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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-26)
Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making

EXECUTIVE SUMMARY

BACKGROUND. Policy D-480.951 "Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making," asked that our American Medical Association (AMA) collaborate with interested parties, including physicians, academic institutions, and industry leaders, to create a report with recommendations for how artificial intelligence (AI) tools used in clinical decision support convey transparency in the quality of medical evidence and the grading of medical evidence to physicians and advanced care practitioners so clinical recommendations can be accurately verified and validated.

METHODS. English-language reports, peer-reviewed articles, white papers, government publications, and grey literature were selected from PubMed and Internet search, using the terms "artificial intelligence", "augmented intelligence", "level of evidence", and "grading of evidence". Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of organizations that specialize in AI, large language models, and medical information. Additional collaboration with the AMA Center on AI and Digital Health and other key parties was utilized to incorporate broad information.

DISCUSSION. Transparency in AI refers to making the design, data sources, training process, and decision-making logic of AI systems understandable to key parties, encompassing both process-level elements and outcome-level explanations. Although explainability is essential, particularly in clinical contexts, meaningful explanation is challenging due to differences between algorithmic computation and human reasoning and must be balanced with safety, efficacy, and contextual expertise. Transparency can be supported through interpretable modeling techniques, documentation, user-centered explanation tools, and third-party evaluation frameworks, yet global standards remain fragmented across domains. Persistent challenges include the inherent opacity of complex deep-learning models, confabulations in generative systems, data biases, lack of consensus on explanation methods, proprietary limitations, and the risk that oversimplified explanations may inflate user trust without improving comprehension. These limitations complicate clinical applications: while AI could help keep evidence-based clinical guidelines current, its lack of transparency undermines reliability; similarly, integrating AI into medical education alongside established evidence-based medicine frameworks is difficult without clear mechanisms for interpretability and explanation.

CONCLUSION. AI-enabled decision support systems are reshaping how information is synthesized and applied across sectors, offering rapid analysis and evidence-informed recommendations that enhance, but do not replace, human expertise. In medicine, these tools may improve efficiency, workflow, and detection of high-risk conditions, yet their effect on patient outcomes remains undetermined due to limited long-term validation and ongoing concerns about transparency, bias, and explainability. Integrating principles of evidence-based medicine into AI design could strengthen trust and alignment with clinical standards, but major challenges persist, including opaque model reasoning, uneven transparency requirements, and risks of confabulation in generative systems. As clinical guidelines and medical education evolve to keep pace with rapid evidence generation, AI can support real-time updates and manage complex information if transparency, reliability, and user-centered design remain central. Ultimately, AI should augment human judgment, reinforce evidence-based practice, and support clinicians in delivering high-quality, patient-centered care.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 7-A-26

Subject:	Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making
Presented by:	Padmini Ranasinghe, MD, MPH, Chair
Referred to:	Reference Committee E

American Medical Association (AMA) Policy D-480.951, "Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making," which was adopted at the 2025 Annual Meeting by the AMA House of Delegates (HOD), and directs the following:

> That our American Medical Association collaborate with stakeholders, including physicians, academic institutions, and industry leaders, to create a report by A-26 with recommendations for how AI tools used in clinical decision support convey transparency in the quality of medical evidence and the grading of medical evidence to physicians and advanced care practitioners so clinical recommendations can be accurately verified and validated.

This report serves as the Council on Science and Public Health's (CSAPH's) findings and recommendations after collaboration with key parties and review of the evidence surrounding transparency of evidence-based medicine in augmented intelligence (AI) tools for clinical decision-making.

METHODS

English-language reports, peer-reviewed articles, white papers, government publications, and grey literature were selected from PubMed and Internet search, using the text terms "artificial intelligence", "augmented intelligence", "level of evidence", and "grading of evidence". Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of organizations that specialize in AI, large language models, and medical information. Additional collaboration with the AMA Center on AI and Digital Health and other key parties was utilized to incorporate broad information.

BACKGROUND

AI-enabled decision support systems are rapidly evolving across sectors such as health care, business, and industrial operations to assist human decision-making by synthesizing complex data, making predictions, and offering evidence-based recommendations. In health care, clinical decision support systems now move beyond traditional rule-based alerts to include real-time evidence synthesis and large language model assistance, helping clinicians interpret patient data, identify high-risk cases, and recommend guideline-aligned interventions while preserving human judgment in final decisions. For example, modern platforms are used for medical imaging alerting and triage in radiology, such as systems that analyze CT scans to flag critical findings and can reduce diagnostic turnaround times and associated mortality.[1]

AI decision support is also widely used in business and industry to forecast trends, optimize resource allocation, and support strategic planning through predictive analytics and prescriptive modeling integrated into enterprise systems.[2] These tools synthesize large datasets and provide decision frameworks that would be infeasible to process manually, improving strategic clarity and operational responsiveness.

Outcomes data for AI-assisted decision support shows promising signals with surveys indicating a growing adoption among clinicians with many reporting perceived improvements in care delivery, and some implementations have demonstrated measurable benefits such as enhanced guideline adherence and faster, more accurate identification of critical clinical events.[3] However, systematic evidence linking AI decision support directly to broad improvements in patient outcomes remains mixed, and many tools still lack validation across diverse real-world settings.[4]

Despite these advances, AI clinical decision support systems cannot replace human expertise - they are constrained by data quality, lack full transparency in reasoning, and are often assistive in nature rather than autonomous decision-makers.[5] In health care, opaque model logic and liability concerns persist. These limitations underscore ongoing challenges in trust, explainability, and regulation as AI continues to support rather than supplant human decision-making.[6]

Evidence-Based Medicine

Evidence-based medicine (EBM) is the cornerstone of clinical decision making in medical practice to provide the best patient outcomes. EBM utilizes rigorous scientific method and critical appraisal to organize and systematize the application of research and data to ground health care decisions.[7,8] By utilizing EBM, physicians are able to implement the most up-to-date scientific information into their practice while also building confidence in medical decisions and discussions with patients.

EBM application is a systematic process. EBM in clinical practice follows five steps: 1. Ask a searchable question; 2. Acquire information; 3. Appraise search results; 4. Apply the evidence in practice; and 5. Assess the provided care.[9] These five steps can be applied to each individual patient in each encounter and also to larger populations of patients in products such as clinical protocols and guidelines.[9] EBM is a key component in medical education to support evidence-based decision-making and these five steps are a framework for clinical teaching.

Levels of evidence play a vital role in evidence-based practice by providing a structured hierarchy for evaluating the quality and relevance of research. Typically illustrated as a pyramid, this framework helps clinicians make well-informed decisions by emphasizing studies with stronger methodologies and lower risk of bias (Appendix 1).[10] Grading systems translate the level of evidence into a commonly understood alphabetic system for hierarchical consumption and application (Appendix 2).[11,12] Clinical guidelines often utilize grading systems to demonstrate the strength of their recommendations based on the level of evidence used for their recommendations.[13,14] These grading systems help to support communication between patients and their physicians and ensure clear understanding of evidence-based practice for high quality care. There are multiple leveling or grading systems for use in EBM, each with their own challenges and drawbacks, particularly how the system can disadvantage certain study designs.[11] By understanding these levels, practitioners can ensure that their clinical decisions are grounded in the most reliable and rigorous evidence available. The integration of an EBM grading system into AI may support transparency but may be complex.

DISCUSSION

Transparency in AI refers to the accessibility and clarity of information about how an AI-enabled system is designed, trained, and makes decisions, such that key parties can understand and justify its behavior and outputs. At its core, transparency covers process-level elements (e.g., intended use, data sources, bias, model structure) and outcome-level explanations (e.g., why the system made a specific prediction), and is closely tied to explainability and interpretability as ethical principles in AI governance.[15,16]

The AMA's Council on Science and Public Health (CSAPH) Report 8-A-25, "Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms," underscores that while explainability is highly desirable (especially for augmented intelligence tools used in clinical care) it is also complex and nuanced, reflecting fundamental differences between algorithmic computation and human reasoning.[17] The report notes that explainability to build transparency is difficult to implement in practice and must be balanced with considerations such as safety, efficacy, and contextual expertise, and that explanations should be evaluated independently rather than relying solely on developer claims.[17]

Mechanisms

Building transparency includes embedding explainability into AI design (e.g., using inherently interpretable models or Explainable AI techniques like LIME and SHAP), documentation and reporting of data and model decisions, user-centered explanation interfaces, and third-party evaluation frameworks that assess explanation quality according to criteria like consistency, plausibility, fidelity, and usefulness.[18,19] At present, there is no single global standardization of transparency in AI; efforts such as principles in the EU AI Act and third-party explainability requirements in health care policy reflect emerging but fragmented standards across domains, and many organizations still lack universally accepted definitions or metrics for transparency.[20,21] Examples of how transparency is built into systems range from open-sourced models with clear documentation of training data and algorithms to clinical AI tools that generate feature attribution heatmaps showing which inputs most influenced a medical prediction, helping clinicians understand and verify outputs.[20] Ideas for improving transparency include adopting standardized explanation frameworks (e.g., model cards), multidisciplinary evaluation involving ethics and domain experts, embedding interpretability mechanisms during early model design, and enhancing communication tools so end users can meaningfully engage with AI reasoning.[22–25]

Challenges

Complex models like deep neural networks are often inherently opaque, presenting a black box problem that complicates transparency. A notable technical issue is "hallucinations" in generative AI, where models produce plausible sounding but incorrect outputs because they lack grounded reasoning tied to factual input data. Given that the industry standard term "hallucination" has specific behavioral health implications, we refer to this occurrence as a "confabulation" for this report.[26] Furthermore, transparency depends heavily on the quality and provenance of input data; datasets that are biased, incomplete, or poorly documented undermine meaningful explanation and increases the risk of misleading outputs.[27]

Many state-of-the-art AI models, especially deep learning and large transformer-based systems, are inherently highly complex and non-linear, with millions or even billions of parameters.[28] These internal representations do not map cleanly to human-understandable concepts, so tracing how an input leads to a specific output becomes extremely difficult even for the engineers who built them.

This "black box" opacity fundamentally limits transparency.[28] There is currently no universally accepted framework for what constitutes transparency or how to measure it reliably across applications. Some techniques produce local feature attributions, and others create surrogate models, but there is no consensus on which methods provide faithful or useful explanations.[29] This means that even when explanations are produced, they may be inconsistent, unvalidated, or misleading. There is no consensus on which methods provide faithful or useful explanations.

Many powerful AI systems are developed by private companies that protect their models and train data as trade secrets. This obscures key information about data provenance, processing steps, and architectural decisions, complicating independent audit or regulatory scrutiny.[30] Transparency is not only a technical issue but also a legal one. Even when explanation tools are used, they can inadvertently create a false sense of understanding. Explanations may oversimplify complex reasoning, leading users to over-trust AI outputs or misinterpret how decisions are reached. Some research suggests that explanations can increase human over-reliance on AI, even when AI is wrong, because explanations inflate perceived reliability without improving actual understanding.[31,32]

Generative AI models like large language models can produce outputs that are fluent and convincing but factually incorrect or fabricated, a phenomenon known as confabulation. Recognition of an AI confabulation is critical in the health care setting, where if not detected, it could cause harm to a patient.[33] These errors highlight a core transparency challenge: appearances of coherence does not guarantee truthfulness or logical validity, and users may mistake fluency for reliability.[34] Because confabulations emerge from the probabilistic nature of these models, they can be difficult to detect or explain post hoc.[20] Transparency is intimately tied to the quality and representativeness of input data. If training datasets are biased, incomplete, or poorly documented, explanations derived from these models may simply reflect those flaws, perpetuating hidden biases (e.g., demographic or cultural skew) that are difficult to uncover without transparent data reporting, and complicating ethical assessment and trust.[35]

Legal and governance frameworks for AI transparency are still evolving and vary significantly across jurisdictions.[30] Most health systems rely on vendor logs, institutional governance committees, and organizational policies to oversee how these technologies are used. Those approaches have worked reasonably well for earlier generations of clinical software. However, as the number of AI systems participating in clinical care grows, that model may outpace our ability to fully understand how these systems are involved in patient care. Regulatory uncertainty can discourage organizations from fully disclosing how their systems operate, and fragmented standards make cross-domain transparency difficult to implement consistently. Highly technical explanations may be accurate but remain incomprehensible to non-expert key parties, undermining transparency's goal of meaningful understanding for decision makers.[36]

As multiple AI systems begin to participate in a single patient visit, the profession will need visibility into that participation that is independent of vendor-controlled logs to preserve patient safety, physician accountability, and evidence-based care. Utilization of agentic AI is an emerging team member for many physicians working with AI in their clinical workflows.[37] If AI contributes to documentation, diagnostic suggestions, treatment recommendations, or other elements of the medical record, physicians and health systems need the ability to understand when those systems participated and how their outputs entered the clinical workflow. Maintaining that level of visibility will also help ensure that physicians remain aware of when AI contributes to patient care and that clear lines of human accountability for clinical decisions are preserved.

Current Upkeep of Clinical Recommendations and Training

Currently with AI, clinical guidelines support EBM in practice, with transparency of inputs and thorough analysis of the evidence for their recommendations. Typically clinical guidelines are developed and updated on a three to five year basis, with a latency period between when incorporation of newer evidence-based practice may lag.[38,39] With new research emerging daily, these time periods are at risk for quickly becoming outdated, with some research showing at least 20 percent of recommendations are outdated within three years of their publication.[40] AI poses possibility in this area with the ability to incorporate data inputs in a real time fashion, however without transparency or explainability capabilities, it is difficult to support clinical decision making in an evidence-based way.

Teaching EBM and training its implementation in practice is embedded into medical education. Originally as a mechanism to teach the skills necessary for information overload, something AI may be taking the workload of, EBM is an empirical approach for medical learners and practitioners to provide quality care and is highly embedded in medical education accreditation structures.[41,42] AI information and utility with best practices is emerging in medical education, similar to EBM decades ago.[42,43] With unclear transparency and explainability mechanisms, applying EBM structures and implementing them into medical education is challenging. Incorporating the intersection of EBM and AI tools, with their limitations and benefits of transparency and explainability, into medical education is prudent to prepare physicians for utilization of AI in their clinical decision-making.

CURRENT AMA POLICY

The AMA has extensive policy on AI in general. Several of these policies specifically discuss the need for transparency of AI used in clinical decision-making. Policy H-480.931, "Augmented Intelligence Development, Deployment, and Use in Health Care," outlined the regulatory landscape and AMA's historical role in AI governance. The section below briefly summarizes the most relevant portions of AMA policy.

H-480.931, "Assessing the Intersection Between AI and Health Care"

- Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
- Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce
- Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
- Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in

institutional settings, consistent with AMA Policy H-225.940, "Augmented Intelligence and Organized Medical Staff."

- When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
- Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
    - AI disclosure should align and meet ethical standards or norms.
    - Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
    - When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
    - When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
- The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.
- Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
    - Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
- Mitigating Misinformation in AI-Enabled Technologies
    - AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training data. Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
    - Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
    - Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
    - Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.

D-480.954, "Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms"

- To maximize the impact and trustworthiness of augmented intelligence and machine-learning (AI/ML) tools in clinical settings, our AMA recognizes that:

        - Explainable AI with safety and efficacy data should be the expected form of AI tools for clinical applications, and exceptions should be rare and justified and require at minimum safety and efficacy data prior to their adoption or regulatory approval;
        - To be considered "explainable," an AI device's explanation of how it arrived at its output must be interpretable and actionable by a qualified human. Claims that an algorithm is explainable should be adjudicated only by independent third parties, such as regulatory agencies or appropriate specialty societies, rather than by declaration from its developer;
        - Explainability should not be used as a substitute for other means of establishing safety and efficacy of AI tools, such as through randomized clinical trials; and
        - Concerns of intellectual property (IP) infringement, when provided as rationale for not explaining how an AI device created its output, does not nullify a patient's right to transparency and autonomy in medical decision-making. While intellectual property should be afforded a certain level of protection, concerns of infringement should not outweigh the need for explainability for AI with medical applications.
    - Our AMA will collaborate with experts and interested parties to develop, and disseminate a list of definitions for key concepts related to medical AI and its oversight.

H-480.939, "Augmented Intelligence in Health Care"

- Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
- Payment and coverage for health care AI systems intended for clinical care must be conditioned on
    - clinical validation.
    - alignment with clinical decision-making that is familiar to physicians.
    - high-quality clinical evidence.
- There should be federal and state interagency collaboration with participation of the physician community and other key parties in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care key parties.

CONCLUSION

AI-enabled decision support systems are transforming how information is synthesized and applied across health care, business, and other sectors, offering rapid data analysis and evidence-informed recommendations that enhance, but do not replace, human expertise. In medicine, these tools show promise in improving efficiency, clinical workflow, and detection of high-risk conditions, yet their full impact on patient outcomes remains undetermined due to limited long-term validation and persistent concerns about transparency, bias, and explainability. EBM remains the foundation for trustworthy clinical decision-making and integrating its principles, such as graded evidence hierarchies and rigorous appraisal, into AI systems could strengthen confidence in integrating AI-enabled technologies into clinical care. However, significant challenges persist, including opaque model reasoning, inconsistent standards for transparency, a lack of transparency mandates in regulatory structures, and risks of confabulations in generative models. As clinical guidelines and medical education continue evolving to keep pace with rapid evidence generation, AI offers

substantial potential to support real-time updates and organize and analyze large amounts of information, provided that transparency, reliability, and user-centered design remain central. Ultimately, AI should be viewed as an augmenting tool that complements human judgment, reinforces evidence-based practice, and supports clinicians in delivering high-quality, patient-centered care.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That our AMA will:
    a. Recognize and promote the importance of transparency and explainability of AI tools used in clinical decision support to ensure the quality of medical evidence and the grading of medical evidence including the sources are clearly conveyed to physicians so clinical recommendations and outputs can be accurately verified and validated as tools to assist physicians in making clinical decisions.
    b. Collaborate with medical specialty societies, relevant key parties, regulators, and AI developers to establish standards and develop a framework for evidence attribution, evaluation, and validation in AI clinical decision support systems.
    c. Encourage medical education key parties to incorporate training on the utility, limitations and interpretation of evidence-based medicine practices when using AI tools in clinical decision- making.
    d. Monitor best practices and policies of AI transparency and evidence-based recommendations to improve the quality and reliability of patient care. (Directive to Take Action)

2. Policy D-480.951, "Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making," be rescinded as having been accomplished by this report. (Rescind AMA Policy)

Fiscal note: Minimal

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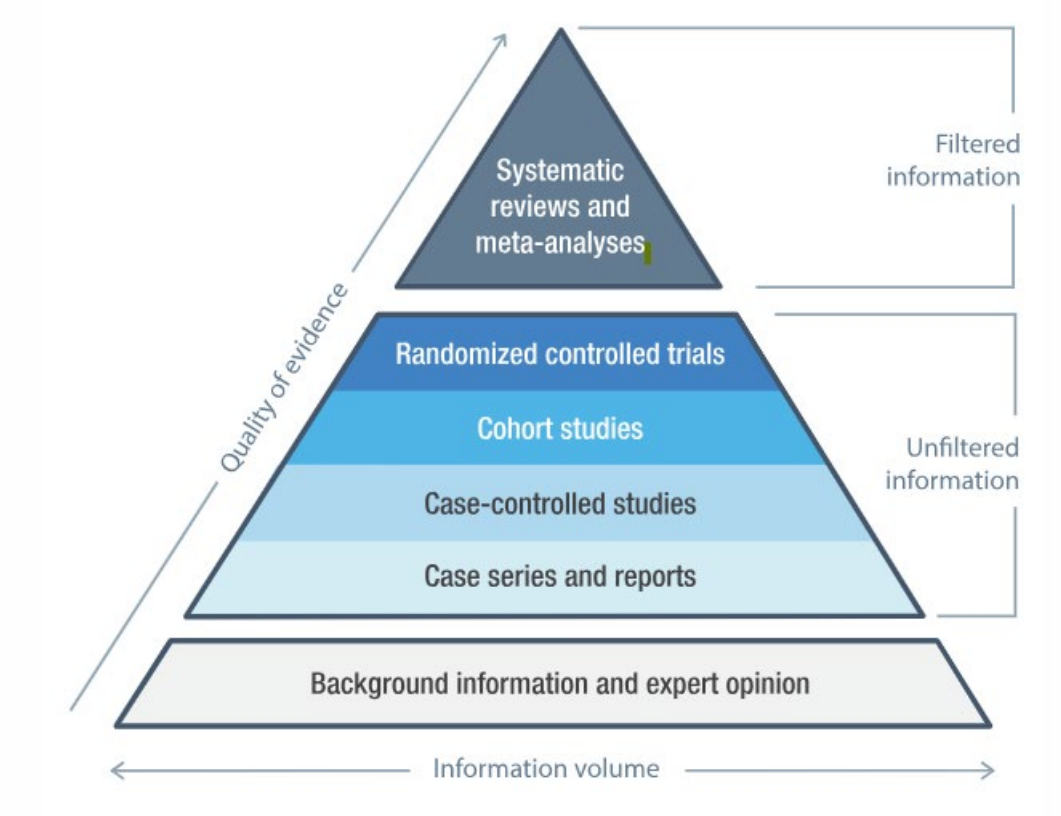
APPENDIX

Appendix 1. Level of Evidence Pyramid[44]



Appendix 2. Level of Evidence and Grades of Recommendations[12]

Grade of Recommendation	Level of Evidence	Type of Study
A	1a	Systematic review of (homogeneous) randomized controlled trials
A	1b	Individual randomized controlled trials (with narrow confidence intervals)
B	2a	Systematic review of (homogeneous) cohort studies of "exposed" and "unexposed" subjects
B	2b	Individual cohort study / low-quality randomized control studies
B	3a	Systematic review of (homogeneous) case-control studies
B	3b	Individual case-control studies
C	4	Case series, low-quality cohort or case-control studies
D	5	Expert opinions based on non-systematic reviews of results or mechanistic studies

REPORT 8 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH
Increased Transparency Among Psychotropic Drug Administration in Prisons

EXECUTIVE SUMMARY

BACKGROUND. American Medical Association (AMA) Policy D-430.990, "Increased Transparency Among Psychotropic Drug Administration in Prisons," requests that our AMA "study issues surrounding the use of psychotropic medications in the carceral system, including inconsistencies in dosage, frequency, duration, allowed formularies, side effects, and oversight by a psychiatrist or another physician with expertise in mental illness."

