

Whereas, a 2023 Department of Defense brief acknowledged over 245 military bases where polyfluoroalkyl substances (PFAS), known endocrine disruptors, may have contaminated groundwater aquifers that serve as sources of drinking water;[10,11] and

Whereas, the Vanadium Corporation's recruitment of Navajo lands to mine uranium for atomic bombs, without informing local community members of the purpose or health risks, led to the Church Rock incident, the largest accidental release of radioactive material in U.S. history into the Rio Puerco, as well as elevated radiation-induced disease in Navajo communities including renal failure, hypertension, cancer, reduced fertility, and more;[12,13] and

Whereas, during and after conflicts, environmental governance, waste management, and ecosystem services often collapse, compounding exposure risks and intensifying future conflict risks;[14] and

Whereas, the American College of Occupation and Environmental Medicine has underscored that capacity building in environmental medicine, including training in taking exposure histories and reporting sentinel events (such as outbreaks of waterborne illness and clusters of toxic exposure), is necessary for clinicians seeing displaced and/or conflict-impacted populations;[15] and

Whereas, military greenhouse gas emissions were excluded from the 1997 Kyoto Protocol, and military emissions reporting under the 2015 Paris Agreement was made voluntary, resulting in systematic underestimation of warfare's climate toll;[16] and

Whereas, the UN General Assembly states that areas of environmental importance should be designated as protected zones in armed conflict;[17] and

Whereas, international law, including the Rome Statute of the ICC and the Geneva Conventions, prohibits methods of warfare that cause widespread, long-term, and severe environmental damage, recognizing such acts as war crimes;[18] therefore be it

RESOLVED, that our American Medical Association supports the inclusion of drinking water sources and sanitation facilities, agricultural land, fisheries, and nature reserves as protected zones during active conflict, weapons production, and military activities that the U.S. is involved in (New HOD Policy); and be it further

RESOLVED, that our AMA supports clean-up and restoration of, toxic exposures and environmental harm related to U.S. and U.S.-supported military activities, including armed conflict and weapons production, that lead to adverse health outcomes (New HOD Policy); and be it further

RESOLVED, that our AMA supports the development, availability, and use of continued medical education for clinicians to take exposure histories, counsel patients, and report sentinel events in displaced and conflict-affected populations impacted by environmental health harms. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

D-135.966 Climate Change as a Public Health Crisis

Our American Medical Association declares climate change a public health crisis that threatens the health and well-being of all individuals.
Our AMA will protect patients by advocating for policies that:
Limit global warming to no more than 1.5 degrees Celsius.
Reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050.
Support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.
Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge and making a commitment to lower its own greenhouse gas emissions.
Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050.
Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.
Our AMA supports the use of international, federal, regional, and state carbon pricing systems as an important tool to reduce global greenhouse gas emissions and achieve net-zero targets. Our AMA recommends that carbon dividends or energy subsidies for low-income households be a key component

of any established carbon pricing system, to reduce the potential economic burden on households with lower incomes. [Res. 420, A-22Appended: CSAPH Rep. 02, I-22Appended: BOT Rep. 11, I-24]

H-135.938 Global Climate Change and Human Health
Our American Medical Association supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.
Our AMA supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

Recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public.
Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.
Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training. [CSAPH Rep. 3, I-08Reaffirmation A-14Reaffirmed: CSAPH Rep. 04, A-19Reaffirmation: I-19Modified: Res. 424, A-22Modified: CSAPH Rep. 2, I-22]

H-135.991 Clean Air / Environmental Health
(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.
(2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.
(4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.
(5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health. [BOT Rep. R, A-82Reaffirmed: CLRPD Rep. A, I-92Amended: CSA Rep. 8, A-03Reaffirmation I-06Reaffirmed in lieu of Res. 509, A-09Reaffirmation I-09Reaffirmation A-14Modified: CSAPH Rep. 01, A-24]

D-440.972 Safety from Nuclear Weapons and Medical Consequences of Nuclear War
1. Our AMA will support legislation that would protect public health and safety, should the testing of nuclear weapons by the United States be resumed.
2. Our AMA will urge the U.S. and all national governments to continue to work to ban and eliminate nuclear weapons and will collaborate with relevant stakeholders to increase public awareness and education on the topic of the medical and environmental consequences of nuclear war. [Res. 436, A-05Appended: Res. 524, A-15Reaffirmed: Res. 007, A-24]

D-135.962 Hazardous Pollutants and Heavy Metals
Our American Medical Association urges governmental agencies to establish and enforce limits for identified hazardous pollutants and heavy metals in our food, water, soil, and air.
Our AMA supports efforts to:
monitor the chronic effects of exposure to hazardous pollutants and heavy metals including at levels below regulation limits;
monitor the burden of toxicity in communities, especially near urban, Superfund, military bases, and industrial sites; and
educate individuals on the chronic effects of those exposures. [Res. 409, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 429
(A-26)

