AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

REFERRAL CHANGES AND OTHER REVISIONS
2026 Annual Meeting

RESOLUTIONS WITH ADDITIONAL SPONSORS
(Additional sponsors underlined)

- Res. 009 - Preserving Access to Care for Undocumented Individuals (Resident and Fellow Section, Underrepresented in Medicine Advocacy Section)
- Res. 201 - Prohibit and Regulate 7-Hydroxymitragynine (7-OH) Kratom Products to Protect Public Health and Youth Safety (Oklahoma, Mississippi, South Carolina)
- Res. 202 - Using and Defining "Unsupervised Practice of Medicine" (Florida, Texas, Oklahoma, South Carolina)
- Res. 203 - Support for Independent Evaluation of Outcomes Associated with Unsupervised Nurse Practitioner Practice (Florida, Texas, Oklahoma, South Carolina)
- Res. 209 - Protecting Mental Health Treatment Privacy in Legal Proceedings (Virginia, Resident and Fellow Section)
- Res. 227 - Standby Capacity Payments and Health IT for Hospitals in Rural Areas (California, Hawaii, Idaho, Oregon, Washington, Wyoming, Resident and Fellow Section)
- Res. 235 – Establishing Healthcare Monitoring and Accountability in Immigration Detention Facilities (Medical Student Section, Underrepresented in Medicine Advocacy Section, Resident and Fellow Section)
- Res. 236 - Extending and Expanding the AMA Task Force to Preserve the Patient-Physician Relationship to Ensure Access and Regulatory Clarity in Gender-Affirming Care (LGBTQ+ Section, Medical Student Section, American College of Physicians, GLMA: Health Professionals Advancing LGBTQ+ Equality)
- Res. 243 - Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions (Association for Clinical Oncology, American Society of Hematology, American Academy of Hospice and Palliative Medicine)
- Res. 310 - Increasing Capacity and Access to Maternal Health Services in Rural Areas (California, ACOG, Hawaii, Idaho, Oregon, Washington, Resident and Fellow Section)
- Res. 401 - Partnership with the Administration to Reduce Harmful Chemicals in Food and Align with European Safety Standards (Organized Medical Staff Section, American College of Lifestyle Medicine)
- Res. 402 - Strengthening Public Health Protections Against Raw Milk–Associated Illness (Oklahoma, American Association of Public Health Physicians, Mississippi, Tennessee, American College of Medical Quality)
- Res. 426 - Integrating Nutrition into Health Care Delivery to Reduce Cardiovascular Risk and Food Insecurity ("Food is Medicine") (American College of Cardiology, American College of Lifestyle Medicine)

- Res. 428 – Protecting Environmental Health Before, During, and After War (Medical Student Section, Resident and Fellow Section)
- Res. 610 - Plant-Based Diets at AMA Meetings (New York, American College of Lifestyle Medicine)
- Res. 615 - Condemnation of Attacks on Healthcare Workers and Facilities in Gaza (Resident and Fellow Section, Underrepresented in Medicine Advocacy Section)
- Res. 616 - Humanitarian and Medical Aid Support to Palestine (Resident and Fellow Section, Underrepresented in Medicine Advocacy Section)
- Res. 617 - Reevaluation of AMA Policy Regarding Support for Specific National Medical Associations in the World Medical Association (Resident and Fellow Section, Underrepresented in Medicine Advocacy Section)
- Res. 710 - Parity in Access to Evidence-Based Obesity Treatment (American Society for Metabolic and Bariatric Surgery, Society of American Gastrointestinal and Endoscopic Surgeons, Obesity Medical Association, American Academy of Sleep Medicine, American Association of Clinical Endocrinology, Medical Student Section, The Endocrine Society)

ORDER OF BUSINESS
SECOND SESSION

Saturday, June 6, 2026
12:00 PM

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

2. **Report of the Rules and Credentials Committee – Deborah Fuller, MD**

3. **Presentation Correction and Adoption of Minutes from the November 2025 Interim Meeting**

4. **Referral Changes and Other Revisions**

5. **Acceptance of Business**

--REPORTS--

Report(s) of the Board of Trustees - David H. Aizuss, MD, Chair

01 Annual Report
02 New Specialty Organizations Representation in the House of Delegates
04 AMA 2027 Dues
08 Council on Legislation Sunset Review of 2016 House Policies
12 The Uniform Health-Care Decisions Act
13 Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medicaid Purposes
14 Binding Arbitration in Health Insurance Contracts
15 Protecting the Prescriptive Authority of Plenary Licensed Physicians
17 Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records Report
19 Root Cause Analysis of the Causes of the Decline of Private Medical Practice
20 Mitigating the Impact of Excessive Prior Authorization Processes
21 Abolishing Venue Shopping
22 Comprehensive AMA Policy Publication Regarding Employed Physicians
23 Liberalized Remorse Period for Medicare Advantage Plan Insureds
24 AMA Advocacy to Mitigate Medicaid Cuts
25 Federal Legislation to Prohibit the Corporate Practice of Medicine
27 Update the Status of Virtual Credit Card Policy, EFT Fees, and Lack of Enforcement of Administrative Simplification Requirements by CMS
28 Accountability in the Use of Augmented Intelligence for Prior Authorization
29 Educational Materials Regarding Ultra-processed Foods
34 Discontinuation of AMA Citation for Distinguished Service
35* Specialty Society Representation in the House of Delegates - Five-Year Review
38* Project IMG Observer Status in the House of Delegates

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

02 HOD Representation and Composition
03 Rights & Privileges of HOD Members
04 Credentialing of HOD Delegates and Alternate Delegates
05 Inclusion of Medical Students and Resident/Fellow Physicians in HOD Delegations
06 Medical Student Regional Delegates and Alternate Delegates and Resident and Fellow Sectional Delegates and Alternate Delegates in the HOD
07 HOD Delegate and Alternate Delegate Vacancies and Meeting Absences
08 Business Meetings of the AMA Sections
09 Continuity of AMA Resident and Fellow Section Governing Council Leadership

Report(s) of the Council on Ethical and Judicial Affairs - Rebecca Brendel, MD, Chair

01 Guidelines on Chaperones for Sensitive Exams
02 Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure
03 Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization
05 CEJA's Sunset Review of 2016 House Policies

Report(s) of the Council on Medical Education - Kelly Caverzagie, MD, MPH, Chair

01 Council on Medical Education Sunset Review of 2016 House of Delegates' Policies
02 Examining ABMS Processes for New Boards
03 Support for the Establishment of Indigenous-Led Medical Schools in the United States
04 Reflecting the Values and Priorities of Tribal Communities in Indigenous-Led Medical Schools in the United States

Report(s) of the Council on Medical Service - Betty Chu, MD, MBA, Chair

01 Council on Medical Service Sunset Review of 2016 House Policies
03 Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts
04 Expanding Medicare Coverage of Medical Nutrition Therapy
05 Inclusion of Discounted Prescription Medication in Patient Cost-Sharing
06 Study of Practice Models for Physicians Performing Procedures Across State Lines
07 Private Insurance Coverage of Anti-Obesity Medications
08 Rural Health Transformation Program Update & Workforce Challenges
09 Nonprofit Status

Report(s) of the Council on Science and Public Health - Padmini Ranasinghe, MD, MPH, Chair

01 Sunset Review of 2016 House Policies
02 Setting Standards for Forensic Toxicology Laboratories Used in Litigation
03 Public Health Implications of Food Subsidies
04 Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers
05 Removing Artificial Turf in Schools, Parks, and Public Places
06 Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities
07 Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making
08 Increased Transparency Among Psychotropic Drug Administration in Prisons
09 In Support of a National Drug Checking Registry
10 Standardizing Safety Requirements for Traditional and Rideshare Based Non-Emergency Medical Transportation

Report(s) of the HOD Committee on Compensation of the Officers - Jessica Krant, MD, Chair

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

—EXTRACTION OF INFORMATIONAL REPORTS—

Report(s) of the Board of Trustees

03 2025 Grants and Donations
05 Update on Corporate Relationships
06 AMA Performance, Activities and Status in 2025
07 Annual Update on Activities and Progress in Tobacco Control: March 2025 through February 2026
09 American Medical Association Optimal Health Outcomes Annual Report
10 AMA Efforts on Medicare Payment Reform
11 AMA Public Health Strategy Update
16 Demographic Report of the House of Delegates and AMA Membership
18 Report on the Preservation of Independent Medical Practice
26 AMA Ethics Fellowships
30 AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates
31 Establishing an Advisory Committee on AI/AN Affairs
32 Disability Advisory Group
33 Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted
36* Update on the Report of the TRHT Task Force to the AMA Board of Trustees
37* AMA Policies on Gender Affirming Care

Report(s) of the Council on Constitution and Bylaws

01 Introducing CCB Reports 2-7 concerning Bylaw 2, House of Delegates

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

04 Carceral Systems and Practices in Behavioral Health Emergency Care
06 Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

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

01 Amendment to Opinion 1.1.1 “Patient-Physician Relationships”
02 Research Involving Pregnant and Lactating Individuals

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

01* Update on CLRPD Evaluation of the Structure of the House of Delegates

Report(s) of the Council on Medical Service

02 Study of the Federal Employees Health Benefits Program (FEHBP)

--INTRODUCTION OF RESOLUTIONS—

001 Ethical Guidance on Postmortem Sample Collection for Genetic Testing
002 Physician Workload and Scheduling
003 Artificial Intelligence to Bolster Physician-Led Team-Based Care

004 Ethical Reproductive Care for Individuals with Intellectual and Developmental Disabilities
005 Impersonation of a Physician
006 Investigating Moral Injury Related to Organ Procurement Practices
007 Supporting Privacy in the Use of Artificial Intelligence Based Scribe Software
008 Senior Physicians Improving Patient Access
009 Preserving Access to Care for Undocumented Individuals
010 Fatigue Mitigation: Supporting Fully-Funded Transportation for Trainee Physicians After Extended or Overnight Shifts
011* Physician Ability to Render Emergency Medical Aid During Immigration Enforcement
101 Revise the Use of Language Stigmatizing Obesity in ICD-10 Code E66.01"Morbid (Severe) Obesity Due to Excess Calories"
102 Study for EMTALA Relief in Psychiatric Facilities
103 Supporting Non-Insurance Directed Sales of Pharmaceuticals to Patients to Improve Access and Reduce Costs
104 Improving Choice, Competition, and Affordability in the ACA Marketplaces
105 Oppose Medicare Advantage Auto Enrollment
106 Insurance Coverage for Scalp Cooling (Cold Capping) Therapy
107 Oversight of Medicare Advantage Plan
108 Ensuring Physician Input in the Development of CMMI Models
109 Insurance Coverage for Pediatric Intracranial Neuromodulation for Drug-Resistant Epilepsy
110 Medicaid Coverage for Incarcerated Individuals
111 Advocating for Insurance Coverage of Scalp Cooling Therapy to Prevent Chemotherapy-Induced Alopecia
112 Ensuring Coverage and Access to Adult Strabismus Surgery
113 Health Insurance Coverage of Hearing Devices and Related Services
114 Opposing Alternative Funding Programs
115 Patient Continuity Protections During Payer, PBM Changes
116 Study of Cost Implications of Medicaid Managed Care Organizations Compared with State-Administered Medicaid Programs
117 Universal Out of Network Benefits
118 Addressing Proposals to Implement International Reference Pricing for Physician-Administered Drugs
201 Prohibit and Regulate 7-Hydroxymitragynine (7-OH) Kratom Products to Protect Public Health and Youth Safety
202 Using and Defining "Unsupervised Practice of Medicine"
203 Support for Independent Evaluation of Outcomes Associated with Unsupervised Nurse Practitioner Practice
204 D-400.982 Revision
205 Repeal of the Merit-Based Incentive Payment System (MIPS)
206 Overall Hospital Quality Star Ratings / CMS Star Ratings
207 Addressing Rural Maternity Care Deserts Through the Conrad 30 Waiver Program
208 Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness
209 Protecting Mental Health Treatment Privacy in Legal Proceedings
210 Eliminating Prescription Drug Adherence (PDA) as a Quality Metric Tied to Physician Ratings or Compensation
211 Preventing Hospital-Based 340B Programs from Unfairly Competing with Independent Physicians

212 Protecting Patient Access to Clinical Trials and Mitigating Administrative Disruptions to NIH Funding
213 Prohibiting Pharmacy Benefit Managers from Owning Pharmacies
214 Medical Student Loans Should Not Be Capped
215 Oppose Medicare Efficiency Adjustments
216 Protecting Healthcare as a Sensitive Location
217 Ensuring Proportional Accountability for Hospital Expenditures Attributed to Medicare ACOs
218 Opposing the Practice of Jury Anchoring in Medical Liability Cases
219 Incorporating Evidence-Based Lifestyle Medicine into Rural Health Transformation Programs
220 Reverse CMS Cuts to Facility-Based Practice Expense Payments for Physicians
221 Universal Newborn Congenital Cytomegalovirus Screening
222 Advocating for a Centralized Medicare Enrollment Platform to Preserve Patient Choice Between Traditional Medicare and Medicare Advantage
223 Ensuring Due Process, Transparency, and Human Clinical Oversight in the Use of Artificial Intelligence for Health Insurance Coverage and Eligibility Determinations
224 Clarity of Signage: Distinguishing Urgent Cares From Emergency Rooms
225 Requiring Periodic Face-to-Face Visits By Board-Certified Specialists Who Delegate Visits to Non-Physician Practitioners for Nursing Home Patients
226 Impact of a Proposed $100,000 H-1B Visa Fee on the NRMP Match, the Physician Workforce, and the U.S. Health Care System
227 Standby Capacity Payments and Health IT for Hospitals in Rural Areas
228 Department of Defense Health Care Investment at Military Bases in Maternity Care Health Professional Shortage Areas
229 Physicians are not Providers
230 Exemption of International Medical Graduates from Presidential Proclamations Restricting Entry into the United States
231 Protecting and Promoting Long Term Care Workforce Amidst Immigration Challenges
232 Banning Flavored Cannabis E-Cigarettes
233 Banning Synthesized, Purified or Derivative Products from Kratom
234 Physician Unity in Advocacy Regarding Physician Reimbursement
235 Establishing Healthcare Monitoring and Accountability in Immigration Detention Facilities
236 Extending and Expanding the AMA Task Force to Preserve the Patient-Physician Relationship to Ensure Access and Regulatory Clarity in Gender-Affirming Care
237 Guaranteed 30-Day Transition Fill of Currently Prescribed Insulin at the Beginning of Each Year Plan
238 Prohibiting the Independent Practice of Medicine by Artificial Intelligence
239 Medicare Administrative Contractor Policy Modification
240 Ending Private Equity Dividend Recapitalization in Healthcare
241 Strengthening Our AMA Efforts Toward CPOM Prohibition
242 Reducing Emergency Department Boarding through Payment Reform
243 Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions
244 Eliminate Administrative Barriers to Appeal Wrongful Denials
245 State Regulation of Non-Preempted “Non-Central Matters” of ERISA Plans—Rutledge v. PCMA
246 Artificial Intelligence Scope of Practice
247 Comprehensive ERISA Reform

248* Medical Staff Oversight of Hospital Augmented Intelligence
249* Bringing Physicians' Voices to the Implementation of AI Prescribers
250* Protecting Resident Physicians with Pending Immigration Status and Ensuring Safe Participation in Professional Activities
251* Minimum Standards for Public Health Leaders
252* Immediate Action to Prevent Further Immigrant Deaths
301 Expanding Resident and Fellow Exposure to Diverse Healthcare Practice Models to Fulfill ACGME Core Competencies
302 Excessive Cost of Multi-State DEA Licensure
303 Allowing Options for Certification Maintenance
304 Increasing the Use of Retired Physicians in Teaching Students and Residents
305 Leadership by Physicians for Physicians in Graduate Medical Education (GME)
306 Competency-Based Portfolio Assessment of Medical Students, Interns, Residents, and Fellows
307 Recognizing Advocacy as a Component of Faculty Appointment and Promotion in Academic Medicine
308 Impact of Federal and State Restrictive Actions on Gender-Affirming Care on Medical Education and Physician Workforce Development
309 Osteoporosis Education, Awareness, and Musculoskeletal Health Optimization
310 Increasing Capacity and Access to Maternal Health Services in Rural Areas
311 Changing the Paradigm of Medical Student Debt to address the Geriatric Physician Shortfall
312 Advocating for Equitable Application Review in a Single Match System
313 Evaluation of Situational Judgement Tests in Medical School Admissions
314 Promoting Sex- and Gender-Inclusive Diagnostic Practices, Language, and Patient Education
315 Expanding the Native Hawaiian Health Scholarship Program Eligibility
316 Addressing Transitions Within GME Regarding Orientation Standards
317 Support for Intern, Resident, and Fellow Jeopardy Pay and Additional Compensation for Gaps in Trainee Coverage
401 Partnership with the Administration to Reduce Harmful Chemicals in Food and Align with European Safety Standards
402 Strengthening Public Health Protections Against Raw Milk–Associated Illness
403 AMA’s continued support for COVID-19 vaccination in pregnant individuals and children
404 Develop Climate-Conscious Resources for Physicians
405 Studying the Environmental Impact of Ambient Clinical Intelligence Use
406 Reduce Environmental Impact of Medical Journals
407 Colorectal Cancer in Alaskan Native Patients
408 Addressing Rural Maternal Morbidity and Mortality through Collaboration and Intersectionality
409 Eliminate PFAS and Glyphosate in our Food and Environment
410 Light Pollution
411 Addressing the Myopia Epidemic, Public Education, and Insurance Coverage for Evidence-Based Myopia Control
412 Guiding Principles of Pandemic Prevention, Preparedness and Response
413 Erosion of the Public Evidence Base for Health Policy
414 Restoring Balanced Scientific Perspective within the ACIP
415 Advocacy for Restoration of the Endangerment Finding Regarding Greenhouse Gas Emissions
416 Clinical Laboratory Workforce Shortage and Sustainability
417 Respiratory Protection for Wildland Firefighters

418 Ensuring Access to Full HIV Post-Exposure Prophylaxis (PEP) Courses for Survivors of Sexual Assault
419 Examining the Impact of Circadian Disruption from Shift Work During Pregnancy
420 Expanding Support for Women Experiencing Homelessness
421 Improving Access to Care and Support for Patients with Inflammatory Bowel Disease in the United States
422 Expanding Access to High Resolution Anoscopy
423 Expanding Access to HIV Pre-Exposure Prophylaxis (PrEP)
424 Supporting Education and Access to Postexposure Doxycycline (DoxyPEP)
425 Prioritizing, Measuring, and Preventing Workplace Violence in Health Care
426 Integrating Nutrition into Health Care Delivery to Reduce Cardiovascular Risk and Food Insecurity ("Food is Medicine")
427 Infant Feeding Options for HIV-Seropositive Individuals
428 Protecting Environmental Health Before, During, and After War
429 Adolescent Dating Violence Comprehensive Screening Tool Development
430 Support Heavy Metal and Toxic Exposure Testing for Residents Affected by Wildfires
431 Supporting Transportation Infrastructure Reform for Public Health
432 Addressing Public Health Risks of Online Sports Betting
433 Addressing the Epidemic of Fragility Fractures Through Improved Osteoporosis Screening and Treatment
434 Vaccinations in Physician Offices
435* Supporting Regulations for More Stringent Safety Measures for Micromobility
436* Protecting Children from Potential Harms of Caffeinated Products
501 Preregistration in Medical Research
502 Support for Rapid Methadone Inpatient Stabilization and Linkage to Care
503 Expansion of Psychedelic Assisted Therapy (PAT)
504 Strengthening U.S. Rubber Glove Production and Purchase While Reducing Foreign Forced-Labor Dependence
505 Avoiding misuse of artificial intelligence (AI) in clinical practice
506 Access To Gender Affirming Healthcare Including Clinical Trials
507 Pairing Behavioral and Lifestyle Medicine Principles and Practice with Glucagon-like Peptide-1 (GLP-1) Receptor Agonists and Other Anti-obesity Medications
508 Aligning Consistency and Credibility Of Direct-To-Consumer Gut Microbiome Testing Services
509 Preserving Gender-Affirming Surgical Care Access
510 Exosome and Peptide Use in Healthcare
511 Preserving Specialty Access to Anti-Cancer Agents
512 Medical Cannabis Use in Older Adults
513 Access, Affordability, and Safety of GLP-1 Receptor Agonists
514 Education, Screening, and Effective Treatment for Obstructive Sleep Apnea During Pregnancy
515 Transparency in AI-Driven Adverse Determinations & Clinical Logic Disclosure
516 FDA Regulation of Unapproved Synthetic Peptides
601 Board Chair Term Limits
602 Protection of Healthcare and Humanitarian Aid Personnel in Conflict Zones
603 Establish AMA Policy and Project to Compile and Distribute JAMA Patient Pages to Enhance Public Medical Literacy

604 Annual Scorecard to Evaluate the AMA's Impact
605 Review of Past Resolutions
606 Further Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations
607 Shortening the AMA House of Delegates Endorsement Process and Timeline
608 Reinstitution of AMA Guides Editorial Panel
609 American Medical Association Board Chair Term Limits
610 Plant-Based Diets at AMA meetings
611 Publicizing, Supporting, and Promoting (Appropriate) AMA Member Physicians and Physician Spouses as Candidates for Local and State Offices
612 Increasing Expert Guidance in AMA Statements
613 Preserving Institutional Equity and Inclusivity Efforts
614 Inclusive Policy Language for Older Adults
615 Condemnation of Attacks on Healthcare Workers and Facilities in Gaza
616 Humanitarian and Medical Aid Support to Palestine
617 Reevaluation of AMA Policy Regarding Support for Specific National Medical Associations in the World Medical Association
618 Ending AMA Investment in Weapons Manufacturers
619* Opposing Federal Immigration Operations at AMA Events and Harm to Lawful Non-Target Individuals
620* Survey of Medical Staffs
701 The Crisis in the Availability of Primary Care: Halt the Required Participation of Small Practices in Value-Based Payment (VBP) Models
702 Physicians Who Do Not Practice in Hospital Setting
703 Parity in Pricing for Anti-Obesity Medications
704 Advocating Against Automatic Refill Requests
705 Recognizing Physicians as Sexual Assault Forensic Examiners
706 Discharge Summaries from Skilled Nursing Facilities
707 Malpractice Insurance for Employed Physicians
708 Oppose Imposition of Fees on Physicians for Electronic Payment Transfers
709 Requiring Transparency and Accountability When Insurers and Third-Party Administrators Require Utilization Review, Thereby Practicing Medicine
710 Parity in Access to Evidence-Based Obesity Treatment
711 Oppose Denials Based on Origin of Referral
712 Addressing the Commoditization of Medicine Through Recognition of the Full Scope of Physician Work and Contributions
713 Reducing Prior Authorization Delays to Improve Access to Neuromodulation and Non-Opioid Pain Therapies
714 Physician Case Log Portability
715 Oppose the Legal Position that Virtual Credit Cards are a Legal Method of Payment under HIPAA
716 Equal Opportunity for Payment for "On Call" Duty
717 Advocacy for a Failure-Proof National Centralized Electronic Transaction Clearinghouse

*Contained in Meeting Tote

Report of the AMPAC Board of Directors

Presented by: John W. Poole, MD
AMPAC Chair

On behalf of the AMPAC Board of Directors, I am pleased to present this report to the House of Delegates regarding our activities this election cycle. As AMPAC marks its 65th anniversary in 2026, our profession continues to face multiple challenges in healthcare policy that will directly impact our practices and our patients. AMPAC will help our profession, and our patients, meet those challenges. We remain committed to our core mission—to provide physicians with opportunities to support physician-friendly candidates who will help advance an advocacy agenda that protects our profession and our patients. In addition, we continue to help physician advocates grow their abilities through our political education programs, which include intensive training sessions that provide them with the tools necessary to successfully take the next step and work on campaigns or run for office themselves.