METHODS. English-language reports, peer-reviewed articles, white papers, government publications, and grey literature were selected from PubMed and Internet search, using the text terms "psychotropic medication," "drug administration," "carceral," "correctional," "prison," and "jail." Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of organizations that specialize in carceral health care including the treatment of mental health disorders and medication management.

RESULTS. This report examines the administration of psychotropic medications in U.S. carceral settings, focusing on transparency, ethical standards, and continuity of care. Findings reveal significant variability in medication practices across federal and state prisons and jails, with limited standardized guidelines and oversight. While psychotropic medications are essential for managing mental health disorders, their use is often constrained by restrictive formularies, staffing shortages, and budget limitations that compromise continuity of care and equitable access to treatment. At the same time, rising prescription trends in jails underscore growing mental health needs, yet variability in policies and practices continues to create disparities. Policies governing involuntary medication lack uniformity, with many states omitting duration limits or independent review mechanisms, raising concerns about patient autonomy and due process. Overall, trends indicate a marked increase in psychotropic prescribing in jails over the past decade, particularly antipsychotics reflecting growing mental health needs but also highlighting systemic gaps in access, monitoring, and ethical safeguards.

CONCLUSION. Psychotropic medication use in carceral settings presents complex clinical, ethical, and operational challenges that demand greater transparency and evidence-based oversight. While these medications are essential for managing mental health disorders, their administration must adhere to rigorous standards of assessment, informed consent, and ongoing monitoring to prevent misuse as a means of control. Addressing these challenges will require policy reforms that strengthen oversight, standardize care protocols, expand affordable drug access, and ensure that carceral settings uphold constitutional and ethical obligations to provide safe, humane, and clinically appropriate treatment.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 8-A-26

Subject: Increased Transparency Among Psychotropic Drug Administration in Prisons

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee E

American Medical Association (AMA) Policy D-430.990, "Increased Transparency Among Psychotropic Drug Administration in Prisons," adopted at the 2025 Annual Meeting directs the following:

1. Our AMA will study issues surrounding the use of psychotropic medications in the carceral system, including inconsistencies in dosage, frequency, duration, allowed formularies, side effects, and oversight by a psychiatrist or another physician with expertise in mental illness.
2. Our AMA supports increased transparency from jails and prisons surrounding protocols pertaining to the administration of psychotropic medications, including components such as dosage, frequency, duration, allowed formularies, management of side effects, and requirements for oversight by a psychiatrist or another physician with expertise in mental illness.

This report examines the use of psychotropic medications in carceral settings (i.e., jails and prisons) including drug formulary considerations, evidence-based policies, as well as the legal right to health care for individuals in carceral settings.

METHODS

English-language reports, peer-reviewed articles, white papers, government publications, and grey literature were selected from PubMed and Internet search, using the text terms "psychotropic medication," AND "carceral," OR "correctional," OR "prison," OR "jail"; "drug administration," AND "carceral," OR "correctional," OR "prison," OR "jail". Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of organizations that specialize in carceral health care including the treatment of mental health disorders and medication management.

BACKGROUND

The U.S. has the largest incarcerated population in the world with over 2 million people in carceral settings.[1] Individuals in jails and prisons have a higher rate of chronic conditions, substance use, and mental health disorders when compared to the general population.[2] A national survey reported that in the U.S. "there are now more than three times more seriously mentally ill persons in jails and prisons than in hospitals;" some states, such as Arizona and Nevada, had almost 10 times more.[3] A 2019 report found that 52 percent of those arrested two or more times reported a substance use disorder in the past year and 25 percent of people with multiple arrests reported having a serious mental illness (See Appendix 1).[4] Mental health courts and other deflection

programs serve as a mechanism to link eligible individuals to court-supervised, community-based treatment. AMA policy is supportive of diversion programs including mental health courts and drug courts to direct people to treatment programs in the community, but these are outside of the scope of this report. Deflection programs, immigration detention, and juvenile detention centers are also beyond the scope of this report.

The most recent government report and survey of incarcerated individuals compiled information from 233 state and federal prisons, 358 jails, and 15 special facilities (military, Indian country, and Immigration and Customs Enforcement facilities).[5] Nearly a quarter (24 percent) of the prisoners who had ever been told they had a mental disorder had major depressive disorder, 18 percent had bipolar disorder, 13 percent had post-traumatic stress disorder (PTSD) or a personality disorder; and 9 percent had schizophrenia or another psychotic disorder.[5] With the exception of personality disorder, local jail inmates were more likely than state prisoners to have been told they had each type of mental health disorder.[5] Studies also indicate that 60–87 percent of people in carceral settings have co-occurring mental health and substance use disorders (CODs).[6,7] However, few existing specialized COD treatment programs have been developed for carceral settings, in part due to the lack of integrated treatment programs in carceral settings.[8] Appropriate psychotropic medications are an effective intervention for treating mental health disorders and are generally the standard of care, particularly for serious mental illness.

DISCUSSION

Mental Health Disorder Screening

Timely psychiatric assessment is essential to prevent psychiatric deterioration following arrest, yet formal guidelines remain limited.[10,11] Best practices recommend screening for high-risk conditions during medical intake and prioritizing rapid evaluation for individuals with serious mental illness, prior hospitalizations, or suicidal behavior.[11] National Commission on Correctional Health Care (NCCHC) standards note that "screening may be done by qualified mental health professionals or by mental health staff, and when the results are positive for mental health problems, the inmate must be referred to qualified mental health professionals (e.g., psychiatrist, psychologist, psychiatric nurse, psychiatric social worker) for further evaluation."[12,13] Research shows that individuals screened for mental health conditions at intake are significantly more likely to be evaluated by a medical professional, which in turn increases the likelihood of receiving consistent pharmacologic treatment for their condition.[9]

Psychotropic Medications

Psychotropic medications are drugs that alter neurotransmitter activity at synapses in the brain and are the cornerstone of treatment for mental health disorders. They are often used to treat and manage behavioral and psychiatric symptoms.[14] There are five major categories of psychotropic medications: (1) antipsychotic medications; (2) antidepressants; (3) anxiolytic medications; (4) stimulants; and (5) mood stabilizers (See Appendix 2 for common psychotropic medications).[15–17]

In addition to providing relief to specific symptoms of mental health disorders, psychotropic medications have adverse side effects including producing a sedative effect, tardive dyskinesia, muscular rigidity, seizures, depression, or increased risk of suicide.[15,33] Inappropriate administration of psychotropic medications can further impair functioning. Although advances in the psychopharmacological field have produced a new generation of psychotropic drugs that result in less adverse side effects, most prisons employ the older medications which are less expensive.[34,35]

Use and Prevalence of psychotropics in prisons and jails

Individuals in carceral settings often face significant barriers to receiving or continuing psychotropics for mental health conditions.[2] Barriers to receiving or continuing psychotropics include a shortage of qualified psychologists and psychiatrists, reliance on screening tools designed primarily for security risk rather than diagnostic accuracy, limited carceral budgets that prioritize only the most severe cases, and the high cost and logistical difficulties associated with off-site specialized programs.[9] Additionally, research on psychotropic medication use among those in carceral settings remains limited, partly because this population is a protected research class.

The prevalence of psychotropic prescribing in carceral settings is substantially elevated compared to the community, with recent data showing significant increases across all medication classes from 2013 to 2023, including a 249 percent increase in antipsychotic prescriptions.[18] Women in prison receive psychotropic medications at particularly high rates (47.9 percent), approximately six times higher than the general population.[19] There are multiple key considerations related to the use of psychotropic medications, particularly in carceral settings.

The states with the highest percentage of prison inmates receiving psychotropic medication report that approximately 20 percent of their inmates were on such medications.[20] In Louisiana, Maine, Nebraska and Wyoming at least one in four inmates participated in mental health therapy or counseling programs.[20] In Nebraska state prisons specifically, 56 percent of inmates suffer from a mental illness, 16 percent have a serious mental illness, and 25 percent of male inmates and 50 percent of female inmates are prescribed psychotropic medications.[21] Only three states, North Dakota, Rhode Island, and Wyoming, lack dedicated psychiatric facilities and instead place prisoners who require mental health treatment in state hospitals, prison infirmaries, or in special needs units within general confinement facilities.[20] However, this data is from 2000-2001 data, and there is a need for updated studies in a field where pharmacologic and administrative processes are rapidly progressing.

Recent data shows a shift towards the increased use of medications in jails. [23-24] An analysis of psychotropic prescribing trends in 34 jails over an 11-year period (2013–2023), based on data from more than 1.25 million detainees' health records, revealed a significant increase in medication use over time (See Appendix 3).[25] Similarly, a study that assessed prescription patterns for individuals before and after COVID-19 in 18 county and municipal jails found that prescription patterns in all major therapeutic drug classes steadily increased, with 10 percent more people prescribed at least one drug post COVID-19 in 2023, despite the jail census decreasing over this time.[26] Prescription increases were observed across central nervous system medications including antipsychotics, antidepressants, and antianxiety medications (See Appendix 4).[26]

Medication Administration, Continuity, and Monitoring

Psychotropics, particularly selective serotonin reuptake inhibitors (SSRIs) or selective norepinephrine reuptake inhibitors (SNRIs), can take up to 12 weeks of administration to achieve efficacy and conversely may cause significant withdrawal symptoms if abruptly stopped.[27] Continuity of psychotropic medications in carceral settings is less than optimal, with reports of more than 50 percent of those on psychotropics for mental health disorders not receiving them while in prison.[9] The NCCHC standard requires that individuals entering a correctional facility continue receiving their clinically indicated prescription medications without interruption, unless a qualified clinician determines a justified change.[28]

Coordination and continuity of care are often disrupted for a multitude of reasons in prisons and jails, such as inadequate screening, lack of health professional staff, and inmate refusal – this can

lead to the people in carceral settings being under prescribed psychotropic medications that they were previously prescribed.[9,29] Maintaining continuity of psychotropic medications in carceral settings is a persistent challenge. During intake, transfers, or initial health assessments, incarcerated individuals often cannot provide complete or accurate details about their medication history—such as drug names, dosages, and schedules.[10] Records from community providers and pharmacies rarely accompany them, and obtaining these records typically requires a signed release of information.[10] Intake staff may attempt to verify prescriptions by contacting community pharmacies, but delays are common. While electronic medical records can enhance communication, the lack of interagency agreements for sharing of information often delays verification of medications, diagnoses, and recent treatment dates.[10]

In jails, where stays are typically short, strategies such as "bridge orders" can help maintain continuity of care by temporarily continuing outpatient medications until a psychiatrist can conduct an evaluation.[11] These orders should be time-limited and supported by collateral information from pharmacies, community providers, or family members to ensure accuracy and expedite appropriate treatment.[11]

Administration of psychotropics often requires significant monitoring, such as electrolytes, renal function, and cardiac monitoring for safety.[30,31] Ongoing assessment of prescription effects are essential to evaluate therapeutic response, detect adverse effects, and adjust treatment plans as clinically indicated. Certain antipsychotics are subject to additional monitoring through Risk Evaluation and Mitigation Strategies (REMS) programs, a Food and Drug Administration (FDA) mandated safety program required for medications that carry serious risks.[32] These additional monitoring requirements limit access to these agents in carceral settings.

Continuity of care, including discharge planning, is equally important to reduce health risks. Discharge planning should include providing enough medication or refills until the patient sees a community provider, using affordable and widely available psychotropics, and considering long-acting formulations.[10] For those on parole, coordination with parole departments can make adherence to mental health treatment a condition of release.[10] Additionally, the release dates for people in local jails are often unpredictable posing significant challenges to discharge planning. These have the potential to be mitigated through bridge prescriptions, rapid medication verification, expedited linkage to care. Medicaid re-enrollment on discharge and telehealth handoffs to community healthcare providers can support the continuity of psychotropic care. When a lack of discharge planning and continuity of care are not executed well this can lead to increased risk of psychiatric decompensation, return to illicit substance use, overdose, and suicide.

Involuntary Administration

Incarceration does not alter the fundamental medical, ethical, or legal requirements for informed consent, and therefore the involuntary administration of psychotropic medications in carceral settings raises significant clinical and ethical concerns. Most available information on the use of psychotropic medications to control, rather than treat, incarcerated individuals comes from inmate self-reports and human rights organizations, as carceral institutions rarely disclose intentional use of psychotropic medications for coercion or control.[33] It is important to distinguish evidence-based psychiatric treatment, delivered to address a diagnosed mental health disorder, from pharmacologic behavioral management used primarily for institutional convenience or security. Chemical restraint, even when framed as treatment, is governed by distinct ethical and clinical standards and requires heightened justification, procedural safeguards, and oversight. Health conditions may result in behavior that puts patients at risk of harming themselves. In such situations, it may be

ethically justifiable for physicians to order the use of chemical or physical restraint to protect the patient (See Code of Medical Ethics 1.2.7 Use of Restraints and CSAPH Report 4, A-25).
An analysis of state Department of Corrections (DOC) and Federal Bureau of Prisons (BOP) policies related to mental health found that 35 out of the 36 states (97 percent) with publicly available information allowed the involuntary use of psychotropic medications in emergency situations; this correlates to 76 percent (one million) of the total incarcerated population in the U.S (See Appendix 5).[36] Additionally, state policies vary widely in both the allowable types and maximum duration of involuntary psychotropic medications; while some states specify these limits in statute or policy, others provide no guidance at all (See Appendix 6).[36] Many laws and policies lack mechanisms for independent review or appeals, effectively placing decisions about treatment in the hands of individuals who may not be mental health professionals.[36]

There are also ethical considerations as carceral facilities may justify involuntary sedation arguing that the policy is necessary for the safety of others in the prison environment.[37] The American Psychiatric Association (APA) states that non-emergency involuntary administration of psychotropic medication in jails presents a complex ethical dilemma, balancing beneficence—the obligation to alleviate suffering and restore functioning—against autonomy, the right of individuals to make decisions about their own care.[38] While such treatment can reduce symptoms, prevent harm of the prisoner and others, and improve outcomes such as reducing disciplinary infractions and facilitating legal resolution, it also carries significant risks.[38] Involuntary medication should only occur after reasonable attempts at voluntary engagement have failed, under strict procedural safeguards, and with adequate clinical oversight.[38] Where clinically appropriate, psychiatric hospitalization should remain an alternative to ensure patient safety and uphold ethical standards.[38]

Psychotropic administration challenges

There are variabilities in medication practices across carceral settings. A survey of 51 county jails in Missouri found that most jails (74 percent) never charged a fee for medication administration, while 22 percent always did, creating potential barriers for individuals without income or Medicaid eligibility.[23] While some states permit correctional officers to administer medications dispensed from the pharmacy, the NCCHC advises that these staff receive specialized training in security, accountability, side effects, and documentation.[10] In a state survey of 51 county jails in Missouri, 57 percent of jails could administer long-acting injectable antipsychotics, and 49 percent performed weekly lab tests.[23]

In the 51 Missouri jails, medication restrictions were common — 11 jails refused all controlled substances, 16 excluded benzodiazepines, and 20 excluded opioids.[23] Additional limitations included quetiapine, gabapentin, bupropion, and trazodone.[23] Many jails did not allow individuals to use their own medications upon discharge from psychiatric facilities.[23] Despite the benefits of LAIAs for treatment, oral medications were preferred due to cost and logistical challenges, especially in facilities lacking on-site medical staff.[23] It is important to note that this is a state specific example and the generalizability to other states is unknown. However, these findings highlight significant gaps in access and continuity of psychiatric care in jails, with financial and operational barriers limiting evidence-based treatment. [23]

Psychotropic drugs are rarely classified as “keep on person,” where incarcerated persons can maintain their own medications, due to concerns about adherence and misuse. Medication diversion represents a significant security concern, necessitating direct observation of medication administration and careful monitoring of controlled substances.[39] While certain state DOC settings have allowed lower-risk psychotropic medications to be self-administered on a case-by-case basis,

at least one system discontinued this practice after discovering that patients were "hoarding" medications for nonmedical purposes.[10]

Drug Formulary Considerations

Drug formularies in carceral settings play a critical role in incarcerated patients' access to psychotropic medications, imposing significant restrictions on treatment options, often to lower cost by providing older medications. Over one-quarter (28 percent) of jails have a formulary. For example, the California Correctional Health Care Services formulary bans or limits access to at least 14 commonly used psychiatric medications, including bupropion, quetiapine, gabapentin, and hydroxyzine.[40] While formulary restrictions can limit access to certain psychotropic medications, they may also serve clinical and security purposes, as some commonly restricted agents carry significant potential for misuse, underscoring that such policies can present both benefits and harms. A review of jail formularies in Texas revealed significant variability in practices, driven primarily by local decision-making rather than medication cost.[40] The Pharmacy and Therapeutics Committee in carceral settings oversees medication management by maintaining the formulary and reviewing requests for nonformulary medications.[10]

There are significant policy-level barriers to pharmaceutical purchasing in carceral systems, notably the restrictions on Medicaid coverage.[41,42] Few jails offer the same range of medications available in state hospitals, and omissions often include inexpensive and commonly used drugs. In some cases, facilities include costly antipsychotics while excluding essential, lower-cost options.[43] These inconsistencies highlight the absence of standardized formulary policies and raise concerns about equitable access to evidence-based psychiatric care as well as unnecessary elevations in cost.[43] Similar restrictions appear in the BOP national formulary, which also limits medications like fluoxetine and venlafaxine, two of the most commonly used antidepressant medications.[40] The BOP allows temporary use of nonformulary medications for up to four days if withholding them would pose a significant risk to the patient.[40] However, determinations of what constitutes a 'significant risk' are inherently subjective and treatment options may depend more on formulary rules than on clinical need or appropriateness of the medication, raising concerns about equitable access to care.[40]

Carceral Health Care Staff and Oversight

The composition of health care teams in carceral facilities varies by facility size and inmate population. Larger institutions often employ multidisciplinary teams, while smaller facilities may rely on a single clinician with specialty care delivered on-site through contracted physicians, telehealth, or off-site referrals. Despite financial incentives state prisons have lost 12 percent of their full-time workforce over the past decade, with most of the decline occurring during the pandemic, while local jails experienced a smaller but notable reduction (7 percent).[44] The APA recommends one prescriber for every 75 to 100 patients with serious mental illness on psychotropic agents in jails, and one prescriber for every 150 such patients in prisons.[45] However, many facilities face persistent staffing shortages utilizing psychologists in place of physicians. Physicians are needed for oversight and to prescribe psychotropic medications because safely managing these powerful drugs requires extensive medical training in physiology, pharmacology, diagnosis, and the management of complex comorbid conditions that psychologists and other non-medical professionals do not receive.[46]

CURRENT AMA POLICY

Our AMA maintains a broad set of policies relevant to this report, including support for diversion programs (H-100.955 "Support for Diversion Programs, Including Drug Courts, Mental Health Courts, Veterans Courts, Sobriety Courts, and Similar Programs"), support for the provision of adolescent health care within detention and correctional facilities (H-60.986, "Health Status of Detained and Incarcerated Youth"), and justice reinvestment initiatives (H-95.931, "AMA Support for Justice Reinvestment Initiatives").

Additional policies address drug safety and REMS (H-100.961, "The Evolving Culture of Drug Safety in the United States: Risk Evaluation and Mitigation Strategies (REMS)"), behavioral health emergency practices in carceral settings (H-345.969, "Carceral Systems and Practices in Behavioral Health Emergency Care"), prevention of unnecessary hospitalization or jail confinement (H-345.995, "Prevention of Unnecessary Hospitalization and Jail Confinement of the Mentally Ill"), and mental health crisis interventions (H-345.972, "Mental Health Crisis Interventions").