Introduced by: Medical Student Section

Subject: Adolescent Dating Violence Comprehensive Screening Tool Development

Referred to: Reference Committee D

Whereas, adolescent dating violence (ADV), also referred to as adolescent intimate partner violence, is a prevalent public health problem in the United States, with national surveys estimating that over 1 in 8 high school students reported experiencing physical violence, sexual violence, or both by someone they were dating in the past year, with trend analyses showing an overall increase in sexual dating violence between 2019 and 2021[1-3]; and

Whereas, psychological and emotional abuse is even more common, with over 60% of adolescent daters reporting such experiences in national surveys, and up to 75% reporting technology-assisted or cyber abuse from people they are dating[4,5]; and

Whereas, adverse childhood experiences (ACEs) increase vulnerability to, but are distinct from, adolescent dating violence, as ACEs typically precede ADV while ADV constitutes a separate form of interpersonal violence with unique risk factors and consequences[6-8]; and

Whereas, those who experience the intersectionality of identities such as racial/ethnic backgrounds, sexual orientation and gender identity, and underserved community status are disproportionately affected by adolescent dating violence; and

Whereas adolescents who experience dating violence are at significantly increased risk for depression, anxiety, suicidality, substance use, high risk sexual behaviors, future intimate partner violence, and significantly higher odds of emergency department utilization, independent of other risk factors[15-18]; and

Whereas, failure to routinely screen adolescents for dating violence in clinical and school settings leads to missed opportunities for early intervention, support, and referral to evidence-based services, perpetuating a cycle of recurrent victimization, perpetration, and chronic mental health and substance use disorders into adulthood[15-18]; and

Whereas, despite these risks, there is a lack of comprehensive, validated, and routinely used screening tools for adolescent dating violence in the United States as adult intimate partner violence screening instruments (HARK, HITS, E-HITS, PVS, WAST) have not been validated for adolescents and are rarely used in pediatric clinical practice—a gap recognized by the U.S. Preventive Services Task Force, despite encouragement from the American Academy of Pediatrics[19-21]; and

Whereas, while the MARSHA-C (Measure of Adolescent Relationship Harassment and Abuse – Compact) was developed with input from diverse youth and shows promising validity, its limited sample size, single online validation, lack of replication in clinical settings, and absence of cross-cultural or long-term outcome data mean it is not yet established for routine clinical use[29-32]; and

Whereas, a recent systematic review found a large degree of mistrust of available dating violence resources among African American and Latino youth, largely due to a lack of culturally sensitive interventions within these resources[32]; and

Whereas, current adult and adolescent dating violence prevention tools have been shown to reduce physical violence, but there has been a lack of statistically significant progress in reducing sexual violence, suggesting that new and more inclusive screening tools and interventions are needed[33]; therefore be it

RESOLVED, that our American Medical Association ask relevant stakeholders, including federal agencies, academic institutions, and professional societies, to support the development of validated, culturally sensitive, LGBTQ+ inclusive adolescent-specific screening tools for adolescent intimate partner violence that can be easily implemented in the clinic setting. (Directive to Take Action)

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

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RELEVANT AMA POLICY

Family and Intimate Partner Violence H-515.965

Our American Medical Association believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To suppor physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.

Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to:

Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care.

Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before they leave the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course.

After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible.

Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid.

Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence.

Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV.

(Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves.

Give due validation to the experience of IPV and of observed symptomatology as possible sequelae.

Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made.

Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

Within the larger community, our AMA:

Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.

Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.

Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA opposes the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, our AMA believes the laws must incorporate provisions that:

do not require the inclusion of survivors' identities;

allow competent adult survivors to opt out of the reporting system if identifiers are required;

provide that reports be made to public health agencies for surveillance purposes only;

contain a sunset mechanism; and

evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.

Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:

Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.

Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.

Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough

to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence. [CSA Rep. 7, I-00Reaffirmed: CSAPH Rep. 2, I-09Modified: CSAPH Rep. 01, A-19Modified: Speakers Rep. 02, I-24]

Education of Medical Students and Residents about Domestic Violence Screening H-295.912
Our American Medical Association will continue its support for the education of medical students and residents on domestic violence by advocating that medical schools and graduate medical education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient. [Res. 303, I-96Reaffirmed: CME Rep. 2, A-06Reaffirmed: CME Rep. 01, A-16]

Improving Screening and Treatment Guidelines for Intimate Partner Violence (IPV) Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (LGBTQ) D-515.980
Our AMA will:
(1) promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ survivors of IPV; (2) encourage physicians to familiarize themselves with resources available in their communities for LGBTQ survivors of IPV; (3) advocate for federal funding to support programs and services for survivors of IPV that do not discriminate against underserved communities, including on the basis of sexual orientation and gender identity; (4) encourage research on intimate partner violence in the LGBTQ community to include studies on the prevalence, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening; and (5) encourage the dissemination of research to educate physicians and the community regarding the prevalence of IPV in the LGBTQ population, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening. [Res. 903, I-17Modified: CSAPH Rep. 01, I-18]