AMPAC Membership Fundraising

AMPAC celebrates its 65th anniversary, marking more than six decades of advocacy for physicians and patients. This milestone year is accompanied by continued growth, with total receipts through May 20 reaching $1.78 million, a 30 percent increase over the same point in the last cycle, driven by a 35 percent increase in hard dollar contributions. This increase reflects expanded educational campaigns, enhanced digital and peer-to-peer outreach and quarterly newsletters that help broaden participation and sustain fundraising momentum. Capitol Club membership remains strong, with 555 members, including 71 Diamond-level contributors. Together, these efforts are strengthening engagement and positioning AMPAC for continued success throughout this anniversary year.

Thank you to those members who have already supported AMPAC this year. AMPAC continues to prioritize House of Delegates engagement, where participation currently stands at 30 percent. Our goal is to achieve 100% HOD participation in AMPAC. To further strengthen HOD involvement, AMPAC is launching a new AMPAC Leadership Cup, designed to encourage state delegation participation. This friendly competition places state delegations head-to-head in groups based on delegate counts, including alternate delegates as well as student and resident delegates and alternates. One AMPAC Leadership Cup trophy will be awarded per group. So, help energize your delegation and stand out within the HOD—all while earning official bragging rights at the AMA Interim Meeting with your state's name engraved on the AMPAC Leadership Cup trophy! We will also debut a Leadership Cup competition for councils at this meeting and plan to include specialty societies in the future.

Finally, as part of this milestone anniversary year, AMPAC will host two signature events at the Annual Meeting on Sunday, June 7. The Capitol Club Luncheon will feature Pulitzer Prize–winning author and historian Rick Atkinson, who will offer a compelling perspective on our nation's Founding Fathers and their continued relevance today. That evening, AMPAC's 65th Anniversary Rock 'n Roll Reception will bring all 2026 AMPAC members together for a celebration with live music, food, and drink with special recognition and exclusive experiences for Capitol Club Diamond members. Don't miss the opportunity to be part of this celebration and help amplify medicine's voice in 2026! Renew your support or join AMPAC today to take part in these exciting events by stopping by the AMPAC Booth located outside the HOD business session meeting room or by visiting: AMPAConline.org

Political Action

This election cycle presents a rare combination of volatility and opportunity for organized medicine. With narrow congressional margins, widespread member departures, and ongoing redistricting, AMPAC is strategically positioned to engage and elect medicine-friendly candidates who will help shape the next Congress.

As of May 28, 70 members of Congress are not seeking re-election or have already lost their primary elections—the second-highest level of turnover in the last century. The Senate could see as many as 16 departures, while the House is expected to lose more than 57 members. AMPAC is closely tracking these developments, along with redistricting activity in several states and more than 85 physicians considering federal office this cycle.

In this challenging political environment, AMPAC is strategically targeting open-seat opportunities, viable physician candidates, and medicine-friendly incumbents to strengthen organized medicine's influence in the next Congress. With bipartisan momentum building around issues such as prior authorization and Medicare physician payment reform, these investments are creating critical opportunities to engage the policymakers best positioned to advance medicine's priorities.

AMPAC has already invested more than $1 million in the 2026 cycle, including two independent expenditure campaigns in competitive primary elections supporting Richard Pan, MD (CA-06), and Tina Shah, MD (NJ-07). With fewer than 150 days until the general election, AMPAC's political activity will continue to accelerate.

Political Education Programs

The 2026 Candidate Workshop took place, April 17-19, at the AMA offices in Washington, DC. Interest in the program remains strong with 23 registrants and 18 participants. This included: 11 member physicians, two non-member physicians, one state staff and four member residents and students.

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

Promotion is currently underway for the 2026 Campaign School. The program will take place September 10-13 at the AMA offices in Washington, DC. As always, the political education programs remain a member benefit with registration fees heavily discounted for AMA members. Future program dates will be announced on AMPAConline.org.

Conclusion

On behalf of the AMPAC Board of Directors, I extend our sincere appreciation to members of the House of Delegates who continue to support AMPAC and our mission. As AMPAC marks its 65th anniversary, your active involvement in both political and grassroots advocacy is especially meaningful and essential to amplifying the voice of organized medicine on Capitol Hill. Your dedication not only helps shape sound health care policy but also ensures that the interests of physicians and patients remain front and center in Washington, DC.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (A-26)

Haddon Christopher Alexander, MD

Introduced by: Virginia

Whereas, Dr. Haddon Christopher Alexander III, a distinguished physician, educator, and leader in organized medicine, passed away peacefully on June 24, 2025, at the age of 92; and

Whereas, Dr. Alexander devoted his life to the practice of medicine, earning his undergraduate degree from Washington and Lee University and his medical degree from the University of Virginia School of Medicine. He completed his residency training at the University of Alabama, thereby beginning a lifelong commitment to excellence in patient care and medical education; and

Whereas, he honorably served his country as a Captain in the United States Air Force during the Vietnam War era, exemplifying dedication to both his nation and his profession; and

Whereas, Dr. Alexander was an astute clinician, practicing rheumatology in Roanoke, Virginia, for over 30 years until January 2000 and continuing to receive calls from grateful patients long after retirement; and

Whereas, Dr. Alexander was a respected member of the medical community, serving as a Fellow of the American College of Physicians and a Master of the American College of Rheumatology, reflecting the highest standards of professional achievement; and

Whereas, his leadership extended to organized medicine through his service as president of the Medical Society of Virginia in 1982 and as an active member of the Virginia Delegation to the American Medical Association. He would go on to be elected to serve on the AMA's Council on Medical Service and numerous AMA committees and panels, where he contributed meaningfully to advancing healthcare policy and patient care; and

Whereas, Dr. Alexander also dedicated himself to the education of future physicians, holding faculty appointments including Clinical Professor of Medicine at the University of Virginia School of Medicine, where he mentored countless students and trainees and went on to serve on the UVA Health System Board for 4 years; and

Whereas, Dr. Alexander continued to serve his profession after retirement by serving as a Social Security Disability case reviewer for several states, helping patients access support for rheumatological conditions from 2000 until 2020; and

Whereas, Dr. Alexander was elected to the American College of Physicians and as a Master of the American College of Rheumatology. In recognition of his outstanding service to patients and the medical profession, he was awarded the prestigious Paulding Phelps Award by the American College of Rheumatology in 1997; and

Whereas, he was preceded in death by his wife, Mary Alexander, and his parents, Haddon C. Alexander, Jr., M.D., and Judith Watson Alexander. He is survived by his children, Susan

Campbell Alexander of Bern, Switzerland, H. Christopher Alexander IV of Egg Harbor, WI, and Margaret Alexander Johnson of Richmond; and his grandchildren, Sophie Lynn Johnson, Mary Lucille Johnson and Evelyn Lee Alexander; therefore be it

RESOLVED, that our American Medical Association recognize Dr. Haddon Christopher Alexander's passing with a moment of silence; and be it further

RESOLVED, that our AMA record this resolution in the minutes and a copy of this resolution be sent to the family of Dr. Haddon Christopher Alexander.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (A-26)

David E.J. Bazzo, MD

Introduced by: California

Whereas, the American Medical Association lost a respected and beloved member when Dr. David E. J. Bazzo, MD, passed away on June 28, 2025; and

Whereas, Dr. Bazzo served as an active member of the San Diego County Medical Society (SDCMS) and the California Medical Association (CMA) for 31 years; and

Whereas, Dr. Bazzo earned his MD at the Rosalind Franklin University of Health Sciences/The Chicago Medical School in 1990, trained in Family Medicine at the University of California San Diego, and followed that with a Sports Medicine fellowship, and a UCSD Faculty Development fellowship; and

Whereas, Dr. Bazzo provided primary care for people in the San Diego community, as well as sports medicine for a wide variety of patients, including elite athletes on the U.S. Olympic team, the San Diego Chargers, the San Diego Seals, and the U.S. Open; and

Whereas, Dr. Bazzo devoted many hours to the medical students and physicians trainees at the University of California San Diego as a Clinical Professor of Family Medicine and also helped physicians through his many roles at UCSD, including Director of the UCSD Physician Assessment and Clinical Education (PACE) Program and Chief Medical Officer of the Physician Retraining and Re-Entry Program; and

Whereas, Dr. Bazzo shared his talents and gifts by serving in many leadership roles for the San Diego County Medical Society, including as President and Chair of the SDCMS Physician Wellness Committee; and

Whereas, Dr. Bazzo was always an example of what a physician should be, and epitomized extraordinary professional competence, dedication, hard work, and community involvement; and

Whereas, Dr. Bazzo's dedication to medicine and the medical profession, and love and devotion for his family and friends, were the benchmark of his life; and

Whereas, he was a friend to all and a mentor to many; therefore be it

RESOLVED, that our American Medical Association recognizes with great admiration and appreciation the outstanding contributions made by Dr. David E.J. Bazzo, MD to the medical profession, his associations, his colleagues, his community, his patients, and extends its sincerest condolences to his family and friends; and be it further

RESOLVED, that our American Medical Association recognize Dr. David E.J. Bazzo's passing with a moment of silence; and be it further

RESOLVED, that our AMA convey this resolution and its deepest sympathy to the family members of Dr. David E.J. Bazzo, MD, and record this resolution in the minutes and a copy of this resolution be sent to the family of Dr. David E.J. Bazzo, MD.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (A-26)

Russell Dougherty Evett, MD

Introduced by: Virginia

Whereas, Dr. Russell Dougherty Evett, a respected physician, leader, and devoted member of his community, passed away peacefully on October 23, 2025, at the age of 93, surrounded by his loving family; and

Whereas, Dr. Evett was born in Norfolk, Virginia, and pursued a life of academic excellence, graduating from Randolph-Macon College, where he was inducted into Phi Beta Kappa, and later earning his medical degree from the Medical College of Virginia; and

Whereas, he honorably served his country as a General Medical Officer in the United States Navy aboard the USS Boxer, demonstrating a lifelong commitment to service; and

Whereas, Dr. Evett completed his residency in internal medicine at the Mayo Clinic and went on to become a founding member of Consultants in Internal Medicine, dedicating more than three decades to the practice of medicine in Norfolk, Virginia, where he viewed caring for patients as both a privilege and a sacred responsibility; and

Whereas, throughout his distinguished career, he provided exceptional leadership, serving as President of the Medical Staff at Leigh Memorial Hospital, Chairman of the Internal Medicine Department at Norfolk General Hospital, and as an Associate Professor of Medicine at Eastern Virginia Medical School, shaping future generations of physicians; and

Whereas, Dr. Evett's commitment to advancing the medical profession extended beyond clinical practice, serving as President of the Medical Society of Virginia, as well as Delegate to the Medical Society of Virginia, Virginia Delegate to the American Medical Association, and participation on numerous boards dedicated to improving healthcare and community well-being; and

Whereas, in retirement, Dr. Evett served as Chairman of the Community Services Board for Norfolk, as a member on the Board of Directors of the Virginia Health Information Board, and served on the Medical College of Virginia Foundation. His contributions were recognized with numerous honors, including the prestigious Laureate Award and fellowship in the American College of Physicians; and

Whereas, Dr. Evett was a man of deep faith and service, remaining an active member of Ghent United Methodist Church, where he contributed his time and talents, including many years in the choir; and

Whereas, Dr. Evett was predeceased by his loving wife of 57 years, Gail Kirby Evett, a son, Stephen Hall Evett, and his twin sister, Margaret Evett Fitch. He is survived by his daughters, Anne Mallonee Bullerjahn and Gail "Dinky" Winn, and his son, John Kirby Evett, and his grandchildren, Andrew Bullerjahn, Peggy Bullerjahn, Virginia Winn, Kendall Winn, Anna Winn, Kirby Evett, Meg Evett, and Neil Evett; therefore, be it

RESOLVED, that our American Medical Association recognize Dr. Russell Dougherty Evett's passing with a moment of silence; and be it further

RESOLVED, that our AMA record this resolution in the minutes and a copy of this resolution be sent to the family of Dr. Russell Dougherty Evett.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (A-26)

Virginia “Ginny” Ettinger Hall, MD

Introduced by: Pennsylvania, Senior Physician Section

Whereas, Virginia “Ginny” Ettinger Hall, MD, FACOG, FACP, FCPP, a distinguished physician leader and longstanding delegate to the American Medical Association (AMA), passed away on January 27, 2026, at the age of 79; and

Whereas, Dr. Hall’s service to the AMA was marked by sustained engagement, principled leadership, and a deep commitment to organized medicine, including her role as Delegate for the Pennsylvania Medical Society, Chair of AMA Reference Committee 6, and as a member of the AMA Senior Physicians Section (SPS) Governing Council, where she served as a national delegate and advocate for senior physicians; and

Whereas, within the AMA Senior Physicians Section, Dr. Hall was a respected voice for the continued engagement, mentorship, and policy contributions of senior physicians, advancing initiatives that strengthened physician leadership across the professional lifespan and ensured that the experience of senior members informed AMA policy and advocacy; and

Whereas, Dr. Hall’s leadership extended across organized medicine, including service as President of the Dauphin County Medical Society and Trustee of The Foundation of the Pennsylvania Medical Society for 24 years, including nine years as Board Chair, reflecting her sustained commitment to physician governance and institutional stewardship; and

Whereas, born in Lewisburg, Pennsylvania, on December 13, 1946, Dr. Hall rose from humble beginnings to a career defined by service, graduating from Albright College and Hahnemann Medical College (now Drexel University College of Medicine), and becoming board certified in both internal medicine and obstetrics and gynecology; and

Whereas, over a career spanning more than four decades, Dr. Hall combined clinical excellence with academic leadership as a faculty member at Penn State’s Milton S. Hershey Medical Center, achieving the rank of Associate Professor and mentoring generations of physicians; and

Whereas, Dr. Hall’s professional career was distinguished by her dedication to women’s health, particularly in underserved communities, co-founding the Network for Better Healthcare for Women and contributing extensively to education and advocacy in maternal health, patient safety, domestic violence, and public health; and

Whereas, her commitment to global health led to firsthand service, teaching, and system development in countries including India and Sierra Leone, work that was recognized with the 2024 International Voluntary Service Award from the Pennsylvania Medical Society; and

Whereas, even following her retirement in 2018, Dr. Hall remained actively engaged in patient care through volunteer service providing prenatal care to underserved populations, reflecting her enduring commitment to the profession; and

Whereas, Dr. Hall's legacy within the AMA, and particularly within the Senior Physicians Section, is defined by her integrity, mentorship, and steadfast advocacy for physician leadership, patient care, and the values of organized medicine; and

Whereas, she is survived by her husband of 54 years, John B. Hall; her children, Melanie R. Hall and Jonathan C. Hall; her grandson, Evan Graham; her sisters Kathleen Taylor, Sylvia Perry (Doug), and Brenda Pascal; her brothers Kenneth Ettinger, James Ettinger (MaryAnn), and Timothy Ettinger (Pam); her son-in-law Bryan Graham; her sister-in-law Dianne Sanford (Jeb); many nieces and nephews; and was preceded in death by her parents and her brother, Robert A. Ettinger; therefore be it

RESOLVED, that our American Medical Association recognizes with gratitude the life and service of Virginia "Ginny" Ettinger Hall, MD, and honors her enduring contributions to the AMA, including her leadership within the Senior Physicians Section; and be it further

RESOLVED, that our AMA observes a moment of silence in her memory at the 2026 House of Delegates; and be it further

RESOLVED, that our AMA recorded in the minutes of the 2026 House of Delegates and that a copy be sent to the family of Dr. Hall.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (A-26)

Edwin James Harvie, MD

Introduced by: Virginia

Whereas, Dr. Edwin James Harvie, Jr., a distinguished physician, devoted family man, and respected leader in organized medicine, passed away on February 27, 2026, at the age of 93; and

Whereas, Dr. Harvie attended Danville Public Schools and demonstrated early leadership and character as an Eagle Scout, later pursuing his academic and medical education at the University of Virginia, where he earned both his Bachelor of Arts and Doctor of Medicine degrees; and

Whereas, following his internship at Kansas University Medical Center, Dr. Harvie honorably served his country as a Captain in the United States Army Medical Corps, providing care in Korea and at Fort Myer, Virginia; and

Whereas, he completed his residency in internal medicine at North Carolina Baptist Hospital in Winston-Salem, thereafter returning to Danville in 1964 to establish the first partnership of internists in the community, which grew into the highly respected Internal Medicine Associates, Ltd., where he practiced with distinction until his retirement in 2006; and

Whereas, Dr. Harvie was committed to organized medicine, serving with the Danville-Pittsylvania Academy of Medicine, Medical Society of Virginia, American Medical Association, and as a Fellow of the American College of Physicians, receiving its Laureate Award in 1995; and Dr. Harvie actively advocated for physicians, representing the AMA Delegation from 1998 to 2006, and chairing it from 2003 to 2006 with effective leadership and representation; and

Whereas, Dr. Harvie generously gave his time and expertise to his community, notably as a volunteer with the Free Clinic of Danville from 1993 to 2015, serving as Medical Director from 2004 to 2015, and was recognized for his humanitarian service with the Virginia Health Care Foundation’s Unsung Hero Physician Award in 2012; and

Whereas, his commitment to service extended beyond medicine through his leadership as a 50-year member and past president of the Rotary Club of Danville, his involvement with the Danville Concert Association, and his faithful service to his church, including as Senior Warden of the Church of the Epiphany; and

Whereas, his contributions to organized medicine strengthened the voice of physicians and advanced policies that improved the practice of medicine and the health of patients; and

Whereas, Dr. Harvie was devoted to his family, preceded in death by his beloved wife of 65 years, Betty, and his brother, Lewis Edwin Harvie. He is survived by his children, grandchildren, and great-grandchildren, who carry forward his legacy of compassion, service, and excellence; therefore be it

RESOLVED, that our American Medical Association recognize Dr. Edwin James Harvie's passing with a moment of silence; and be it further

RESOLVED, that our AMA record this resolution in the minutes and a copy of this resolution be sent to the family of Dr. Edwin James Harvie.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (A-26)

Leonard J. Morse, MD

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

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Whereas, Leonard J. Morse, MD, a distinguished physician, public health leader, educator, and advocate for medical ethics, passed away on December 12, 2025; and

Whereas, Dr. Morse devoted his professional life to the practice of medicine and public service, exemplifying the highest ideals of professionalism, compassion, and ethical responsibility; and

Whereas, Dr. Morse was a dedicated leader in organized medicine, serving as AMA Delegate President of the Massachusetts Medical Society, and President of the Boston Medical Library, and earning the respect of colleagues at the local, state, and national levels; and

Whereas, Dr. Morse provided significant service to the American Medical Association, including serving as Chair of the AMA Council on Ethical and Judicial Affairs, where he played a critical role in shaping national ethical guidance and policy deliberations for the medical profession; and

Whereas, as an educator and academic physician, Dr. Morse served as Professor of Clinical Medicine at the University of Massachusetts Medical School, mentoring generations of physicians and fostering a commitment to excellence in patient care and ethical practice; and

Whereas, Dr. Morse was a respected public health leader, serving as Commissioner of Public Health for the City of Worcester and contributing to nationally significant public health work, including leadership in the investigation of a major hepatitis A outbreak that informed public health practice and policy; and

Whereas, through his lifelong dedication to medicine, ethics, education, and public service, Dr. Morse made enduring contributions to the medical profession and to the communities he served; therefore be it

RESOLVED, that our American Medical Association express its profound sorrow at the passing of Leonard J. Morse, MD, and extend its deepest sympathies to his family, friends, colleagues, and loved ones; and be it further

RESOLVED, that our AMA honor and recognize the life, service, and legacy of Leonard J. Morse, MD, whose leadership in organized medicine, commitment to medical ethics, and dedication to public health exemplified the values of the medical profession; and be it further

RESOLVED, that our AMA send a copy of this resolution to the family of Leonard J. Morse, MD, as an expression of the respect and gratitude of the American Medical Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (A-26)

Robert W. Panton, MD

Introduced by: Illinois

Whereas, the death of Robert William Panton, M.D., on February 22, 2026, was a profound loss to his family, friends, the state of Illinois, and the medical profession; and

Whereas, Dr. Panton grew up in the Chicago metropolitan area and graduated Oak Park-River Forest High School as the class valedictorian, receiving his undergraduate, master's and medical degrees from Brown University and completing his ophthalmology residency at the University of Illinois Hospital and his fellowship in cornea and cataract surgery at Johns Hopkins Hospital; and