The AMA also supports access to health care while incarcerated (H-430.986, "Health Care While Incarcerated") and standards of care for correctional facilities (H-430.997, "Standards of Care for Inmates of Correctional Facilities"). Further policies include guidance on medications for opioid use disorder (H-430.987, Medications for Opioid Use Disorder in Correctional Facilities"), minimum requirements for medication formularies (H-110.958, "Minimum Requirements for Medication Formularies"), and best practices for acute care of patients in law enforcement or correctional custody (D-430.993, "Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections").

In efforts to improve the administration of psychotropic medications, in 2024 AMA released "Psychopharmacology How-To Guide," which offers primary care physicians practical strategies and evidence-based resources on when and how to treat patients with psychotropic medications if deemed medically necessary.[47] This is part of AMA's efforts to improve health care by overcoming obstacles to accessible and equitable treatment for patients' behavioral, mental, and physical health needs.

CONCLUSION

Psychotropic medication use in carceral settings presents complex clinical, ethical, and operational challenges that demand greater transparency and evidence-based oversight. While these medications are essential for managing mental health disorders, their administration must adhere to rigorous standards of screening and assessment, informed consent, and ongoing monitoring to prevent misuse and improve outcomes. Involuntary treatment, though sometimes clinically necessary, raises profound ethical concerns and procedural safeguards should be in place to balance beneficence with autonomy. Systemic barriers, including inconsistent formularies, staffing shortages, and opaque pharmaceutical purchasing processes, further compromise continuity of care and equitable access to psychotropic medications and treatment.

RECOMMENDATION

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That policy D-430.990, "Increased Transparency Among Psychotropic Drug Administration," be amended by addition and deletion to read as follows:

   A. ~~Our AMA will study issues surrounding the use of psychotropic medications in the carceral system, including inconsistencies in dosage, frequency, duration, allowed formularies, side effects, and oversight by a psychiatrist or another physician with expertise in mental illness.~~

   Our AMA supports increased transparency from jails and prisons surrounding mental health care, including utilization ~~protocols pertaining to the administration~~ of psychotropic medications, and corresponding patient outcomes, potential harms, and system challenges. ~~including components such as dosage, frequency, duration, allowed formularies, management of side effects, and requirements for oversight by a psychiatrist or another physician with expertise in mental illness.~~

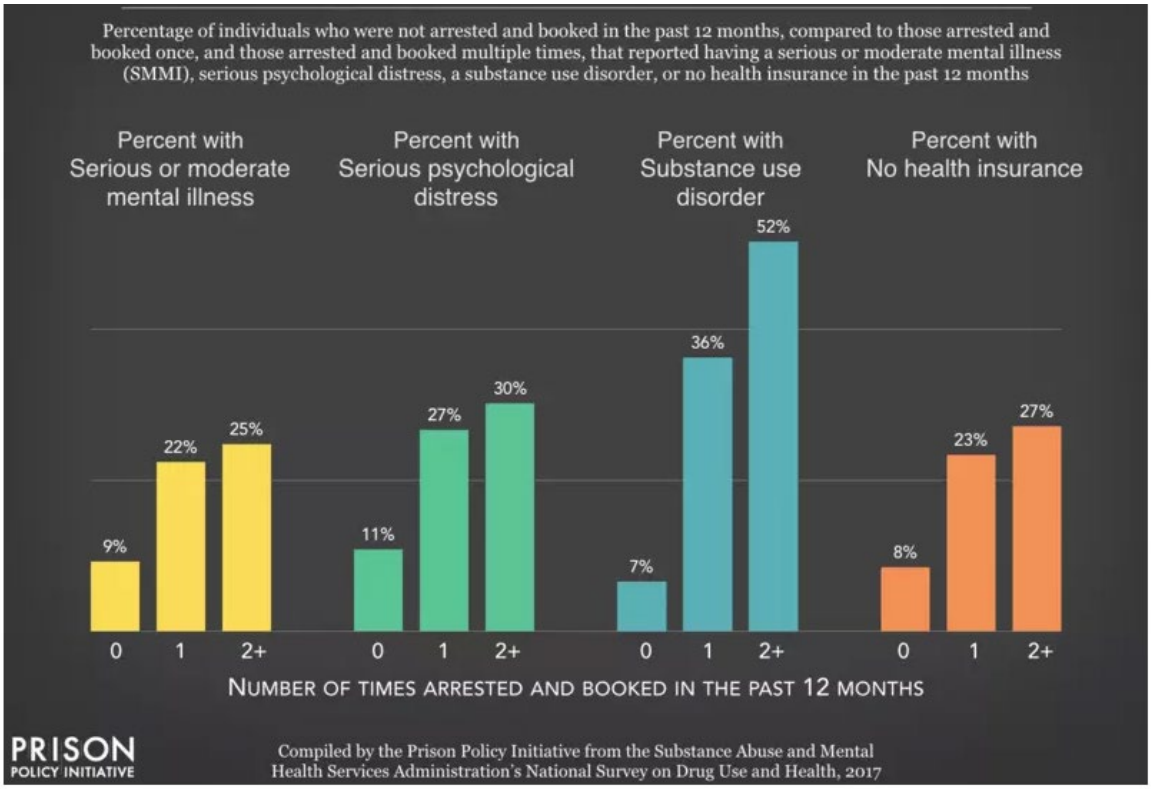
   B. Our AMA acknowledges the importance of continuity of care for mental health disorders in carceral settings and encourages incorporation of programs and procedures to promote evidence-based continuity of care, including bridge programs, medication verification protocols, access to qualified physicians, and post-release linkage to community clinics for continued care. (Modify Current HOD Policy)

2. That our AMA reaffirm the following HOD policies:

   H-130.932, "Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting;" H-430.997, "Standards of Care for Inmates of Correctional Facilities;" H-430.986, "Health Care While Incarcerated;" D-430.997, "Support for Health Care Services to Incarcerated Persons;" and H-110.958, "Minimum Requirements for Medication Formularies." (Reaffirm HOD Policy)

Fiscal Note: Minimal

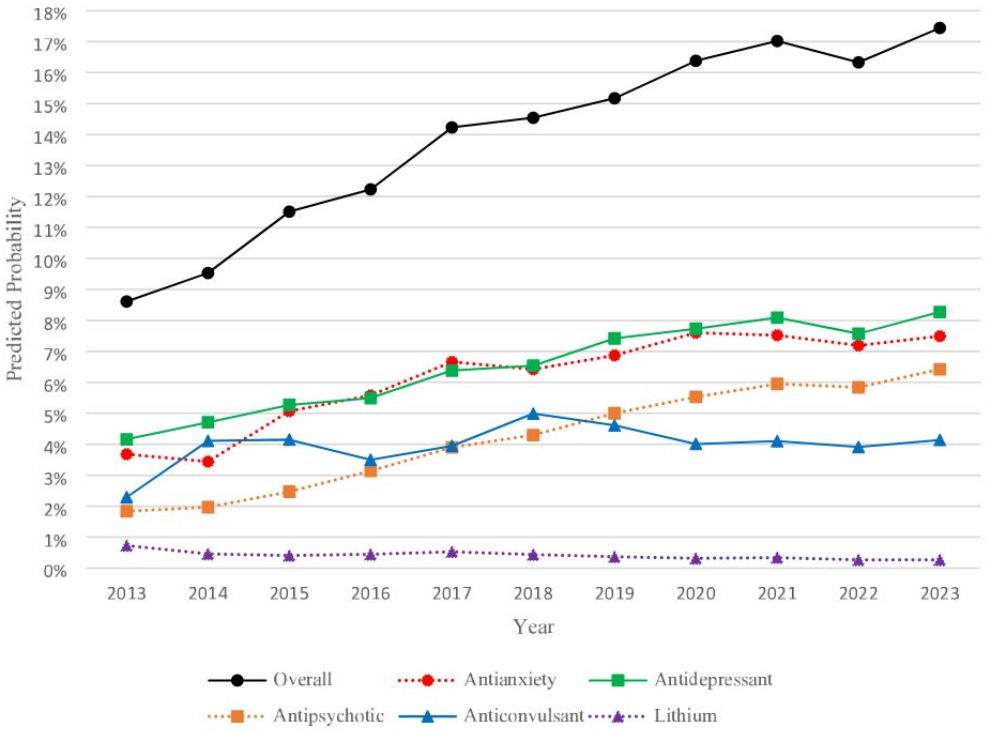
APPENDIX 1. People with Multiple Arrests that have Serious Health Needs[4]



APPENDIX 2. Common Psychotropic Medications, Their Indications, and Considerations[30,31,48–57]

Class	Examples	Typical Dosing	Primary Indications	Key Side Effects	Monitoring
SSRIs	Sertraline, Escitalopram, Fluoxetine, Citalopram, Paroxetine	Sertraline: 50-200 mg/day; Escitalopram: 10-20 mg/day; Fluoxetine: 20-80 mg/day; Citalopram: 20-40 mg/day	Depression, anxiety disorders	GI symptoms, sexual dysfunction, hyponatremia, insomnia; Citalopram: QTc prolongation	Hyponatremia risk (especially with thiazides), bleeding risk with anticoagulants
SNRIs	Venlafaxine, Duloxetine, Desvenlafaxine	Venlafaxine: 150-375 mg/day; Duloxetine: 60-120 mg/day; Desvenlafaxine: 50 mg/day	Depression, anxiety, neuropathic pain	Hypertension, tachycardia, GI symptoms, sexual dysfunction, increased sweating	Blood pressure (especially venlafaxine >300 mg/day), lipids
Atypical Antidepressants	Bupropion, Mirtazapine, Trazodone	Bupropion: 300-450 mg/day; Mirtazapine: 15-45 mg/day; Trazodone: 150-500 mg/day	Depression, insomnia (trazodone)	Bupropion: insomnia, anxiety; Mirtazapine: sedation, weight gain; Trazodone: sedation, priapism	Bupropion: seizure risk; Trazodone: QTc, orthostatic hypotension
Tricyclic Antidepressants	Amitriptyline, Nortriptyline, Desipramine	Amitriptyline: 25-300 mg/day; Nortriptyline: 25-150 mg/day; Desipramine: 25-300 mg/day	Depression, neuropathic pain	Anticholinergic effects, sedation, weight gain, orthostatic hypotension, arrhythmias	ECG, avoid in ischemic heart disease; therapeutic drug levels for nortriptyline
Second-Generation Antipsychotics	Risperidone, Quetiapine, Aripiprazole, Olanzapine, Lurasidone	Risperidone: 0.25-6 mg/day; Quetiapine: 150-800 mg/day; Aripiprazole: 2-30 mg/day; Olanzapine: 5-20 mg/day	Schizophrenia, bipolar disorder, augmentation for depression	Metabolic syndrome (weight gain, hyperglycemia, dyslipidemia), sedation, EPS, hyperprolactinemia, QTc prolongation	Baseline and periodic: BMI/waist circumference (monthly x3, then at 6 mo, yearly), fasting glucose/HbA1c, lipids; AIMS for tardive dyskinesia
Mood Stabilizers	Lithium, Valproate	Lithium: 600-1,200 mg/day; Valproate: variable	Bipolar disorder, augmentation for depression	Lithium: tremor, polyuria, hypothyroidism, renal impairment; Valproate: weight gain, sedation, hepatotoxicity, teratogenicity	Lithium: levels (0.6-1.2 mEq/L), renal function, thyroid; Valproate: levels, LFTs, CBC
Stimulants	Methylphenidate, Amphetamines	Methylphenidate: variable; Amphetamines: variable	ADHD, narcolepsy	Decreased appetite, insomnia, cardiovascular effects, growth suppression in children	Blood pressure, heart rate, growth parameters in children
Anxiolytics/Hypnotics	Benzodiazepines, Z-drugs	Variable by agent	Anxiety, insomnia	Sedation, dependence, cognitive impairment, falls	Assess for dependence, falls risk in elderly

APPENDIX 3. Predicted Probabilities of Prescribed Psychotropic Medications by Year[25]



APPENDIX 4. Prevalence Estimates and Demography of Individuals Prescribed Select Pharmaceutical Agents / Products by Year[26]

	Year				
GPI therapeutic class	*2019* N = *17,607*	*2020* N = *12,158*	*2021* N = *14,249*	*2022* N = *15,125*	*2023* N = *16,062*
Analgesic and anesthetics					
# Individuals prescribed agent	1,142 (6.5)	988 (8.1)	1,162 (8.2)	1,420 (9.4)	1,630 (10.2)
Total agents prescribed	1,233	1,086	1,268	1,578	1,852
Drug class					
Analgesics—narcotics	241 (1.4)	218 (1.8)	336 (2.4)	536 (3.5)	541 (3.4)
Analgesics—non-narcotics	446 (2.5)	467 (3.8)	521 (3.7)	541 (3.6)	645 (4.0)
Antirheumatic	497 (2.8)	350 (2.9)	336 (2.4)	440 (2.9)	574 (3.6)
Gout	29 (0.2)	34 (0.3)	36 (0.3)	34 (0.2)	56 (0.3)
Age, years					
15–19	8 (0.7)	9 (0.9)	7 (0.6)	19 (1.3)	14 (0.9)
20–34	404 (35.4)	355 (35.9)	390 (33.6)	538 (37.9)	559 (34.3)
35–54	515 (45.1)	437 (44.2)	526 (45.3)	639 (45.0)	777 (47.7)
55+	215 (18.8)	187 (18.9)	239 (20.6)	224 (15.8)	280 (17.2)
Sex * Race					
Female	193 (16.9)	98 (9.9)	137 (11.8)	189 (13.3)	282 (17.3)
Black	34 (3.0)	30 (3.0)	30 (2.6)	33 (2.3)	72 (4.4)
White	133 (11.7)	54 (5.5)	95 (8.4)	121 (8.5)	152 (9.3)
Other	5 (0.4)	4 (0.4)	3 (0.3)	8 (0.6)	8 (0.5)
Unknown	21 (1.8)	10 (1.0)	9 (0.8)	27 (1.9)	50 (3.1)
Male	949 (83.1)	889 (90.1)	1,025 (88.2)	1,231 (86.7)	1,348 (82.7)
Black	416 (36.4)	428 (43.3)	454 (39.1)	479 (33.7)	592 (36.3)
White	427 (37.4)	374 (37.9)	465 (40.0)	529 (37.3)	562 (34.5)
Other	18 (1.6)	12 (1.2)	25 (2.2)	34 (2.4)	28 (1.7)
Unknown	88 (7.7)	76 (7.7)	81 (7.0)	189 (13.3)	166 (10.2)
Central nervous system					
# Individuals prescribed agent	4,526 (25.7)	3,917 (32.2)	4,797 (33.7)	4,878 (32.3)	5,212 (32.5)
Total agents prescribed	8,848	8,300	9,734	9,610	10,214
Drug class					
Antianxiety	1,508 (8.6)	1,319 (10.8)	1,525 (10.7)	1,425 (9.4)	1,682 (10.5)
Antidepressant	3,291 (18.7)	2,910 (23.9)	3,457 (24.3)	3,479 (23.0)	3,685 (22.9)
Antipsychotic	2,375 (13.5)	2,149 (17.7)	2,670 (18.7)	2,675 (17.7)	2,840 (17.7)
Hypnotics	5 (<0.1)	5 (<0.1)	3 (<0.1)	4 (<0.1)	4 (<0.1)
Lithium	141 (0.8)	110 (0.9)	122 (0.9)	105 (0.7)	121 (0.8)
Stimulants	3 (<0.1)	5 (<0.1)	7 (<0.1)	7 (<0.1)	11 (<0.1)
Miscellaneous psychotherapeutics	9 (0.1)	9 (0.1)	7 (<0.1)	11 (0.1)	5 (<0.1)
Age, years					
15–19	102 (2.3)	101 (2.6)	112 (2.3)	114 (2.3)	105 (2.0)
20–34	2,031 (44.9)	1,862 (47.5)	2,204 (45.9)	2,253 (46.2)	2,262 (43.4)
35–54	1,953 (43.2)	1,630 (41.6)	2,055 (42.8)	2,056 (42.1)	2,348 (45.0)
55+	440 (9.7)	324 (8.3)	426 (8.9)	455 (9.3)	497 (9.5)
Sex * Race					
Female	978 (21.6)	683 (17.4)	725 (15.1)	822 (16.9)	1,035 (19.9)
Black	214 (4.7)	170 (4.3)	192 (4.0)	221 (4.5)	373 (7.2)
White	698 (15.4)	481 (12.3)	492 (10.3)	535 (11.0)	581 (11.2)
Other	25 (0.6)	12 (0.3)	11 (0.2)	25 (0.5)	24 (0.5)
Unknown	41 (0.9)	20 (0.5)	30 (0.6)	41 (0.8)	57 (1.1)
Male	3,548 (78.4)	3,234 (82.6)	4,072 (84.9)	4,056 (83.1)	4,177 (80.1)
Black	1,431 (31.6)	1,467 (37.5)	1,803 (37.6)	1,831 (37.5)	1,915 (36.7)
White	1,897 (41.9)	1,585 (40.5)	2,009 (41.9)	1,897 (38.9)	1,915 (36.7)
Other	101 (2.2)	79 (2.0)	93 (1.9)	112 (2.3)	113 (2.2)
Unknown	119 (2.6)	103 (2.6)	167 (3.5)	216 (4.4)	234 (4.5)

APPENDIX 5. State Policies on Emergency and Non-Emergency Administration of Psychotropic Medications[36]

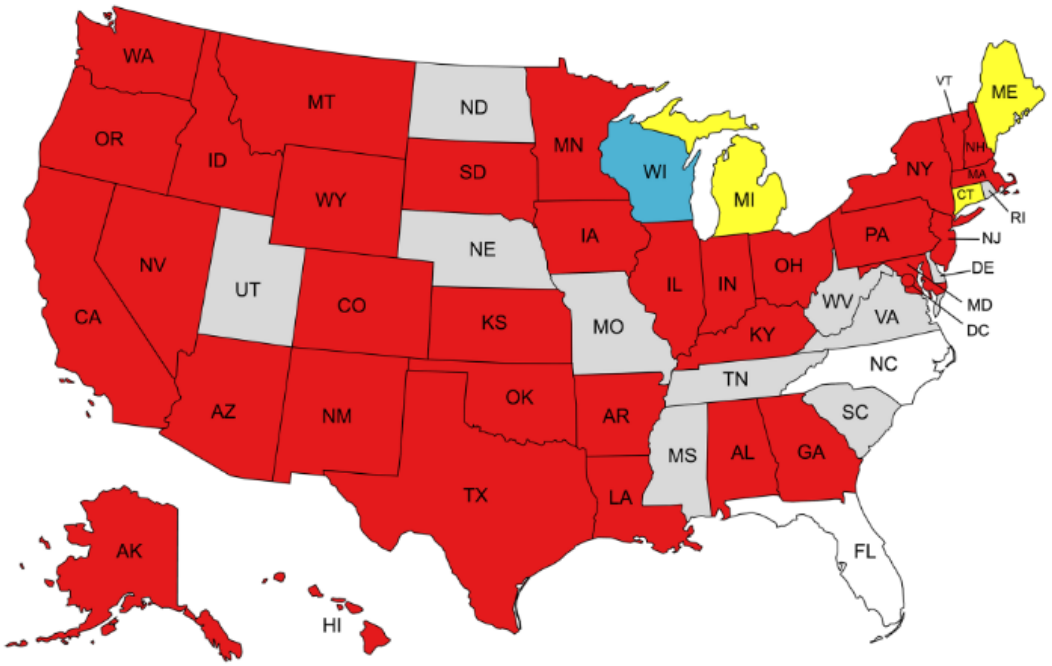
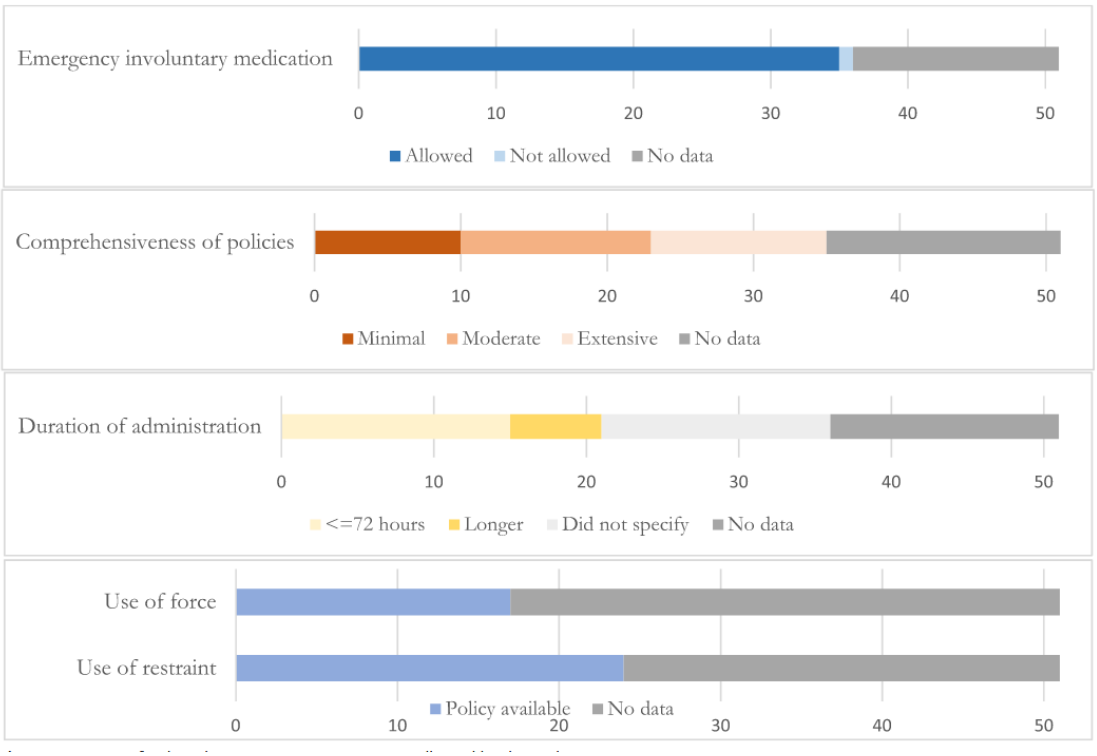


Fig. 1 Policies regarding emergency and non-emergency involuntary administration of psychotropic medication across the United States. Federal Bureau of Prisons is represented by District of Columbia (DC). Red = available policies on involuntary administration of psychotropic medication explicitly allow use in emergency situations, Blue = available policies on involuntary administration of psychotropic medication allow use in non-emergency situations, but do not specify use in emergency situations, Yellow = available policies on involuntary administration of psychotropic medication do not distinguish between emergency and non-emergency use, Gray = no policy data or insufficient data, White = excluded from analysis due to withdrawn policy or limited in scope. Source: Data collected by the authors; map created in mapchart.net

APPENDIX 6. Summary of State Policy Characteristics for the Use of Psychotropic Medications[36]



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REPORT 9 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-26)
In Support of a National Drug Checking Registry

EXECUTIVE SUMMARY

BACKGROUND. Policy D-95.950, "In Support of a National Drug Checking Registry" as adopted by the House of Delegates at 2025 Annual Meeting and asked that our AMA "study the creation of a national drug-checking data system that would provide a mechanism whereby community-run drug-checking services may communicate their de-identified results, with legal protections, data use agreements, and user opt-in/opt-out mechanisms."