Adverse Childhood Experiences and Trauma-Informed Care H-515.952
Our American Medical Association recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.
Our AMA supports:
evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs).
evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs.
efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.
efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting.
funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life.
increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant. increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.
Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.
Our AMA will collaborate with the CDC and other relevant interested parties to advocate for the inclusion of additional evidence-based categories to the currently existing Adverse Childhood Experiences (ACEs)

categories for the purposes of continuing to improve research into the health impacts of ACEs and how to mitigate them.

Our AMA will work with the CDC and other relevant interested parties to advocate for resources to expand research into ACEs and efforts to operationalize those findings into effective and evidence-based clinical and public health interventions.

Our AMA will support the establishment of a national ACEs response team grant to dedicate federal resources towards supporting prevention and early intervention efforts aimed at diminishing the impacts ACEs have on the developing child. [Res. 504, A-19Appended: CSAPH Rep. 3, A-21Appended: Res. 914, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 430
(A-26)

Introduced by: Medical Student Section, Oregon, Washington

Subject: Support Heavy Metal and Toxic Exposure Testing for Residents Affected by Wildfires

Referred to: Reference Committee D

Whereas, wildfires in the United States are increasing in frequency and intensity, driven in part by climate change, with the annual acreage burned doubling in recent decades[1]; and

Whereas, urban and suburban wildfires increasingly burn homes, vehicles, electronics, and industrial facilities, producing hazardous air, soil, and water contamination distinct from forest-only fires[2]; and

Whereas, toxic substances released by burning urban infrastructure include heavy metals such as lead, arsenic, mercury, and cadmium, as well as polycyclic aromatic hydrocarbons (PAHs), dioxins, and volatile organic compounds (VOCs)[3]; and

Whereas, wildfire smoke can travel hundreds of miles, exposing populations far beyond the burn zone to toxic pollutants, with documented effects on air quality across entire regions[4]; and

Whereas, wildfire smoke exposure is associated with increased hospital admissions for respiratory disease, cardiovascular events, and premature mortality, as well as with increased risk of some types of cancer[5-7]; and

Whereas, wildfire byproduct exposure is estimated to cause tens of thousands of hospitalizations and premature deaths each year, resulting in billions of dollars in health care costs and lost productivity nationwide[8-11]; and

Whereas, fire suppressants used to combat wildfires often themselves contain heavy metals contributing to environmental contamination[12]; and

Whereas, toxic heavy metals such as lead and cadmium persist in the environment long after fires are extinguished, contaminating soil, groundwater, and household dust[13,14]; and

Whereas, the CDC lowered the blood lead reference value for children in 2021, monitoring for mild or moderate environmental exposures and chronic exposure is associated with irreversible neurocognitive deficits in children, as well as hypertension, renal dysfunction, and adverse pregnancy outcomes[15-17]; and

Whereas, first responders, cleanup workers, utility crews, and residents can become exposed to harmful smoke during and after fires, and this exposure can be detected and quantified with post-incident urine testing for smoke byproducts (PAHs)[18]; and

Whereas some state public health agencies, in coordination with national agencies, have tested residents for heavy metal toxicity following wildfire, yet such testing is not standardized nor implemented after all wildfires[19,20]; therefore be it

RESOLVED, that our American Medical Association supports the development, dissemination, and implementation of voluntary post-wildfire toxicant exposure screening protocols, covering heavy metals, polycyclic aromatic hydrocarbons (PAHs), and other dangerous air pollutants and toxic substances, for wildfire-impacted individuals and communities, in coordination with appropriate public health and environmental agencies, universities, public health schools and societies (New HOD Policy); and be it further

RESOLVED, that our AMA support federal and state efforts, in partnership with public health and environmental agencies, to ensure access to environmental monitoring, mobile health services, medical follow-up, and treatment for individuals exposed to toxic substances during or after wildfire events, with particular attention to frontline, vulnerable and disproportionately impacted communities. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

H-135.938 Global Climate Change and Human Health
Our American Medical Association supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.
Our AMA supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

Recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public.
Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.
Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training. [CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22]

D-135.962 Hazardous Pollutants and Heavy Metals
Our AMA (1) urges governmental agencies to establish and enforce limits for identified hazardous pollutants and heavy metals in our food, water, soil, and air. (2a) monitor the chronic effects of exposure to hazardous pollutants and heavy metals including at levels below regulation limits; (2b) monitor the burden of toxicity in communities, especially near urban, Superfund, military bases, and industrial sites; and (2c) educate individuals on the chronic effects of those exposures. [Res. 409, A-24]