Whereas, Dr. Panton joined his late father, John Panton, M.D., brother Peter Panton, M.D. and sister Elizabeth Panton Karkazis, M.D., in practice in 1991 at the Panton Eye Center, where he and his siblings carried on his father's tradition of compassion and care for 35 years; and

Whereas, he is survived by his wife, Marika; his three children: Jonathan (J.D.), James, and Zoe. He was immensely proud of his family and enjoyed sharing updates on their educational advancements and outside pursuits with his medical friends; and

Whereas, he was very interested in data and policy analysis. He was elected to the Illinois Delegation to the American Medical Association in 2015 as an alternate delegate and as a full delegate in 2019. A longtime AMA supporter, he strived to be part of the solution to the many challenges facing healthcare and enjoyed the debate. He was always eager to volunteer when help was needed and support AMA causes, such as AMPAC; and

Whereas, he was elected ISMS President in 2020, using the platform to advocate for multiple issues, including prior authorization reform, expanded access to telemedicine coverage, and medical liability reform; and

Whereas, during the peak of the COVID-19 crisis, he led with courage, clarity, and resolve, assisting the state in refining the state's pandemic strategy and keeping doctors informed, as well as entertained, with his monthly columns in the ISMS newsletter amid the nation's rapidly evolving understanding of the virus; and

Whereas, Dr. Panton was incredibly generous with his time and resources, supporting ISMS, the AMA and many other organizations and causes. He was especially generous supporting physicians in training to ensure they felt welcome and could access meetings and events; therefore be it

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

RESOLVED, that our AMA record this resolution in the minutes of this meeting and a copy of this resolution be sent to the family of Dr. Robert W. Panton and express its gratitude to them for his years of service to ISMS.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (A-26)

Thomas E. Sullivan, MD

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

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Whereas, Thomas Edward Sullivan, MD, born February 28, 1943, of Beverly, Massachusetts, passed away peacefully on January 19, 2026, at the age of 82; and was a devoted husband, father, brother, and grandfather whose life was defined by service, compassion, and leadership; and

Whereas, Dr. Sullivan was a board-certified specialist in cardiology and internal medicine and maintained a distinguished clinical practice for more than 37 years on the North Shore of Massachusetts, where he was widely respected for his clinical skill and humanity toward patients and colleagues; and

Whereas, Dr. Sullivan was a visionary leader in healthcare information technology, serving over 20 years at Dr First — including as Chief Strategy Officer and Chief Privacy Officer from 2004 to 2022, and later as Senior Advisor for Clinical Innovation & Vendor Strategy — helping shape national standards for interoperability and clinical summaries; and

Whereas, he served as President of the Massachusetts Medical Society (MMS) from 2003 to 2004, during which time the MMS became one of the first state medical societies to endorse e-prescribing, demonstrating his early leadership in advancing clinical technology for patient safety; and

Whereas, his extensive leadership within the MMS included long-term service as a delegate and alternate to the MMS House of Delegates, former chair/vice chair of the New England delegation, and vice chair of MMS' Committee on Senior Physicians in 2023; and

Whereas, Dr. Sullivan's national engagement in organized medicine included service to the American Medical Association, including roles as a founding chair of the AMA e-Medicine Advisory Committee, past Chair of the AMA Council on Medical Service; and

Whereas, Dr. Sullivan served admirably as Alternate Delegate for the Senior Physician Section during Covid, applying his wisdom and experience gained from leading the MMS, AMA CMS, and MMS Committee on Senior Physicians to advance the goals of the AMA SPS, resulting in passage of many resolutions of importance to seniors and to the profession; and

Whereas, he served his country as a Lieutenant Commander in the United States Navy, bringing honor and commitment to military and clinical care; and

Whereas, he was widely acknowledged as the "Father of the Continuity of Care Record (CCR)", architecting an ASTM standard that became foundational for Meaningful Use clinical summaries and interoperability in health IT; and

Whereas, beyond his professional achievements, Dr. Sullivan was known for his deep faith, scholarly curiosity, love of family, and interests in sailing, gardening, astronomy, and innovation; therefore be it

RESOLVED, that our American Medical Association honors the life, legacy, and extraordinary contributions of Thomas E. Sullivan, MD, whose leadership in clinical medicine, medical society governance, and health information technology advanced the art and science of medical practice; and be it further

RESOLVED, that our AMA extends its heartfelt condolences to Dr. Sullivan's family, friends, and professional colleagues, acknowledging his profound impact on physicians and patients alike; and be it further

RESOLVED, that our AMA record this memorial tribute into the official proceedings of the AMA and transmit a copy to his family as a testament to his enduring legacy.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (A-26)

Kenneth Douglas Tuck, MD

Introduced by: Virginia

Whereas, Dr. Kenneth Douglas Tuck, a distinguished physician, devoted community leader, and beloved family man, passed away peacefully on March 31, 2026, at the age of 94, surrounded by his family in Moneta, Virginia; and

Whereas, born on March 20, 1932, in Moneta, Virginia, Dr. Tuck developed a lifelong work ethic rooted in his upbringing on a family farm, where perseverance, discipline, and humility shaped his character; and

Whereas, he pursued education with determination, becoming the first in his family to attend college, graduating from Maryville College, and earning his medical degree from the University of Virginia School of Medicine, ultimately fulfilling his dream of becoming a physician; and

Whereas, Dr. Tuck dedicated more than five decades to the practice of ophthalmology, providing compassionate, high-quality care to countless patients and advancing the field through leadership and service; and

Whereas , Dr. Tuck's distinguished career included serving as President, Foundation President, and PAC Board Chair of the Medical Society of Virginia, as well as Delegate to the Medical Society of Virginia and, for 17 years, Virginia Delegate to the American Medical Association. He also served as an AMPAC Board member for the American Medical Association, President of the American Academy of Ophthalmology, and President of the Virginia Society of Eye Physicians and Surgeons, reflecting his profound impact on medicine at both the state and national levels; and

Whereas, Dr. Tuck personally supported, encouraged and mentored generations of MSV leaders, including at least three presidents, and many other leaders with his enthusiasm and political insights, reminding them of their duty of service to the profession; and

Whereas, beyond his clinical practice, Dr. Tuck was deeply committed to service, volunteering extensively, mentoring physicians globally, and working tirelessly to combat preventable blindness, embodying a lifelong mission to improve the lives of others; and

Whereas, his contributions extended to numerous civic and charitable organizations, including Rotary International—where he received its highest honor, the "Service Above Self Award"—as well as leadership roles supporting education, music, and community health initiatives; and

Whereas, even in retirement, Dr. Tuck continued to serve his community through volunteer work at free clinics, demonstrating his unwavering dedication to caring for those in need; and

Whereas, he is survived by his beloved wife of 67 years, Sara Kathryn Tuck, his three daughters, numerous grandchildren and great-grandchildren, and a legacy of love, service, and integrity that will endure for generations; therefore be it

RESOLVED, that our American Medical Association recognize Dr. Kenneth Douglas Tuck's passing with a moment of silence; and be it further

RESOLVED, that our AMA record this resolution in the minutes and a copy of this resolution be sent to the family of Dr. Kenneth Douglas Tuck.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Supplementary Report of Committee on Rules and Credentials
Saturday, June 6, 2026

Madam Speaker, Members of the House of Delegates:

The Committee on Rules and Credentials met Friday, June 5, to discuss Late Resolutions. The sponsors of the late resolutions met with the committee and were given the opportunity to present for the committee's consideration the reason the resolution could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting.

Recommended for acceptance:

- Late 1001 – Addressing Housing Needs of the Native Hawaiian and their Diaspora
- Late 1002 – Preserving and Strengthening Maternal Mortality Review Committees
- Late 1003 – Taking Action on Deaths in Custody
- Late 1004 – Protection of Medicaid Beneficiaries from Politically Motivated and Procedurally Deficient Federal Funding Deferrals
- Late 1005 – Age Verification and ENDS Products
- Late 1006 – OMB Proposed Rule: Regulation for Federal Financial Assistance

Madam Speaker, this concludes the Supplementary Report of the Committee on Rules and Credentials. I would like to thank Mark Bair, MD, RPh; Kathleen Doo, MD; Robert Gibbs, MD; Christopher Gribbin, MD; Tochi Iroku-Malize, MD; Jason Jameson, MD; and on behalf of the committee those who appeared before the committee.

Mark Bair, MD, RPh
Utah

Kathleen Doo, MD
Society of Critical Care Medicine

Deborah Fuller, MD, Chair*
Texas

Robert Gibbs, MD
Kansas

Christopher Gribbin, MD
New Jersey

Tochi Iroku-Malize, MD
American Academy of Family Physicians

Jason Jameson, MD
American Urological Association

*Alternate Delegate

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1001
(A-26)

Introduced by: Underrepresented in Medicine Advocacy Section, Medical Student Section

Subject: Addressing Housing Needs of the Native Hawaiian and their Diaspora

Referred to: Reference Committee D

Whereas, Hawaii is ranked as the second-highest state in the U.S. for rate of homelessness;[1-3] and

Whereas, according to the Office of Hawaiian Affairs, more Native Hawaiians now reside on the U.S. continent than in Hawai‘i itself;[4] and

Whereas, Native Hawaiians and Pacific Islanders have the highest rates of homelessness compared to any other racial group, at a rate of 121 out of every 10,000 people;[5] and

Whereas, Native Hawaiian diaspora communities on the continental United States experience significant housing insecurity and discrimination, contributing to increased rates of chronic illness, mental health stressors, and cultural disconnection;[6,7] and

Whereas, Native Hawaiian leaders and advocates have emphasized that housing solutions must be developed in partnership with Native organizations to rebuild trust, promote cultural safety, and ensure community-defined priorities are respected;[8] and

Whereas, mistrust of government institutions has been shown to worsen health disparities by discouraging Indigenous communities from engaging with federal and state programs, including housing and healthcare;[9,10] and

Whereas, the Native American Housing Assistance and Self-Determination Act (NAHASDA) consolidated federal housing grant allocation to federally recognized tribes, created the Indian Housing Block Grant program, and offered tribal autonomy by allowing tribes to develop their own “Indian Housing Plans” to address financial needs;[11-14] and

Whereas, despite the beneficial effects of NAHASDA, Native Hawaiians do not have federally recognized sovereign states as federally recognized tribes do;[14] and

Whereas, NAHASDA has been effective for Native Hawaiian housing programs, though at a scale far smaller than federal housing programs for federally recognized tribes;[12] and

Whereas, due to lack of sovereignty, funds allocated to NAHASDA programs are channeled through the Department of Hawaiian Home Lands (DHHL) rather than to any Native Hawaiian government, which has been criticized for inefficiency;[11,12, 15] and

Whereas, the blood quantum requirement severely limits eligibility for Native Hawaiian housing assistance, has been recognized as a colonial strategy that undermines sovereignty, and Native Hawaiian organizations have called for self-determined criteria instead;[16,17] and

Whereas, various Native Hawaiian organizations have called for a re-defining of “blood quantum” to be inclusive of more individuals and as a way to establish some level of sovereignty for tribal affairs, culture, and identity[18,19]; therefore be it

RESOLVED, that our American Medical Association support federal funding for housing programs, including efforts by the Department of Hawaiian Home Lands (DHHL), that prioritizes tribal self-determination for Indigenous communities and inclusion of Native Hawaiians regardless of geographic location (New HOD Policy); and be it further

RESOLVED, that our AMA recognize Native Hawaiian Organizations as the authoritative bodies for determining Native Hawaiian membership and lineage, and oppose the use of externally imposed criteria, such as blood quantum, to determine eligibility for any form of federal, state, or local assistance. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 04/21/2026

REFERENCES

1. Henry M, Watt R, Mahathey A, Ouellette J, Sitler A. The 2019 Annual Homeless Assessment Report (AHAR) To Congress. The U.S. Department of Housing and Urban Development; 2020:24.
2. Ka Mana O Na Helu. Bridging The Gap Homeless Point-In-Time Count. 2020. https://www.btghawaii.org/media/uploads/2020_btg_pit_count_report_final_-_5.6.20.pdf
3. Census Bureau QuickFacts. 2020. U.S. Census Bureau Quickfacts: Hawaii. https://www.census.gov/quickfacts/HI. Accessed August 30, 2025.
4. New census data confirms more Native Hawaiians reside on the continent than in Hawai‘i. oha.org. Published September 22, 2024. Accessed August 30, 2025. https://www.oha.org/news/new-census-data-more-native-hawaiians-reside-continent/
5. Soucy D, Janes M, Hall A. State of Homelessness: 2024 Edition. National Alliance to End Homelessness. Published August 5, 2024. Accessed August 30, 2025. https://endhomelessness.org/state-of-homelessness/
6. Andersen JA, Willis DE, Kaholokula JK, et al. Experiences of Discrimination Among Native Hawaiians and Pacific Islanders Living in the USA. J Racial Ethn Health Disparities. 2024;11(1):184-191. doi:10.1007/s40615-022-01509-x
7. Morisako AK, Tauali'i M, Ambrose AJH, Withy K. Beyond the Ability to Pay: The Health Status of Native Hawaiians and Other Pacific Islanders in Relationship to Health Insurance. Hawaii J Med Public Health. 2017;76(3 Suppl 1):36-41.
8. Addressing Native Homelessness with Culturally Appropriate Housing | Data-Smart City Solutions. February 16, 2024. Accessed August 30, 2025. https://datasmart.hks.harvard.edu/addressing-native-homelessness-culturally-appropriate-housing
9. Gardner, Betsy. n.d. “Addressing Native Homelessness with Culturally Appropriate Housing.” Accessed August 30, 2025. https://datasmart.hks.harvard.edu/addressing-native-homelessness-culturally-appropriate-housing.
10. National Collaborating Centre for Indigenous Health. Access to Health Services as a Social Determinant of First Nations, Inuit and Métis Health. Prince George, BC: National Collaborating Centre for Indigenous Health; 2019. Accessed August 30, 2025.
11. Espinoza, S., & Orbach, R. (2024, November 15). Meeting the housing needs of Native communities. Bipartisan Policy Center. https://bipartisanpolicy.org/blog/meeting-the-housing-needs-of-nativecommunities/#:~:text=The%20eligible%20activities%20for%20NHHBG,and%20rehabilitated%20only%20765%20homes.
12. National Low Income Housing Coalition. (2025, January 21). Hud announces Indian Housing Block Grant Competitive Awards for 32 tribal communities. https://nlihc.org/resource/hud-announces-indian-housing-block-grant-competitive awards-32-tribalcommunities#:~:text=Funding%20for%20the%20IHBG%20program,and%20descriptions%20of%20projects%20here
13. S. Rept. 112-251 - TO EXPRESS THE POLICY OF THE UNITED STATES REGARDING THE UNITED STATES RELATIONSHIP WITH NATIVE HAWAIIANS AND TO PROVIDE PARITY AND A PROCESS FOR THE RECOGNITION BY THE UNITED STATES OF THE NATIVE HAWAIIAN GOVERNING ENTITY. (2025, April 6). https://www.congress.gov/congressional-report/112th-congress/senate-report/251/1
14. Department of Hawaiian Home Lands. (n.d.). Hawaiian Homes Commission act. Hawaii.govhttps://dhhl.hawaii.gov/hhc/laws-and-rules/
15. Perez, R., & Philip, A. (2020, December 19). The government promised to return ancestral Hawaiian land, then never finished the job. ProPublica. https://www.propublica.org/article/the-government-promised-to-return-ancestral-hawaiian-land-then-never-finished the-job
16. Hill, M., Rule, E., Doerfler, J., & Galanda, G. (2024, October 24). Blood quantum and sovereignty: A guide. Native Governance Center. https://nativegov.org/resources/blood-quantum-and-sovereignty-a-guide/
17. Kauanui, J.K., Hawaiian Blood: Colonialism and the Politics of Sovereignty and Indigeneity (Duke University Press, 2008)

18. Rice K. Blood quantum and its role in Native identity. The Indigenous Foundation. July 26, 2022. Accessed September 20, 2025. https://www.theindigenousfoundation.org/articles/bloodquantum.
19. Blood quantum and sovereignty: A guide. Native Governance Center. October 24, 2024. Accessed September 20, 2025. https://nativegov.org/resources/blood-quantum-and-sovereignty-a-guide/.

RELEVANT AMA POLICY

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

1. Our American Medical Association recommends that all individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens.
2. Our AMA recommends that the federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives.
3. Our AMA recommends that state and local governments give special attention to the health and health-related needs of nonreservation American Indians and Alaska Natives in an effort to improve their quality of life.
4. Our AMA recommends that American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
5. Our AMA recognizes practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives.
6. Our AMA monitors Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care.
7. Our AMA supports consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs.
8. Our AMA recommends strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
9. Our AMA recommends a team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
10. Our AMA will continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
11. Our AMA recommends that state and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside.
12. Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian and Alaska Native health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians and Alaska Natives.
13. Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

[CLRPD Rep. 3 I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09 A-23; Modified: CMS Rep. 03, A-24; Reaffirmed: Res. 244, A-24]

H-160.903 Eradicating Homelessness

1. Our American Medical Association supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services.
2. Our AMA recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless.

3. Our AMA recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis.
4. Our AMA supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance.
5. Our AMA recognizes the need for an effective, evidence-based national plan to eradicate homelessness.
6. Our AMA encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.
7. Our AMA will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs.
8. Our AMA encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital.
9. Our AMA encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients.
10. Our AMA:
    a. supports laws protecting the civil and human rights of individuals experiencing homelessness, and
    b. opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available.
11. Our AMA recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.
12. Our AMA:
    a. supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties;
    b. supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and
    c. will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.
13. Our AMA encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1002
(A-26)

Introduced by: Underrepresented in Medicine Advocacy Section

Subject: Preserving and Strengthening Maternal Mortality Review Committees

Referred to: Reference Committee D

Whereas, the United States faces a maternal health crisis representing the highest maternal mortality rate among high-income nations;[1] and

Whereas, stark racial disparities persist with Black women experiencing maternal mortality at 2.6 times the rate of White women and rural women facing nearly double the risk compared to urban women;[2,3] and

Whereas, the Centers for Disease Control and Prevention (CDC) estimates that 80% of maternal deaths are preventable through timely medical intervention, comprehensive data collection, and implementation of evidence-based recommendations;[4] and

Whereas, Maternal Mortality Review Committees (MMRCs) represent the "gold standard" for understanding the circumstances surrounding maternal deaths through comprehensive, confidential, multidisciplinary case review that examines clinical, social, and systemic factors contributing to each death;[5] and

Whereas, MMRCs exist in nearly all 50 states and territories, conducting detailed reviews that identify preventable factors and generate actionable recommendations to save lives; and

Whereas, MMRCs provide critical data that vital statistics and hospital reporting systems alone cannot capture, including information about social determinants of health, healthcare access barriers, quality of care issues, and systemic racism as contributing factors to maternal mortality;[6] and

Whereas, MMRC findings have directly informed successful, actionable state-level interventions, such as Texas MMRC findings led to extending Medicaid postpartum coverage to 12 months, California's comprehensive quality improvement initiatives that reduced maternal mortality by approximately 50% through implementation of MMRC recommendations, and ensuring hospital adopt best practices on OB emergencies, hemorrhage, and cardiac conditions;[7] and

Whereas, the federal Preventing Maternal Deaths Act was reauthorized 2025 providing crucial support for state MMRCs through the CDC's ERASE MM (Enhancing Reviews and Surveillance to Eliminate Maternal Mortality) program, providing funding, technical assistance, and standardized data collection tools;[8] and

Whereas, MMRCs face unprecedented threats in the current polarized climate, with multiple states experiencing interference, funding cuts, and dismantlement of committees, including:

1. Georgia dismissing all 32 MMRC members in November 2024 following public reporting of preventable deaths linked to abortion restrictions, with the reconstituted committee's membership now kept secret;
2. Idaho allowing its MMRC to sunset in July 2023 following opposition to the committee's recommendation for postpartum Medicaid expansion, leaving the state without maternal death review for over a year despite having one of the highest maternal mortality rates in the nation;
3. Arkansas creating a parallel governor-appointed advisory committee in March 2024 after the state MMRC recommended postpartum Medicaid expansion, potentially undermining the independence of evidence-based recommendations;[9-12] and

Whereas, MMRCs require specific protections to function effectively, including:

1. Statutory authority to access all relevant medical records and death investigation reports;
2. Confidentiality protections for case information and committee deliberations;
3. Immunity from liability for committee members, witnesses, and information providers;
4. Protection from discovery and subpoena for MMRC discussions and findings;
5. Independence from political interference in member selection, case review, and recommendation development;
6. Adequate and stable funding to support staff, data systems, and committee operations;
7. Diverse, representative membership including community members with lived experience;[13] and

Whereas, MMRCs are only one component of the broader public health infrastructure necessary to address maternal mortality, which also includes:

1. State and local health departments with adequate workforce and resources;
2. Perinatal quality collaboratives that translate MMRC findings into clinical practice improvements;
3. Community-based organizations serving pregnant and postpartum individuals;
4. Data systems for surveillance, reporting, and evaluation;
5. Programs addressing social determinants of health affecting maternal outcomes;[14] and

Whereas, the systematic dismantling or political manipulation of MMRCs represents a direct threat to data-driven governance, scientific integrity, and ultimately to the lives of pregnant and postpartum individuals, particularly Black, Indigenous, rural, and low-income women who already face the highest mortality risks;[15,16] therefore be it

RESOLVED, that our American Medical Association strongly opposes suppression of, or dismantlement of state and local Maternal Mortality Review Committees (MMRCs), including but not limited to: dismissal of committee members in retaliation for findings, refusal to review deaths from specific time periods, exclusion of community representatives, transparent committee membership, selective implementation of recommendations, or any other actions that undermine the independence, transparency, or scientific integrity of maternal mortality review and advocates for continued reauthorization and funding of the Preventing Maternal Deaths Act to support state MMRC (New HOD Policy); and be it further