METHODS. English-language reports, peer-reviewed articles, white papers, government publications, and grey literature were selected from PubMed and Internet search, using the text terms "drug checking." Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of organizations that specialize in community drug checking, data collection, and legal protections of public health data.

DISCUSSION. Drug checking programs across the United States (U.S.) provide valuable, timely insights into the evolving illicit drug supply, using a range of technologies, from inexpensive test strips to advanced spectrometry, to detect adulterants including unexpected or novel psychoactive substances. These programs have demonstrated measurable effects on participant attitudes and intended behaviors, with many individuals reducing doses, modifying practices, consuming more slowly, using test shots, or disposing of contaminated substances after receiving unexpected results. Multiple states, including Michigan, Illinois, Rhode Island, and North Carolina, have shown that drug checking and dashboards are both feasible and valuable, providing timely insight into local drug markets and supporting more informed public health responses. As these systems continue to expand, the challenge is how to scale such models in ways that are ethical, safe, and responsive to the needs of diverse populations and stakeholders. This report highlights significant legal variability across states regarding the possession, distribution, and use of drug checking equipment, creating ongoing barriers to scaling these services nationally. Finally, existing data systems, funding structures, and public health frameworks illustrate both the usefulness of drug checking data and the need for stronger, more consistent protections, governance models, and infrastructure to support emerging statewide and multistate dashboards.

CONCLUSION. Despite their promise, national drug checking efforts face substantial feasibility barriers. Legal uncertainty, state by state variability in paraphernalia laws, and the persistent risk of criminalization complicate implementation and may deter program participation. Governance questions—including who oversees the data, how it may be used, and what protections prevent misuse—are particularly critical given the vulnerabilities of the communities served and the increasingly politicized landscape surrounding harm reduction strategies. To move forward responsibly, any national drug checking registry must be grounded in data protection standards, privacy compliance, deidentification, and ethical principles that minimize risks and ensure public health benefits are achieved without exacerbating harm.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 9-A-26

Subject: In Support of a National Drug Checking Registry

Presented by: Padmini Ranasinghe, MD, MPH, Chair

Referred to: Reference Committee E

Policy D-95.950, "In Support of a National Drug Checking Registry," was adopted by the House of Delegates at the 2025 Annual Meeting and directs the following:

> Our AMA will study the creation of a national drug-checking data system that would provide a mechanism whereby community-run drug-checking services may communicate their de-identified results, with legal protections, data use agreements, and user opt-in/opt-out mechanisms.

This report focuses on the value of drug checking tools and services, evidence for the use of drug checking, data protection measures, and ethical considerations.

METHODS

English-language reports, peer-reviewed articles, white papers, government publications, and literature were selected from PubMed and Internet search, using the text terms "drug checking." Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of organizations that specialize in community drug checking, data collection, and legal protections of public health data.

BACKGROUND

Despite decades of prohibition under the 1970 Controlled Substances Act, illicit drug use remains widespread in the United States (U.S).[1] People who use drugs (PWUD) often lack accurate information about the substances they ingest, inhale, insert and inject, increasing the likelihood of polydrug exposure and unexpected contact with potent adulterants such as fentanyl and its analogues. In this context, drug checking is a critical tool for improving safety by providing real-time insight into drug composition for PWUD, community outreach, researchers, and health care professionals.[2]

Drug checking, the use of technology to provide user insight into the contents of illicit drug products, is an overdose prevention strategy with an emerging evidence base.[3–8] There were 105,007 overdose deaths in 2023 and 80,135 in 2024, primarily from illicit drug use.[9] According to the European Union Drugs Agency, "drug-checking services…provid[e] information on the content of the samples as well as advice, and, in some cases, counselling or brief interventions."[10] Drug checking provides real-time, accurate information on street-level drug composition allowing PWUD to understand the composition of the substances they consume.

In addition to illicit substances, drug checking services are increasingly encountering regulated pharmaceuticals that are being diverted, compounded, or sold on the illicit market, including products such as hormones and GLP-1 medications. Studies on hormones are limited and often do not reflect the U.S. context, but they have documented counterfeit semaglutide products entering the U.S. through illegal online pharmacies. One investigation found that test-purchased semaglutide products from unregulated online vendors contained 7-14 percent purity (versus advertised 99 percent), delivered 29-39 percent more semaglutide than labeled, and showed evidence of endotoxin contamination.[11] The American Diabetes Association has warned that counterfeit products have made their way into the U.S. drug supply chain through online and unregulated sources.[12] Compounded GLP-1s (primarily semaglutide and tirzepatide) have proliferated through online vendors, with 79 websites identified selling these products, though these represent unregulated pharmaceutical products rather than illicit drugs.[13] A poison center study documented a sharp increase in GLP-1 exposures, predominantly from unintentional therapeutic errors, with some patients obtaining medications through online platforms and poorly regulated compounding sources.[14] These findings highlight that drug checking contends not only with illicit substances but also misrepresented or compounded regulated drugs, reinforcing the need for adaptable testing strategies capable of handling a diverse and unpredictable drug supply.

Drug Checking Technologies

There are a wide range of analytical instruments utilized in drug checking including immunoassay test strips, reagent tests, infrared absorption spectroscopy , Raman spectroscopy, surface-enhanced Raman spectroscopy (SERS), and gas chromatography mass spectrometry (GCMS). Each technology presents a unique balance of strengths and limitations, often requiring programs to weigh accuracy, portability, cost, required expertise, and environmental constraints when choosing testing mechanisms (See Appendix 1).

Drug checking technologies vary widely in complexity, sensitivity, and practical application, offering complementary strengths for identifying substances in an increasingly unpredictable drug supply. Basic tools such as immunoassay test strips and reagent tests are inexpensive, easy to use, portable, and well-suited for high volume or low resource environments, though they are limited by risks of false positives or negatives, lack of standardization, and their inability to detect concentration levels or all drug analogues.[15] More advanced spectroscopic methods, Fourier Transform Infrared Spectroscopy (FTIR), Infrared Raman (IR), and its enhanced form SERS, provide rapid, nondestructive identification of major components through chemical "fingerprinting," but their performance varies depending on sampling conditions, fluorescence interference, and instrument sensitivity, especially for trace substances.[15] At the highest level of analytical rigor, portable GCMS delivers highly accurate, trace-level detection and remains the gold standard for confirmatory testing, though it requires technical expertise, careful calibration, and laboratory grade procedures.[15] Together, these technologies illustrate the spectrum of tools available to meet diverse drug checking needs across community, clinical, and mobile settings.

Because each technology involves tradeoffs in cost, portability, speed, and training requirements, drug checking programs benefit from access to multiple technologies. A multi-instrument approach provides clear advantages by allowing verification across methods, increasing confidence when substances are detected by more than one technique. Rapid optical tools like test strips, IR and handheld Raman are sufficient for identifying major components or confirming drug classes, particularly in high population/dense settings such as music concerts and festivals. However, these portable methods struggle when active ingredients are at very low concentrations. In these cases, confirmatory laboratory-based analysis, often using mass spectrometry, remains essential for accurate trace-level detection and quantification. Ultimately, drug checking and an understanding,

of each technology's capabilities and constraints can deliver accurate, actionable, and timely information.[15]

Generalizability of Drug Checking Results

The hyper-variability of the unregulated drug supply necessitates a shift toward precision-based harm reduction. A Philadelphia-based program illustrated this by documenting two separate overdose clusters on the same block involving entirely different substances within a 15-minute window.[16] Rather than diminishing the value of the data, this case highlights why drug checking is an indispensable tool for real-time risk assessment. While geopolitical boundaries and historical data offer limited predictive power, drug checking fills a critical gap by providing the individualized, immediate information required to navigate a rapidly shifting supply environment.

DISCUSSION

Potential Health Care and Physician Utilization of Drug Checking Results

Drug checking has the potential to meaningfully inform health care practices by providing clinicians with timely, real-world insight into the rapidly shifting illicit and counterfeit drug supply. Because drug checking technologies can identify both major and trace components in substances, drug checking data can help clinicians better understand what their patients are likely exposed to and tailor clinical care accordingly. For physicians, access to drug checking results can improve the accuracy of overdose assessments, guide decisions about reversal and withdrawal management agents, anticipate polysubstance complications, and inform conversations about secondary prevention. These insights can also help clinicians counsel patients on adulterants that may not be apparent, especially given the rise of counterfeit and substandard regulated pharmaceuticals circulating alongside illicit drugs.

Beyond direct clinical care, drug checking can strengthen surveillance systems and bridge gaps between frontline health care, community-based programs, and public health agencies. Physicians who understand drug checking data may be better equipped to identify emerging trends, such as novel psychoactive substances or unexpected adulteration patterns, before they appear in traditional toxicology or mortality reporting, which often lags behind real-time trends. National efforts like National Drug Early Warning System (NDEWS) and state-level dashboards already demonstrate the value of integrating early warning systems to inform prevention and response strategies across health sectors.[17] As drug checking becomes more widespread, physicians may increasingly rely on these data to guide evidence-informed decision-making, advocate for safer drug supply interventions, and contribute to a more coordinated public health response.

Drug Checking Evidence and Outcomes

Drug checking programs have demonstrated measurable impacts on attitudes and intended behaviors among people who use drugs. Studies consistently show that when individuals receive unexpected or concerning test results—such as confirmation of fentanyl adulteration—they are more likely to express intentions to reduce their dose or avoid using the substance altogether. For example, a supervised injection site in Vancouver, BC reported that 36.3 percent of participants planned to reduce their drug dose after receiving concerning test results, and similar findings were observed in festival settings where unexpected results prompted users to reconsider their intended use.[18,19] However, attitude changes do not always translate into actual behavior change, highlighting the need for education and counseling to reinforce secondary harm prevention practices.[20]

Evidence on actual drug use behavior changes is mixed but generally positive. While some participants disposed of adulterated substances after testing, many continued to use them, often with modifications such as smaller doses, slower administration, or using with others present. For instance, in San Francisco, among those who received positive fentanyl test strip (FTS) results, 26.5 percent disposed of the substance, 30.1 percent reduced their use, and 43.4 percent made no changes.[21] Other programs reported adoption of risk reduction behaviors, such as keeping naloxone nearby or injecting a test shot, particularly among individuals who were previously unaware of adulteration. For example, a drug checking program at a syringe services site in the southeastern U.S. reported that 63 percent of FTS results were positive, and individuals who received a positive result were five times more likely to change their drug use behavior compared to those with negative results.[6] Additional positive behaviors included a willingness to share information about FTS and distribute them to peers at high risk of exposure.[22] These findings suggest that drug checking can change behavior, and reduce anticipated lethality, even though complete avoidance usually does not occur.

Legality of Drug Checking

In the absence of federal laws, the legality of drug checking is governed at the state-level. A 50 state survey on the legality of drug checking equipment found that state paraphernalia laws remain a major barrier to scaling drug checking initiatives.[23] Most of these laws are modeled after a DEA framework from the late 1970s which categorize nearly all items associated with illicit drug use as "drug paraphernalia." While enforcement against drug checking equipment (DCE) is rare, these statutes create confusion and may discourage the implementation and funding of drug checking programs.[23]

A review of laws across all 50 states, the District of Columbia, and Puerto Rico between 2021 and 2024 revealed persistent structural barriers that complicate the implementation of drug checking services.[8] The review concluded "…that all forms of DCE are legal to sell, give away, and possess in 20 states. Massachusetts and Michigan allow possession and free distribution of DCE but prohibit its sale. Six states allow possession of all DCE but restrict or prohibit both free distribution and sale. Thirteen states expressly allow the possession, free distribution, and sale of DCE only for specific drugs or with certain types of testing modalities—most commonly fentanyl and fentanyl test strips—while the same activities with all other forms of DCE remains illegal. Two states restrict possession of DCE to only fentanyl test strips, while allowing distribution or sale of DCE more generally. In five states and territories (Indiana, Iowa, North Dakota, Puerto Rico, and Texas) possession, free distribution, and sale of all drug checking equipment remains arguably a crime, typically because the law both defines paraphernalia as including testing equipment and criminalizes the possession of such paraphernalia."[23] The wide variation and criminalization of DCE hinders the ability to establish a national framework for drug checking.

Laws regarding the distribution of DCE by syringe exchange programs (SSPs) are at times legally unclear. In approximately six states, SSPs are permitted to distribute DCE even when such distribution is not otherwise permitted. [23] Good Samaritan laws in 39 states provide protection from criminal action related to DCE. [23] Recently, many states have modified their laws to increase access to DCE. Between August 2021 and August 2024, 37 states modified their laws to increase access to DCE including possession and distribution.[23] However, laws vary by state. [23] For example, the laws in Georgia, Kentucky, and Tennessee are limited to devices used to detect synthetic opioids, while laws in Alabama, Arizona, Florida, Louisiana, Mississippi, Missouri, and South Dakota apply only to objects used to test for fentanyl or fentanyl analogues. Those in Hawaii, and Oklahoma apply only to FTS.[23] In many states where DCE is not clearly legal, distribution occurs through health departments and other entities (Appendix 2).[23] These findings

underscore the need for federal and state-level action to provide legal protections for programs and people conducting services. Without such changes, efforts to establish a national drug checking data system will face significant legal and operational challenges.

Funding of Drug Checking Programs

Drug checking programs in the U.S are typically associated with universities, public health departments, and community-based organizations that often work together to publish data and dashboards regarding drugs in their communities. [24–28] Locally, community programs are either privately funded through grants or have grants with their local or state health department through federal funding sources such as Centers for Disease Control and Prevention (CDC). The current government grant funding for drug checking is through the CDC's Overdose Data to Action Local (OD2A: LOCAL) surveillance grants which, "fund jurisdictions to test drug products and/or drug paraphernalia to identify and track emerging public health threats in illicit drug markets so they can understand and respond to drug overdose outbreaks."[29] As of February 2026, 40 health departments are funded by OD2A: LOCAL program in 25 states.[30]

Opioid litigation settlement funds represent a major opportunity to support evidence-based secondary prevention strategies, including drug checking, by financing the infrastructure, workforce, laboratory capacity, and community-based services needed to detect emerging drug threats and reduce overdose deaths. As of November 2025, most states and several U.S. territories have enacted laws governing how opioid settlement funds may be used, while a smaller number rely on written policies, and others absorb the funds into their general budget without spending guidance or are overseen by established councils/committees to approve disbursements or provide recommendations.[31]

Data Protection Measures

Key components for national standards for data protection are adherence to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, safeguarding personally identifiable health information (PII), under HIPAA, the privacy rule sets limits on how protected health information may be used or disclosed, The Security Rule established technical, administrative, and physical safeguards that organizations must implement to protect electronic health information, and The Health Information Technology for Economic and Clinical Health Data Act, which expands HIPAA's privacy and security protections, enhances breach-notification standards, and increases accountability for improper handling of personal health information.[32] These national protection standards are essential for some drug checking efforts because they ensure that sensitive health related information is handled safely, reducing the risk of criminal-legal consequences or misuse of data for people who use these services.

Drug checking and health information can contain highly sensitive details, which, if disclosed, could lead to stigma, reputational harm, and barriers to employment, insurance, or housing. To mitigate these risks, strong privacy protections and data security measures are essential. De-identification is a common strategy that removes direct identifiers, but it does not fully eliminate the risk of re-identification, especially when quasi-identifiers—such as gender or ZIP code—remain in the dataset.[33] De-identified information is commonly used in public health research to prevent information from being traced back to an individual. Although the likelihood of re-identification under HIPAA's Safe Harbor standard is very low (estimated at 0.04 percent), rare attributes can increase this risk.[33] Examples of the types of public health data, vulnerable populations associated with de-identified information, and federal laws governing disclosure are available in Appendix 3 and 4.

Drug Databases that Currently Exist

As of winter 2026, the CDC monitors drug overdoses through two primary systems: the Nonfatal Drug Overdose Surveillance and Epidemiology system, which tracks nonfatal overdoses using near–real-time syndromic emergency department data and finalized hospital discharge records, and State Unintentional Drug Overdose Reporting System, which collects detailed information on fatal overdoses from death certificates, medical examiner and coroner reports, autopsies, and toxicology results across 49 states and DC, together providing a comprehensive picture of both nonfatal and fatal overdose trends.[34,35]

Complementing these systems, the National Drug Early Warning System functions as a real-time national surveillance network that detects emerging drug threats by integrating traditional data sources with rapid signal indicators such as community reports, 911 dispatch data, wastewater analysis, darknet monitoring, and machine learning detection of new psychoactive substances, producing timely intelligence that fills critical gaps left by slower indicators like mortality and treatment data and offering a proactive framework for tracking shifts in drug availability, use patterns, and emerging risks.[17]

In some jurisdictions, useful information can be obtained from data systems covering emergency medical services; from poison centers; and from health departments that maintain records of drug "overdoses" and poisonings. These programs vary between states and within states, and specifics are beyond the scope of this report. Such relationships can enable the sharing of important and mutually helpful statistical data, but the confidentiality requirements of each service must be scrupulously respected. This focus on confidentiality is especially important for drug checking services, which depend entirely on voluntary cooperation from persons who use drugs and thus are especially reliant on their reputation for confidentiality.

Several states have developed online platforms to share drug checking data with the public and health professionals. For example, New York State provides a dedicated webpage through its Department of Health that publishes results from local drug checking programs, including information on substances detected and adulterant trends.[36] Washington State, through the University of Washington, offers a comprehensive drug checking data portal that aggregates results from community-based programs and highlights emerging substances and adulteration patterns.[37]

In addition to dashboards, there are also applications that have been created to allow drug sample collection reporting across programs. The StreetCheck app, developed by Brandeis University's Opioid Policy Research Collaborative and funded through the Massachusetts Department of Public Health, enables users to log test samples—from simple strips to advanced spectrometers—streamlining result delivery and reinforcing prevention messaging in real time.[38] However, users may face challenges without the technical familiarity needed for accurate reporting, whereas trained staff are equipped to ensure correct, complete, and reliable data entry.