H-60.924 Reducing Lead Poisoning
Our American Medical Association:
supports regulations and policies designed to protect young children from exposure to lead;
urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure;
encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories;

promotes community awareness of the hazard of lead-based paints; and
urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.
Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level >5 µg/dL (>50 ppb) by 2021, and (b) eliminate lead exposures to pregnant people and children, so that by 2030, no child would have a blood lead level >1 µg/dL (10 ppb).
Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals:
adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant people and children from lead toxicity and neurodevelopmental impairment;
identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed;
continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services;
eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions;
provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and
establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant people and children, defined as blood lead levels above 1 µg/dL (10 ppb).
Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply.
Our AMA advocates for accessible testing of domestic water supplies, prioritizing testing for lead in potable water used by pregnant people, newborns and young children, and with the provision of accessible water filters in homes found to have elevated lead levels in potable water.
Our AMA supports increased funding for lead pipe replacement and other steps to eliminate lead from public and private drinking water supplies.
Our AMA promotes community awareness and education campaigns on the causes and risks of lead in drinking water and steps that can be taken to eliminate these risks.
Our AMA supports the development and use of searchable registries of housing units known to have unresolved lead in the drinking water due to lead connectors to water mains or other sources of lead in the drinking water in cities with significant public lead exposure.
Our AMA urges healthcare providers to increase screening for lead exposure, particularly in areas known to have lead pipes, and particularly in underserved areas.
Our AMA calls for research into innovative and cost-effective methods for elimination of lead in public and private water supplies and lead from lead pipe connectors to such water supplies. [CCB/CLRPD Rep. 3, A-14Appended: Res. 926, I-16Appended: Res. 412, A-17Modified: Res. 432, A-24Modified: Speakers Rep. 02, I-24]

D-135.992 Mercury Pollution
Our American Medical Association recognizes that the trading of air pollutants is potentially harmful for vulnerable populations.
Our AMA encourages state governments to be proactive in protecting citizens from harmful mercury emissions.
Our AMA encourages reduction in mercury use in manufacturing wherever possible, and recognize that more must be done using available and emerging technology to reduce mercury emissions.
Our AMA recommends increased vigilance, monitoring and tracking of mercury use and emissions in chlor-alkali facilities that use mercury in manufacturing processes.
Our AMA encourages the US government to assume a leadership role in reducing the global mercury burden and work toward promoting binding, health-protective international standards.

Our AMA supports the Environmental Protection Agency's national mercury emissions standards for cement kilns at limits based on the latest pollution control technology.
Our AMA supports modern and strict source monitoring of mercury emissions from cement plants. [CSAPH Rep. 1, I-06Appended: Res. 501, A-11Reaffirmation A-14Modified: CSAPH Rep. 01, A-24]

H-135.999 Federal Programs
The AMA believes that the problem of air pollution is best minimized through the cooperative and coordinated efforts of government, industry and the public. Current progress in the control of air pollution can be attributed primarily to such cooperative undertakings. The Association further believes that the federal government should play a significant role in these continuing efforts. This may be done by federal grants for (1) the development of research activity and (2) the encouragement of local programs for the prevention and control of air pollutants. [BOT Rep. M, A-63Reaffirmed: CLRPD Rep. C, A-88Reaffirmed: Sunset Report, I-98Reaffirmation I-06Reaffirmation I-07Reaffirmed: CSAPH Rep. 01, A-17]

H-135.923 AMA Advocacy for Environmental Sustainability and Climate
Our American Medical Associaiton supports initiatives to promote environmental sustainability and other efforts to halt global climate change.
Our AMA will incorporate principles of environmental sustainability within its business operations.
Our AMA supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
Our AMA supports a resilient, accountable health care system capable of delivering effective and equitable care in the face of changing health care demands due to climate change.
Our AMA encourages health care organizations to develop climate resilience plans, for the continuity of operations in an emergency, that take into account the needs of groups in their community that experience disproportionate risk of climate-related harm and ensure the necessary collaboration between different types of healthcare facilities.
Our AMA recognizes that climate resilience and mitigation efforts will be community-specific and supports physician engagement at the local level to promote community alliances for environmental justice and equity.
Our AMA supports the Joint Commission’s Sustainable Healthcare Certification, which supports health systems in pursuing decarbonization by establishing greenhouse gas (GHG) baseline emissions as well as measuring and documenting GHG reductions.
Our AMA supports the development of strategies and technologies to strengthen supply chain networks, including economic incentives for building climate and disaster resiliency and redundancy into new or updated facilities, increasing emergency stockpiles of key products, and incentivizing the innovation and adoption of reusable medical products to resist the impact of supply chain disturbances. [Res. 924, I-16Reaffirmation: I-19Modified: Res. 415, A-24Appended: Res. 907, I-24Appended: Res. 914, I-24]

H-135.973 Stewardship of the Environment
Our AMA encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients.
Our AMA encourages the medical community to cooperate in reducing or recycling waste.
Our AMA encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner.
Our AMA supports enhancing the role of physicians and other scientists in environmental education.
Our AMA endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention.
Our AMA encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes.
Our AMA encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation.
Our AMA encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment.
Our AMA encourages educational programs for worldwide family planning and control of population growth.
Our AMA encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy.
Our AMA encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.