RESOLVED, that our AMA supports federal legislation establishing minimum standards and protections for state MMRCs, including:

a) Mandatory comprehensive review of all pregnancy-associated deaths (during pregnancy through one year postpartum) regardless of cause
b) Required access to all relevant medical records, death certificates, autopsy reports, and related documentation

c) Confidentiality protections and immunity from liability for committee members and information providers
d) Protection of committee deliberations and findings from discovery in civil or criminal proceedings
e) Requirements for representative, multidisciplinary committee membership including community representatives with personal experience
f) Prohibition on political interference in committee composition, case selection, or recommendation development
g) Timely public reporting of aggregated findings and recommendations while maintaining individual case confidentiality
h) Accountability mechanisms for states that fail to conduct comprehensive, timely maternal death reviews (New HOD Policy);

and be it further

RESOLVED, that our AMA urge Congress to:

a) Require all states use centralized maternal child health surveillance and data systems, such as MMRIA, to ensure consolidated US maternal data
b) Require states to review all pregnancy-associated deaths without exception for specific time periods or circumstances
c) Mandate public disclosure of committee membership composition
d) Establish accountability for states that fail to implement MMRC recommendations without documented justification
e) Create whistleblower protections for MMRC members who report undue influence or data suppression (New HOD Policy);

and be it further

RESOLVED, that our AMA calls upon state medical societies and physician advocates to:

a) Monitor state MMRC activities for signs of interference or funding threats
b) Advocate for state legislation protecting MMRC independence and adequate funding
c) Support MMRC recommendations that lead to quality improvement, reduction in preventable deaths, and address non-medical drivers of health (New HOD Policy);

and be it further

RESOLVED, that our AMA condemn undue interference with state MMRCs. (New HOD Policy)

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

Received: 04/21/2026

REFERENCES

1. Health Affairs, “We Must Protect the Only National Data on Preventable Maternal Deaths” February 2026
2. Centers for Disease Control and Prevention. *Pregnancy Mortality Surveillance System*. Updated 2024. Accessed February 2026.
3. Hoyert DL. *Maternal Mortality Rates in the United States, 2021*. NCHS Health E-Stats. 2023. DOI: 10.15620/cdc:124678.
4. Petersen EE, Davis NL, Goodman D, et al. Vital Signs: Pregnancy-Related Deaths, United States, 2011-2015, and Strategies for Prevention, 13 States, 2013-2017. *MMWR Morb Mortal Wkly Rep*. 2019;68(18):423-429.
5. Building U.S. Capacity to Review and Prevent Maternal Deaths. Report from nine maternal mortality review committees. 2018. Available at: http://reviewtoaction.org/Report_from_Nine_MMRCs
6. Main EK, McCain CL, Morton CH, Holtby S, Lawton ES. Pregnancy-Related Mortality in California: Causes, Characteristics, and Improvement Opportunities. *Obstet Gynecol*. 2015;125(4):938-947.
7. Declercq E, Zephyrin L. Maternal Mortality in the United States: A Primer. Commonwealth Fund. December 2020.
8. Trost SL, Beauregard JL, Chandra G, et al. Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017-2019. CDC. September 2022.
9. ProPublica. "Georgia Dismisses Entire Maternal Mortality Committee After Reports on Abortion Ban Deaths." November 2024.
10. Texas Tribune. "Texas Maternal Mortality Committee Won't Review 2022-2023 Deaths." September 2024.
11. Idaho Capital Sun. "Idaho's Maternal Mortality Review Committee Sunsets as Legislature Fails to Renew." July 2023.
12. Arkansas Advocate. "Gov. Sanders Creates Maternal Health Advisory Committee, Opposes Medicaid Expansion." March 2024.
13. Preventing Maternal Deaths Act of 2018, Pub. L. No. 115-344, 132 Stat. 5047 (2018).
14. H.R. 1706 - Preventing Maternal Deaths Reauthorization Act of 2023. 118th Congress (2023-2024).
15. American College of Obstetricians and Gynecologists. *Committee Opinion No. 662: Emerging Issues in Maternal Health: Deaths, Late Maternal Deaths, and Severe Maternal Morbidity*. Obstet Gynecol. 2016;127:e75-e78.
16. Association of State and Territorial Health Officials. *Maternal Mortality Review Committees: A View from the States*. 2022.

RELEVANT AMA POLICY

H-60.909 State Maternal Mortality Review Committees

1. Our American Medical Association supports the important work of maternal mortality review committees.
2. Our AMA supports work with state and specialty medical societies to advocate for state and federal legislation establishing Maternal Mortality Review Committees.
3. Our AMA supports work with state and specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees.

[Res. 911, I-17; Reaffirmed: Res. 229, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1003
(A-26)

Introduced by: Underrepresented in Medicine Advocacy Section

Subject: Taking Action on Deaths in Custody

Referred to: Reference Committee on Ethics and Bylaws

Whereas, a death in custody is the death of a person in the custody of the police (or other authorities) or in prison. Deaths in custody result both from natural causes and from situations, as studies have shown, where authorities demonstrate abuse, neglect, racism, and cover-ups of the causes of these deaths. Policy changes are needed to reduce custody deaths;[1] and

Whereas, the Death in Custody Reporting Act, 1 (DRCA) enacted in 2013, requires the US attorney general to collect information from states and territories regarding the death of any person who is under arrest, is en route to being incarcerated, or is incarcerated at a municipal or county jail, state prison, or other local or state correctional facility;[2] and

Whereas, the Act defines a death in custody as any time someone dies under the following conditions: *Being detained by police *While under arrest by law enforcement *During the process of arrest *Being transported to a correctional or detention facility;[3] and

Whereas, the DCRA has not been fully implemented and therefore data on those who are dying in the custody of the criminal legal system is inaccurate, incomplete, and should undergo comprehensive standardized enhancements to limit variability;[4] therefore be it

RESOLVED, that our American Medical Association endorse and support the recommendations of the National Academies of Science Committee on Advancing the Field of Forensic Pathology: Lessons Learned from Death-in-Custody Investigations Consensus Report to strengthen the U.S. medicolegal death investigation system. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 04/21/2026

REFERENCES

1. R.A., Mitchell, Diaz, F., et. al (2017)National Association of Medical Examiners Position Paper; Dec 1;7(4):604–618.
2. The Death in Custody Reporting Act of 2013, 42 U.S.C. 750, et seq
3. The Death in Custody Reporting Act of 2013, 42 U.S.C. 750, et seq
4. Deaths in Custody:Additional Action Needed to Help Ensure Data Collected by DOJ Are Utilized GAO-22-106033 Published: Sep 20, 2022. Publicly Released: Sep 20, 2022. efaidnbmnnnibpcajpcglclefindmkaj/https://www.gao.gov/assets/gao-22-106033.pdf
5. NASEM Consensus Study Report, Strengthening the U.S. Medicolegal Death Investigation System: Lessons from Deaths in Custody, Oct. 2025;

RELEVANT AMA POLICY

D-65.987 Policing Reform

1. Our American Medical Association will advocate for efforts to implement evidence-based policing and the creation of evidence-based standards for law enforcement.
2. Our AMA will advocate for sentinel event reviews in the criminal justice system following an adverse event, such as an in-custody death.
3. Our AMA encourages further research by subject matter experts on the issues related to the transfer of military equipment to law enforcement agencies, including the impact on communities, particularly those in minoritized and marginalized communities.
4. Our AMA supports greater police accountability, procedurally just policing models, and greater community involvement in policing policies and practices.

1. Our American Medical Association advocates for research to be conducted that examines the public health consequences of negative interactions with police, including the impact on civilians and law enforcement professionals.
2. Our AMA advocates for a change to the U.S. Standard Certificate of Death to include a “check box” that would capture deaths in custody and further categorize the custodial death using cause and manner of death and information from the “How Injury occurred” section of the death certificate.

[BOT Rep. 2, I-21Appended: Res. 425, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1004
(A-26)

Introduced by: California, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, Minnesota, Washington, Idaho, Colorado

Subject: Protection of Medicaid Beneficiaries from Politically Motivated and Procedurally Deficient Federal Funding Deferrals

Referred to: Reference Committee B

Whereas, Medicaid serves as the essential safety-net health care program for more than 90 million Americans, including low-income children, elderly individuals, persons with disabilities, and working families, whose access to care depends on the reliable and lawful disbursement of federal matching funds; and

Whereas, the federal-state partnership structure of Medicaid, established under Title XIX of the Social Security Act and governed by 42 C.F.R. Part 430, obligates the federal government to disburse matching funds to states on a timely and predictable basis, and establishes specific due process requirements, including notice, an opportunity to respond, and individualized findings, before any withholding of funds may lawfully occur; and

Whereas, since January 2026, the Centers for Medicare and Medicaid Services has employed the administrative deferral mechanism to withhold Medicaid matching funds from multiple states, beginning with Minnesota, where a single deferral exceeded fifteen times the largest previously issued to that state, and extending to California, where $1.3 billion in deferral was announced on May 13, 2026, a pattern that state officials and legal filings characterize as arbitrary, capricious, and motivated by political rather than programmatic considerations; and

Whereas, affected states have received no specific findings of noncompliance, no identification of the claims or providers at issue, and no meaningful opportunity to respond prior to the withholding of funds, a departure from the corrective action framework established by federal statute and regulation that applies regardless of the political affiliation of a state's government; and

Whereas, the Administrator of the Centers for Medicare and Medicaid Services has publicly stated his intent to issue compliance demands to all fifty states with an explicit threat to "turn off the money" for states deemed deficient, extending the coercive use of this mechanism beyond any single state or political context and placing the Medicaid programs of every state, territory, and the patients they serve at risk; and

Whereas, the disruption of Medicaid funding flows, whether in states that have already received deferrals or those that may receive them, threatens provider liquidity, endangers continuity of care for the most medically vulnerable patients, and may force reductions in covered services or closure of safety-net facilities serving populations with no alternative source of care; now, therefore; therefore be it

RESOLVED, that our American Medical Association oppose any policy or practice, regardless of stated justification, that employs the withholding of Medicaid funds as a coercive instrument directed at state governments in ways that predictably injure patients and disrupt the continuity of care for vulnerable beneficiaries (New HOD Policy); and be it further

RESOLVED, that our AMA advocate that CMS immediately restore withheld Medicaid funds to affected states pending the completion of any proper administrative or judicial review process, in order to prevent irreparable harm to patients currently dependent on Medicaid-funded services (Directive to Take Action); and be it further

RESOLVED, that our AMA request that the relevant congressional committees conduct immediate oversight of the Administration's use of the Medicaid deferral mechanism. (Directive to Take Action)

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

Received: 5/21/26

RELEVANT AMA POLICY

Federal Medicaid Funding H-290.963
1. Our AMA opposes caps on federal Medicaid funding.

2. Our AMA will advocate that Congress and the Department of Health and Human Services seek and take into consideration input from our AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors, and other stakeholders during the process of developing federal legislation, regulations, and guidelines on Medicaid funding.
CMS Rep. 09, A-17 Reaffirmed: CMS Rep. 05, I-17 Reaffirmed: CMS Rep. 5, I-20

Opposition to Medicaid Work Requirements H-290.961
Our AMA opposes work requirements as a criterion for Medicaid eligibility.
Res. 802, I-17 Reaffirmation: A-18

Affordable Care Act Medicaid Expansion H-290.965
1. Our American Medical Association encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.

8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.
12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.

CMS Rep. 02, A-16 Reaffirmation: A-17 Reaffirmed in lieu of: Res. 807, I-18 Reaffirmed: CMS Rep. 02, A-19 Reaffirmed: CMS Rep. 5, I-20 Reaffirmed: CMS Rep. 3, I-21 Reaffirmed: Res. 122, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1005
(A-26)

Introduced by: American Thoracic Society

Subject: Age Verification and ENDS Products

Referred to: Reference Committee D

Whereas, the FDA recently issued a draft guidance (Flavored Electronic Nicotine Delivery Systems (ENDS) Premarket Applications – Considerations Related to Youth Risk: Draft Guidance for Industry) proposing to expand the availability of flavored electronic nicotine delivery devices ENDS; and

Whereas, before the public comment period for the proposed policy closed, FDA issued pre-market tobacco product authorization for two new fruit flavored ENDS products (a mango flavored product and a blueberry flavored product); and

Whereas, existing AMA HOD policy (H-495.973) opposes ENDS products that have characterizing flavors that appeal to youth; and

Whereas, the products authorized by FDA contain fruit characterizing flavors (mango and blueberry) that likely appeal to youth; and

Whereas, nearly 90% of youth who use e-cigarettes report using flavored products with fruit being the most popular flavor (63%) by far among youth users; and

Whereas, FDAs authorization of the ENDS products heavily relies on “device access restriction technology” (DAR), cell phone-based technology that uses age verification to enable ENDS activation; and

Whereas, FDA expressed reservations about DAR to block underage use in the March Draft Guidance citing “the current lack of real-world experience regarding use of DAR to prevent or sufficiently mitigate the risk of youth use; therefore be it

RESOLVED, that our American Medical Association opposes FDA’s decision to authorize ENDS products with fruit characterizing flavors (New HOD Policy); and be it further

RESOLVED, that our AMA continues to oppose the authorization of any ENDS products with characterizing flavors, including but not limited to fruit, candy, dessert, mint, and menthol flavors, that may enhance the appeal of such products to youth (New HOD Policy); and be it further

RESOLVED, that our AMA advocate FDA and any future authorized product share the data used to prove the effectiveness and durability of age-verification used (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate FDA CTP require and implement effective post market surveillance data collection to measure the effectiveness and durability of any ENDS age-verification systems (Directive to Take Action); and be it further

RESOVED, that our AMA urge FDA to take immediate action to remove authorized ENDS products from the market should age-verification technology prove to be insufficient to prevent youth initiation (New HOD Policy); and be it further

RESOLVED, that our AMA advocate FDA establish and maintain a high proof of effectiveness and durability threshold for ENDS products that rely on age-verification systems to prevent youth initiation. (Directive to Take Action)

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

Received: 5/26/26

RELEVANT AMA POLICY

FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973

Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 21; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth; and (3) urges federal officials, including but not limited to the U.S. Food and Drug Administration to: (a) prohibit the sale of any e-cigarette cartridges and e-liquid refills that do not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling); and (b) require that an accurate nicotine content of e-cigarettes, e-cigarette cartridges, and e-liquid refills be prominently displayed on the product alongside a warning of the addictive quality of nicotine.
Res. 206, I-13 Modified in lieu of Res. 511, A-14 Modified in lieu of Res. 518, A-14 Modified in lieu of Res. 519, A-14 Modified in lieu of Res. 521, A-14 Modified: CSAPH Rep. 2, I-14 Reaffirmation A-15 Reaffirmed in lieu of Res. 412, A-15 Reaffirmed in lieu of Res. 419, A-15 Reaffirmed: Res. 421, A-15 Reaffirmation A-16 Appended: Res. 429, A-18 Modified: CSAPH Rep. 05, A-18 Reaffirmation: I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1006
(A-26)

Introduced by: American Thoracic Society, American Academy of Allergy Asthma & Immunology

Subject: OMB Proposed Rule: Regulation for Federal Financial Assistance

Referred to: Reference Committee B

Whereas, the scientific peer review process is the cornerstone of scientific advancement and core value of the US scientific enterprise; and

Whereas, protecting scientists from undue political influence in the selection, conduct and dissemination of scientific information is essential for continued scientific process; and

Whereas, we as physicians and the patients we serve rely on scientific progress to bring new and improved treatments and cures to treat the sick and improve health for all our patients; and

Whereas, the Office of Management and Budget (OMB) recently issued a proposed rule that establishes new policy for application, receipt and conduct of nearly all federal grant programs, including federally funded research, public health and medical grant programs; and

Whereas, the draft OMB rule gives the Executive branch the authority to undermine the scientific peer review process by inserting explicit political oversight into the issuing of request for proposal announcements, selection of specific scientific proposals and gives the executive branch explicit authority to retract already awarded grants that do not comport with the political priorities of the Administration; and

Whereas, the proposed OMB rule would give the Executive branch the authority to monitor the activities of research grant recipients and the institutions that host the grant recipient and terminate grants if the grantee or their host institutions engage in any “anti-American values” or other activities that do not align the Administration priorities; and

Whereas, the proposed OMB rule requires grantees to seek explicit permission from the administration to present their research findings at scientific meetings; and

Whereas, the OMB proposal would interfere with academic journals by limiting grantees on which journals they can submit manuscripts to and establishing price controls on publication costs; and

Whereas, the OMB proposed rule would codify political interference into the scientific peer review process for all federal research programs; and

Whereas, disruption or rescission of discretionary grants that support public health programs, community-based services, workforce training, and safety-net activities could reduce access to essential care and prevention services for patients and communities that rely on these resources; and

Whereas, uncertainty, delay, or termination of federal grants that support research, education, training, and clinical programs could destabilize the health care workforce by jeopardizing jobs, trainee pathways, and institutional capacity needed to deliver timely, high-quality patient care; and

Whereas, finalization and implementation of the proposed OMB rule will undermine the US scientific enterprise, impede cutting edge research and delay the development of new treatments and cures that our patients depend upon; therefore be it

RESOLVED, that our American Medical Association expresses its strong support for the scientific peer review process, academic journal independence and the immense value of merit-based scientific investments unimpeded by political interference (New HOD Policy); and be it further

RESOLVED, that our AMA submit comments during the public comment period expressing our strong concerns with the proposed rule (Directive to Take Action); and be it further

RESOLVED, that our AMA consider taking legal action to challenge implementation of the proposed OMB rule. (Directive to Take Action)

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

Received: 6/4/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

AGENDA

Reference Committee on Ethics and Bylaws
In-Person Reference Committee Hearing

Carlos Latorre, MD, Chair

RECOMMENDED FOR ADOPTION

1. BOT Report 02 - New Specialty Organizations Representation in the House of Delegates
2. CCB Report 02 - HOD Representation and Composition
3. CCB Report 04 - Credentialing of HOD Delegates and Alternate Delegates
4. CCB Report 05 - Inclusion of Medical Students and Resident/Fellow Physicians in HOD Delegations
5. CCB Report 06 - Medical Student Regional Delegates and Alternate Delegates and Resident and Fellow Sectional Delegates and Alternate Delegates in the HOD
6. CCB Report 07 - HOD Delegate and Alternate Delegate Vacancies and Meeting Absences
7. CCB Report 08 - Business Meetings of the AMA Sections
8. CCB Report 09 - Continuity of AMA Resident and Fellow Section Governing Council Leadership
9. CEJA 02 - Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure
10. CEJA 05 - CEJA's Sunset Review of 2016 House Policies
11. Resolution 001 - Ethical Guidance on Postmortem Sample Collection for Genetic Testing
12. Resolution 003 - Artificial Intelligence to Bolster Physician-Led Team-Based Care
13. Resolution 008 - Senior Physicians Improving Patient Access
14. Resolution 009 - Preserving Access to Care for Undocumented Individuals

RECOMMENDED FOR ADOPTION AS AMENDED

15. CCB Report 03 - Rights & Privileges of HOD Members
16. Resolution 002 - Physician Workload and Scheduling
17. Resolution 004 - Ethical Reproductive Care for Individuals with Intellectual and Developmental Disabilities
18. Resolution 005 - Impersonation of a Physician
19. Resolution 010 - Fatigue Mitigation: Supporting Fully-Funded Transportation for Trainee Physicians After Extended or Overnight Shifts

RECOMMENDED FOR REFERRAL

20. CEJA 01- Guidelines on Chaperones for Sensitive Exams
21. CEJA 03 - Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization
22. Resolution 006 - Investigating Moral Injury Related to Organ Procurement Practices
23. Resolution 007 - Supporting Privacy in the Use of Artificial Intelligence Based Scribe Software

RECOMMENDATION NOT YET DETERMINED

24. BOT Report 35 - Specialty Society Representation in the House of Delegates – Five-Year Review
25. Resolution 011 - Physician Ability to Render Emergency Medical Aid During Immigration Enforcement
26. Resolution Late 1003 - Taking Action on Deaths in Custody

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

Livestream of Reference Committee Hearing: Zoom Link

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

Agenda

Reference Committee A
In-Person Hearing
Christine Kim, MD, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 23 – Liberalized Remorse Period for Medicare Advantage Plan Insureds
2. Council on Medical Service Report 5 - Inclusion of Discounted Prescription Medication in Patient Cost-Sharing
3. Council on Medical Service Report 8 - Rural Health Transformation Program Update & Workforce Challenges
4. Resolution 103 - Supporting Non-Insurance Directed Sales of Pharmaceuticals to Patients to Improve Access and Reduce Costs
5. Resolution 104 – Improving Choice, Competition, and Affordability in the ACA Marketplaces
6. Resolution 105 – Oppose Medicare Advantage Auto Enrollment
7. Resolution 109 – Insurance Coverage for Pediatric Intercranial Neuromodulation for Drug-Resistant Epilepsy
8. Resolution 110 – Medicaid Coverage for Incarcerated Individuals
9. Resolution 112 – Ensuring Coverage and Access to Adult Strabismus Surgery
10. Resolution 113 – Health Insurance Coverage of Hearing Devices and Related Services

RECOMMENDED FOR ADOPTION AS AMENDED

11. Council on Medical Service Report 3 - Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts
12. Resolution 101 - Revise the Use of Language Stigmatizing Obesity in ICD-10 Code E66.01“Morbid (Severe) Obesity Due to Excess Calories”
13. Resolution 108 – Ensuring Physician Input in the Development of CMMI Models
14. Resolution 114 – Opposing Alternative Funding Programs
15. Resolution 115 – Patient Continuity Protections During Payer, PBM Changes
16. Resolution 116 – Study of Cost Implications of Medicaid Managed Care Organizations Compared with State-Administered Medicaid Programs

RECOMMENDED FOR ADOPTION IN LIEU OF

17. Resolution 106 – Insurance Coverage for Scalp Cooling (Cold Capping) Therapy
    Resolution 111 – Advocating for Insurance Coverage of Scale Cooling Therapy to Prevent Chemotherapy-Induced Alopecia

RECOMMENDED FOR REFERRAL

18. Resolution 107 – Oversight of Medicare Advantage Plan
19. Resolution 118 - Addressing Proposals to Implement International Reference Pricing for Physician-Administered Drugs