There are also dashboards that show available data sent by multiple states. The University of North Carolina at Chapel Hill Street Drug Analysis Lab provides analytical chemistry services to support public health. The lab utilizes GC-MS to confirm chemical formulas of various drugs, enabling highly sensitive and definitive substance identification.[39] The lab is DEA-authorized to handle Schedule I–V controlled substances. As of January 15, 2026, the lab has analyzed 18,667 samples from 41 states, making it a key resource for monitoring drug composition and trends.[40]

The ToxIC SCANNED (Substance Checking and Analysis of New and Evolving Drug) Overdose Surveillance Program is funded by the White House Office of National Drug Control Policy to

address critical gaps in understanding the rapidly evolving illicit drug supply.[41] ToxIC SCANNED combines advanced laboratory toxicology, emergency department data, and national drug-checking data to provide real-time insights on geographic trends, patient characteristics, and clinical outcomes.[42] Using residual urine and serum specimens from routine emergency care, the program can identify over 1,200 drugs and metabolites, offering a comprehensive view of substances contributing to medical emergencies and overdoses.[42] This initiative builds on the ToxIC Core Registry, which comprises over 50 locations throughout the U.S., with several international sites also participating. [43] The majority of active U.S. medical toxicology practices and accredited fellowship programs contribute to this registry, creating a robust network for data collection and analysis.[43] By integrating multiple data streams, from biological specimens to seized drug analyses, ToxIC SCANNED delivers a snapshot of the changing drug market.[43] However, while this registry includes some community based drug checking programs, it does not capture all of them.

The Substance Abuse and Mental Health Administration recently affirmed support for education, naloxone, drug-checking supplies, and sharps disposal kits.[44]

CURRENT AMA POLICY

Our AMA supports a comprehensive drug policy approach that includes decriminalizing secondary prevention supplies to reduce health risks associated with drug use (H-95.900, "Supporting Harm Reduction"), eliminating criminal penalties for personal drug possession, and ensuring access to evidence based prevention, treatment, and supportive services tailored to community needs (H-95.901, "Drug Policy Reform"). Additionally, our AMA advocates for removing fentanyl test strips and other drug checking tools from the legal definition of drug paraphernalia, expanding civil and criminal immunity for their possession and distribution, and increasing access to drug checking supplies as a critical strategy to prevent drug related overdose (D-95.987, "Prevention of Drug-Related Overdose").

CONCLUSION

Multiple states have shown that drug checking and dashboards are both feasible and valuable, providing timely insight into local drug markets and supporting more informed public health responses. As these systems continue to expand, the challenge is no longer whether drug checking data can be collected, but how to scale such models in ways that are ethical, safe, and responsive to the needs of diverse populations and stakeholders. Despite their promise, national drug checking efforts face substantial feasibility barriers. Legal uncertainty, state by state variability in paraphernalia laws, and the persistent risk of criminalization complicate implementation and may deter program participation. Governance questions—including who oversees the data, how it may be used, and what protections prevent misuse—are particularly critical given the vulnerabilities of the communities served and the increasingly politicized landscape surrounding harm reduction strategies.

Given these considerations, strong data protection standards must form the foundation of any drug checking data initiative. Safeguards should include strict adherence to federal and state privacy requirements and ethical principles, rigorous deidentification protocols, and protections that minimize both individual and community-level risks of reidentification and to ensure that expanding public health surveillance data does not inadvertently perpetuate stigma, inequity, or harm. With these protections in place, a national framework has the potential to support public health goals while honoring the priorities and safety of the populations most affected.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That our AMA: (1) supports drug checking that provides real-world insight into the rapidly shifting drug supply, which helps reduce harm among people who use drugs, better inform clinicians, and enhance public health surveillance efforts; (2) advocates for funding and legal authorization to support drug checking services at the local, county, state, and national level; and (3) will continue to monitor ongoing drug checking efforts. (New HOD Policy)

2. That our AMA reaffirm the following HOD policies: H-95.900, "Supporting Harm Reduction,"; H-95.901, "Drug Policy Reform," and D-95.987, "Prevention of Drug-Related Overdose," (Reaffirm HOD Policy)

Fiscal Note: Minimal

APPENDIX 1 – Comparison Chart of Drug Checking Equipment

Technology	Discrimination / Accuracy	Substances Detected	Identifies Specific Compounds?	Quantifies?	Training Needed	Cost Range (USD)	Ease of Use	Time to Results	Portability / Infrastructure	Servicing / Support	Notes
Immunoassay (test strips)	★★	Specific, but not all compounds (e.g., fentanyl, metabolites)	Yes	No	None	Low: few dollars/strip; $50–400/mo	Basic–intermediate	Seconds–minutes	Highly portable; point-of-care	Free support (some makers)	No ongoing op costs besides strips
Infrared spectroscopy (FTIR)	★★★★	Virtually any	Yes	Yes	1–2 days	$30k–$60k + licensing	Basic–intermediate	<2 minutes	Portable; vehicles	Included: updates, warranty, support	Widely used; fast results
Raman/ NIR/SERS	★★★★	Virtually any	Yes	Yes	Training needed	Midrange; licensing	Basic	5–15 minutes	Portable	Included: software, warranty	Often paired with test strips
Mass spectrometry	★★★★★	Virtually any	Yes	Yes	Trained tech required	High: $100k+; high	Intermediate–advanced	<3 min (mini)	Not portable except mini-MS	Included (varies)	Highest accuracy

						recurring		/ 5–20 min			
Thin-layer chromatography (TLC)	★★★	Most organics; common drugs	Yes	Yes	Basic–intermediate	$200–$500; <$300/mo	Basic–intermediate	Minutes	Portable	Minimal support	Good for low-resource settings
Ultraviolet spectroscopy	★★	Drugs w/ UV-absorbing groups	Yes	No	Basic	$1k–$3k	Basic–intermediate	Minutes	Portable	Some support	Less common in harm reduction
X-ray diffraction	★★★	Crystalline solids	Yes	Yes	Advanced-expert	$15k–$60k	Intermediate–advanced	Minutes–hours	Lab-bound	Varies	Confirms crystal structure
Reagent tests	★	Broad categories	No	No	None	Very low cost	Basic	Seconds	Portable	None	High false results
Microcrystal tests	★★	Several	Yes	No	Intermediate	Low; $300–800/yr	Intermediate	Minutes	Portable	Some	Identifies certain substances

Harper J, Powell J, Pijl E. An overview of forensic drug testing methods and their suitability for harm reduction point-of-care services. *Harm Reduction Journal*. 2017;14(52). doi:10.1186/s12954-017-0179-5 [45]

Canadian Journal of Health Technologies. Drug-Checking Technologies to Detect Compositions of Unregulated Substance Samples. *Canadian Journal of Health Technologies*. 2026;6(1).[46]

APPENDIX 2. 2024 Legal Status of Drug Checking Equipment

State	Possession of DCE generally permitted[26]	Free distribution of DCE generally permitted	Sale of DCE generally permitted	Free distribution of DCE from SSPs clearly permitted	Possession of DCE obtained from SSPs clearly permitted	Good Samaritan law covers DCE
Alabama	Fentanyl: Yes Others: No[27]	Fentanyl: Yes Others: No[28]	Fentanyl: Yes Others: No[29]	N/A[30]	N/A[31]	Yes[32]
Alaska	Yes[33]	Yes[34]	Yes[35]	Yes[36]	Yes[37]	N/A
Arizona	Fentanyl: Yes Others: No[38]	Fentanyl: Yes Others: No[39]	Fentanyl: Yes Others: No[40]	Fentanyl: Yes Others: No[41]	Fentanyl: Yes Others: No[42]	Yes[43]
Arkansas	Fentanyl test strips: Yes Others: No[44]	Yes[45]	Yes[46]	Yes[47]	Fentanyl test strips: Yes Others: No [48]	No[49]
California	Yes[50]	Fentanyl and analogs, ketamine, and gamma hydroxybutyric acid: Yes Others: No[51]	Fentanyl and analogs, ketamine, and gamma hydroxybutyric acid: Yes Others: No[52]	Yes[53]	Yes[54]	Yes[55]
Colorado	Yes[56]	Yes[57]	Yes[58]	Yes[59]	Yes[60]	Yes[61]
Connecticut	Yes[62]	Yes[63]	Yes[64]	Yes[65]	Yes[66]	Yes[67]
Delaware	Fentanyl and xylazine test strips: Yes Others: No[68]	Fentanyl and xylazine test strips: Yes Others: No[69]	Fentanyl and xylazine test strips: Yes Others: No[70]	Fentanyl and xylazine test strips: Yes Others: No[71]	Fentanyl and xylazine test strips: Yes Others: No[72]	Yes[73]

Florida	Fentanyl: Yes Others: No[74]	Fentanyl: Yes Others: No[75]	Fentanyl: Yes Others: No[76]	Fentanyl: Yes Others: No[77]	Fentanyl: Yes Others: No[78]	Yes[79]
Georgia	Synthetic Opioids: Yes Others: No[80]	Synthetic Opioids: Yes Others: No[81]	Synthetic Opioids: Yes Others: No[82]	Synthetic Opioids: Yes Others: No[83]	Synthetic Opioids: Yes Others: No[84]	Yes[85]
Hawaii	Fentanyl test strips: Yes Others: No[86]	Fentanyl test strips: Yes Others: No[87]	Fentanyl test strips: Yes Others: No[88]	Fentanyl strips: Yes Others: No[89]	Fentanyl strips: Yes Others: No[90]	Yes[91]
Idaho	Fentanyl, fentanyl analogs, and derivatives: Yes Others: No[92]	Fentanyl, fentanyl analogs, and derivatives: Yes Others: No[93]	Fentanyl, fentanyl analogs, and derivatives: Yes Others: No[94]	N/A[95]	N/A[96]	Yes[97]
Illinois	Yes[98]	Yes[99]	Yes[100]	Yes[101]	Yes[102]	Yes[103]
Indiana	No[104]	No[105]	No[106]	Yes[107]	No[108]	Yes[109]
Iowa	No[110]	No[111]	No[112]	N/A[113]	N/A[114]	Yes[115]
Kansas	Fentanyl, fentanyl analogs, ketamine and gamma hydroxybutyric acid: Yes Others: No[116]	Fentanyl, fentanyl analogs, ketamine and gamma hydroxybutyric acid: Yes Others: No[117]	Fentanyl, fentanyl analogs, ketamine and gamma hydroxybutyric acid: Yes Others: No[118]	N/A[119]	N/A[120]	No[121]
Kentucky	Synthetic Opioids: Yes Others: No[122]	Synthetic Opioids: Yes Others: No[123]	Synthetic Opioids: Yes Others: No[124]	Yes[125]	Synthetic Opioids: Yes Others: No[126]	Yes[127]
Louisiana	Fentanyl: Yes Others: No[128]	Fentanyl: Yes Others: No [129]	Fentanyl: Yes Others: No[130]	Yes[131]	Yes[132]	Yes[133]

State	Possession of DCE generally permitted[26]	Free distribution of DCE generally permitted	Sale of DCE generally permitted	Free distribution of DCE from SSPs clearly permitted	Possession of DCE obtained from SSPs clearly permitted	Good Samaritan law covers DCE
Maine	Yes[134]	Yes[135]	Yes[136]	Yes[137]	Yes[138]	Yes[139]
Maryland	Yes[140]	Yes[141]	Yes[142]	Yes[143]	Yes[144]	Yes[145]
Massachusetts	Yes[146]	Yes[147]	No[148]	Yes[149]	Yes[150]	N/A[151]
Michigan	Yes[152]	Yes[153]	No[154]	Yes[155]	Yes[156]	N/A[157]
Minnesota	Yes[158]	Yes[159]	Yes[160]	Yes[161]	Yes[162]	Yes[163]
Mississippi	Fentanyl: Yes Others: No[164]	Fentanyl: Yes Others: No[165]	Fentanyl: Yes Others: No[166]	N/A[167]	N/A[168]	Yes[169]
Missouri	Fentanyl and fentanyl analogs: Yes[170] Others: No	Fentanyl and fentanyl analogs: Yes[171] Others: No	Fentanyl and fentanyl analogs: Yes[172] Others: No	N/A[173]	N/A[174]	Yes[175]
Montana	Yes[176]	No[177]	No[178]	Yes[179]	No[180]	Yes[181]
Nebraska	Yes[182]	Yes[183]	Yes[184]	N/A[185]	N/A[186]	Yes[187]
Nevada	Yes[188]	Yes[189]	Yes[190]	Yes[191]	Yes[192]	Yes[193]
New Hampshire	Yes[194]	Fentanyl and xylazine: Yes Others: No[195]	Fentanyl and xylazine: Yes Others: No[196]	Fentanyl and xylazine: Yes Others: No[197]	Yes[198]	N/A[199]
New Jersey	Yes[200]	Yes[201]	Yes[202]	Yes[203]	Yes[204]	Yes[205]
New Mexico	Yes[206]	No[207]	No[208]	Yes[209]	Yes[210]	Yes[211]
New York	Yes[212]	Yes[213]	Yes[214]	Yes[215]	Yes[216]	Yes[217]
North Carolina	Yes[218]	No[219]	No[220]	Yes[221]	Yes[222]	Yes[223]

North Dakota	No[224]	No[225]	No[226]	No[227]	No[228]	Yes[229]
Ohio	Fentanyl test strips: Yes Others: No[230]	Yes[231]	No[232]	Yes[233]	Fentanyl strips: Yes (within 1,000 feet of SSP only) Others: No[234]	Yes[235]
Oklahoma	Fentanyl test strips: Yes Others: No[236]	Fentanyl test strips: Yes Others: No[237]	Fentanyl test strips: Yes Others: No[238]	Yes[239]	Fentanyl strips: Yes Others: No[240]	Yes[241]
Oregon	Yes[242]	Yes[243]	Yes[244]	Yes[245]	Yes[246]	Yes[247]
Pennsylvania	Yes[248]	Yes[249]	Yes[250]	N/A[251]	N/A[252]	Yes[253]
Puerto Rico	No[254]	No[255]	No[256]	Yes[257]	Yes[258]	No[259]
Rhode Island	Yes[260]	Yes[261]	Yes[262]	Yes[263]	Yes[264]	N/A[265]
South Carolina	Yes[266]	Yes[267]	Yes[268]	Yes[269]	Yes[270]	Yes[271]
South Dakota	Fentanyl: Yes Others: No[272]	Fentanyl: Yes Others: No[273]	Fentanyl: Yes Others: No[274]	N/A[275]	N/A[276]	No[277]
Tennessee	Synthetic opioid: Yes Others: No[278]	Synthetic opioid: Yes Others: No[279]	Synthetic opioid: Yes Others: No[280]	Synthetic opioid: Yes Others: No[281]	Synthetic opioid: Yes Others: No[282]	Yes[283]
Texas	No[284]	No[285]	No[286]	N/A[287]	N/A[288]	Yes[289]
Utah	Yes[290]	Yes[291]	Yes[292]	Yes[293]	Yes[294]	Yes[295]
Vermont	Yes[296]	Yes[297]	Yes[298]	Yes[299]	Yes[300]	N/A[301]
Virginia	Yes[302]	Yes[303]	Fentanyl: Yes Others: No[304]	Yes[305]	Yes[306]	Yes[307]
Washington D.C.	Yes[308]	No[309]	No[310]	Yes[311]	Yes[312]	Yes[313]
Washington	Yes[314]	Yes[315]	Yes[316]	Yes[317]	Yes[318]	N/A[319]
West Virginia	Yes[320]	Yes[321]	Yes (with some exceptions)[322]	Yes[323]	Yes[324]	N/A[325]
Wisconsin	Fentanyl and Xylazine: Yes Others: No[326]	Fentanyl and Xylazine: Yes Others: No[327]	Fentanyl and Xylazine: Yes Others: No[328]	Yes[329]	Yes[330]	Yes[331]
Wyoming	Yes[332]	Yes[333]	Yes[334]	N/A[335]	N/A[336]	N/A[337]

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APPENDIX 3. Vulnerable Populations Associated with Different Types of Public Health Data

Centers for Disease Control and Prevention. Legal and Ethical Framework to Use Centers for Disease Control and Prevention Data for Patient-Centered Outcomes Research.

Degrees of identifiability	Explanation of terms	Examples	Possible vulnerable populations	CDC safeguards in addition to technical safeguards
Data with direct identifiers	Information that relates specifically to an individual. The inclusion of a name, Social Security number, or phone number, makes data identifiable.	US Zika Pregnancy Registry[79]	Pregnant women whose fetuses would be at high risk for complications	No access to individual-level data. Information is released to the public in an aggregate form.
Linkable or coded data	Data that is not identifiable, but can be linked to a named person with the use of a secure code.	HIV case reports[80]	Patients infected with HIV	Data is sent from the state health department to CDC using a Soundex code.
Data with indirect identifiers	Information that can be combined with other information to identify specific individuals. Information about location, race, and sex can identify an individual.	National ART Surveillance System (NASS)[81]	Egg donors, surrogate mothers, and children	Only onsite access allowed with a member of the ART team.
De-identified data	Direct and known indirect identifiers in any information are removed or obscured to minimize the risk of unintended disclosure of the identity of individuals.	National Program of Cancer Registry (NPCR) Cancer Surveillance System[82]	Individuals residing in areas with high incidence of certain cancers	Most of the de-identified datasets are publicly available.
Anonymized data	Direct and indirect identifiers have been irreversibly removed or altered so that re-identification is impossible.	NHANES Genetic Data Repository[83]	Patients belonging to minority ethnic groups	Anonymized data is available with a data use agreement.

APPENDIX 4. Federal Laws Governing Exposure of Health Data

Centers for Disease Control and Prevention. Legal and Ethical Framework to Use Centers for Disease Control and Prevention Data for Patient-Centered Outcomes Research.

Law	Provision(s) that allow disclosure of de-identified information	Criteria or standard for determining whether information is identifiable
Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, implemented by the HIPAA Privacy Rule, 45 CFR Part 160 and Part 164.	The HIPAA Privacy Rule applies to protected health information (PHI). The Privacy Rule does not apply to health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. 45 CFR § 160.103, 45 §164.500.	Information may be de-identified by removing 18 identifiers specified in the Rule, provided that the covered entity does not have actual knowledge that the remaining information can be used alone or in combination with other reasonably available information to identify a subject (safe harbor de-identification). These identifiers include personal identifiers (such as name, address, telephone number, birth date, Social Security number) and non-personal identifiers (such as geographic information smaller than a state and dates directly associated with an individual). Alternatively, a covered entity may rely on a determination by a properly qualified statistician using accepted analytic techniques who determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information (statistical de-identification). 45 CFR § 164.514.
Protection of Human Research Subjects (Common Rule), 45 CFR part 46, subpart A.	The Common Rule applies when an investigator conducting research **obtains** identifiable "private information" of a living individual (human subject) for use, study, or analysis. Private information must be **"individually identifiable"** for the Common Rule to apply. 45 CFR § 46.102(f).	Private information is individually identifiable when the identity of the subject is or may readily be ascertained by the investigator or associated with the information. 45 CFR § 46.102(f). Note: In its application of the law, the Office for Human Research Protections (OHRP) considers private information or specimens not to be individually identifiable when they cannot be linked to specific individuals by the investigator either directly or indirectly through coding systems. Examples of identifiers would include names, Social Security numbers, medical record numbers, or pathology accession numbers, or any other "code" that permits specimens or data to be linked to individually identifiable living individuals and perhaps also to associated medical information. https://humansubjects.nih.gov/from-applicants https://www.hhs.gov/ohrp/regulations-and-policy/guidance/research-involving-coded-private-information/index.html
Federal Privacy Act 5 U.S.C. § 552a.	The Federal Privacy Act establishes a code of fair information practices that governs the collection, maintenance, use, and dissemination of information about individuals that is maintained in systems of records by federal agencies. The Act protects a "record" of a U.S. citizen or alien lawfully admitted for permanent residence. A "record" includes any item, collection, or grouping of information about an individual that is maintained by a federal agency, including, but not limited to, his education, financial transactions, medical history, and criminal or employment history and that contains his name, or the identifying number, symbol, or other identifying particular assigned to the individual, such as a finger or voice print or a photograph. 5 U.S.C. § 552a(a)(4).	The law does not define or describe de-identification directly, but suggests that a record is de-identified by removing all "identifying particulars." 5 U.S.C. § 552a(a)(4).
Federal Assurance of Confidentiality, Section 308(d) of the Public Health Service Act, 42 U.S.C. § 242m.	This law prohibits use, release, and publication of information, if an establishment or person supplying the information or described in it is identifiable. Applies to information obtained in the course of health statistical, epidemiological, or other activities obtained in the course of certain activities undertaken or supported under the Public Health Service Act.	The law does not define or describe de-identification directly.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 501
(A-26)

Introduced by: Academic Physicians Section

Subject: Preregistration in Medical Research

Referred to: Reference Committee E

Whereas, the scientific method relies on the clear distinction between hypothesis generation (postdiction) and hypothesis testing (prediction) to maintain the credibility of research findings[1-3]; and

Whereas, current practices in medical research often fail to adequately differentiate these processes, leading to overconfidence in findings and the increased likelihood of irreproducible results due to hindsight bias and selective reporting[2-5]; and

Whereas, preregistration is a proven methodology that requires researchers to define and publicly document their research questions, study designs, and analysis plans before data collection or analysis begins, which helps clarify the distinction between exploratory and confirmatory research[1, 2-9]; and

Whereas, evidence suggests that preregistration improves the reproducibility, transparency, and credibility of research findings by reducing biases, clarifying the distinction between exploratory and confirmatory analyses, and mitigating the misuse of statistical inference methods such as null hypothesis significance testing[1, 2, 6, 7, 9]; and

Whereas, numerous platforms and frameworks now exist to facilitate preregistration across disciplines, including clinical trials, and its adoption has been associated with improved research practices, including increased detection of reporting biases and enhanced public trust in scientific findings[2, 6, 8]; and

Whereas, AMA policy H-460.941 supports preregistration; therefore be it

RESOLVED, that our American Medical Association amend policy H-460.941 by addition and deletion to read as follows:

Our AMA will:

(1) take every appropriate opportunity during the health system reform debate and implementation stages to educate the public, the Administration, and Congress about the importance of support for science and biomedical research and about the potential problems if these areas are not given sufficient consideration in health system reform;

(2) take steps to become the coordinating point for efforts, both within and outside of the Federation, to promote, enhance, and defend biomedical science;

(3) continue and expand its efforts to advocate for the primacy of science and biomedical research as the basis of quality medical care by working with and influencing both the private sector and the federal government, including the legislative, executive, and judicial branches;

(4) take necessary steps to monitor the scientific enterprise, establish programs and policies as appropriate, and initiate advocacy efforts as needed;

(5) consider and take the necessary steps to anticipate and establish guidelines to assist physicians and others in responding to the ethical issues emerging from the scientific revolution;

(6) increase its educational efforts to the public and to the profession to explain how science is critical to the future of the profession and to the future development of high quality medical care; and

~~(7) support preregistration in order to mitigate publication bias and improve the reproducibility of biomedical research.~~

(7) recognize the importance of preregistration as a cornerstone of rigorous and reproducible biomedical research:

(8) collaborate with relevant stakeholders to advocate for the integration of preregistration into medical research protocols, emphasizing its use for clinical trials, observational studies, and other research contexts;

(9) collaborate with relevant stakeholders to support efforts to provide training and resources for medical researchers to implement preregistration effectively, including access to standardized registries and education on preregistration practice; and

(10) collaborate with relevant stakeholders in the medical and scientific community to promote policies and incentives that align preregistration with the goals of career advancement, funding acquisition, and publication, fostering a culture of transparency and accountability in medical research.