Our AMA encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment.
Our AMA encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives.
Our AMA encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues.
Our AMA will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS).
Our AMA encourages expanded funding for environmental research by the federal government.
Our AMA encourages family planning through national and international support.
Our AMA recognizes that clinical quality and safety should not be sacrificed as strategies for reducing greenhouse gasses and waste.
Our AMA recognizes that animal-based agriculture is a significant contributor to greenhouse gas emissions and supports efforts to increase and promote plant-based menu options in hospital food services, for both health and environmental reasons.
Our AMA expects that health systems will provide transparency and avoid misleading the public regarding their greenhouse gas emissions, including but not limited to providing definitions used in the calculations of their net-zero emissions.
Our AMA opposes corporate “greenwashing,” or the act of making misleading statements about the environmental benefits of products and/or services.
Our AMA supports the development of locally managed and reliable electrical microgrids that operate independently from the larger electrical grid for hospitals and other health care facilities to use as a way to reduce reliance on diesel generation for back-up services while maintaining critical care functions during emergencies and supports grants being provided to independent practices to facilitate this development.
Our AMA supports the use of virtual health care, where appropriate, with reasonable reimbursement, as a strategy to reduce the carbon footprint of health care.
Our AMA supports financial assistance for health care entities, including community health centers, clinics, rural health centers, small- and medium-sized physician practices, transitioning to environmentally sustainable operations.
Our AMA supports the development of concise clinical guidelines and patient education materials to assist physician practices and patients to reduce adverse organizational and personal impacts on climate change.
Our AMA supports further research on the health- and climate-related effects of consuming plant-based and lab-grown meat. [CSA Rep. G, I-89Amended: CLRPD Rep. D, I-92Amended: CSA Rep. 8, A-03Reaffirmed in lieu of Res. 417, A-04Reaffirmed in lieu of Res. 402, A-10Reaffirmation I-16Modified: Res. 414, A-24Appended: Res. 420, A-25]

D-440.912 AMA Public Health Strategy
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.
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 en 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.
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.
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.
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-23Modified: BOT Rep. 05, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 431
(A-26)

Introduced by: Medical Student Section, American Association of Public Health Physicians

Subject: Supporting Transportation Infrastructure Reform for Public Health

Referred to: Reference Committee D

Whereas, the American Medical Association (AMA) recognizes robust transportation infrastructure as a fundamental social determinant of health that directly impacts patient access to medical facilities, pharmacies, and essential community services [1–4]; and

Whereas, in 2017, 5.8 million individuals in the United States delayed medical care due to a lack of transportation, with such barriers being responsible for 25% of all missed clinic appointments, representing a significant risk factor for long-term mortality among patients with chronic conditions [5–7]; and

Whereas, segments of transportation often have poor connectivity in the United States due to lack of suitable pedestrian infrastructure, with sidewalks having 45% less spatial access than roads, thus disproportionately disadvantaging individuals reliant on them, such as elderly, children, and individuals with disabilities [8]; and

Whereas, since the 1980s, U.S. transportation infrastructure has prioritized automobile access, allocating approximately 80% of federal transportation funding to highways and less than 20% to public transit infrastructure, while active transport networks face an estimated $7 billion funding shortfall, resulting in consistently underfunded, unaffordable, and unreliable accessible transportation options [3,9]; and

Whereas, current federal transportation formulas and design standards (e.g. reliance on vehicle miles traveled and road throughput), prioritize automobile speed over safety, incentivizing road designs that endanger pedestrians, cyclists, and transit users [6]; and

Whereas, vulnerable road users (e.g. cyclists, pedestrians) comprise approximately 20% of all traffic fatalities with pedestrian deaths reaching a 40-year high, yet many states have raised the allowable numbers of deaths and serious injuries among these users, with a disproportionate burden in marginalized communities [3,6]; and

Whereas, “Complete Streets” is a transportation policy approach that requires streets to be designed for safe access for pedestrians, bicyclists, public transportation, as well as motorists for users of all ages and abilities, incorporating robust pedestrian and cycling infrastructure, traffic calming measures, and public transport accommodations [10]; and