RECOMMENDED FOR NOT ADOPTION

20. Resolution 102 – Study for EMTALA Relief in Psychiatric Facilities

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

21. Resolution 117 – Universal Out of Network Benefits

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

A Zoom webinar link is provided below. Registration is required to view the zoom. This link is view-only. Testimony cannot be accepted via Zoom.
https://events.zoom.us/ev/AtCkqu_4w3Nc8jcAJkkhriP0ViAyRJPoZFP7i0u4h-Q3KRw31uRZ~Aizi0XDOL13gMBDAl0ebk9vNNwuVRI3oU7WoQs-NxC41p05lUsZmbqBH2g

(REVISED)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

Agenda
Reference Committee B
In-Person Hearing
Jennifer Hone, MD, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 08 - Council on Legislation Sunset Review of 2016 House Policies
2. Board of Trustees Report 12 - The Uniform Health-Care Decisions Act
3. Board of Trustees Report 13 - Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medical Purposes
4. Board of Trustees Report 19 - Root Cause Analysis of the Causes of the Decline of Private Medical Practice
5. Board of Trustees Report 21 - Abolishing Venue Shopping
6. Board of Trustees Report 27 - Update the Status of Virtual Credit Card Policy, EFT Fees, and Lack of Enforcement of Administrative Simplification Requirements by CMS
7. Resolution 209 - Protecting Mental Health Treatment Privacy in Legal Proceedings
8. Resolution 213 - Prohibiting Pharmacy Benefit Managers from Owning Pharmacies
9. Resolution 218 - Opposing the Practice of Jury Anchoring in Medical Liability Cases
10. Resolution 228 - Department of Defense Health Care Investment at Military Bases in Maternity Care Health Professional Shortage Areas
11. Resolution 235 - Establishing Healthcare Monitoring and Accountability in Immigration Detention Facilities
12. Resolution 237 - Guaranteed 30-Day Transition Fill of Currently Prescribed Insulin at the Beginning of Each Year Plan

RECOMMENDED FOR ADOPTION AS AMENDED

13. Board of Trustees Report 14 - Binding Arbitration in Health Insurance Contracts
14. Board of Trustees Report 15 - Protecting the Prescriptive Authority of Plenary Licensed Physicians

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15. Board of Trustees Report 24 - AMA Advocacy to Mitigate Medicaid Cuts
16. Board of Trustees Report 28 - Accountability in the Use of Augmented Intelligence for Prior Authorization
17. Resolution 203 - Support for Independent Evaluation of Outcomes Associated with Unsupervised Nurse Practitioner Practice
18. Resolution 207 - Addressing Rural Maternity Care Deserts Through the Conrad 30 Waiver Program
19. Resolution 208 - Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness
20. Resolution 212 - Protecting Patient Access to Clinical Trials and Mitigating Administrative Disruptions to NIH Funding
21. Resolution 216 - Protecting Healthcare as a Sensitive Location
22. Resolution 219 - Incorporating Evidence-Based Lifestyle Medicine into Rural Health Transformation Programs
23. Resolution 229 - Physicians are not Providers
24. Resolution 232 - Banning Flavored Cannabis E-Cigarettes
25. Resolution 239 - Medicare Administrative Contractor Policy Modification
26. Resolution 240 - Ending Private Equity Dividend Recapitalization in Healthcare
27. Resolution 243 - Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions
28. Resolution 244 - Eliminate Administrative Barriers to Appeal Wrongful Denials
29. Resolution 247 - Comprehensive ERISA Reform

RECOMMENDED FOR ADOPTION IN LIEU OF

30. Board of Trustees Report 25 - Federal Legislation to Prohibit the Corporate Practice of Medicine
    Resolution 241 - Strengthening Our AMA Efforts Toward CPOM Prohibition
31. Resolution 201 - Prohibit and Regulate 7-Hydroxymitragynine (7-OH) Kratom Products to Protect Public Health and Youth Safety
    Resolution 233 - Banning Synthesized, Purified or Derivative Products from Kratom
32. Resolution 226 - Impact of a Proposed $100,000 H-1B Visa Fee on the NRMP Match, the Physician Workforce, and the U.S. Health Care System

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Resolution 230 - Exemption of International Medical Graduates from Presidential Proclamations Restricting Entry into the United States

RECOMMENDED FOR REFERRAL

33. Resolution 202 - Using and Defining "Unsupervised Practice of Medicine"
34. Resolution 221 - Universal Newborn Congenital Cytomegalovirus Screening
35. Resolution 223 - Ensuring Due Process, Transparency, and Human Clinical Oversight in the Use of Artificial Intelligence for Health Insurance Coverage and Eligibility Determinations
    Resolution 238 - Prohibiting the Independent Practice of Medicine by Artificial Intelligence
    Resolution 246 - Artificial Intelligence Scope of Practice
36. Resolution 225 - Requiring Periodic Face-to-Face Visits By Board-Certified Specialists Who Delegate Visits to Non-Physician Practitioners for Nursing Home Patients

RECOMMENDED FOR REFERRAL FOR DECISION

37. Resolution 236 - Extending and Expanding the AMA Task Force to Preserve the Patient-Physician Relationship to Ensure Access and Regulatory Clarity in Gender-Affirming Care

RECOMMENDED FOR NOT ADOPTION

38. Resolution 245 - State Regulation of Non-Preempted "Non-Central Matters" of ERISA Plans—Rutledge v. PCMA

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

39. Resolution 204 - D-400.982 Revision
40. Resolution 205 - Repeal of the Merit-Based Incentive Payment System (MIPS)
41. Resolution 206 - Overall Hospital Quality Star Ratings / CMS Star Ratings
42. Resolution 210 - Eliminating Prescription Drug Adherence (PDA) as a Quality Metric Tied to Physician Ratings or Compensation

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43. Resolution 211 - Preventing Hospital-Based 340B Programs from Unfairly Competing with Independent Physicians
44. Resolution 214 - Medical Student Loans Should Not Be Capped
45. Resolution 215 - Oppose Medicare Efficiency Adjustments
46. Resolution 217 - Ensuring Proportional Accountability for Hospital Expenditures Attributed to Medicare ACOs
47. Resolution 220 - Reverse CMS Cuts to Facility-Based Practice Expense Payments for Physicians
48. Resolution 222 - Advocating for a Centralized Medicare Enrollment Platform to Preserve Patient Choice Between Traditional Medicare and Medicare Advantage
49. Resolution 224 - Clarity of Signage: Distinguishing Urgent Cares From Emergency Rooms
50. Resolution 227 - Standby Capacity Payments and Health IT for Hospitals in Rural Areas
51. Resolution 231 - Protecting and Promoting Long Term Care Workforce Amidst Immigration Challenges
52. Resolution 234 - Physician Unity in Advocacy Regarding Physician Reimbursement
53. Resolution 242 - Reducing Emergency Department Boarding through Payment Reform

RECOMMENDATION NOT YET DETERMINED

54. Resolution 248 - Medical Staff Oversight of Hospital Augmented Intelligence
55. Resolution 249 - Bringing Physicians' Voices to the Implementation of AI Prescribers
56. Resolution 250 - Protecting Resident Physicians with Pending Immigration Status and Ensuring Safe Participation in Professional Activities
57. Resolution 251 - Minimum Standards for Public Health Leaders
58. Resolution 252 - Immediate Action to Prevent Further Immigrant Deaths
59. *Late 1004 - Protection of Medicaid Beneficiaries from Politically Motivated and Procedurally Deficient Federal Funding Deferrals*
60. *Late 1006 - OMB Proposed Rule: Regulation for Federal Financial Assistance*

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

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

CONSENT AGENDA

Reference Committee C, In-Person Hearing

June 6, 2026 in Crystall Ballroom

Alena Balasanova, MD, DFAPA, Chair

RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 1 - Council on Medical Education Sunset Review of 2016 House of Delegates' Policies
2. Council on Medical Education Report 3 - Support for the Establishment of Indigenous-Led Medical Schools in the United States
3. Council on Medical Education Report 4 - Reflecting the Values and Priorities of Tribal Communities in Indigenous-Led Medical Schools in the United States
4. Resolution 302 - Excessive Cost of Multi-State DEA Licensure
5. Resolution 306 - Competency-Based Portfolio Assessment of Medical Students, Interns, Residents, and Fellows
6. Resolution 307 - Recognizing Advocacy as a Component of Faculty Appointment and Promotion in Academic Medicine
7. Resolution 308 - Impact of Federal and State Restrictive Actions on Gender-Affirming Care on Medical Education and Physician Workforce Development
8. Resolution 313 - Evaluation of Situational Judgement Tests in Medical School Admissions
9. Resolution 314 - Promoting Sex- and Gender-Inclusive Diagnostic Practices, Language, and Patient Education
10. Resolution 316 - Addressing Transitions Within GME Regarding Orientation Standards

RECOMMENDED FOR ADOPTION AS AMENDED

11. Council on Medical Education Report 2 - Examining ABMS Processes for New Boards
12. Resolution 304 - Increasing the Use of Retired Physicians in Teaching Students and Residents
13. Resolution 305 - Leadership by Physicians for Physicians in Graduate Medical Education (GME)
14. Resolution 310 - Increasing Capacity and Access to Maternal Health Services in Rural Areas
15. Resolution 312 - Advocating for Equitable Application Review in a Single Match System
16. Resolution 315 - Expanding the Native Hawaiian Health Scholarship Program Eligibility

RECOMMENDED FOR ADOPTION IN LIEU OF

17. Resolution 309 - Osteoporosis Education, Awareness, and Musculoskeletal Health Optimization

RECOMMENDED FOR REFERRAL

18. Resolution 317 - Support for Intern, Resident, and Fellow Jeopardy Pay and Additional Compensation for Gaps in Trainee Coverage

RECOMMENDED FOR NOT ADOPTION

19. Resolution 303 - Allowing Options for Certification Maintenance
20. Resolution 311 - Changing the Paradigm of Medical Student Debt to address the Geriatric Physician Shortfall

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

21. Resolution 301 - Expanding Resident and Fellow Exposure to Diverse Healthcare Practice Models to Fulfill ACGME Core Competencies

Notes:

- Amendments and supplemental material must be sent to referencecommitteec@ama-assn.org
- For technical assistance, email HODMeetingSupport@ama-assn.org or call 800-337-1599.
- Handbook (resolutions and reports)
- Online Reference Committee (closed)
- Preliminary Report
- Zoom link

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

AGENDA
Reference Committee D
In-Person Reference Committee Hearing
June 6, 2026
Regency D
~ 1:00 pm – 5:00 pm Local Time (CDT)
Cheryl Hurd, MD, Chair

RECOMMENDED FOR ADOPTION

1. BOT 17 - Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records Report
2. BOT 29 - Educational Materials Regarding Ultra-processed Foods
3. CSAPH 01 - Council on Science and Public Health Sunset Review of 2016 House Policies
4. CSAPH 02 - Setting Standards for Forensic Toxicology Laboratories Used in Litigation
5. CSAPH 03 – Public Health Implications of Food Subsidies
6. CSAPH 04 - Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers
7. CSAPH 05 - Removing Artificial Turf in Schools, Parks, and Public Places
8. CSAPH 10 - Standardizing Safety Requirements for Traditional and Rideshare Based Non-Emergency Medical Transportation
9. Resolution 404 - Develop Climate-Conscious Resources for Physicians
10. Resolution 411 - Addressing the Myopia Epidemic, Public Education, and Insurance Coverage for Evidence-Based Myopia Control
11. Resolution 413 - Erosion of the Public Evidence Base for Health Policy
12. Resolution 414 - Restoring Balanced Scientific Perspective within the ACIP
13. Resolution 415 - Advocacy for Restoration of the Endangerment Finding Regarding Greenhouse Gas Emissions
14. Resolution 417 - Respiratory Protection for Wildland Firefighters
15. Resolution 421 - Improving Access to Care and Support for Patients with Inflammatory Bowel Disease in the United States
16. Resolution 422 - Expanding Access to High Resolution Anoscopy
17. Resolution 423 - Expanding Access to HIV Pre-Exposure Prophylaxis (PrEP)
18. Resolution 424 - Supporting Education and Access to Postexposure Doxycycline (DoxyPEP)
19. Resolution 429 - Adolescent Dating Violence Comprehensive Screening Tool Development
20. Resolution 430 - Support Heavy Metal and Toxic Exposure Testing for Residents Affected by Wildfires
21. Resolution 431 - Supporting Transportation Infrastructure Reform for Public Health
22. Resolution 433 - Addressing the Epidemic of Fragility Fractures Through Improved Osteoporosis Screening and Treatment

Zoom Link: https://events.zoom.us/ejl/AtCkqu_4w3Nc8jcAJkkhriP0ViAyRJPoZFP7i0u4h-Q3KRw31uRZ~A5s785-N_x61-xqQ-QAcB2nJxeGBH0-4Q-IVhQayOVBQC4Wd7u-xNDKababuqbq3GZ9-_MztYpgvUkuMxFOi-kqB3_-4XqMgmjs21-41lC1fxvmRY

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RECOMMENDED FOR ADOPTION AS AMENDED

23. CSAPH 06 - Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities
24. Resolution 401 - Partnership with the Administration to Reduce Harmful Chemicals in Food and Align with European Safety Standards
25. Resolution 402 - Strengthening Public Health Protections Against Raw Milk–Associated Illness
26. Resolution 403 - AMA's continued support for COVID-19 vaccination in pregnant individuals and children
27. Resolution 405 - Studying the Environmental Impact of Ambient Clinical Intelligence Use
28. Resolution 407 - Colorectal Cancer in Alaskan Native Patients
29. Resolution 408 - Addressing Rural Maternal Morbidity and Mortality through Collaboration and Intersectionality
30. Resolution 409 - Eliminate PFAS and Glyphosate in our Food and Environment
31. Resolution 416 - Clinical Laboratory Workforce Shortage and Sustainability
32. Resolution 418 - Ensuring Access to Full HIV Post-Exposure Prophylaxis (PEP) Courses for Survivors of Sexual Assault
33. Resolution 419 - Examining the Impact of Circadian Disruption from Shift Work During Pregnancy
34. Resolution 420 - Expanding Support for Women Experiencing Homelessness
35. Resolution 425 - Prioritizing, Measuring, and Preventing Workplace Violence in Health Care
36. Resolution 426 - Integrating Nutrition into Health Care Delivery to Reduce Cardiovascular Risk and Food Insecurity ("Food is Medicine")
37. Resolution 427 - Infant Feeding Options for HIV-Seropositive Individuals
38. Resolution 428 - Protecting Environmental Health Before, During, and After War
39. Resolution 432 - Addressing Public Health Risks of Online Sports Betting
40. Resolution 434 - Vaccinations in Physician Offices

RECOMMENDED FOR REFERRAL

41. Resolution 406 - Reduce Environmental Impact of Medical Journals
42. Resolution 410 - Light Pollution
43. Resolution 412 - Guiding Principles of Pandemic Prevention, Preparedness and Response; Support for the World Health Organization Pandemic Agreement

RECOMMENDATION NOT YET DETERMINED

44. Resolution 435 - Supporting Regulations for More Stringent Safety Measures for Micromobility
45. Resolution 436 - Protecting Children from Potential Harms of Caffeinated Products
46. *Late 1001 – Addressing Housing Needs of the Native Hawaiian and their Diaspora*
47. *Late 1002 – Preserving and Strengthening Maternal Mortality Review Committees*
48. *Late 1005 - Age Verification and ENDS Products*

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

AGENDA

Reference Committee E

In-Person Reference Committee Hearing

Raymond Lorenzoni, MD, Chair

RECOMMENDED FOR ADOPTION

1. CSAPH 08 - Increased Transparency Among Psychotropic Drug Administration in Prisons
2. CSAPH 09 - In Support of a National Drug Checking Registry

RECOMMENDED FOR ADOPTION AS AMENDED

3. CSAPH 07 - Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making
4. Resolution 501 - Preregistration in Medical Research
5. Resolution 502 - Support for Rapid Methadone Inpatient Stabilization and Linkage to Care
6. Resolution 505 - Avoiding Misuse of Artificial Intelligence (AI) in Clinical Practice
7. Resolution 507 - Pairing Behavioral and Lifestyle Medicine Principles and Practice with Glucagon-like Peptide-1 (GLP-1) Receptor Agonists and Other Anti-obesity Medications
8. Resolution 512 - Medical Cannabis Use in Older Adults
9. Resolution 513 - Access, Affordability, and Safety of GLP-1 Receptor Agonists
10. Resolution 515 - Transparency in AI-Driven Adverse Determinations & Clinical Logic Disclosure

RECOMMENDED FOR ADOPTION IN LIEU OF

11. Resolution 506 - Access To Gender Affirming Healthcare Including Clinical Trials and Resolution 509 - Preserving Gender-Affirming Surgical Care Access
12. Resolution 511 - Preserving Specialty Access to Anti-Cancer Agents
13. Resolution 514 - Education, Screening, and Effective Treatment for Obstructive Sleep Apnea During Pregnancy

RECOMMENDED FOR REFERRAL

14. Resolution 508 - Aligning Consistency and Credibility Of Direct-To-Consumer Gut Microbiome Testing Services
15. Resolution 510 - Exosome and Peptide Use in Healthcare

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

16. Resolution 503 - Expansion of Psychedelic Assisted Therapy (PAT)
17. Resolution 504 - Strengthening U.S. Rubber Glove Production and Purchase

RECOMMENDATION NOT YET DETERMINED

19. Resolution 516 - FDA Regulation of Unapproved Synthetic Peptides

Zoom Link: https://events.zoom.us/ejl/AtCkqu_4w3Nc8jcAJkkhriP0ViAyRJPoZFP7i0u4h-Q3KRw31uRZ~A5s785-N_x61-xqQ-QAcB2nJxeGBH0-4Q-lVhQayOVBQC4Wd7u-xNDKababuqbq3GZ9-_MztYpgvUkuMxFOi-kqB3_-4XqMgmjs21-41lC1fxvmRY

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

AGENDA
Reference Committee F
In-Person Hearing

Robert A. Gilchick, MD, MPH, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 4 - AMA 2027 Dues
2. Board of Trustees Report 34 - Discontinuation of AMA Citation for Distinguished Service
3. Report of the House of Delegates Committee on the Compensation of the Officers
4. Resolution 607 - Shortening the AMA House of Delegates Endorsement Process and Timeline

RECOMMENDED FOR ADOPTION AS AMENDED

5. Resolution 603 - Establish AMA Policy and Project to Compile and Distribute JAMA Patient Pages to Enhance Public Medical Literacy
6. Resolution 610 - Plant-Based Diets at AMA Meetings
7. Resolution 612 - Increasing Expert Guidance in AMA Statements
8. Resolution 613 - Preserving Institutional Equity and Inclusivity Efforts
9. Resolution 615 - Condemnation of Attacks on Healthcare Workers and Facilities in Gaza

RECOMMENDED FOR ADOPTION IN LIEU OF

10. Resolution 601 - Board Chair Term Limits
    Resolution 609 - American Medical Association Board Chair Term Limits

RECOMMENDED FOR REFERRAL

11. Resolution 604 - Annual Scorecard to Evaluate the AMA's Impact
12. Resolution 605 - Review of Past Resolutions
13. Resolution 608 - Reinstitution of AMA Guides Editorial Panel
14. Resolution 611 - Publicizing, Supporting, and Promoting (Appropriate) AMA Member Physicians and Physician Spouses as Candidates for Local and State Offices
15. Resolution 616 - Humanitarian and Medical Aid Support to Palestine

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

Zoom Webinar Link:
https://events.zoom.us/ev/AtCkqu_4w3Nc8jcAJkkhriP0ViAyRJPoZFP7i0u4h-Q3KRw31uRZ~Aizi0XDOL13gMBDAI0ebk9vNNwuVRI3oU7WoQs-NxC41p05IUsZmbqBH2g

RECOMMENDED FOR NOT ADOPTION

16. Resolution 606 - Further Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations
17. Resolution 614 - Inclusive Policy Language for Older Adults
18. Resolution 618 - Ending AMA Investment in Weapons Manufacturers

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

19. Resolution 602 - Protection of Healthcare and Humanitarian Aid Personnel in Conflict Zones
20. Resolution 617 - Reevaluation of AMA Policy Regarding Support for Specific National Medical Associations in the World Medical Association

RECOMMENDED FOR FILING

21. Board of Trustees Report 1 - Annual Report

RECOMMENDATION NOT YET DETERMINED

22. Board of Trustees Report 38 - Project IMG Observer Status in the House of Delegates
23. Resolution 619 - Opposing Federal Immigration Operations at AMA Events and Harm to Lawful Non-Target Individuals
24. Resolution 620 - Survey of Medical Staffs

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

AGENDA

Reference Committee G
In-Person Reference Committee Hearing

Robert Dannenhoffer, MD, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 22 – Comprehensive AMA Policy Publication Regarding Employed Physicians
2. Council on Medical Service Report 1 – Council on Medical Service Sunset Review of 2016 House Policies
3. Council on Medical Service Report 4 – Expanding Medicare Coverage of Medical Nutrition Therapy
4. Council on Medical Service Report 6 – Study of Practice Models for Physicians Performing Procedures Across State Lines
5. Council on Medical Service Report 7 – Private Insurance Coverage of Anti-Obesity Medications
6. Resolution 704 – Advocating Against Automatic Refill Requests
7. Resolution 708 – Oppose Imposition of Fees on Physicians for Electronic Payment Transfers
8. Resolution 711 – Oppose Denials Based on Origin of Referral
9. Resolution 712 – Addressing the Commoditization of Medicine Through Recognition of the Full Scope of Physician Work and Contributions
10. Resolution 715 – Oppose the Legal Position that Virtual Credit Cards are a Legal Method of Payment under HIPAA

RECOMMENDED FOR ADOPTION AS AMENDED

11. Board of Trustees Report 20 – Mitigating the Impact of Excessive Prior Authorization Processes
12. Council on Medical Service Report 9 – Nonprofit Status
13. Resolution 701 – The Crisis in the Availability of Primary Care: Halt the Required Participation of Small Practices in Value-Based Payment (VBP) Models
14. Resolution 702 – Physicians Who Do Not Practice in Hospital Setting
15. Resolution 703 – Parity in Pricing for Anti-Obesity Medications
16. Resolution 705 – Recognizing Physicians as Sexual Assault Forensic Examiners
17. Resolution 706 – Discharge Summaries from Skilled Nursing Facilities
18. Resolution 707 – Malpractice Insurance for Employed Physicians
19. Resolution 709 – Requiring Transparency and Accountability When Insurers and Third-Party Administrators Require Utilization Review, Thereby Practicing Medicine
20. Resolution 710 – Parity in Access to Evidence-Based Obesity Treatment
21. Resolution 713 – Reducing Prior Authorization Delays to Improve Access to Neuromodulation and Non-Opioid Pain Therapies
22. Resolution 714 – Physician Case Log Portability

RECOMMENDED FOR REFERRAL

23. Resolution 717 – Advocacy for a Failure-Proof National Centralized Electronic Transaction Clearinghouse

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

24. Resolution 716 – Equal Opportunity for Payment for "On Call" Duty

Please submit amendments to referencecommitteeg@ama-assn.org.