(Modify Current HOD Policy)

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

Received: 3/17/26

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RELEVANT AMA POLICY

Science and Biomedical Research H-460.941

Opportunities, Challenges and Health System Reform
Our AMA will:
(1) take every appropriate opportunity during the health system reform debate and implementation stages to educate the public, the Administration, and Congress about the importance of support for science and biomedical research and about the potential problems if these areas are not given sufficient consideration in health system reform;
(2) take steps to become the coordinating point for efforts, both within and outside of the Federation, to promote, enhance, and defend biomedical science;
(3) continue and expand its efforts to advocate for the primacy of science and biomedical research as the basis of quality medical care by working with and influencing both the private sector and the federal government, including the legislative, executive, and judicial branches;
(4) take necessary steps to monitor the scientific enterprise, establish programs and policies as appropriate, and initiate advocacy efforts as needed;
(5) consider and take the necessary steps to anticipate and establish guidelines to assist physicians and others in responding to the ethical issues emerging from the scientific revolution;
(6) increase its educational efforts to the public and to the profession to explain how science is critical to the future of the profession and to the future development of high quality medical care; and
(7) support preregistration in order to mitigate publication bias and improve the reproducibility of biomedical research. [CSA Rep. 8, A-94; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Appended: Res. 901, I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 502
(A-26)

Introduced by: Washington

Subject: Support for Rapid Methadone Inpatient Stabilization and Linkage to Care

Referred to: Reference Committee E

Whereas, Opioid Use Disorder (OUD) impacts 2.5 million adults a year, and in 2021 only 22% of adults with OUD received medications to treat OUD[1]; and

Whereas, emergency department visits and hospitalizations for complications from untreated OUD are teachable moments and opportunities to initiate medications for opioid use disorder; and

Whereas, methadone is an effective treatment for withdrawal management and stabilization for OUD in the fentanyl era[2]; and

Whereas, the Washington state legislature approved a 2024 budget proviso to devote $2,000,000 of the opioid abatement settlement account to implement a rapid methadone inpatient stabilization pilot program designed by the Washington Society of Addiction Medicine (WSAM); and

Whereas, WSAM worked with the Washington State Health Care Authority to create a policy for rapid methadone inpatient stabilization for treatment of OUD in pregnant patients that includes higher-than-traditional doses given twice daily, and linkage to care at time of discharge along with dispensing of naloxone and 72 hours of methadone; and

Whereas, this innovative treatment strategy has demonstrated effectiveness with initial data[3] showing 100% methadone stabilization, 86% attending an opioid treatment program intake visit, and 57% remaining on methadone at 30 days post-discharge; therefore be it

RESOLVED, that our American Medical Association will endorse and advocate for implementation of a rapid methadone inpatient stabilization pathway for treatment of Opioid Use Disorder in pregnant patients, with higher-than-traditional doses given twice daily, and linkage to care at time of discharge along with dispensing an appropriate amount of naloxone and methadone. (Directive to Take Action)

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

Received: 3/13/26

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RELEVANT AMA POLICY

H-420.950 Substance Use Disorders During Pregnancy

1. Our American Medical Association supports brief interventions (such as engaging a patient in a short conversation, providing feedback and advice) and referral for early comprehensive treatment of pregnant individuals with opioid use and opioid use disorder (including naloxone or other overdose reversal medication education and distribution) using a coordinated multidisciplinary approach without criminal sanctions.
2. Our AMA acknowledges the health benefits of identifying substance use during pregnancy and opposes any efforts, including mandatory reporting laws, that imply a positive verbal substance use screen, a positive toxicology test, or the diagnosis of substance use disorder during pregnancy automatically represents child abuse or neglect.
3. Our AMA supports legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy.
4. Our AMA opposes the filing of a child protective services report or the removal of infants from their parent(s) solely based on a prenatal drug screen and/or biological test(s) for substance use without appropriate evaluation.
5. Our AMA advocates for appropriate medical evaluation prior to the removal of a child, which takes into account:
   a. the desire to preserve the individual's family structure;
   b. the patient's treatment status; and
   c. current impairment status when substance use is suspected or confirmed.
6. Our AMA advocates that state and federal child protection laws be amended so that pregnant people with substance use and substance use disorders are only reported to child welfare agencies when protective concerns are identified by the clinical team, rather than through automatic or mandated reporting of all pregnant people with a positive toxicology test, positive verbal substance use screen, diagnosis of a substance use disorder, or use of evidence-based treatments for substance use disorder.
7. Our AMA encourages ongoing research on the benefits and risks of universal screening for substance use during pregnancy including the impact of mandatory reporting laws, evaluation of patient outcomes, effectiveness across different age groups, optimal screening intervals, equity considerations, and efficacy of different screening tools.
8. Our AMA supports the development and dissemination of physician education and training on federal and state laws governing mandatory notification and reporting of substance use during pregnancy, and the benefits and consequences of screening implementation in health care settings on a state-by-state basis.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 503
(A-26)

Introduced by: Pennsylvania

Subject: Expansion of Psychedelic Assisted Therapy (PAT)

Referred to: Reference Committee E

Whereas, other psychedelic and/or psychotherapeutic compounds with novel uses, such as MDMA, have received Breakthrough Therapy designation from the U.S. Food and Drug Administration (FDA); and

Whereas, other psychedelic and/or psychotherapeutic compounds with novel uses such as ketamine are already being prescribed for various mood disorders, but often with little oversight or widely-recognized standard of care; and

Whereas, the American Medical Association has a vested and explicit interest in the safe, evidence-based practice of medicine; and therefore be it

RESOLVED, that our American Medical Association reaffirm policies H-120.917 and H-100.943. (Reaffirm HOD Policy)

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

Received: 4/9/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 504
(A-26)

Introduced by: Delaware

Subject: Strengthening U.S. Rubber Glove Production and Purchase While Reducing Foreign Forced-Labor Dependence

Referred to: Reference Committee E

Whereas, rubber gloves have been in use since Dr. William Halsted from The Johns Hopkins Hospital had the Goodyear Rubber Products company produce thin gloves to protect the nursing staff from harsh chemicals and disinfectants in the late nineteenth century;[1] and

Whereas, rubber glove development evolved over time leading to gloves that are sturdy and protective for many health care workers and others involved in patient care in various inpatient and outpatient settings; and

Whereas, the Buy American Act (BAA) requires Federal agencies to prioritize the production and purchase of domestic, U.S. manufactured goods and materials for public use in the United States with the materials used in manufacturing present in the U.S. in sufficient and reasonably available commercial quantities of a satisfactory quality, creating a preference for purchasing and manufacturing domestically and restricting the purchase of supplies that are not domestic end products;[2] and

Whereas, the Buy American Act (BAA) provisions can be waived if the procuring agency determines the act to be inconsistent with the public interest or the cost of acquiring the domestic product is unreasonable; and

Whereas, the HIV/AIDS epidemic, the Asian financial crisis, and more recently the COVID-19 pandemic fueled a worldwide demand for rubber gloves in a variety of health care settings;[3] and

Whereas, demand for rubber gloves led to major rubber glove producers in Malaysia and Thailand, such as Top Glove and WRP, to employ children as young as eight years old and exploited migrants from Nepal, India, Myanmar, and Bangladesh by having them work in unsafe factories, work up to 160 hours of overtime, withhold salaries for months, utilize high recruitment fees that led to debt bondage, and confiscated passports;[4-15] and

Whereas, on July 15, 2020, United States Customs and Border Protection (CBP) issued a Withhold Release Order (WRO) that banned Top Glove-produced rubber gloves from import into the United States because the gloves were made by forced labor and under the WRO, the CBP seized several shipments of disposable gloves that originated in Malaysia;[16, 17] and

Whereas, on September 9, 2021, the Customs and Border Protection (CBP) issued a modification[18,19] of its forced labor findings on Top Glove, allowing imports to resume, with the CBP affirming that Top Glove had issued “more than $30 million in remediation payments to workers and [is] improving labor and living conditions at the company’s facilities”; and

Whereas, Smart Glove, a collective group of Malaysian glove makers, faced a U.S. ban in 2021 for debt bondage and other labor allegations;[20] and

Whereas, unfair labor practices and overall safety persist in major rubber glove companies in Malaysia, in particular;[21,22] and

Whereas, on January 26, 2026, the Centers for Medicare & Medicaid Services (CMS) issued an Advance Notice of Proposed Rulemaking seeking public input on strengthening the domestic supply chain for personal protective equipment (PPE) and essential medicines, exploring ways to reduce reliance on foreign-made medical supplies and enhance the nation's readiness for future emergencies while supporting American workers and manufacturers and also considering a "Secure American Medical Supplies" friendly designation earned by hospitals that demonstrate a commitment to domestic procurement;[23] and

Whereas, the Medical Society of Delaware has informed its federal Congressional Delegation requesting emphasis of the need for reliance on U..S. companies for more domestic rubber glove production than what is now the case and as prioritized by the Buy American Act to purchase domestic, U.S. manufactured goods and materials for public use;[24] now therefore be it

RESOLVED, that our American Medical Association advocate with the appropriate Federal agencies to prioritize production and procurement of domestically manufactured rubber gloves and their component materials consistent with the Buy American Act (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage health care systems, physicians and other health care professionals, and affiliated entities to source rubber gloves from U.S. manufacturers whenever feasible, with preference for products whose raw materials originate within the domestic supply chain (New HOD Policy); and be it further

RESOLVED, that our AMA promote rigorous supply chain transparency by urging federal regulators and relevant authorities to strengthen import enforcement, enhance due-diligence requirements, and conduct independent audits to ensure that imported rubber gloves meet appropriate ethical labor standards. (Directive to Take Action)

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

Received: 4/13/26

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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, I-20; Appended: Res. 414, A-21; Modified: Res. 410, I-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 505
(A-26)

Introduced by: New York

Subject: Avoiding misuse of artificial intelligence (AI) in clinical practice

Referred to: Reference Committee E

Whereas, artificial intelligence(AI) is finding its way into the clinical practice of medicine; and Whereas, physicians, nurse, practitioners, physicians, assistance, CRNA's and other healthcare professionals have begun using AI to generate notes in an effort to become more efficient and save time in the care of patients; and

Whereas, physicians and other healthcare professionals become medically and legally responsible for the care of their own patients and the patients receiving care from non-physician professionals for whom they may be collaborating for or supervising; and

Whereas, the review of all documentation in the patient's medical record, whether entered by the physician or other healthcare professional, a scribe or AI is owned by the author who signed that documentation; and

Whereas, the possibility that there could be an error in the medical record specifically related to documentation generated by AI, that could become a medical or medical legal issue; therefore be it

RESOLVED, that prior to the use of Artificial Intelligence (AI) in the medical record, training in the use of AI is highly recommended and to include the benefits of AI, as well as the potential harms that could exist in an AI generated document (New HOD Policy); and be it further

RESOLVED, that any physician or healthcare professional, who chooses to use Artificial Intelligence (AI) in the creation of the medical record, understands that the accuracy of that record is completely the responsibility of that author. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 506
(A-26)

Introduced by: New York

Subject: Access To Gender Affirming Healthcare Including Clinical Trials

Referred to: Reference Committee E

Whereas, gender dysphoria in children and adolescents is a complex clinical condition that requires careful, individualized, and multidisciplinary evaluation involving medical, surgical, and mental health expertise; and

Whereas, the current scientific evidence regarding gender-affirming hormonal therapies and surgical procedures in minors remains limited and evolving, with a lack of robust, long-term data on physical health outcomes, mental health outcomes, fertility, sexual function, and regret; and

Whereas, existing studies related to gender-affirming surgery in pediatric populations are largely observational, involve small cohorts, and have relatively short follow-up periods, further limiting the ability to draw definitive conclusions regarding long-term safety and effectiveness; and

Whereas, more research is needed in order to properly address gender dysphoria in minors; therefore be it

RESOLVED, that our American Medical Association affirms that Gender affirming healthcare (GAHC) includes social, medical and surgical GAHC with a shared decision-making process involving the physician, patient and legal guardians (New HOD Policy); and be it further

RESOLVED, that our AMA calls for continued research including clinical trials regarding the evidence of the effectiveness of puberty blockers (GnRH analogs) on transgender and non-binary youth (New HOD Policy); and be it further

RESOLVED, that our AMA calls for the restoration of previously allocated federal, state and institutional funding for pediatric gender clinics, puberty blocker research protocols, and supportive mental health services. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 4/14/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 507
(A-26)

Introduced by: American College of Lifestyle Medicine, Underrepresented in Medicine Advocacy Section

Subject: Pairing Behavioral and Lifestyle Medicine Principles and Practice with Glucagon-like Peptide-1 (GLP-1) Receptor Agonists and Other Anti-obesity Medications

Referred to: Reference Committee E

Whereas, obesity is a chronic disease, requiring long-standing therapy, that has historically been difficult to ameliorate for long-term results other than with the modality of bariatric surgery; and

Whereas, obesity represents a worldwide pandemic with multiple, adverse sequelae, including type 2 diabetes and cardiovascular diseases; and

Whereas, over 74% of the U.S. population is either overweight or obese; and

Whereas, worldwide, 2.1 billion individuals suffer from obesity and these numbers are projected to grow to over 3.1 billion individuals by 2050; and

Whereas, in recent years, glucagon-like peptide-1 (GLP-1) receptor agonists were synthesized as a class of medication, mimicking a neural hormone (incretin) of the small intestine that regulates blood sugar, decreases appetite and promotes satiety as well as additional benefits that include cardiovascular and renal protections; and

Whereas, the GLP-1 receptor agonists trigger insulin release from the pancreas, block glucagon secretion which, in turn, blocks added glucose into the blood, slows emptying of the stomach, increases satiety, lowers blood pressure, improves lipid disorders, improves fatty liver disease, delays progression of diabetic related nephropathies and helps reduce cravings for toxic substances; and

Whereas, the GLP-1 receptor agonists have been prescribed specifically for the management of obesity and Type 2 Diabetes because they help lower blood sugar levels and promote satiety as a means of weight loss; and

Whereas, the most effective management of both obesity and Type 2 Diabetes requires the combination of healthy lifestyle choices, diet modifications. behavioral modifications and select medications hinge on how one modifies their lifestyle in the areas of exercise, diet, restorative rest, stress management, control of toxic exposures and supportive social interaction; and

Whereas, the GLP-1 receptor agonists can serve as a metabolic catalyst, helping regulate appetite, alleviate joint pain, and enhance mobility, which in turn supports the adoption of sustainable lifestyle changes; and

Whereas, optimizing lifestyle choices, achieved through durable behavioral modification, serves as a foundational component of whole person clinical care; informed by shared goal setting and key lifestyle domains such as nutrition, physical activity, restorative sleep, healthy stress management strategies, avoidance of harmful exposures, and prioritizing social relationships; and

Whereas, the American College of Lifestyle Medicine, The Obesity Society, The Obesity Medicine Association and the American Society for Nutrition recently issued its joint position statement on the use of GLP-1 receptor agonists for obesity indicating that such modalities be administered in conjunction with planned and monitored adaptations to the forementioned six lifestyle pillars, ergo - all clinicians prescribing GLP-1(RA)s for obesity management should establish a thoughtful plan of care that includes thorough nutritional and lifestyle counseling before, during and after the weight reduction period; and

Whereas, the World Health Organization recently issued its Guidelines on the use of GLP-1 receptor agonists to treat obesity, placing obesity in the same category as hypertension and diabetes, and recommending that (i) GLP-1 receptor agonist therapies be used by non-pregnant adults for long-term obesity treatment and improving metabolic health outcomes and (ii) that intensive behavioral interventions for lifestyle modifications be offered in conjunction with prescribed GLP-1 receptor agonist medications; and

Whereas, access to structured, evidence-based lifestyle intervention programs and trained inter-professional care teams varies significantly by geography, insurance coverage, and socioeconomic status, creating the potential for health disparities among patients prescribed GLP-1 receptor agonist therapy; therefore be it

RESOLVED, that our American Medical Association support, publicize, and advocate for the concomitant use of evidence-based, structured lifestyle and behavioral intervention programs, delivered with ongoing clinician and care-team support, in conjunction with the prescribed use of glucagon-like peptide-1 receptor agonists for obesity and other related, preventable disease states and illnesses (Directive to Take Action); and be it further

RESOLVED, that our AMA recognize and address potential health disparities associated with recommendations for structured lifestyle intervention programs accompanying glucagon-like peptide-1 receptor agonist’s therapy, and advocate for equitable access to evidence-based, clinician-supported lifestyle interventions across diverse care settings, including community-based, digital, hybrid, and safety-net models of care (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for coverage, reimbursement, and sustainable payment models that support the delivery of clinician-led, therapeutic, and structured lifestyle intervention programs as a component of glucagon-like peptide-1 receptor agonist’s therapy, particularly for underserved, rural, and historically marginalized populations, to mitigate disparities in access and outcomes. (Directive to Take Action)

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

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RELEVANT AMA POLICY

D-100.960 Creating a Registry of Potential Side Effects of GIP and GLP-1 Medications
Our AMA supports and calls for a registry of GIP and GLP-1 receptor agonists' side effects, as well as potential impacts on pregnancy. [Res. 516, A-25]

H-150.953 Obesity As a Major Public Health Problem
1. Our American Medical Association will urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions.
2. Our AMA will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs.
3. Our AMA will urge federal support of research to determine:
- the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance;
- the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery;
- effective interventions to prevent obesity in children and adults; and
- the effectiveness of weight loss counseling by physicians.
4. Our AMA will encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight.
5. Our AMA will urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity.
6. Our AMA will urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain.
7. Our AMA will encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients.
8. Our AMA will urge the appropriate federal agencies to work with organized medicine and the

health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.
9. Our AMA will urge all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs. [CSA Rep. 6, A-99 Reaffirmation A-09 Reaffirmed: CSAPH Rep. 1, A-09 Reaffirmation A-10 Reaffirmation I-10 Reaffirmation A-12 Reaffirmed in lieu of Res. 434, A-12 Reaffirmation A-13 Reaffirmed: CSAPH Rep. 3, A-13 Reaffirmation: A-19 Appended: Res. 806, I-23]

H-150.944 Combatting Obesity and Health
Our AMA supports and calls for a registry of GIP and GLP-1 receptor agonists side effects, as well as potential impacts on pregnancy. [Res. 413, A-07 Reaffirmation A-12 Reaffirmation A-13 Modified: CSAPH Rep. 03, A-17]

H-440.842 Recognition of Obesity as a Disease
Our AMA supports and calls for a registry of GIP and GLP-1 receptor agonists side effects, as well as potential impacts on pregnancy.[Res. 420, A-13 Reaffirmed: CSAPH Rep. 08, A-23]

H-440.801 Advocacy Against Obesity-Related Bias By Insurance Providers
A. Our American Medical Association will urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to:
- Revise their policies to ensure that bariatric surgery are covered for patients who meet the appropriate medical criteria.
- Eliminate criteria that place unnecessary time-based mandates that are not clinically supported nor directed by the patient's medical provider.
- Ensure that insurance policies in their states do not discriminate against potential metabolic surgery patients based on age, gender, race, ethnicity, socioeconomic status.
- Advocate for the cost-effectiveness of all obesity treatment modalities in reducing healthcare costs and improving patient outcomes.
- Reduce the prior authorization burden for the coverage of anti-obesity medications, to include not requiring a new prior authorization for every dose change.
- Allow a patient's physician to prescribe anti-obesity medication and have it covered by insurance, without a requirement that patients must receive the prescription only from contracted disease management companies.