Whereas, access to sidewalks, bike lanes, and other active mobility infrastructure has been shown to significantly improve physical activity levels and health outcomes, with systematic reviews highlighting that walkability interventions reduce chronic disease burden and enhance equity in urban environments, as well as reduce pedestrian and biker fatalities [11-14]; and

Whereas the Federal Highway Administration released a report in March 2022 setting forth an initiative to adopt the Complete Streets design model in its approach to funding and designing most federally funded roads [15]; and

Whereas, the Complete Streets Act of 2025 has been introduced to Congress and the House of Representatives, requiring states to establish Complete Street programs and dedicating 5% of federal highway funding to providing technical assistance and incentives for their development, further promoting safer streets for all users [16,17]; therefore be it

RESOLVED, that our American Medical Association support street design strategies that 1.) facilitate the construction of integrated, multimodal transportation infrastructure; 2.) ensure safe and accessible travel for pedestrians, bicyclists, public transit users, and motorists of all ages and abilities; and 3.) place a special emphasis on addressing safety in underserved communities including but not limited to rural areas, low-income neighborhoods, and communities of color (New HOD Policy); and be it further

RESOLVED, that our AMA support reform of federal transportation funding formulas, to explicitly prioritize pedestrian safety metrics, transit accessibility, and health outcomes alongside vehicle miles traveled and level-of-service when calculating success of roads. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

Health Promotion and Disease Prevention H-425.993
The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; (5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and preferably clean-energy public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention. [Presidential Address, A-82Reaffirmed: CLRPD Rep. A, I-92Reaffirmed: CSA Rep. 8, A-03Reaffirmed: BOT Rep. 8, I-06Reaffirmed: CSAPH Rep. 01, A-16Modified: Res. 923, I-19]

H-135.939 Green Initiatives and the Health Care Community
1. Our AMA supports responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction.
2. Our AMA supports the use of ecologically sustainable products, foods, and materials when possible.
3. Our AMA supports the development of products that are non-toxic, sustainable, and ecologically sound.
4. Our AMA supports building practices that help reduce resource utilization and contribute to a healthy environment.
5. Our AMA supports the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation.
6. Our AMA supports community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.
7. Our AMA encourages pilot studies on the feasibility of urban ambulance fleets being replaced with renewably-powered vehicles when current petroleum-powered EMS ambulances become retired from service.

[CSAPH Rep. 1, I-08Reaffirmation A-09Reaffirmed in lieu of Res. 402, A-10Reaffirmed in lieu of: Res. 504, A-16Modified: Res. 516, A-18Modified: Res. 923, I-19Appended: Res. 406, A-25]

H-470.991 Promotion of Exercise
1. Our American Medical Association:
    a. supports the promotion of exercise, particularly exercise of significant cardiovascular benefit.
    b. encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest.
2. Our AMA supports National Bike to Work Day and encourages active transportation whenever possible.

[Res. 83, parts 1 and 2, I-77Reaffirmed: CLRPD Rep. C, A-89Reaffirmed: Sunset Report, A-00Reaffirmed: CSAPH Rep. 1, A-10Appended: Res. 604, A-11Reaffirmed: CSAPH Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 432
(A-26)

Introduced by: Medical Student Section, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Addiction Psychiatry, American Academy of Psychiatry and the Law

Subject: Addressing Public Health Risks of Online Sports Betting

Referred to: Reference Committee D

Whereas, since the 2018 Murphy v National Collegiate Athletic Association ruling enabled state authorization of legalized mobile sports betting,33 states and the District of Columbia have enacted laws with others actively considering legislation;[1-4] and

Whereas, professional sports leagues and broadcasters such as the NFL have fueled growth of this industry through heavy advertising, ultimately contributing to a 750% increase in industry advertising expenditures between 2019 and 2021;[5,6] and

Whereas, consumer engagement continues to rise, with an estimated 68 million Americans wagering $23.1 billion on the 2024 Super Bowl alone, a 41% increase from the prior year;[7] and

Whereas, evidence indicates DFS participation can act as a gateway to sports betting and impulsive gambling, especially among adolescents and young adults, with recent studies documenting mental health problems and addictive behaviors among DFS players resembling those observed in sports bettors;[8,9] and

Whereas, young adults are the fastest growing group of sports bettors, with 58% of college students reporting sports betting in the past year, and studies show that early exposure increases the likelihood of developing gambling disorder which is associated with financial hardship, relationship strain, depression, suicidality, and substance use;[10-15] and

Whereas, national prevalence surveys of gambling disorder largely predate the 2018 Murphy v NCAA ruling, leaving a critical data gap in understanding the scope of gambling-related harm in the online era, especially among adolescents and young adults;[16] and

Whereas, evidence suggests that online sports bettors have double the rates of gambling disorder as compared to those who gamble in other forms, but the lack of data collection since the 2018 ruling obscures the true characterization of the effect of online betting;[17] and