Link to livestream:
https://events.zoom.us/ev/AtCkqu_4w3Nc8jcAJkkhriP0ViAyRJPoZFP7i0u4h-Q3KRw31uRZ~Aizi0XDOL13gMBDAI0ebk9vNNwuVRI3oU7WoQs-NxC41p05lUsZmbgBH2g

Reference Committee on Ethics and Bylaws

Report(s) of the Board of Trustees

02 New Specialty Organizations Representation in the House of Delegates
35* Specialty Society Representation in the House of Delegates - Five-Year Review

Report of the Council on Constitution and Bylaws

02 HOD Representation and Composition
03 Rights & Privileges of HOD Members
04 Credentialing of HOD Delegates and Alternate Delegates
05 Inclusion of Medical Students and Resident/Fellow Physicians in HOD Delegations
06 Medical Student Regional Delegates and Alternate Delegates and Resident and Fellow Sectional Delegates and Alternate Delegates in the HOD
07 HOD Delegate and Alternate Delegate Vacancies and Meeting Absences
08 Business Meetings of the AMA Sections
09 Continuity of AMA Resident and Fellow Section Governing Council Leadership

Report of the Council on Ethical and Judicial Affairs

01 Guidelines on Chaperones for Sensitive Exams
02 Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure
03 Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization
05 CEJA's Sunset Review of 2016 House Policies

Resolutions

001 Ethical Guidance on Postmortem Sample Collection for Genetic Testing
002 Physician Workload and Scheduling
003 Artificial Intelligence to Bolster Physician-Led Team-Based Care
004 Ethical Reproductive Care for Individuals with Intellectual and Developmental Disabilities
005 Impersonation of a Physician
006 Investigating Moral Injury Related to Organ Procurement Practices
007 Supporting Privacy in the Use of Artificial Intelligence Based Scribe Software
008 Senior Physicians Improving Patient Access
009 Preserving Access to Care for Undocumented Individuals
010 Fatigue Mitigation: Supporting Fully-Funded Transportation for Trainee Physicians After Extended or Overnight Shifts
011 Physician Ability to Render Emergency Medical Aid During Immigration Enforcement

*Contained in Meeting Tote

Reference Committee A

Report(s) of the Board of Trustees

23 Liberalized Remorse Period for Medicare Advantage Plan Insureds

Report(s) of the Council on Medical Service

03 Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts
05 Inclusion of Discounted Prescription Medication in Patient Cost-Sharing
08 Rural Health Transformation Program Update & Workforce Challenges

Resolutions

101 Revise the Use of Language Stigmatizing Obesity in ICD-10 Code E66.01"Morbid (Severe) Obesity Due to Excess Calories"
102 Study for EMTALA Relief in Psychiatric Facilities
103 Supporting Non-Insurance Directed Sales of Pharmaceuticals to Patients to Improve Access and Reduce Costs
104 Improving Choice, Competition, and Affordability in the ACA Marketplaces
105 Oppose Medicare Advantage Auto Enrollment
106 Insurance Coverage for Scalp Cooling (Cold Capping) Therapy
107 Oversight of Medicare Advantage Plan
108 Ensuring Physician Input in the Development of CMMI Models
109 Insurance Coverage for Pediatric Intracranial Neuromodulation for Drug-Resistant Epilepsy
110 Medicaid Coverage for Incarcerated Individuals
111 Advocating for Insurance Coverage of Scalp Cooling Therapy to Prevent Chemotherapy-Induced Alopecia
112 Ensuring Coverage and Access to Adult Strabismus Surgery
113 Health Insurance Coverage of Hearing Devices and Related Services
114 Opposing Alternative Funding Programs
115 Patient Continuity Protections During Payer, PBM Changes
116 Study of Cost Implications of Medicaid Managed Care Organizations Compared with State-Administered Medicaid Programs
117 Universal Out of Network Benefits
118 Addressing Proposals to Implement International Reference Pricing for Physician-Administered Drugs

Reference Committee B

Report(s) of the Board of Trustees

08	Council on Legislation Sunset Review of 2016 House Policies
12	The Uniform Health-Care Decisions Act
13	Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medicaid Purposes
14	Binding Arbitration in Health Insurance Contracts
15	Protecting the Prescriptive Authority of Plenary Licensed Physicians
19	Root Cause Analysis of the Causes of the Decline of Private Medical Practice
21	Abolishing Venue Shopping
24	AMA Advocacy to Mitigate Medicaid Cuts
25	Federal Legislation to Prohibit the Corporate Practice of Medicine
27	Update the Status of Virtual Credit Card Policy, EFT Fees, and Lack of Enforcement of Administrative Simplification Requirements by CMS
28	Accountability in the Use of Augmented Intelligence for Prior Authorization

Resolutions

201	Prohibit and Regulate 7-Hydroxymitragynine (7-OH) Kratom Products to Protect Public Health and Youth Safety
202	Using and Defining "Unsupervised Practice of Medicine"
203	Support for Independent Evaluation of Outcomes Associated with Unsupervised Nurse Practitioner Practice
204	D-400.982 Revision
205	Repeal of the Merit-Based Incentive Payment System (MIPS)
206	Overall Hospital Quality Star Ratings / CMS Star Ratings
207	Addressing Rural Maternity Care Deserts Through the Conrad 30 Waiver Program
208	Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness
209	Protecting Mental Health Treatment Privacy in Legal Proceedings
210	Eliminating Prescription Drug Adherence (PDA) as a Quality Metric Tied to Physician Ratings or Compensation
211	Preventing Hospital-Based 340B Programs from Unfairly Competing with Independent Physicians
212	Protecting Patient Access to Clinical Trials and Mitigating Administrative Disruptions to NIH Funding
213	Prohibiting Pharmacy Benefit Managers from Owning Pharmacies
214	Medical Student Loans Should Not Be Capped
215	Oppose Medicare Efficiency Adjustments
216	Protecting Healthcare as a Sensitive Location
217	Ensuring Proportional Accountability for Hospital Expenditures Attributed to Medicare ACOs
218	Opposing the Practice of Jury Anchoring in Medical Liability Cases
219	Incorporating Evidence-Based Lifestyle Medicine into Rural Health Transformation Programs
220	Reverse CMS Cuts to Facility-Based Practice Expense Payments for Physicians

221	Universal Newborn Congenital Cytomegalovirus Screening
222	Advocating for a Centralized Medicare Enrollment Platform to Preserve Patient Choice Between Traditional Medicare and Medicare Advantage
223	Ensuring Due Process, Transparency, and Human Clinical Oversight in the Use of Artificial Intelligence for Health Insurance Coverage and Eligibility Determinations
224	Clarity of Signage: Distinguishing Urgent Cares From Emergency Rooms
225	Requiring Periodic Face-to-Face Visits By Board-Certified Specialists Who Delegate Visits to Non-Physician Practitioners for Nursing Home Patients
226	Impact of a Proposed $100,000 H-1B Visa Fee on the NRMP Match, the Physician Workforce, and the U.S. Health Care System
227	Standby Capacity Payments and Health IT for Hospitals in Rural Areas
228	Department of Defense Health Care Investment at Military Bases in Maternity Care Health Professional Shortage Areas
229	Physicians are not Providers
230	Exemption of International Medical Graduates from Presidential Proclamations Restricting Entry into the United States
231	Protecting and Promoting Long Term Care Workforce Amidst Immigration Challenges
232	Banning Flavored Cannabis E-Cigarettes
233	Banning Synthesized, Purified or Derivative Products from Kratom
234	Physician Unity in Advocacy Regarding Physician Reimbursement
235	Establishing Healthcare Monitoring and Accountability in Immigration Detention Facilities
236	Extending and Expanding the AMA Task Force to Preserve the Patient-Physician Relationship to Ensure Access and Regulatory Clarity in Gender-Affirming Care
237	"Guaranteed 30-Day Transition Fill of Currently Prescribed Insulin at the Beginning of Each Year Plan "
238	Prohibiting the Independent Practice of Medicine by Artificial Intelligence
239	Medicare Administrative Contractor Policy Modification
240	Ending Private Equity Dividend Recapitalization in Healthcare
241	Strengthening Our AMA Efforts Toward CPOM Prohibition
242	Reducing Emergency Department Boarding through Payment Reform
243	Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions
244	Eliminate Administrative Barriers to Appeal Wrongful Denials
245	State Regulation of Non-Preempted “Non-Central Matters” of ERISA Plans—Rutledge v. PCMA
246	Artificial Intelligence Scope of Practice
247	Comprehensive ERISA Reform
248*	Medical Staff Oversight of Hospital Augmented Intelligence
249*	Bringing Physicians' Voices to the Implementation of AI Prescribers
250*	Protecting Resident Physicians with Pending Immigration Status and Ensuring Safe Participation in Professional Activities
251*	Minimum Standards for Public Health Leaders
252*	Immediate Action to Prevent Further Immigrant Deaths

*Contained in Meeting Tote

Reference Committee C

Report(s) of the Council on Medical Education

01 Council on Medical Education Sunset Review of 2016 House of Delegates' Policies
02 Examining ABMS Processes for New Boards
03 Support for the Establishment of Indigenous-Led Medical Schools in the United States
04 Reflecting the Values and Priorities of Tribal Communities in Indigenous-Led Medical Schools in the United States

Resolutions

301 Expanding Resident and Fellow Exposure to Diverse Healthcare Practice Models to Fulfill ACGME Core Competencies
302 Excessive Cost of Multi-State DEA Licensure
303 Allowing Options for Certification Maintenance
304 Increasing the Use of Retired Physicians in Teaching Students and Residents
305 Leadership by Physicians for Physicians in Graduate Medical Education (GME)
306 Competency-Based Portfolio Assessment of Medical Students, Interns, Residents, and Fellows
307 Recognizing Advocacy as a Component of Faculty Appointment and Promotion in Academic Medicine
308 Impact of Federal and State Restrictive Actions on Gender-Affirming Care on Medical Education and Physician Workforce Development
309 Osteoporosis Education, Awareness, and Musculoskeletal Health Optimization
310 Increasing Capacity and Access to Maternal Health Services in Rural Areas
311 Changing the Paradigm of Medical Student Debt to address the Geriatric Physician Shortfall
312 Advocating for Equitable Application Review in a Single Match System
313 Evaluation of Situational Judgement Tests in Medical School Admissions
314 Promoting Sex- and Gender-Inclusive Diagnostic Practices, Language, and Patient Education
315 Expanding the Native Hawaiian Health Scholarship Program Eligibility
316 Addressing Transitions Within GME Regarding Orientation Standards
317 Support for Intern, Resident, and Fellow Jeopardy Pay and Additional Compensation for Gaps in Trainee Coverage

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Report(s) of the Board of Trustees

17 Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records Report
29 Educational Materials Regarding Ultra-processed Foods

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

01 Sunset Review of 2016 House Policies
02 Setting Standards for Forensic Toxicology Laboratories Used in Litigation
03 Public Health Implications of Food Subsidies
04 Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers
05 Removing Artificial Turf in Schools, Parks, and Public Places
06 Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities
10 Standardizing Safety Requirements for Traditional and Rideshare Based Non-Emergency Medical Transportation

Resolutions

401 Partnership with the Administration to Reduce Harmful Chemicals in Food and Align with European Safety Standards
402 Strengthening Public Health Protections Against Raw Milk–Associated Illness
403 AMA's continued support for COVID-19 vaccination in pregnant individuals and children
404 Develop Climate-Conscious Resources for Physicians
405 Studying the Environmental Impact of Ambient Clinical Intelligence Use
406 Reduce Environmental Impact of Medical Journals
407 Colorectal Cancer in Alaskan Native Patients
408 Addressing Rural Maternal Morbidity and Mortality through Collaboration and Intersectionality
409 Eliminate PFAS and Glyphosate in our Food and Environment
410 Light Pollution
411 Addressing the Myopia Epidemic, Public Education, and Insurance Coverage for Evidence-Based Myopia Control
412 Guiding Principles of Pandemic Prevention, Preparedness and Response
413 Erosion of the Public Evidence Base for Health Policy
414 Restoring Balanced Scientific Perspective within the ACIP
415 Advocacy for Restoration of the Endangerment Finding Regarding Greenhouse Gas Emissions
416 Clinical Laboratory Workforce Shortage and Sustainability
417 Respiratory Protection for Wildland Firefighters
418 Ensuring Access to Full HIV Post-Exposure Prophylaxis (PEP) Courses for Survivors of Sexual Assault
419 Examining the Impact of Circadian Disruption from Shift Work During Pregnancy
420 Expanding Support for Women Experiencing Homelessness

421 Improving Access to Care and Support for Patients with Inflammatory Bowel Disease in the United States
422 Expanding Access to High Resolution Anoscopy
423 Expanding Access to HIV Pre-Exposure Prophylaxis (PrEP)
424 Supporting Education and Access to Postexposure Doxycycline (DoxyPEP)
425 Prioritizing, Measuring, and Preventing Workplace Violence in Health Care
426 Integrating Nutrition into Health Care Delivery to Reduce Cardiovascular Risk and Food Insecurity ("Food is Medicine")
427 Infant Feeding Options for HIV-Seropositive Individuals
428 Protecting Environmental Health Before, During, and After War
429 Adolescent Dating Violence Comprehensive Screening Tool Development
430 Support Heavy Metal and Toxic Exposure Testing for Residents Affected by Wildfires
431 Supporting Transportation Infrastructure Reform for Public Health
432 Addressing Public Health Risks of Online Sports Betting
433 Addressing the Epidemic of Fragility Fractures Through Improved Osteoporosis Screening and Treatment
434 Vaccinations in Physician Offices
435* Supporting Regulations for More Stringent Safety Measures for Micromobility
436* Protecting Children from Potential Harms of Caffeinated Products

*Contained in Meeting Tote

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07	Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making
08	Increased Transparency Among Psychotropic Drug Administration in Prisons
09	In Support of a National Drug Checking Registry

Resolutions

501	Preregistration in Medical Research
502	Support for Rapid Methadone Inpatient Stabilization and Linkage to Care
503	Expansion of Psychedelic Assisted Therapy (PAT)
504	Strengthening U.S. Rubber Glove Production and Purchase While Reducing Foreign Forced-Labor Dependence
505	Avoiding misuse of artificial intelligence (AI) in clinical practice
506	Access To Gender Affirming Healthcare Including Clinical Trials
507	Pairing Behavioral and Lifestyle Medicine Principles and Practice with Glucagon-like Peptide-1 (GLP-1) Receptor Agonists and Other Anti-obesity Medications
508	Aligning Consistency and Credibility Of Direct-To-Consumer Gut Microbiome Testing Services
509	Preserving Gender-Affirming Surgical Care Access
510	Exosome and Peptide Use in Healthcare
511	Preserving Specialty Access to Anti-Cancer Agents
512	Medical Cannabis Use in Older Adults
513	Access, Affordability, and Safety of GLP-1 Receptor Agonists
514	Education, Screening, and Effective Treatment for Obstructive Sleep Apnea During Pregnancy
515	Transparency in AI-Driven Adverse Determinations & Clinical Logic Disclosure
516*	FDA Regulation of Unapproved Synthetic Peptides

*Contained in Meeting Tote

Reference Committee F

Report(s) of the Board of Trustees

01	Annual Report
04	AMA 2027 Dues
34	Discontinuation of AMA Citation for Distinguished Service
38*	Project IMG Observer Status in the House of Delegates

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

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

Resolutions

601	Board Chair Term Limits
602	Protection of Healthcare and Humanitarian Aid Personnel in Conflict Zones
603	Establish AMA Policy and Project to Compile and Distribute JAMA Patient Pages to Enhance Public Medical Literacy
604	Annual Scorecard to Evaluate the AMA's Impact
605	Review of Past Resolutions
606	Further Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations
607	Shortening the AMA House of Delegates Endorsement Process and Timeline
608	Reinstitution of AMA Guides Editorial Panel
609	American Medical Association Board Chair Term Limits
610	Plant-Based Diets at AMA meetings
611	Publicizing, Supporting, and Promoting (Appropriate) AMA Member Physicians and Physician Spouses as Candidates for Local and State Offices
612	Increasing Expert Guidance in AMA Statements
613	Preserving Institutional Equity and Inclusivity Efforts
614	Inclusive Policy Language for Older Adults
615	Condemnation of Attacks on Healthcare Workers and Facilities in Gaza
616	Humanitarian and Medical Aid Support to Palestine
617	Reevaluation of AMA Policy Regarding Support for Specific National Medical Associations in the World Medical Association
618	Ending AMA Investment in Weapons Manufacturers
619*	Opposing Federal Immigration Operations at AMA Events and Harm to Lawful Non-Target Individuals
620*	Survey of Medical Staffs

*Contained in Meeting Tote

Reference Committee G

Report(s) of the Board of Trustees

20 Mitigating the Impact of Excessive Prior Authorization Processes
22 Comprehensive AMA Policy Publication Regarding Employed Physicians

Report of the Council on Medical Service

01 Council on Medical Service Sunset Review of 2016 House Policies
04 Expanding Medicare Coverage of Medical Nutrition Therapy
06 Study of Practice Models for Physicians Performing Procedures Across State Lines
07 Private Insurance Coverage of Anti-Obesity Medications
09 Nonprofit Status

Resolutions

701 The Crisis in the Availability of Primary Care: Halt the Required Participation of Small Practices in Value-Based Payment (VBP) Models
702 Physicians Who Do Not Practice in Hospital Setting
703 Parity in Pricing for Anti-Obesity Medications
704 Advocating Against Automatic Refill Requests
705 Recognizing Physicians as Sexual Assault Forensic Examiners
706 Discharge Summaries from Skilled Nursing Facilities
707 Malpractice Insurance for Employed Physicians
708 Oppose Imposition of Fees on Physicians for Electronic Payment Transfers
709 Requiring Transparency and Accountability When Insurers and Third-Party Administrators Require Utilization Review, Thereby Practicing Medicine
710 Parity in Access to Evidence-Based Obesity Treatment
711 Oppose Denials Based on Origin of Referral
712 Addressing the Commoditization of Medicine Through Recognition of the Full Scope of Physician Work and Contributions
713 Reducing Prior Authorization Delays to Improve Access to Neuromodulation and Non-Opioid Pain Therapies
714 Physician Case Log Portability
715 Oppose the Legal Position that Virtual Credit Cards are a Legal Method of Payment under HIPAA
716 Equal Opportunity for Payment for “On Call” Duty
717 Advocacy for a Failure-Proof National Centralized Electronic Transaction Clearinghouse

REPORT OF THE BOARD OF TRUSTEES

BOT Report 35-A-26

Subject:	Specialty Society Representation in the House of Delegates - Five-Year Review
Presented by:	David H. Aizuss, MD, Chair
Referred to:	Reference Committee on Amendments to Ethics and Bylaws

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The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) required to submit information and materials for the 2026 American Medical Association (AMA) Annual Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic Review Process."

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

The following organizations were reviewed for the 2026 Annual Meeting:

American Academy of Child and Adolescent Psychiatry
American Association of Clinical Endocrinology
American Association of Physicians of Indian Origin
American College of Medical Genetics and Genomics
American College of Radiation Oncology
American Institute of Ultrasound in Medicine
American Orthopaedic Foot and Ankle Society
American Society for Clinical Pathology
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society of Dermatopathology
American Society of Neuroradiology
Obesity Medicine Association
Post-Acute and Long-Term Care Medical Association
Renal Physicians Association
Society of Critical Care Medicine
Society of Interventional Radiology

The American Vein and Lymphatic Society and The Triological Society were also reviewed at this time because they failed to meet the requirements in June 2025 and were granted a one-year grace period.

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Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group's membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

The materials submitted indicate that: American Academy of Child and Adolescent Psychiatry, American Association of Clinical Endocrinology, American College of Medical Genetics and Genomics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Orthopaedic Foot and Ankle Society, American Society for Clinical Pathology, American Society of Anesthesiologists, American Society of Colon and Rectal Surgeons, American Society of Dermatopathology, American Society of Neuroradiology, Obesity Medicine Association, Post-Acute and Long-Term Care Medical Association, Renal Physicians Association, Society of Critical Care Medicine, and Society of Interventional Radiology meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that The Triological Society met all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that the American Association of Physicians of Indian Origin, American Society of Cataract and Refractive Surgery, and American Vein and Lymphatic Society did not meet all guidelines and are not in compliance with the five-year review requirements of specialty organizations represented in the AMA HOD.