B. Our AMA will support and provide resources to state delegations in their efforts to advocate for the reduction of bias against patients that suffer from obesity for the actions listed. [Res. 224, A-23 Appended: Res. 230, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 508
(A-26)

Introduced by: American College of Lifestyle Medicine

Subject: Aligning Consistency and Credibility Of Direct-To-Consumer Gut Microbiome Testing Services

Referred to: Reference Committee E

Whereas, the accurate and precise assessment of the gut microbiome has significant utility in the determination of gastrointestinal health and related at-risk prognoses of other bodily functions and conditions; and

Whereas, consumer interest in personal health has led to the development of, increasingly accessible, direct-to-consumer (DTC) gut microbiome testing services with varied analytical and clinical validities and consumer safety; and

Whereas, the quality, reliability and reproducibility of such testing services, prominently featured by media outlets, vary from more strictly regulated medical devices to more minimally regulated imprecise health and wellness products; and

Whereas, there are currently no regulatory-approved, DTC gut microbiome diagnostic tests in the U.S.; and

Whereas, such tests cannot diagnose a specific disease state; and

Whereas, our scientific knowledge corroborating the gut microbiome's relationship between structure and function is so limited that the French Society of Microbiology has advised against premature microbiome testing given the uncertainty of what is a "healthy" microbiome; and

Whereas, many of these DTC companies have extended their services beyond gut microbiome profiling to include: (i) microbe classifications as pathogenic or beneficial, (ii) comparing consumer microbiome profile to random comparative populations, (iii) postulating indices for gut microbiome health; (iv) advertising recommendations for lifestyle changes, dietary changes and/or adding dietary supplements sold by the same company (e.g., probiotics); and

Whereas, these DTC gut microbiome testing services have brought about a technological shift from methodic and standardized protocols with end-to end diagnostic testing (traditionally confined to clinical settings and trained medical professionals) to DTC at-home tests that do not undergo the same rigorous oversight per the analytical validation of traditional medical diagnostic tests that assure clinicians, patients and regulators of the reliability and actionability of reproducible test results; and

Whereas, a recent, double-blind-type study was carried out employing the services of seven commercial, DTC gut microbiome testing companies - with each company analyzing three identical, homogenous and stable gut products for a total of 21 identical samples — provided anonymously by the National Institute of Standards and Technology (NIST)— with the

surreptitious intent of assessing the precision and reproducibility of gut microbiome measurements within and across the seven companies; and

Whereas, the seven microbiome testing companies were unaware of this ongoing assessment until after all the samples had been processed and final reports received by the NIST; and

Whereas, uncontrolled variables, providing opportunity for the introduction of random bias, in the samples collection and microbiome sequencing methodologies between the seven companies included: (i) considerable variability in consumer protocols for sample collection, storage, stable temperature and shipping methods, (ii) variability in laboratory protocols for nucleic acid extraction, (iii) variabilities in sequencing technology and (iv) variabilities in bioinformatic analyses; and

Whereas, the common failing of poor comparability in the seven sets of results was methodologic variability, given the use of 21 identical homogenous samples voided the introduction of confounding factors such as biologic and composition heterogeneity, otherwise found in non-identical samples; and

Whereas, methodologic variability is the antithesis of reproducibility in scientific validation and may be extrapolated to align with an assumed, inconsistent precision of the samples' processing workflows; and

Whereas, the transparency, reliability and validity of the findings of these DTC gut microbiome testing services are paramount and critical in order for consumers to accurately prognosticate informed decisions regarding their health status and health care, rather than potentially risking unwarranted or unsafe lifestyle and healthcare decisions; and

Whereas, the findings of the seven testing services are returned to the consumer, most commonly, in the absence of clinical validity, i.e., validated diagnostic evidence, and instead rely upon inferred or correlative versus causative data; and

Whereas, the varied analytical conduct of the seven and similar kinds of testing companies would best be served and balanced by health industry and clinical users developing guidelines via a consensus document or minimum requirements to support test validity and consumer and clinician confidence; therefore be it

RESOLVED, that our American Medical Association develop policy that specifically addresses concerns about the design, use and oversight of commercial gut microbiome testing methods with regards to quality, reliability and reproducibility of results and assessments provided to lay consumers, upon which such consumers prognosticate informed decisions regarding their health status and subsequent health care (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for review and graded recommendation by the United States Preventive Services Task Force on the use of Direct-to-Consumer Gut Microbiome Testing Services with regard to quality, reliability, reproducibility and validity (Directive to Take Action); and be it further

RESOLVED, that our AMA work with the Consumer Protection Agency to establish transparent safe guards and evidence-based, scientific oversight of Direct-to-Consumer Gut Microbiome Testing Services for lay and professional clinical use. (Directive to Take Action)

Fiscal Note: (Assigned by HOD)

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RELEVANT AMA POLICY

H-480.941 Direct-to-Consumer Laboratory Testing
1. Our American Medical Association will advocate for vigilant oversight of direct-to-consumer (DTC) laboratory testing by relevant state and federal agencies.
2. Our AMA will encourage physicians to educate their patients about the risks and benefits of DTC laboratory tests, as well as the risks associated with interpreting DTC test results without input from a physician or other qualified health care professional.[Res. 526, A-18 Reaffirmed: BOT Rep. 12, I-21 Reaffirmed: CSAPH Rep. 03, A-2]

D-480.987 Direct-to-Consumer Marketing and Availability of Genetic Testing
Our American Medical Association recommends that genetic testing be carried out under the personal supervision of a qualified health care professional.
1. Our AMA encourages individuals interested in obtaining genetic testing to contact a qualified healthcare professional for further information.
2. Our AMA will work with relevant organizations to develop criteria on what constitutes an acceptable advertisement for a direct-to-consumer genetic test.
3. Our AMA encourages the U.S. Federal Trade Commission, with input from the U.S. Food and Drug Administration and the Centers for Medicare and Medicaid Services, to require that direct-to-consumer advertisements for genetic testing are truthful and not misleading; such advertisements should include all relevant information regarding capabilities and limitations of the tests, and contain a statement referring patients to physicians to obtain further information;
4. Our AMA will work to educate and inform physicians regarding the types of genetic tests that are available directly to consumers, including information about the lack of scientific validity associated with some direct-to-consumer genetic tests, so that patients can be appropriately counseled on the potential harms. [Res. 502, A-04 Modified: BOT Rep. 7, A-08 Reaffirmed: CSAPH Rep. 4, A-10 Reaffirmed: Joint CMS/CSAPH Rep. 01, I-17 Reaffirmed: BOT Rep. 12, I-21]

9.6.8 Direct-to-Consumer Diagnostic Imaging Tests
Diagnostic imaging tests are sometimes marketed directly to consumers before they have been scientifically validated. This can help consumers prevent disease and promote health, but may also expose patients to risk without benefit, create conflicts of interests for physicians, and be abused for profits.
Individually, physicians who offer diagnostic imaging services that have not been scientifically validated and for which a patient has not been referred by another physician have an ethical obligation to:
(a) Perform a requested diagnostic imaging test only when, in the physician's judgment, the possible benefits of the service outweigh its risks.
(b) Recognizing that in agreeing to perform diagnostic imaging on request, the physician:
(i) establishes a patient-physician relationship, with all the ethical and professional obligations such relationship entails;
(ii) assumes responsibility for relevant clinical evaluation, including pre- and post-test counseling about the test, its results, and indicated follow-up. Physicians may choose to refer the patient for post-test

counseling to an appropriate physician who accepts the patient.
(c) Obtain the patient's informed consent. In addition to the usual elements of informed consent, the physician should disclose:
(i) that the diagnostic imaging test has not been validated scientifically;
(ii) the inaccuracies inherent in the proposed test;
(iii) the possibility of inconclusive results;
(iv) the likelihood of false positive and false negative results;
(v) circumstances that may require further assessments and additional cost.
(d) Ensure that the patient's interests are primary and place patient welfare above physician interests when the physician has a financial interest in the imaging facility.
(e) Ensure that any advertisements for the services are truthful and not misleading or deceptive, in keeping with ethics guidance and applicable law.
Collectively, physicians should:
(f) Advocate for the conduct of appropriate trials aimed at determining the predictive power of diagnostic imaging tests and their sensitivity and specificity for target populations.
(g) Develop suitable guidelines for specific diagnostic imaging tests when adequate scientific data become available. [Issued: 2016]

H-460.908 Genomic-Based Personalized Medicine
Our AMA: (1) acknowledges the increasingly important role of genomic-based personalized medicine applications in the delivery of care, and will continue to assist in informing physicians about relevant personalized medicine issues; (2) will continue to develop educational resources and point-of-care tools to assist in the clinical implementation of genomic-based personalized medicine applications, and will continue to explore external collaborations and additional funding sources for such projects; and (3) will continue to represent physicians' voices and interests in national policy discussions of issues pertaining to the clinical implementation of genomic-based personalized medicine, such as genetic test regulation, clinical validity and utility evidence development, insurance coverage of genetic services, direct-to-consumer genetic testing, and privacy of genetic information.[CSAPH Rep. 4, A-10 Reaffirmed: Joint CMS/CSAPH Rep. 01, I-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 509
(A-26)

Introduced by: LGBTQ+ Section

Subject: Preserving Gender-Affirming Surgical Care Access

Referred to: Reference Committee E

Whereas, gender-affirming surgeries (GAS) are medical procedures that involve altering an individual's physical appearance and function of their existing sexual characteristics to resemble those of their identified gender [1]; and

Whereas, GAS includes procedures for nonbinary, queer, cis-, and transgender individuals and include examples like top surgery (breast augmentation or mastectomy), bottom surgery (hysterectomy, and salpingectomy/oophorectomy, vaginoplasty, phalloplasty, or metoidioplasty), feminization or masculinization surgeries, and many others [2-3]; and

Whereas, unlike cis-gender-affirming surgery and care, nonbinary, queer, and trans-gender-affirming surgery and care have been considered controversial and received increased scrutiny and persecution in recent years [4-9]; and

Whereas, despite increased security, outcomes from GAS have noted high levels of surgical satisfaction, improved dysphoria, reduced mental health comorbidities, and improved quality of life [10-14]; and

Whereas, under the second Trump Administration, attacks on pediatric and adult gender-affirming care for nonbinary, queer, and transgender individuals have increased with an increase in legislation against GAS [4-9,15-21]; and

Whereas, on February 4, 2026, the AMA publicized a statement regarding gender-affirming surgery for patients under 19, following the American Society of Plastic Surgeons' statement change [22]; and

Whereas, this statement was a significant deviation from typical AMA statements, as it stepped into a specialty society space without active input from said specialty societies, nor did it involve AMA members with expertise in pediatric gender affirming surgery or inform AMA LGBTQ+ leaders of its publicization [23,24]; and

Whereas, the AMA has extensive policy supporting evidence-based gender affirming care [25]; and

Whereas, AMA policy H-185.927 states that "our AMA will work with state and specialty societies and other interested stakeholders to advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence [and] oppose laws and policies that criminalize, prohibit, or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care"; and

Whereas, AMA policy H-185.927 further states that our AMA will work with aforementioned stakeholders to "support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based gender-affirming care and patients who seek and/or receive such care, as well as their parents and guardians"; and

Whereas, AMA policy H-160.991 states that "our AMA is committed to taking a leadership role in educating physicians on the current state of research in and knowledge of LGBTQ+ health… educating physicians to recognize the physical and psychological needs of LGBTQ+ patients… encouraging physicians to seek out local or national experts in the health care needs of LGBTQ+ people… and working with LGBTQ+ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ+ patients"; and

Whereas, AMA policy H-60.927 states that "our American Medical Association will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ+) youth suicide and improve health among LGBTQ+ youth"; and

Whereas, AMA policy H-65.965 states that "our American Medical Association continues to support the dignity of the individual, human rights and the sanctity of human life… reaffirms its longstanding policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, … opposes any discrimination based on an individual's sex, sexual orientation, gender identity"; and

Whereas, the American Academy of Pediatrics "does not include a blanket recommendation for surgery for minors. The AAP continues to hold to the principle that patients, their families, and their physicians—not politicians—should be the ones to make decisions together about what care is best for them" [26]; and

Whereas, expert guidance from the World Professional Association for Transgender emphasizes individualized care for medical and surgical care for transgender and gender diverse youth, with longitudinal patient-physician-guardian relationships, comprehensive biopsychosocial assessment, thorough health information and informed consent, multidisciplinary care, and only recommending gender-affirming surgical care to adolescents when meeting diagnostic criteria of gender incongruence that is sustained and marked, adolescent demonstration of emotional and cognitive maturity to provide informed consent/assent, thorough exploration of reproductive effects and fertility preservation options, and at least 12mo of gender-affirming hormone therapy to achieve the desired surgical result [27]; and

Whereas, research indicates that the rate of undergoing gender-affirming surgery for transgender and gender diverse minors is 2.1 per 100,000 minors ages 15-17 years, 0.1 per 100,000 minors aged 13-14 years, and 0 among minors 12 and younger [#]; and

Whereas, of the gender-affirming surgical procedures identified in transgender and gender diverse minors, 92 of 95 (96.4%) were chest-related procedures, and of the 151 breast reductions performed on cisgender male and transgender/gender diverse minors, 97% were performed on cisgender male minors [28]; and

Whereas, as gender-affirming mastectomy is the predominant surgical procedure performed in this small subset of gender diverse adolescents in the US, research on gender-affirming

mastectomy in adolescents had a median age at time of referral was 16 years, the documented regret rate was 0.95%, due in part to unsupportive home and social environment, and the prevalence of any surgical complications and revisions were comparable to or lower than rates in adults [29]; and

Whereas, gender-affirming surgical care is provided at significantly higher rates to cisgender youth, yet current political efforts explicitly target such surgical care only when provided to transgender and gender diverse youth, making these political efforts discriminatory by sex and gender identity [4-9, 30-33,]; and

Whereas, the aforementioned statement is technically in line with AMA policy, though its media manipulation counters best practice and existing research, thus leading to harm related to the statement that contradicts AMA policy; therefore be it

RESOLVED, that our American Medical Association reaffirm and recognize that decisions regarding gender-affirming surgical care rest with physicians, patients, and families, and support evidence-based, patient-centered, shared decision-making for such care (New HOD Policy); and be it further

RESOLVED, that our AMA advocate and support funding and opportunities for gender-affirming care research across modalities and age ranges, ensuring that such research and guideline development meaningfully involve clinicians who provide this care, researchers who study affected populations, and members of the impacted communities to strengthen the evidence base and uphold scientific integrity (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with relevant specialty societies and multidisciplinary experts to support education and promote educational resources for physicians and trainees on evidence-based, patient-centered, shared decision-making gender-affirming surgical and medical care. (Directive to Take Action)

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

Received: 4/15/26

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RELEVANT AMA POLICY

Support of Human Rights and Freedom H-65.965

1. Our American Medical Association continues to support the dignity of the individual, human rights and the sanctity of human life,
2. Our AMA reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age.
3. Our AMA opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies.
4. Our AMA recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Clarification of Evidence-Based Gender-Affirming Care H-185.927

1. Our American Medical Association recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice.
2. Our AMA will work with state and specialty societies and other interested stakeholders to:
    a. advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence;
    b. oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care;
    c. support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, genderaffirming care and patients who seek and/or receive such care, as well as their parents and guardians; and
    d. communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence.
3. Our AMA will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers.

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

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.

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927

Our American Medical Association will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 510
(A-26)

Introduced by: North Carolina

Subject: Exosome and Peptide Use in Healthcare

Referred to: Reference Committee E

Whereas, Exosomes and Peptides are distinct regenerative tools: Exosomes serve as cellular "couriers" that deliver bioactive molecules to stimulate healing and regenerative processes, while Peptides are amino acid chains acting as targeted messengers to influence similar specific cellular functions as well; and

Whereas, Exosomes and Peptides can have many uses as they can contribute significantly to longevity, improved health and wound-healing processes through their antimicrobial, immunomodulatory and regenerative processes in all stages of aging and healing, including inflammation and wound healing; and

Whereas, currently there needs to be better guidance in the proper sourcing and use of Exosomes and Peptides, including supporting the manufacture of these substances domestically in the United States and transparent composition and strength of these products to guide proper dosing protocol; and

Whereas, the NDAA (National Defense Authorization Act) for FY2027 which includes funding for national defense, implements significant guidelines for buying equipment and products favoring “best value” over just lower cost, and includes provisions for improvements to healthcare for active military and veteran members is currently in a phase where amendments can be proposed and passed that can improve the healing of acute and chronic wounds as well as neurologic and psychological disease states that are a consequence of the service that these active Soldiers and Veteran members provide to defend our country and freedoms; therefore be it

RESOLVED, that our AMA take the lead in advising Congress, the FDA and our regulatory agencies in:

1) Categorizing Exosomes and Peptides by their longevity, wound healing and regenerative potentials.

2) Encouraging the manufacture and processing of Exosomes and Peptides in the United States.

3) Work with the FDA to reclassify Exosomes and Peptides to allow Physicians to order and dispense Exosomes and Peptides properly sourced in single dose syringes individualized to patients to treat appropriate patient medical concerns including wound healing, improved health and longevity.

4) Work with Congress to propose an amendment to the NDAA 2027 that addresses appropriate use of Exosomes and Peptides within the Armed Services and VA system to improve Soldier and Veteran Healthcare, especially in acute and chronic wound healing.

5) Encourage additional trials and testing of Exosome and Peptide use protocols to firmly establish their efficacy.

6) Refer this issue to the Council on Science and Public Health for study and report back at Interim 2026.
(Directive to Take Action)

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

Received: 4/15/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 511
(A-26)

Introduced by: American Academy of Dermatology, American College of Mohs Surgery, Society for Investigative Dermatology

Subject: Preserving Specialty Access to Anti-Cancer Agents

Referred to: Reference Committee E

Whereas, certain health systems have implemented restrictive policies that limit the prescription and administration of anti-cancer agents exclusively to the specialty of medical oncology; and

Whereas, these policies may be couched in concern for proper care and disposal of these agents but in practice they can be motivated by limiting patient access to treatment options as a cost control measure; and

Whereas, such restrictions can create unnecessary barriers to patient care, delay treatment, and overlook the clinical expertise of other specialists who are highly trained in the management of specific malignancies; and

Whereas, different anti-cancer agents have significantly different levels of concern about care, use and disposal, particularly comparing large-volume intravenous solutions of cytotoxic agents with oral agents prescribed for patient self-administration at home; and

Whereas, physicians in diverse specialties have been instrumental in the development and clinical trials of breakthrough targeted therapies for a variety of malignancies;[1] and

Whereas, physicians in multiple specialties outside of medical oncology contribute to clinical innovation by actively enrolling patients in and conducting studies on chemotherapeutic[2-6] and immunotherapeutic[7] agents for the treatment of malignancies; and

Whereas, the safe handling, transportation, administration, and proper disposal of chemotherapeutic and immunotherapeutic agents are critical components of patient and healthcare worker safety that should be governed by targeted institutional protocols regardless of the prescribing physician's specialty; therefore be it

RESOLVED, that our American Medical Association support multidisciplinary, evidence-based cancer care models and oppose categorical specialty-based restrictions on physician prescribing and/or administering anti-cancer agents when the physician is appropriately trained in their use and institutional safety standards are met (New HOD Policy); and be it further

RESOLVED, that our AMA support appropriate, targeted policies and protocols related to the safe transportation, administration, and proper disposal of chemotherapeutic and other anti-cancer agents (New HOD Policy); and be it further

RESOLVED, that our AMA advocate against policies that restrict physician use of anti-cancer agents based solely on specialty designation rather than clinical competency, training, and patient need. (Directive to Take Action)

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

Received: 4/15/26

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RELEVANT AMA POLICY

Practice Parameters - Their Relevance to Physician Credentialing H-410.987
1. The term practice guidelines should be used to refer to strategies for patient management that are designed to assist physicians in clinical decision-making. The terms should not be used to refer to the criteria for professional training, skills and experience utilized in the granting of general or procedure-specific clinical privileges.
2. The documentation of adherence to, or intent to practice within, relevant practice guidelines should not be used as an additional criterion for the granting of general or procedure-specific clinical privileges unless and until a relationship between adherence to such practice guidelines and desired patient outcomes is adequately documented.
3. Practice guidelines developed by a particular medical specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice guideline by physicians not formally credentialed in that specialty or specialties. Individual character, training, competence, experience, and judgment should continue to be the criteria for granting general or procedure-specific clinical privileges.