Whereas, Daily Fantasy Sports (DFS) platforms operate in a legal gray area under the 2006 Unlawful Internet Gambling Enforcement Act, which classifies DFS as a game of skill rather than gambling; however, regulators have increasingly scrutinized DFS contests for their resemblance to sports wagering, with one sportsbook fined millions of dollars in 2025;[18-21] and

Whereas, state regulatory frameworks for online sports betting differ substantially, with wide inconsistencies in consumer protections, allocation of funds for responsible gaming initiatives, and the types of contests permitted for wagering;[22-24] and

Whereas, many state regulatory frameworks fail to require online sportsbooks to meet the Internet Responsible Gaming Standards (IRGS) and the consumer protection guidelines set by the National Council on Problem Gambling (NCPG), leaving major gaps in protections for individuals at risk of gambling disorder;[17, 22, 25, 26,] and

Whereas, the NCPG has developed a comprehensive package of responsible online gaming standards, grounded in evidence and expert consensus, that includes self-limiting tools, access to betting history, and readily available treatment resources, representing a strong framework for uniform consumer protection and harm reduction;[26] and

Whereas, voluntary self-exclusion has been shown to be an effective tool to curb gambling disorder, however current policies are not currently effective due to lack of advertisement, promotion, monitoring, staff training, and active engagement by operators;[27] and

Whereas, gambling is increasingly recognized as a public health concern, with recent federal initiatives such as the GRIT Act (2023) and SAFE Bet Act (reintroduced 2025) underscoring bipartisan recognition of gambling disorder as a national issue requiring updated epidemiological studies and a stronger understanding of consumer protections;[28-31] therefore be it

RESOLVED, that our American Medical Association support efforts to establish federal and state consumer protections for online gambling, including sports betting and daily fantasy sports, to reduce harms associated with gambling disorder and other related behaviors (New HOD Policy); and be it further

RESOLVED, that our AMA support epidemiological research to characterize the health impacts of online gambling, including sports betting and daily fantasy sports, with particular attention to adolescents, young adults, older adults, people with cognitive impairment, and other vulnerable populations. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

H-440.922 Gambling Disorder

The AMA: (1) encourages physicians to advise their patients of the addictive potential of gambling; (2) encourages states which operate gambling programs to provide a fixed percentage of their revenue for education, prevention, and treatment of gambling disorder; and (3) requests that states which operate gambling programs affix to all lottery tickets and display at all lottery counters a sign which states that gambling may become a gambling disorder and help is available through your local gambling hotline. [Res. 430, A-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Modified: CSAPH Rep. 01, A-24]

H-275.939 Internet Gambling

Our AMA informs physicians and patients of the dangers of addiction associated with Internet gambling and supports prohibiting the availability of Internet gambling to children. [Res. 217, A-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 01, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 433
(A-26)

Introduced by: Texas Medical Association

Subject: Addressing the Epidemic of Fragility Fractures Through Improved Osteoporosis Screening and Treatment

Referred to: Reference Committee D

Whereas, fragility fractures—defined as fractures resulting from low-energy mechanisms such as a fall from standing height—represent a major and growing public health crisis, leading to significant morbidity, mortality, and health care costs; and

Whereas, fewer than 25% of patients who experience a fragility fracture currently receive appropriate osteoporosis evaluation or pharmacologic treatment within one year of their fracture; and

Whereas, timely screening with dual-energy X-ray absorptiometry and fracture-risk assessment lead to reduced incidence of subsequent fractures; and

Whereas, coordinated fracture liaison services and evidence-based osteoporosis care models have demonstrated substantial reductions in secondary fractures and the resultant long-term health care expenditures; and

Whereas, the growing population of aging Americans at risk for osteoporosis and fragility fractures places an increasing burden on the state's health care system, workforce, and economic resources; therefore be it

RESOLVED, that our American Medical Association recognize fragility fractures and untreated osteoporosis as a significant and urgent public health issue in the United States (New HOD Policy); and be it further

RESOLVED, that our AMA support expanded and evidence-based osteoporosis screening efforts, including improved access to dual-energy X-ray absorptiometry scanning and Fracture Risk Assessment Tool evaluations for at-risk populations (New HOD Policy); and be it further

RESOLVED, that our AMA encourage health systems, hospitals, and physician groups to develop and implement coordinated fracture liaison services and secondary fracture prevention programs (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for legislation or regulation for improved insurance coverage and payment policies for osteoporosis screening, diagnosis, pharmacologic treatment, and follow-up care (Directive to Take Action); and be it further

RESOLVED, that our AMA support nationwide public and physician education initiatives aimed at increasing awareness of osteoporosis risk factors, prevention, and the importance of post-fracture evaluation. (New HOD Policy)