RECOMMENDATIONS

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

1. The American Academy of Child and Adolescent Psychiatry, American Association of Clinical Endocrinology, American College of Medical Genetics and Genomics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Orthopaedic Foot and Ankle Society, American Society for Clinical Pathology, American Society of Anesthesiologists, American Society of Colon and Rectal Surgeons, American Society of Dermatopathology, American Society of Neuroradiology, Obesity Medicine Association, Post-Acute and Long-Term Care Medical Association, Renal Physicians Association, Society of Critical Care Medicine, and Society of Interventional Radiology retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

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

3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in the AMA Bylaw B-8.5 at the end of the one-year grace period, the American Vein and Lymphatic Society lose representation in the AMA HOD but retain it for the AMA Specialty and Service Society (SSS) and may apply for reinstatement in the HOD, through the SSS, when they believe they can comply with all of the current guidelines for representation in the HOD, in accordance with AMA Bylaw B-8.5.3.2.2. (Directive to Take Action)

Fiscal Note: Less than $500

APPENDIX

Exhibit A - Summary Membership Information

Organization	**AMA Membership of Organization's Total Eligible Membership**
American Academy of Child and Adolescent Psychiatry*	1,796 of 8,292 (22%)
American Association Clinical Endocrinology	757 of 3,156 (24%)
American Association of Physicians of Indian Origin	Did not submit data
American College of Medical Genetic and Genomics	415 of 996 (42%)
American College of Radiation Oncology	169 of 585 (29%)
American Institute of Ultrasound in Medicine	703 of 3,209 (22%)
American Orthopaedic Foot and Ankle Society	177 of 833 (20%)
American Society for Clinical Pathology	1,570 of 7,463 (21%)
American Society of Anesthesiologists*	9,428 of 49,594 (19%)
American Society of Cataract and Refractive Surgery*	604 of 3,335 (18%)
American Society of Colon and Rectal Surgeons *	680 of 2,927 (23%)
American Society of Dermatopathology	279 of 1,047 (27%)
American Society of Neuroradiology	765 of 3,294 (23%)
American Vein and Lymphatic Society	199 of 1,102 (18%)
Obesity Medicine Association	704 of 2,699 (26%)
Post-Acute and Long-Term Care Medical Association	362 of 1,615 (22%)
Renal Physicians Association	566 of 2,173 (26%)
Society of Critical Care Medicine	1,957 of 7,597 (26%)
Society of Interventional Radiology	688 of 3,244 (21%)
The Triological Society	123 of 571 (22%)

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

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

Policy G-600.020

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

2. The organization must:

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

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

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

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

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

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

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

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

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

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

Exhibit C

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

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

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

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

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

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

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

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

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

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

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

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

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

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

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

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

REPORT OF THE BOARD OF TRUSTEES

BOT Report 36-A-26

Subject: Update on the Report of the TRHT Task Force to the AMA Board of Trustees

Presented by: David H. Aizuss, MD

At the June 2021 Special Meeting of the American Medical Association (AMA) House of Delegates (HOD), AMA took a critical step toward addressing historical and contemporary injustices in medicine by adopting, as amended, the Council on Medical Education Report 5 (CME 5) entitled, "Promising Practices Among Pathway Programs to Increase Diversity in Medicine". This report recognized longstanding systemic barriers that have marginalized certain populations in medicine and called for the establishment of a task force to guide the AMA's transformation toward restorative justice. The directive emphasized a commitment to truth, reconciliation, and healing in both medicine and medical education.

In response, the AMA Truth, Reconciliation, Healing and Transformation (TRHT) task force was formed and convened quarterly between 2023-2024. The task force conducted historical research, collected contemporary narratives, and developed a final consensus report with actionable recommendations.

In 2025, the AMA Board of Trustees received the final TRHT task force's report, which documented historical findings related to the AMA's role in creating and perpetuating concepts, structures, and systems that marginalized or directly harmed multiple groups of medical aspirants, trainees, and physicians, as well as contributed to inequitable health outcomes. The report also outlined a series of recommendations aimed at addressing both historical and ongoing harms and strengthening equitable systems of care.

The Board agreed to engage in thoughtful and deliberate review of the report's recommendations, including:

- a legal and regulatory assessment to determine how the AMA can best advance the recommendations consistent with our mission, governance structure, and organizational capacity;
- a review in alignment with our AMA's Constitution and Bylaws and internal financial operating procedures; and
- structured Board discussions to determine the best path forward for public management and future action.

While the legal and regulatory review has been completed, the financial review and structured dialogue are ongoing. The Board remains committed to ensuring that implementation efforts are

thoughtful, compliant with applicable legal frameworks, financially responsible, and aligned with the AMA's long-term strategic priorities.

DISCUSSION

Strengthening Strategic Partnerships and Collaborative Policy Development

The AMA continues to engage with the Strategic Opportunities Workgroup, an internal initiative that aligns closely with TRHT recommendations related to trust-building, partnership, and shared policy development.

The workgroup convenes national physician organizations, including the National Medical Association (NMA), National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians, Association of American Indian Physicians (AAIP), and GLMA: Health Professionals Advancing LGBTQ+ Equality. These organizations represent physicians and communities that have historically experienced exclusion or harm within the health care system.

Through this workgroup, the AMA facilitates structured dialogue to identify and advance policy opportunities, elevate community-informed solutions, support coordinated national strategies, and inform AMA policy priorities. While the workgroup predates the TRHT task force report, its continued evolution reflects a deliberate shift toward sustained engagement and co-development of policy. In support of this work, each participating organization received $40,000 in grant funding during the current 2026 cycle to strengthen infrastructure, support mission-aligned programming, and enhance membership development. This investment recognizes the critical role these organizations play in advancing physician leadership and addressing emerging health system challenges.

The AMA expanded its broader partnership strategy in 2026 to further advance reconciliation, rebuild trust and support organizations representing historically marginalized communities. This includes engagement across key convenings such as the NMA Annual Convention and National Colloquium on African American Health, the Congressional Black Caucus Foundation Annual Legislative Conference, the Asian Pacific American Institute for Congressional Studies Awards Gala, the National Hispanic Health Foundation Health Professional Student Scholarship Gala, the Bernard Lown Social Responsibility Conference and Awards Dinner, and the Anarcha, Lucy, Betsey Conference. These engagements are supplemented by sponsorships and collaborations with organizations such as the Association of Black Cardiologists, Minority Health Institute, and the American Society of Medical Association Counsel.

The AMA has also expanded partnerships tied to the Release the Pressure (RTP) campaign, including collaboration with the American Heart Association, health systems, and community-based organizations to address hypertension disparities through culturally responsive outreach and community engagement. The RTP public materials, initially focused on African American women, has expanded to include Latina women, South Asian women, American Indian and Alaska Native (AI/AN) women, and White women in rural communities. Further partnerships with organizations such as the National Health Council, National Rural Health Association,

National Medical Fellowships and the National Hispanic Health Foundation extend the AMA's reach across policy, workforce development and community-based initiatives.

The AMA has also strengthened partnerships focused on educational and workforce development efforts. This includes hosting Internal Medicine Residents from the University of California, Los Angeles in the Washington, DC office for a second consecutive year to provide direct exposure to federal equity advocacy. Additionally, the AMA has expanded its partnership with the Morehouse School of Medicine Satcher Health Leadership Institute by doubling participation in the Medical Justice in Advocacy Fellowship (MJAF) from 10 to 20 fellows for the 2026–2027 cycle and collaborating on the development of a Health Policy, Advocacy, and Justice Lectureship at Morehouse School of Medicine. There are 33 MJAF alumni, and the AMA's Center for Optimal Health Outcomes is working to develop more consistent engagement.

Complementing these efforts, the AMA remains engaged with West Side United, where ongoing work includes the development of a Social Return on Investment (SROI) analysis of its Anchor Mission Partnership. Preliminary findings demonstrate a 4.4x to 8.6x return on investment across community-focused initiatives, including support for local businesses and strengthened clinical-community linkages. AMA is also partnering with Live Healthy Chicago (LHC), a citywide civic initiative to reduce heart attack and stroke risk via improving blood pressure control. It is an innovative outcomes-based prevention financing model building clinical workflow transformation by integrating the AMA MAP™ framework for hypertension control into primary care, deploying mobile community care teams and launching a public health awareness campaign. LHC targets 27 South and West Side Chicago neighborhoods—nearly 740,000 residents—where cardiovascular risk is nearly double the citywide rate and mortality from heart attacks and strokes is disproportionately high. Another organization AMA is working with is the Atlanta Hypertension Initiative (AHI), which brings together public health, health care, community and faith-based organizations, government, academia and professional associations to address longstanding inequities in hypertension control across metro Atlanta. Grounded in truth and accountability for disparate outcomes, AHI focuses on repair and healing through community partnership, clinical quality improvement, and shared capacity-building. Over the next five years, the initiative aims to improve blood pressure control for more than 500,000 adults by contributing to transformative reductions in preventable heart attacks, strokes, and cardiovascular disease.

These engagements further reinforce the value of collaborative, community-informed investment strategies. Collectively, these efforts reflect a coordinated and intentional approach to strengthening partnerships, investing in trusted organizations, and ensuring that policy development and implementation are informed by those most directly impacted by inequities in care delivery.

Advancing Policy Supporting Indigenous Health and Sovereignty

In parallel with partnership-building efforts, the AMA has advanced internal policy initiatives that align with TRHT recommendations focused on structural change and support for historically excluded communities.

At the 2025 AMA Annual Meeting, the House of Delegates adopted Resolution 303-A-25: Support for the Establishment of Indigenous-Led Medical Schools in the United States, which supports the establishment of Indigenous-led medical schools in the United States. This policy emphasizes governance structures grounded in tribal sovereignty, cultural integrity, accountability to Indigenous Nations, inclusion of Indigenous leadership, and alignment with community-defined priorities.

Additionally, the House of Delegates adopted Resolution 604-A-25: Advisory Committee on Tribal Affairs, which directs the AMA to establish a Task Force on Tribal Affairs composed of individuals with lived experience, professional engagement, or direct service within American Indian and Alaska Native (AI/AN) communities. This task force is charged with advising the Board of Trustees on implementation of policies impacting AI/AN communities and developing recommendations for the creation of a permanent Advisory Committee on Tribal Affairs. To date, seven members have been appointed by the Board to serve on the Advisory Committee, and a charter has been drafted. Terms will begin immediately and will end upon the conclusion of the Annual Meeting in the appropriate year for the term length.

This work also includes efforts to promote educational opportunities that enhance understanding of AI/AN contributions to medicine and public health. In support of these efforts, the AMA has collaborated with the AAIP to identify individuals with the expertise and experience necessary to inform this work.

In preparation for the 2026 Annual Meeting, the Council on Medical Education has submitted the following two reports for consideration:

- CME Report 3: Support for the Establishment of Indigenous-Led Medical Schools in the United States
- CME Report 4: Reflecting the Values and Priorities of Tribal Communities in Indigenous-Led Medical Schools in the United States

Together, these actions represent meaningful steps toward strengthening Indigenous representation, advancing culturally grounded approaches to medical education, and ensuring sustained attention to tribal health equity.

Strengthening Maternal Health Systems and Workforce Through Advocacy

Consistent with TRHT recommendations related to maternal health equity, the AMA has advanced its policy and advocacy efforts to strengthen access to care, workforce capacity and care delivery systems.

The AMA has engaged in federal policymaking through input on the Center for Medicare & Medicaid Services Innovation Center's Transforming Maternal Health Model and has submitted recommendations to Congress aimed at strengthening and retaining the maternal health workforce, particularly in rural and underserved areas. The AMA has also supported legislation such as the Rural Obstetrics Readiness Act to expand emergency obstetric training in facilities without dedicated obstetric units.

In addition, the AMA has advanced policies supporting telehealth and remote patient monitoring, including support for the Connected MOM Act, to improve access to maternal health services in shortage areas. Ongoing work related to AMA's Current Procedural Technology (CPT®) coding reforms, including the proposed unbundling of global maternity care CPT codes, may further support flexible, team-based models of care. The AMA has also supported initiatives to expand maternal health workforce pathways, including rural residency training programs and efforts such as the Teaching Health Center Graduate Medical Education Program and the National Health Service Corps' Maternity Care Target Area initiative. These efforts aim to strengthen care delivery in communities disproportionately impacted by maternal health inequities.

CONCLUSION

The AMA will continue to further its ongoing work aligned with TRHT recommendations through strengthened partnerships, focused policy development, and strategic investments. At the same time, as the AMA looks ahead to future implementation, sustained commitment, dedicated resources and coordinated action across the organization which will be essential to building on this foundation. Continued focus on partnership, accountability and measurable impact will be critical to advancing reconciliation and strengthening equitable systems of care. The AMA remains committed to this work and to advancing policies and practices that improve health outcomes for all communities.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 37-A-26

Subject: AMA Policies on Gender Affirming Care

Presented by: David H. Aizuss, MD, Chair

This report is submitted as information to the House of Delegates as a summary of the policies that form the foundation of our American Medical Association's (AMA) position on gender affirming care and to address concerns related to our failure to accurately and completely communicate those policies. Specifically, the report addresses the medical necessity of such care, the role of shared decision-making, and considerations related to gender-affirming surgery.

BACKGROUND

The policies outlined in this report establish the basis of the AMA's position on gender-affirming care. Taken together, they inform an approach to medical and surgical interventions, including in minors, that supports evidence-based treatment.

Intending to align with these policies, the AMA Board of Trustees approved the following statement:

> "We support evidence-based treatment for medical care, including gender affirming care. Currently, the evidence for surgical intervention in minors is insufficient for us to make a definitive statement. In the absence of clear evidence, surgical interventions in minors should be generally deferred to adulthood.
>
> Treatment decisions should be made between the physician and the patient (and family) based on the best medical evidence and clinical judgment."

This statement was not intended to change existing or establish new AMA policy. Nothing in this statement was intended to alter the AMA's support for access to medically-necessary gender affirming care, our reliance on evidence-based guidance from relevant specialty societies, our support of shared decision making between patients, families and the health care team, or our opposition to government or third-party interference in the patient-physician relationship.

We recognize, however, that this statement failed to accurately and completely reflect the breadth of AMA policy on gender affirming care, and that the way it was communicated to the media compounded that failure. We further recognize that some characterizations of our statement created confusion about AMA policy and caused concerns and harm among members and stakeholders. After much discussion, we have taken steps to ensure the future comments undergo more thorough review, are vetted by the appropriate experts, and are communicated with greater clarity, precision, and transparency. We remain committed to the health and well-being of transgender and gender diverse people.

AMA POLICY

AMA Policy H-185.927, "Clarification of Evidence-Based Gender-Affirming Care," states that:

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> "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. 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; 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; 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 communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence. Our AMA will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers."

AMA Policy H-185.905, "Advocating for the Informed Consent for Access to Transgender Health," states that:

> "Our American Medical Association unambiguously supports access to and insurance coverage of medically necessary gender-affirming care but does not identify a preferred model of care for determining medical necessity. The AMA vigorously advocates for equitable payment policies, relying on the evidence-based professional guidelines and recommendations set by professional medical associations, as well as individual physician clinical judgment, on questions of appropriate clinical criteria."

AMA Policy H-460.893, "Patient-Reported Outcomes in Gender Confirmation Surgery," states that:

> "Our AMA supports: (1) initiatives and research developed by specialty societies and other relevant stakeholders to establish standardized protocols for patient selection, surgical management, and preoperative and postoperative care for transgender patients undergoing gender confirmation surgeries; and (2) implementation of standardized tools, such as questionnaires, developed by specialty societies and other relevant stakeholders to evaluate outcomes of gender confirmation surgeries."

AMA Policy H-140.824, "Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population," states that:

> "Our American Medical Association supports shared decision making between gender diverse individuals, their health care team, and, where applicable, their families and caregivers. Our AMA supports treatment models for gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third-party involvement outside of the physician-patient relationship in the decision-making process."

DISCUSSION

AMA policy affirms that gender-affirming care is medically necessary, as articulated in AMA Policy H-185.927. Adopted by the House of Delegates in 2016 and amended and reaffirmed on several occasions since, this policy states that our AMA "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 the generally accepted standards of medical and surgical practice." AMA Policy H-185.905, adopted in 2024, reiterates our position and states that the AMA "unambiguously supports access to and insurance coverage of medically necessary gender-affirming care."

Furthermore, while these policies do not explicitly address application to minors, language regarding civil and criminal legal protections, including "parents and guardians," imply that support for the medical necessity of gender-affirming care extends to all patients. Accordingly, the reference to "generally accepted standards of medical and surgical practice" in AMA Policy H-185.927 applies to all patient populations, including minors.

As a general principle, the AMA does not typically endorse guidelines or establish standards of care, including any specific treatments for gender dysphoria or gender incongruence. Instead, the AMA defers to national medical specialty societies on these matters.

Specifically, regarding gender-affirming surgery, AMA Policy H-460.893 expressly supports specialty societies' development of "standardized protocols for patient selection, surgical management, and preoperative and postoperative care." Further, AMA Policy H-185.905 relies on "evidence-based professional guidelines and recommendations set by professional medical associations, as well as individual physician clinical judgment, on questions of appropriate clinical criteria" for gender affirming care. Accordingly, on these matters, the AMA relies on the expertise of relevant national medical specialty associations.

According to the policy statements and recommendations of these organizations, surgical interventions are generally postponed until adulthood. Otherwise, the consensus of the recommendations is that gender-affirming surgical interventions be approached through an individualized, developmentally informed framework. Comprehensive mental health assessment and treatment of any relevant co-occurring conditions, social transition and hormonal therapies are considered before surgical interventions. As with all surgical interventions, decisions regarding gender affirming surgery in minors require individualized assessments of risks, benefits, and alternatives.

Clinical decision-making must ultimately be individualized, with physicians tailoring recommendations, including the type and timing of interventions, to each patient's unique circumstances and clinical context. As such, the AMA "supports shared decision-making between gender-diverse individuals, their health care team, and, where applicable, their families and caregivers," as articulated in AMA Policy H-140.824.

The AMA opposes laws and policies that criminalize, prohibit, or otherwise impede access to gender-affirming care, as stated in AMA Policy H-185.927. This position is consistent with broader AMA policy opposing governmental or third-party interference in medical decision-making, including Policies H-373.995, H-5.989, H-270.959, and H-160.946, all of which affirm the importance of preserving physician clinical judgment and the integrity of the patient-physician relationship.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 38-A-26

Subject: Project IMG Observer Status in the House of Delegates

Presented by: David Aizuss, MD, Chair

Referred to: Reference Committee F

The Board of Trustees has received a request from Project IMG to be considered for Official Observer status in the House of Delegates (HOD) of the American Medical Association (AMA). The Project IMG's request has been considered using the criteria below (Policy G-600.025, "Official Observers in Our AMA House"):

1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both;
2. The organization should be national in scope and have similar goals and concerns about health care issues;
3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD; and
4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

DISCUSSION

As part of its request, Project IMG submitted information on how it has met the criteria for Official Observer status, which is summarized below.

Criterion 1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both.

Project IMG has collaborated with the AMA on key events and initiatives, including events in New York and Miami. Most recently, the CEO, Dr. Sebastian Arruarna was a featured speaker at the AMA Distinguish Yourself IMG Summit. This involvement reflects the strong alignment of the AMA's goals of inclusion, education and advancement for international physicians. Project IMG has also worked with AMA to support national advocacy efforts, particularly surrounding the J-1 visa process. There has been involvement with the AMA IMG Section including exchanging critical information and ideas – particularly during the J-1 visa pause and other urgent matters impacting IMGs nationwide.

Criterion 2. The organization should be national in scope and have similar goals and concerns about health care issues.

Project IMG has active chapters in the majority of the U.S. states and mobilizes students and trainees through a three-pronged approach of education, advocacy and service. Project IMG also engages in policy conversations and public discourse to advocate for sustainable immigration

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pathways and address workforce gaps across the country. In addition, Project IMG actively partners with U.S. hospitals to increase meaningful clinical opportunities for IMGs and collaborates with free clinics nationwide to empower their members to serve underserved communities while gaining vital hands-on experience.

Criterion 3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD.

Project IMG is prepared to maintain a consistent presence with the HOD to help amplify and support the AMA's initiatives and priorities. This presence would also allow Project IMG to gain a broader understanding of issues and solutions across the wider medical field, which it will then share with their members. Project IMG's members offer both national and global perspectives on the status of international medical students and graduates, as well as U.S.-based residents, fellows and practicing physicians. This perspective can make a valuable contribution to policy discussions and healthcare reform efforts that directly shape the future of medicine in the United States.

Criterion 4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

Project IMG is a mission-driven collective supporting more than 100,000 International Medical Graduates (IMGs) and medical students from over 120 countries. Although focused on IMGs, Project IMG's membership is completely free and open to anyone – ensuring that their resources, programs and support structures are accessible to all who wish to join.

CONCLUSION

The Board of Trustees appreciates the previous collaboration with Project IMG and their willingness to amplify and support AMA's initiatives and priorities while also bringing a unique perspective to the HOD. Therefore, your Board believes that Project IMG should be recognized as an Official Observer and welcomed to the House in that capacity.

RECOMMENDATION

The Board of Trustees recommends that Project IMG be admitted as an Official Observer in the House of Delegates, and the remainder of this report be filed.

Fiscal Note: Minimal

Appendix - Official Observers to the House of Delegates as of May 2026

Organization	Year Admitted
Accreditation Council for Continuing Medical Education	2025
Ambulatory Surgery Center Association	2005
American Academy of Physician Associates	1994
American Association of Medical Assistants	1994
American Board of Medical Specialties	2014
American Dental Association	1982
American Podiatric Medical Association	2019
Association of periOperative Registered Nurses	2000
Association of State and Territorial Health Officials	1990
Council of Medical Specialty Societies	2008
Federation of State Medical Boards	2000
Federation of State Physician Health Programs	2006
Intealth (ECFMG)	2011
Medical Professional Liability Association (formerly PIAA)	2013
Society for Academic Continuing Medical Education	2003
United States Professional Association for Transgender Health	2024
World Medical Association	2024

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-A-26

Subject: Update on CLRPD Evaluation of the Structure of the House of Delegates

Presented by: Jan Kief, MD, Chair

BACKGROUND

As it continues its evaluation of the size and structure of the American Medical Association (AMA) House of Delegates (HOD), the Council on Long Range Planning and Development (CLRPD) wished to provide the House and Board of Trustees (BOT) with an update on its progress, processes, and key takeaways to date.

CLRPD continues to vet all potential solutions; no decisions on final recommendations have been made at this juncture. The council welcomes feedback from the board on all these proposals and will continue to seek ways to present these proposals to an ever-widening group of stakeholders for its feedback and to work together toward consensus. Throughout this process, the council has emphasized objectivity, impartiality, transparency and collaboration as it works toward a future HOD based on the principles of efficiency, effectiveness and fair representation. Any significant changes to HOD processes will require bylaws changes and a supermajority vote. Therefore, while identifying viable solutions is an important part of the equation, providing education on the necessity for action and building consensus on the identified recommendations will be a priori to this project's ultimate success.