Medical Specialty Board Certification Standards H-275.926
1. The term practice guidelines should be used to refer to strategies for patient management that are designed to assist physicians in clinical decision-making. The terms should not be used to refer to the criteria for professional training, skills and experience utilized in the granting of general or procedure-specific clinical privileges.
1. Our American Medical Association opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Our AMA opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
3. Our AMA continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet accepted standards for certification that include both a process for defining specialty-specific standards for knowledge and skills and offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. In addition, accepted standards, such as

those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.
4. Our AMA opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
5. Our AMA advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
6. Our AMA encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
7. Our AMA encourages continued advocacy to federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other interested parties to define physician board certification as the medical profession establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification.

Privileging for Ultrasound Imaging H-230.960
1. AMA affirms that ultrasound imaging is within the scope of practice of appropriately trained physicians;
2. AMA policy on ultrasound acknowledges that broad and diverse use and application of ultrasound imaging technologies exist in medical practice;
3. AMA policy on ultrasound imaging affirms that privileging of the physician to perform ultrasound imaging procedures in a hospital setting should be a function of hospital medical staffs and should be specifically delineated on the Department's Delineation of Privileges form; and
4. AMA policy on ultrasound imaging states that each hospital medical staff should review and approve criteria for granting ultrasound privileges based upon background and training for the use of ultrasound technology and strongly recommends that these criteria are in accordance with recommended training and education standards developed by each physician's respective specialty.

Protecting the Prescriptive Authority of Plenary Licensed Physicians D-120.920
1. Our American Medical Association will study the national prevalence and patterns of pharmacists refusing to fill valid prescriptions from plenary licensed physicians, including impact on patient outcomes and prescriber autonomy.
2. Our AMA will work with state medical boards, pharmacy boards, and appropriate federal agencies to protect the authority of plenary licensed physicians to prescribe all legal medications in accordance with their training and medical judgment.
3. Our AMA will reaffirm and publicize existing policy opposing unauthorized medication substitution, inappropriate pharmacy inquiries, and unauthorized treatment modification by pharmacists.
4. Our AMA supports legislation or regulatory action requiring pharmacists and pharmacy chains to either fill a valid prescription or immediately refer the patient to an alternative dispensing pharmacy, with notification to the prescribing physician.
5. Our AMA encourages interprofessional collaboration to clarify scope-of-practice boundaries, educate interested parties on the legal authority of plenary licensure, and promote policies that ensure timely patient access to physician led care.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 512
(A-26)

Introduced by: Senior Physicians Section

Subject: Medical Cannabis Use in Older Adults

Referred to: Reference Committee E

Whereas, cannabis consumption among older adults (aged 65 years and above) has risen markedly over the past two decades in the United States, increasing from 0.4 percent in 2006 to 7 percent in 2023[1,2]; and

Whereas, medical cannabis is now legal in thirty-eight states, with recreational cannabis permitted in twenty-four states[3]; and

Whereas, the approval and expansion of state medical cannabis laws throughout the United States have greatly increased both the availability and use of cannabis, especially through medical cannabis programs; and

Whereas, recent studies suggest a higher incidence of dementia among individuals who use cannabis[4,5]; and

Whereas, cannabis may offer therapeutic benefits for managing agitation in dementia patients, potentially serving as an alternative to antipsychotic medications[6,7]; and

Whereas, greater transparency regarding both the potential benefits and adverse effects of cannabis use in older adults would be valuable to physicians, particularly given the current paucity of research that is focused on this population[8,9,10]; and

Whereas, adequate physician education regarding appropriate prescribing, therapeutic indications, and potential adverse effects is needed; therefore be it

RESOLVED, that our American Medical Association support the development and publication of educational resources on medical cannabis directed towards clinicians, including a virtual educational presentation that reviews the known effects of medical cannabis in older adults that highlights both its potential benefits and risks (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage expanded research into the therapeutic uses of cannabis in older adults—such as for managing agitation in individuals with cognitive impairment—as well as its possible adverse effects. (New HOD Policy)

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

Received: 4/16/26

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RELEVANT AMA POLICY

D-95.949 Advocacy for More Protective Regulations on Distribution of Cannabis

1. Our AMA will advocate that any monies paid to the states, received as a result of a settlement or judgment, or other financial arrangement or agreement as a result of litigation for cannabis-related harms or violations of law, be used exclusively for research, education, prevention, and treatment of cannabis-related harms, as well as expanding physician training opportunities to provide clinical experience in the screening, diagnosis, and treatment of cannabis misuse and cannabis use disorder.
2. Our AMA supports legislation and/or regulation of all cannabis products that:
   a. prohibit cannabis use in all places that tobacco use is prohibited, including in hospitals and other places in which health care is delivered;
   b. apply the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople as well as avenues for legal and financial penalties for marketing to youth;
   c. prohibit product claims of reduced risk or effectiveness as tobacco cessation tools;
   d. require the use of secure, child- and tamper-proof packaging and design, and safety labeling on all cannabis products;
   e. establish manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use;
   f. require transparency and disclosure concerning product design, contents, and emissions; and
   g. prohibit the use of characterizing flavors that may enhance the appeal of such products to youth.
3. Our AMA encourages state medical associations to strengthen existing cannabis marketing and advertising restrictions, including consideration of prohibitions on marketing and advertising to children.
4. Our AMA supports the review of conditions that states have approved to authorize cannabis for medical use and recommend the removal of those conditions without scientifically valid and well-controlled clinical trials supporting the use of cannabis.

[BOT Rep. 21, A-25]

H-95.952 Cannabis and Cannabinoid Research

1. Our American Medical Association calls for further adequate and well-controlled studies of cannabis and related cannabinoids, including Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids (HDICs), in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.
2. Our AMA urges that cannabis's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and

alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of cannabis, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.
3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include:
a. disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation;
b. sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes;
c. confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.
4. Our AMA supports research to determine the consequences of long-term cannabis use, as well as the use of Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids, especially among youth, adolescents, pregnant people, and people who are breastfeeding.
5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.
6. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.
7. Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.
[CSA Rep.10, I-97; Modified: CSA Rep. 6, A-01; Modified: CSAPH Rep.3, I-09; Modified in lieu of Res. 902; BOT Action in response to referred for decision: Res. 503, A-24 I-10; Reaffirmed in lieu of Res. 523, A-11; Reaffirmed in lieu of Res. 202, I-12; Reaffirmed: CSAPH Rep. 2, I-13; Modified: CSAPH Rep. 05, I-17; Reaffirmed in lieu of Res. 434, A-19; Appended: Res. 913, I-19; Reaffirmation: A-22; Reaffirmed: Res. 212, A-23; Reaffirmed: CSAPH Rep. 6 I-23; Modified: Speakers Rep. 02, I-24; BOT Action in response to referred for decision: Res. 503, A-24]

D-95.958 Marketing Guardrails for the "Over-Medicalization" of Cannabis Use

1. Our American Medical Association will send a formal letter to the Food and Drug Administration and Federal Trade Commission requesting more direct oversight of the marketing of cannabis for medical use.
2. Our AMA will generate a formal letter for use by state medical societies requesting more direct oversight by state government of the marketing of cannabis and Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids.
3. Our AMA will support and encourage federal, state, and private sector research on the effects of cannabis and Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids marketing to identify best practices in protecting vulnerable populations, as well as the benefits of safety campaigns such as preventing impaired driving or dangerous use.
4. Our AMA will encourage state regulatory bodies to enforce cannabis-related marketing laws as well as laws related to marketing of Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids and to publicize and make publicly available the results of such enforcement activities.
5. Our AMA will encourage social media platforms to set a threshold age of 21 years for exposure to cannabis, and Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids, advertising and marketing and improve age verification practices on social media platforms.
6. Our AMA will encourage regulatory agencies to research how marketing best practices learned from tobacco and alcohol policies can be adopted or applied to cannabis and Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids marketing.

7. Our AMA will support using existing AMA channels to educate physicians and the public on the health risks of cannabis and Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids to children and potential health risks of cannabis and Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids to people who are pregnant or lactating.
8. Our AMA will work with relevant stakeholders to strengthen cannabis marketing and advertising regulations, including efforts to ensure that packaging does not appeal to youth and marketing is restricted to prevent exposure to young audiences.
9. Our AMA opposes cannabis and cannabis-based product advertising that includes claims or statements that are not supported by peer-reviewed scientific evidence.
10. Our AMA will continue to monitor regulatory approaches to cannabis marketing.

[Res. 501, A-22; Modified: CSAPH Rep. 6, I-23; Appended: BOT Action in response to referred for decision Res. 508, A-24; Appended: CSAPH Rep. 01, I-24; BOT Action in response to referred for decision: Res. 503, A-24]

D-95.969 Cannabis Legalization for Medicinal Use

1. Our American Medical Association believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products, Derived Psychoactive Cannabis Products (DPCPs), and Hemp-Derived Intoxicating Cannabinoids for medical use.
2. Our AMA believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process.
3. Our AMA will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process.
4. Our AMA supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws.
5. Our AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions.
6. Our AMA will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians.
7. Our AMA encourages hospitals and health systems to:
    a. not recommend patient use of non-FDA approved cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use.
    b. educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome.

[CSAPH Rep. 05, I-17; Appended: Res. 211, A-18; Appended: CSAPH Rep. 3, I-19; Reaffirmed: Res. 212, A-23; BOT Action in response to referred for decision: Res. 503, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 513
(A-26)

Introduced by: Texas

Subject: Access, Affordability, and Safety of GLP-1 Receptor Agonists

Referred to: Reference Committee E

Whereas, GLP-1 receptor agonists (e.g. semaglutide, tirzepatide, liraglutide) are FDA-approved medications that have demonstrated significant benefit for patients with type 2 diabetes and obesity, improving glycemic control, reducing cardiovascular risk, and promoting clinically meaningful weight loss; and

Whereas, the American Diabetes Association's Standards of Medical Care in Diabetes recommend GLP 1 receptor agonists as a preferred therapeutic option for patients with type 2 diabetes who have established cardiovascular disease, high cardiovascular risk, or require additional weight reduction, thereby establishing their role in evidence-based treatment algorithms; and

Whereas, obesity and diabetes are major public health burdens in Texas, contributing to increased morbidity, mortality, and health care costs, particularly among underserved and high-risk populations; and

Whereas, despite their proven clinical effectiveness, GLP-1 receptor agonists are often placed on higher formulary tiers with restrictive prior authorization criteria and prohibitively high out-of-pocket costs, limiting patient access; and

Whereas, many Americans face high deductibles or lack insurance coverage, leading some to seek compounded versions of GLP-1 receptor agonists; and although compounding can expand access, these preparations are not FDA-approved, may vary in purity or potency, and should be subject to clear, consistent regulatory oversight to promote patient safety; and

Whereas, the current pricing of GLP-1 receptor agonists has contributed to rising health care costs for both public and private payers, with annual out-of-pocket expenses for uninsured patients often exceeding $12,000, while manufacturers of GLP-1 agents have reported combined global revenues exceeding $50 billion in 2024; and

Whereas, large health systems and self-funded employers across Texas have curtailed GLP-1 coverage due to cost, including the University of Texas System, whose monthly spending on GLP-1 medications rose from $1.5 million to more than $5 million over 18 months; and

Whereas, the free market has not succeeded in making these life-changing medications broadly affordable to the patients who need them most, and meaningful price reductions will likely require greater governmental oversight, negotiation, or regulatory intervention to promote fair pricing and equitable access; and

Whereas, while GLP-1 receptor agonists have proven benefits in the management of type 2 diabetes, their widespread adoption for obesity management is relatively new, with limited long-term data and potential for weight regain after discontinuation; and

Whereas, sustainable obesity management requires comprehensive approaches including nutrition, physical activity, behavioral support, and long-term follow-up to promote durable success; therefore be it

RESOLVED, that our American Medical Association advocate for legislation and/or regulation so that public and private health insurers provide GLP-1 receptor agonists for the treatment of type 2 diabetes and obesity at affordable formulary pricing, thereby reducing out-of-pocket costs for patients (Directive to Take Action); and be it further

RESOLVED, that our AMA support regulatory oversight and quality-assurance standards for compounding of GLP-1 receptor agonists to promote patient safety while maintaining access for those who cannot otherwise afford FDA-approved medications (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for pricing transparency and cost-containment strategies among manufacturers, payers, and policymakers to improve affordability and access to evidence-based obesity and diabetes treatments (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage the use of GLP-1 receptor agonists in accordance with evidence based clinical indications, within comprehensive care plans that include behavioral and lifestyle interventions. (New HOD Policy)

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

Received: 4/20/26

RELEVANT AMA POLICY

Addressing Adult and Pediatric Obesity D-440.954

1. Our American Medical Association will:
    a. Assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations.
    b. Encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations.
    c. Continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3. Our AMA will work with interested national medical specialty societies and state medical associations to increase public insurance coverage of and payment for the full spectrum of evidence-based adult and pediatric obesity treatment.
4. Our AMA will:

a. work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment.
b. work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.

5. Our AMA will leverage existing channels within AMA that could advance the following priorities:
   - Promotion of awareness amongst practicing physicians and trainees that obesity is a treatable chronic disease along with evidence-based treatment options.
   - Advocacy efforts at the state and federal level to impact the disease obesity.
   - Health disparities, stigma and bias affecting people with obesity.
   - Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
   - Increasing obesity rates in children, adolescents and adults.
   - Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods and food marketing practices.
6. Our AMA will conduct a landscape assessment that includes national level obesity prevention and treatment initiatives, and medical education at all levels of training to identify gaps and opportunities where AMA could demonstrate increased impact.
7. Our AMA will convene an expert advisory panel once, and again if needed, to counsel AMA on how best to leverage its voice, influence and current resources to address the priorities listed in item 5 above.

Advocacy Against Obesity-Related Bias by Insurance Providers H-440.801

1. Our American Medical Association will urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to:
   a. Revise their policies to ensure that bariatric surgery are covered for patients who meet the appropriate medical criteria.
   b. Eliminate criteria that place unnecessary time-based mandates that are not clinically supported nor directed by the patient's medical provider.
   c. Ensure that insurance policies in their states do not discriminate against potential metabolic surgery patients based on age, gender, race, ethnicity, socioeconomic status.
   d. Advocate for the cost-effectiveness of all obesity treatment modalities in reducing healthcare costs and improving patient outcomes.
   e. Reduce the prior authorization burden for the coverage of anti-obesity medications, to include not requiring a new prior authorization for every dose change.
   f. Allow a patient's physician to prescribe anti-obesity medication and have it covered by insurance, without a requirement that patients must receive the prescription only from contracted disease management companies.
2. Our AMA will support and provide resources to state delegations in their efforts to advocate for the reduction of bias against patients that suffer from obesity for the actions listed.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 514
(A-26)

Introduced by: Texas

Subject: Education, Screening, and Effective Treatment for Obstructive Sleep Apnea During Pregnancy

Referred to: Reference Committee E

Whereas, maternal morbidity and mortality are increasing despite quality improvements, with evidence showing there is a correlation between the prevalence of obstructive sleep apnea (OSA) and associated adverse pregnancy outcomes in the obstetrical population; and

Whereas, after controlling obesity and other potential confounders, OSA was associated with increased odds of pregnancy-related morbidities including preeclampsia, eclampsia, cardiomyopathy, and pulmonary embolism with more than fivefold increased odds of in hospital mortality; and

Whereas, during late pregnancy women with OSA had eight times the odds of having depressive symptoms; and

Whereas, OSA has been associated with adverse neonatal outcomes, such as preterm birth and growth restriction in some studies; and

Whereas, OSA in pregnancy continues to be underdiagnosed, resulting in missed opportunities to prevent adverse outcomes; and

Whereas, it is important to screen for OSA in women, and if clinically indicated, order a home sleep test which can be shipped to the patient's home and follow-up care can be provided via telemedicine until OSA resolves to improve maternal health; therefore be it

RESOLVED, that our American Medical Association adopt policy to screening and educating about obstructive sleep apnea:

That AMA supports obstructive sleep apnea screening to reduce negative outcomes
That AMA supports physician payment for obstructive sleep apnea screening and treatment.
That AMA advocates for more research on obstructive sleep apnea in pregnancy.
That AMA supports education about obstructive sleep apnea in pregnancy.

(New HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal legislation aligning with this policy. Routine screening, early diagnosis, and effective treatment of obstructive sleep apnea are recommended in pregnant women, particularly during mid and late pregnancy. (Directive to Take Action)

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

Received: 4/20/26

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RELEVANT AMA POLICY

H-290.953 State Medicaid Coverage of Home Sleep Testing
Our American Medical Association supports efforts to expand access to and insurance coverage of physician-ordered home sleep testing, including for Medicaid beneficiaries, for the purpose of identifying sleep apnea and related sleep conditions.

H-35.963 Appropriate Use of Objective Tests for Obstructive Sleep Apnea
It is the policy of our AMA that: (1) ordering and interpreting objective tests aiming to establish the diagnosis of obstructive sleep apnea (OSA) or primary snoring constitutes the practice of medicine; (2) the need for, and appropriateness of, objective tests for purposes of diagnosing OSA or primary snoring or evaluating treatment efficacy must be based on the patient's medical history and examination by a licensed physician; and (3) objective tests for diagnosing OSA and primary snoring are medical assessments that must be ordered and interpreted by a licensed physician.

H-440.795 Obstructive Sleep Apnea
1. Our American Medical Association recognizes Obstructive Sleep Apnea (OSA) as a major public health issue.
2. Our AMA encourages a national public education campaign by appropriate federal agencies and relevant advocacy groups.
3. Our AMA encourages research into the association of OSA with metabolic, cardiovascular, respiratory, and other diseases.
4. Our AMA encourages that all physicians become knowledgeable about the diagnosis and management of OSA.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 515
(A-26)

Introduced by: Association for Clinical Oncology

Subject: Transparency in AI-Driven Adverse Determinations & Clinical Logic Disclosure

Referred to: Reference Committee E

Whereas, health plans increasingly utilize augmented intelligence (AI) and algorithmic black box tools to issue adverse determinations, often relying on datasets that fail to reflect monthly updates in oncology clinical guidelines (e.g., National Comprehensive Cancer Network, American Society of Clinical Oncology (ASCO)); and

Whereas, the ASCO 2025 Position Statement on AI in Prior Authorization explicitly calls for federal and state legislation mandating proper disclosure regarding the use of AI in coverage determinations; and

Whereas, current American Medical Association human-in-the-loop policy ensures a physician makes the final call, but does not mandate that the payer disclose the specific clinical logic or version history necessary for a physician to successfully appeal a denial; therefore be it

RESOLVED, that our American Medical Association advocate for federal and state regulations and legislation requiring health plans and third-party payers to provide physicians with the specific clinical logic, evidence-based sources, and version history of any augmented intelligence (AI) or algorithmic tools used in the issuance of an adverse determination (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that any AI-driven or algorithmic tool used for clinical review must be transparently audited to ensure it reflects the most recent peer-reviewed clinical guidelines and recognized standards of care. (Directive to Take Action)

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

Received: 4/20/26

REFERENCES
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2. Centers for Medicare & Medicaid Services. CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F). Effective January 1, 2026. https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f
3. American Medical Association. AMA Center for Digital Health and AI. March 2026. https://www.ama-assn.org/about/ama-center-digital-health-and-ai

RELEVANT AMA POLICY

H-480.939 Augmented Intelligence in Health Care
Our AMA will advocate that: Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: transparency; evidence of safety, efficacy, and equity; and level of automation. 2. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it. [Res. 611, A-19; Reaffirmed: 2025]

D-480.952 Ensuring Transparency and Accountability in Clinical Use of Augmented Intelligence
Our AMA recognizes the need for clear disclosure to the healthcare provider whenever artificial intelligence (AI) is used in the delivery of clinical care... [and] advocates that entities provide for clinically useful transparency, such as clear labeling of AI-generated outputs for end users, including disclosure of the algorithm's level of confidence in those outputs. [Council on Science and Public Health Rep. 02, A-24; Modified: June 2025]

H-320.939 Prior Authorization and Utilization Management Reform
Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician. [Sub. Res. 701, A-17; Reaffirmed: 2026]