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

Received: 4/20/26

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RELEVANT AMA POLICY

H-425.981 Reimbursement of Screening Bone Densitometry

Our AMA: (1) advocates for the use of bone densitometry as an important tool in assessing fracture risk and in the diagnosis of osteoporosis; (2) advocates that a clinical evaluation accompany any bone mass measurement for the evaluation of fracture risk and osteoporosis; (3) advocates for the continued participation of the patient's physician in the diagnosis, treatment, and prevention of osteoporosis; (4) encourages private third party payers to provide coverage for bone mass measurement technology and services for those individuals at high risk of osteoporosis; and (5) will lobby Congress to add men undergoing testosterone-suppressing treatment for prostate cancer and men who are at high risk for any other reason to the list of beneficiaries receiving Medicare coverage of bone density testing to screen for osteoporosis.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 434
(A-26)

Introduced by: Private Practice Physicians Section

Subject: Vaccinations in Physician Offices

Referred to: Reference Committee D

Whereas, vaccination rates improve with physician recommendation; and

Whereas, Medicare Part B only covers influenza, pneumonia, hepatitis B, COVID, and occasionally TDAP vaccinations; and

Whereas, Medicare Part D covers all Advisory Committee on Immunization Practices (ACIP) recommended vaccines; therefore be it

RESOLVED, that our American Medical Association advocate for all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines to be covered by Medicare Part B. (Directive to Take Action)

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

Received: 4/20/26

RELEVANT AMA POLICY

Financing of Adult Vaccines: Recommendations for Action H-440.860

1. Our American Medical Association supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing.
2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States: Provider-related
    a. Develop a data-driven rationale for improved vaccine administration fees.
    b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
    c. Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
    d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.

Federal-related

a. Increase federal resources for adult immunization to:
    i. Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations.
    ii. Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered.

iii. Fund an adequate universal reimbursement rate for all federal and state immunization programs.

b. Optimize use of existing federal resources by, for example:
   i. Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding.
   ii. Capitalizing on public health preparedness funding.
c. Ease federally imposed immunization burdens by, for example:
   i. Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B.
   ii. Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient.
   iii. Simplifying the reimbursement process to eliminate payment-related barriers to immunization.
d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.

State-related

a. State Medicaid programs should increase state resources for funding vaccines by, for example:
   i. Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees.
   ii. Establishing and requiring payment of a minimum reimbursement rate for administration fees.
   iii. Increasing state contributions to vaccination costs.
   iv. Exploring the possibility of mandating immunization coverage by third party payers.
b. Strengthen support for adult vaccination and appropriate budgets accordingly.

Insurance-related

1. Provide assistance to providers in creating efficiencies in vaccine management by:
   i. Providing model vaccine coverage contracts for purchasers of health insurance.
   ii. Creating simplified rules for eligibility verification, billing, and reimbursement.
   iii. Providing vouchers to patients to clarify eligibility and coverage for patients and providers.
   iv. Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as of May 1, 2025, and national medical specialty society recommended vaccines.
      a. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
      b. Improve accountability by adopting performance measurements.
      c. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as of May 1, 2025, and national medical specialty society recommended vaccines as <b>partb> of the health plan.
      d. Provide incentives to encourage providers to begin immunizing by, for example:
         i. Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations.
         ii. Simplifying payment to and encouraging immunization by nontraditional providers.
         iii. Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).

Manufacturer-related

Market stability for adult vaccines is essential. Thus:

i. Solutions to the adult vaccine financing problem should not deter research and development of new vaccines.
ii. Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets.
iii. Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP recommend adult vaccines as of May 1, 2025, and national medical specialty society recommended adult vaccines.

iv. Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.

3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.

Citation: CSAPH Rep. 4, I-08; Reaffirmed: I-10; Reaffirmed: I-12; Reaffirmed: I-14; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: A-22; Modified: BOT Rep. 24, I-25

Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875

1. All persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as of May 1, 2025, or national medical specialty society recommended vaccines as soon as possible following publication of these recommendations.
2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.
3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.
4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of recommended vaccines, and the timely distribution of recommended vaccines to providers).
5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer recommended vaccines.
6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.
7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.
8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.
9. Until compliance of our AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients.
10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines, including those from national medical specialty societies.

Citation: BOT Action in response to referred for decision: Res. 524, A-06; Reaffirmed: A-07; Appended: Res. 531, A-07; Reaffirmed: A-09; Reaffirmed: Res. 501, A-09; Reaffirmed: I-10; Reaffirmed: A-11; Reaffirmed in lieu of: Res 422, A-11; BOT action in response to referred for decision: Res. 422, A-11; Reaffirmed: I-12; Appended: Res. 227, I-12; Appended: Res. 824, I-14; Reaffirmed: Res. 411, A-17; Reaffirmed> CMS Rep. 3, I-20; Reaffirmed: Res. 228, A-21; Reaffirmed: A-22; Modified: BOT Rep. 24, I-25