TIMELINE AND PROCESS

BOT Report 27-A-25, "AMA Reimbursement of Necessary HOD Business Expenses for Delegates and Alternates" tasked CLRPD to comprehensively study and report back on potential changes to the length, format and structure of future AMA HOD meetings for report at the 2026 Interim Meeting. The charge to CLRPD was further refined to studying possible solutions to address the issue of the rapid growth of the HOD while preserving its representative nature and improving efficiency and effectiveness.

CLRPD Report 2-I-25 provided a detailed timeline and summary of the policy decisions that led to the current state of HOD delegate apportionment and recommended a one year pause on delegate growth so that these policies could be thoroughly evaluated and potential solutions could be offered. This report was not adopted by the HOD.

Also at the 2025 Interim Meeting, the council hosted a listening session open to all meeting attendees to provide background information on the causes of the rapid growth of the HOD and asked a series of questions to attendees to obtain initial reactions to the ideas presented. The session was attended by hundreds of AMA members and staff, and around thirty members offered their perspectives during the one-hour session. A follow-up survey containing the same questions using a Likert scale was made available to all meeting attendees to obtain further feedback, to which 191 members responded. Analysis of those responses was conducted in collaboration with AMA's Strategic Insights team and can be found in Appendix B of this memo.

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Since January 2026, the council has been meeting on average every two weeks to continue this effort. In January, BOT Chair David Aizuss MD issued a call for volunteers to participate in a focus group related to CLRPD's ongoing HOD work. Of over 100 applicants, 15 were selected and they participated in three focus groups facilitated by CLRPD to help vet and identify the most viable potential solutions. Throughout those sessions, the council has obtained invaluable feedback and begun to refine its eventual recommendations. The focus group has agreed to potentially reconvene as the report submission approaches. The focus group also received a follow-up survey to collect in-depth personalized feedback on potential HOD proposals.

Prior to and during the February meetings of CLRPD, the council received input from staff to understand organizational capabilities with respect to declaring state and specialty affiliations and insight into the group membership space, which included proprietary data. As will be discussed below, certain capabilities are still being explored with the appropriate AMA business units as the council continues its due diligence.

Further events and outreach efforts are still under consideration as the council works toward I-26. As noted previously, the council hopes to engage with as many members of the HOD and AMA as possible to ensure that its ultimate recommendations are both thoroughly understood and sensible to increase the likelihood for acceptance by two-thirds of voting delegates. While we all recognize the challenge of reaching this high bar of acceptance, the process so far has been encouraging in that, at least from the perspective CLRPD, it has become apparent that when presented with data and clear, concise accompanying visualizations outlining the realities of recent HOD growth, and when given the opportunity for open and respectful discussion about those challenges and potential solutions, members engage and consider possibilities that they may have initially opposed.

In advance of I-26, and taking in feedback from AMA business units, CLRPD board liaisons, and the CLRPD's April BOT presentation, a final update will be presented to the BOT during its September meeting in which the council will outline its complete list of suggested proposals for consideration and feedback.

KEY THEMES AND CONSIDERATIONS

Before discussing specific proposals under consideration, the council would like to highlight some key themes and ideas that are continually informing its work.

Apportionment of Delegates in the Strictest Sense Based Upon AMA Members' Geographic and Primary Specialty Designations

As the most basic of a contextual perspective, at the current 1:1000 apportionment for a delegate seat, if based upon the current total AMA membership of ~300,000, theoretically, there would be 300 delegate seats. Allowing for all AMA members to be counted twice, once by geographic demography and a second time by their primary specialty, there would be 300 x 2 = 600 Delegate Seats. This is further extrapolated under "Multiplicative Counting."

Urgency

The council understands the importance of finding a viable solution to addressing HOD growth. Appendix A contains three graphics that CLRPD has developed to demonstrate the scope of this issue, both in the present and future. Graphic 1 shows a timeline of HOD growth through this year along with various policy decisions that have led to the HOD's current size, and graphic 3 shows the current breakdown of delegates by category. Graphic 2 presents growth scenarios based on four

possible compound annual growth rates (CAGR). Since current apportionment practices were last modified in 2016, the HOD has grown at an average CAGR of 4.0 percent annually. Were that to continue, the HOD would eclipse 1,000 members by 2032. At a more modest 2.0 percent CAGR, the HOD would eclipse 1,000 delegates by 2037. Graphic 2 also demonstrates that the issue is accelerating; the more the HOD grows, the faster it will grow in the future due to current apportionment policies. The council has investigated and benchmarked other similar bodies within the United States as requested by focus group members. These examples display organizations with similar governing bodies, and the council has been unable to identify any other representative bodies with similar HOD sizes as the AMA. In fact, as the AMA HOD approaches 800 voting members, CLRPD was unable to identify another professional interest association with more than 600 members of its policymaking body. The council considers these other organizations as benchmarking examples since an oversized HOD impacts the efficiency of its deliberations.

Organization	**Membership**	**Policymaking Body Size**
American Academy of Family Physicians	~124,500	~120-130
American Bar Association	~227,000	~550-600
American Nurses Association	~200,000	~400
American Institute of CPAs	~428,000	~265
American Osteopathic Association	~207,000	564 (2025)

State and Specialty Parity

No single policy decision has more significantly contributed to the recent, rapid growth of the House than the decision made at I-16, which established Policy G-600.027, which stated that "…specialty society allocation in the House of Delegates be determined so that the total number of specialty society delegates shall be equal to the number of delegates apportioned to constituent societies…" This decision was made in response to a desire within the HOD for equal representation between states and specialties, a simple mechanism to do so, and the ineffectiveness of the ballot system that asked members to select a specialty society to represent them because few members completed the ballot. Referring again to Graphic 1 in Appendix A, since the establishment of that policy, the HOD has grown by 44 percent in the last ten years, after being nearly stable in size for the previous fifteen. Introducing parity between state and specialty societies without simultaneously adjusting the delegate apportionment ratio has directly led to the dramatic increase in delegates over the past decade.

The question has been raised frequently as to whether this policy is necessary, or whether the unintended consequences of its adoption might suggest that a recommendation to rescind G-600.027 would in and of itself solve the HOD's growth problem. It is likely that such a policy change would lead to a quick reduction in the size of the HOD, but the council has strong doubts about the likelihood of such a proposal being accepted by two-thirds of the House.

Multiplicative Counting

As noted in BOT Report 6-I-16, "Designation of Specialty Societies for Representation in the House of Delegates," which established Policy G-600.027, "…every AMA member should be represented by both a constituent association and a specialty society in the HOD—the stated goal since 1996…" However, it has become apparent that many AMA members are counted more than two times for the purposes of delegate apportionment. Some examples include:

- A physician who is a member of multiple specialty societies will be counted for his/her state as well as any specialty society in which they are a member.
- Residents are counted for apportionment of the state in which they reside, for the apportionment of resident sectional delegates, and for the apportionment of any specialty to which they belong.
- Delegates are apportioned to state medical associations for any physicians and medical students residing in a state whether or not the individual is a member of that state association. E.g., a physician member of the AMA and AAFP will count toward the apportionment of the Florida Medical Association (FMA) even if he/she is not a member of FMA.
- CLRPD analysis found that as of 2025, students and residents made up approximately 47.5 percent of state AMA membership populations, with some states as high as 60-70 percent. However, as very few delegations are represented by those groups at such high proportions, state delegation growth is driven in large part by groups that may not be appropriately represented among their ranks.

This multiplicative counting combined with the parity policy (and without any adjustment being made to apportionment ratios) has led to a situation of compounding growth of delegations. On the state side, any member residing within a state will contribute to delegate growth among state medical associations, even if those members do not belong to those respective associations. This increase in the total state delegation apportionment then increases the total number of specialty delegates per the previously referenced parity policy. On the specialty side, members can and will be counted as part of any specialty or subspecialty to which they belong, and the increasing number of subspecialties in the HOD (135 total specialty societies in 2026) increases the likelihood of an individual member being counted across multiple specialties. Additionally, residents and students are counted for the purposes of resident sectional and student regional delegates. As a result, individual members, under current practices, are being counted multiple times, artificially inflating delegate count.

The council identified this issue early in its deliberations, and it is one that has resonated with those with whom the council has discussed it, including members of the BOT and the CLRPD focus group, attendees of the HOD listening session and survey respondents. The council has had numerous discussions with AMA management concerning the issue, and to this point, has been advised that determining the prevalence of this multiplicative counting may be exceptionally challenging, if not impossible. Multiple methods have been discussed, including instituting a modernized ballot system to require all AMA members to declare both a state and single specialty affiliation for the purposes of apportionment, and cross-referencing delegation rosters to identify overlapping membership. The former, the council has been advised, presents a series of both technological and logistical challenges, including that (1) for the numbers to be usable, a one hundred percent response rate would be required and (2) in some cases, particularly due to evolving group membership practices, physicians do not sign-up for or renew their AMA memberships themselves, and those completing those steps on their behalf would be unlikely to accurately capture their appropriate specialty affiliations.

The council has also been advised that cross-referencing members across specialties is not within the AMA's current capabilities given that the AMA only analyzes specialty member data every five years (on a rotating basis) and looks at overall AMA membership percentages from each organization, not individual physicians. These ideas are still being explored; as noted previously, and all possibilities are being considered. However, from the information obtained from AMA management that the council has received, solutions are unlikely feasible.

Dues/group membership

The idea has been raised by several stakeholders that consideration should be given to how members join the AMA, and, more specifically, whether the dues members pay should have an impact on delegates are apportioned in relation to their membership. This issue is also related to the increasing proportion of AMA members who join through health systems and other group membership programs like the GME Competency Education Program (GCEP) for residents and the UME Curricular Enrichment Program (UCEP) for students and therefore often pay less in dues than their colleagues who are individual members.

Within the council and the focus group, this concept faced a great deal of skepticism, largely due to perception that such a recommendation would be viewed as a "pay-to-play" policy in which influence is tied to payment and at odds with the AMA's commitment to a democratic process. Such a model is also complicated by the fact that even among individual members there is a wide range of dues paid depending on career stage and other factors. For instance, among post-residency physicians, dues in 2026 range from $60/year for physicians in their first year in practice to $315/year in their fourth before reaching the full $420/year. Semi-retired physicians pay $210/year, while fully retired physicians pay $84/year. Different fee structures are also in place for members of the military/veterans affairs, students, and resident physicians and fellows. These factors suggest that implementing an apportionment process related to dues paid would be a logistical challenge. Given that the idea was generally not well received by members of the focus group or CLRPD, the council believes that, at this time, any proposal tying dues to apportionment is unlikely to gain approval from two-thirds of the HOD.

DRAFT TIMELINE FOR APPORTIONMENT CHANGES

A consistent theme raised throughout discussions among the council and the focus group was the preference for a gradual, phased-in implementation process for any policy changes to allow state and specialty societies to adjust to new practices. As noted previously, however, CLRPD recognizes that to avoid major disruption during HOD business sessions, some level of change must be implemented as soon as possible.

Another recurring theme during discussions among the council, board liaisons, and the focus group was a preference for simple solutions over more complex overhauls of current practices. This echoes the previously referenced BOT Report 6-I-16—when the last significant changes were made to HOD apportionment practices—which noted that during debate on the issue of parity at A-16, a desire emerged for a simple method of allocation. The council sees the wisdom in this approach, as any proposal to decrease the size of the HOD will already be viewed as a disruption, introducing and attempting to explain and create buy-in for complex structural change will likely add to the challenge. Given the need for two-thirds of the House to support any of these proposed measures, the council believes that simple, progressive and equitable measures are more likely to be accepted than more drastic or conceptual changes. These conversations are ongoing.

What follows is an illustrative timeline of potential policy changes that the council believes could balance the need for immediate action with a phased implementation that would allow the HOD's component groups time to adjust to a new approach. The recommendations presented below have been discussed at length among the council and focus group, and based on feedback received, were perceived most positively and were identified as those most likely to be acceptable to the HOD.

Timeline

2026 Interim Meeting:

1. Pause delegate growth for two years (2027-2028) while changes are phased in.
2. Eliminate the language "…and fraction thereof" from bylaws and policy related to delegate apportionment.

As was noted during the board's April meeting in discussion of this topic, a potential issue that may have led to non-adoption of a proposed pause at I-25 was a lack of specifics on how such a pause would be implemented and who would be impacted. Those details would be addressed were this solution to be proposed in a future report. For instance, new societies that have gained representation to the HOD through current policy could still be granted membership despite the suggested pause.

The elimination of "…and fraction thereof…" would, using data from this year's apportionment, decrease the size of the HOD by 94 delegates from state and specialty delegations (via a reduction of 47 delegates from state medical associations and the associated parity adjustment). During discussions among the focus group, this was overall viewed as a fair and reasonable measure. Using current practices, a delegation with membership of 1,001 is apportioned the same number of delegates as one with a membership of 1,999. It was also noted that member numbers for states and specialties are readily available within the first three weeks in January, so this rounding is no longer necessary and artificially elevates delegate numbers.

An alternative proposal is to institute standard rounding practices (rounding half up) so that an additional delegate would be granted to a state or specialty society once they reached the halfway point to the next delegate, e.g., using current apportionment ratios an association would receive a second delegate once they reached 1,500 members. Using 2026 figures, this would result in a reduction of 48 state and specialty delegates.

2027 Annual Meeting:

3. CLRPD will issue a revised report on meeting venues for HOD meetings.

As the question of meeting venues is regularly discussed in relation to the discussion of HOD sizing, CLRPD will revise its previous report on meeting venues for submission to the HOD. In addition to geographic considerations, this report can also address the logistics and costs required for relocating future meetings to larger venues, including convention centers, and would add transparency to the process.

2027 Interim Meeting:

4. Implement a revised apportionment ratio so that societies will be allocated one delegate for every 1,250 AMA members. An Association would receive its next delegate seat at 2,500 members, and so forth.
5. Revise student and resident apportionment so that student regional delegates and resident sectional delegations will be allocated one delegate per 2,500 AMA members. The next delegate seat would be allocated at 5,000 members, and so forth.

Using 2026 figures this would decrease the size of the HOD by 130 state and specialty delegates, five student regional delegates and eight resident sectional delegates. When combined with the

previous recommendations this would lead to an HOD of approximately 556 delegates for 2028 (without considering potential future membership growth). Overall, this was viewed as a reasonable proposal by both the council and the focus group. In general, the proposals that received the most support were those viewed as impacting all component groups equitably.

A recommendation of adjusting apportionment ratios to one delegate per 1,500 members and one student/resident delegate per 3,000 members is still under consideration as well. This would reduce the number of state/specialty delegates by 210, student regional delegates by nine and resident sectional delegates by fourteen. The council also considered adjusting the ratios to one delegate per 2,000 members and one delegate per 4,000 student/resident members but determined that adjustment to be too extreme.

2028 Interim Meeting:

6. Establish an HOD with a fixed size of 600.

Under this proposal, the size of the House would be fixed, with 261 delegates apportioned to states, 261 to specialty societies, and 78 to students, residents, sections and other groups. CLRPD has considered methods of apportionment that could "future-proof" the HOD for future membership fluctuations. Mathematical models (such as the Method of Equal Proportions (MEP), or Huntington-Hill Method, used by the U.S. House of Representatives) are used worldwide to organize representative bodies and would help our HOD avoid regularly running into issues related to sizing. The MEP and other similar models assign seats based on mathematically neutral priority values rather than arbitrary thresholds. Adopting the MEP would modernize AMA representation and align it with long-standing, globally accepted apportionment standards. Appendix C contains a document outlining the processes involved in such a model.

While this solution is more complex than those previously presented, its adoption would set a clear direction for the HOD that would be transparent to all members and would not fluctuate with membership changes. Specifics of this proposal are still being considered within the council and in consultation with AMA staff.

Other recommendations for consideration:

- The Speakers and BOT will continue to evaluate cost-saving considerations, efficiencies, length and locale of HOD meetings.
- During implementation and into the future, CLRPD will regularly poll members of the HOD on its structure and operations to create a culture of continual assessment.
- Specialty society membership numbers will be obtained every three years as opposed to every five years for increased accuracy.

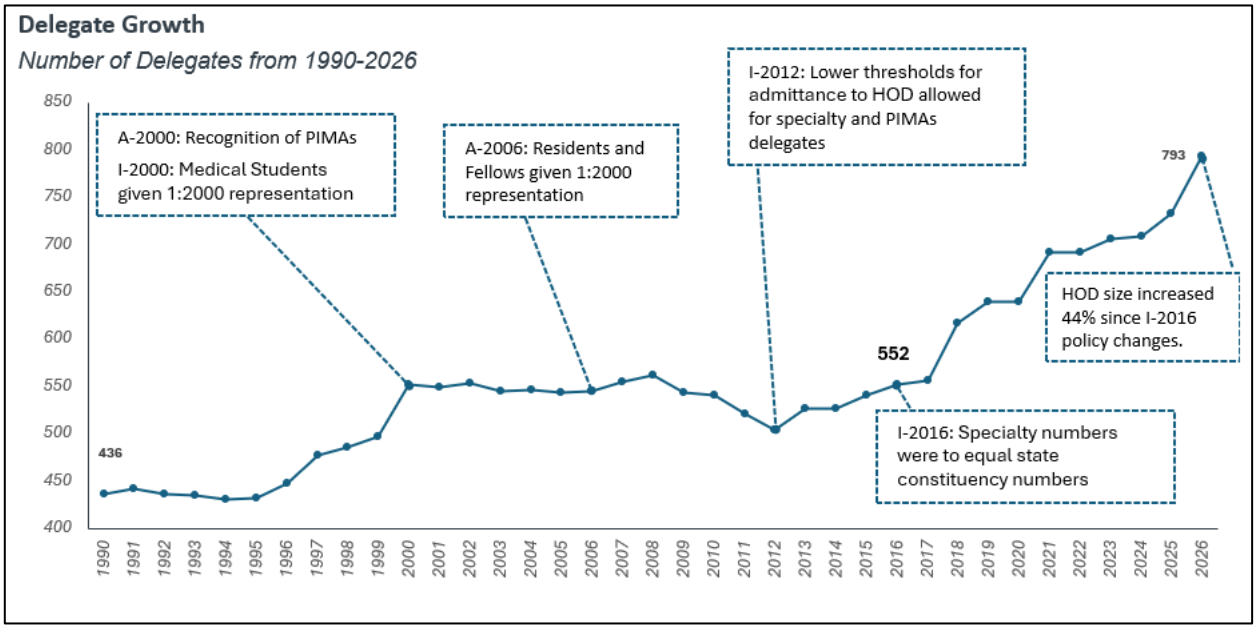
CONCLUSION

As noted previously, CLRPD has not ruled out any potential recommendations and is still gathering information and investigating potential solutions related to multiplicative counting and state/specialty parity. The solutions contained in the timeline above have been most favorably received by members of the council and the convened focus group and seem most likely to obtain the two-thirds vote required for implementation. As the council works towards its final recommendations, it will continue to consider the expert opinions of the HOD, BOT and AMA executive leadership and welcomes all feedback on the ideas and proposals contained in this report.

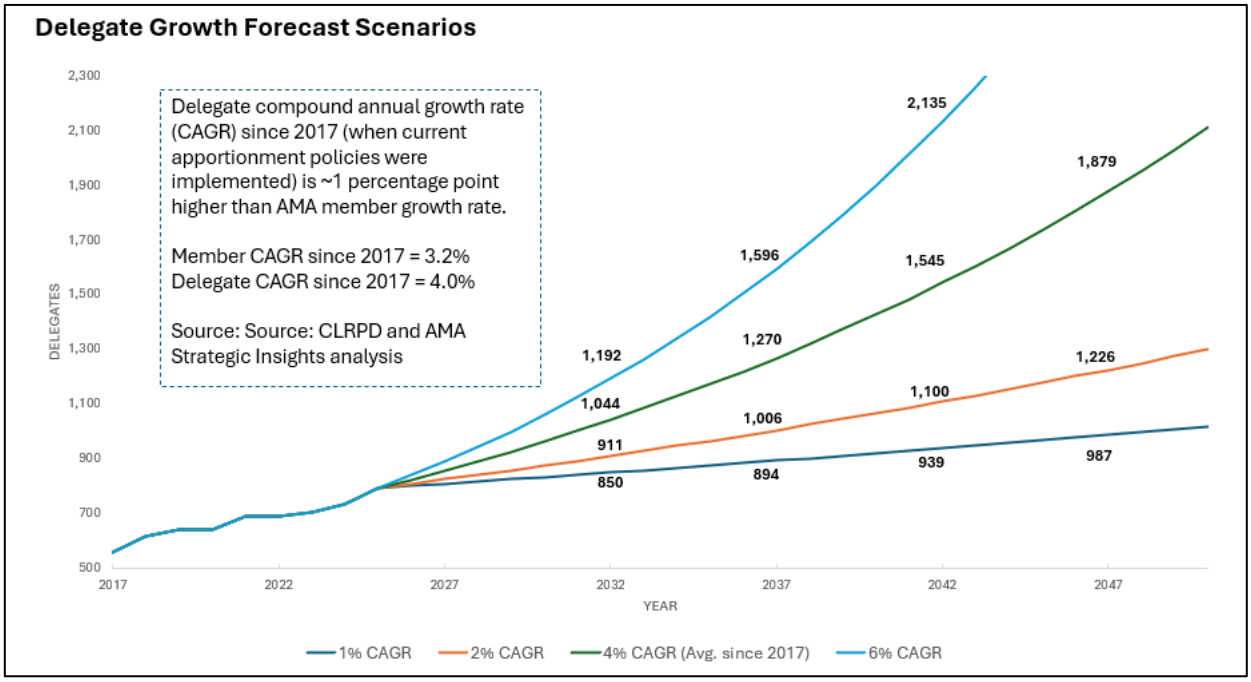
As noted previously, the council also recognizes that it will be essential to provide education for members of the HOD to make it clear why change is needed and to build consensus on recommendations.

The council's focus will remain on identifying solutions that enhance efficiency, effectiveness and fairness within the HOD, while honoring tradition and working toward future sustainability. The council appreciates the guidance and partnership the BOT and members of the House have offered throughout this process and looks forward to continued collaboration as the process moves forward.

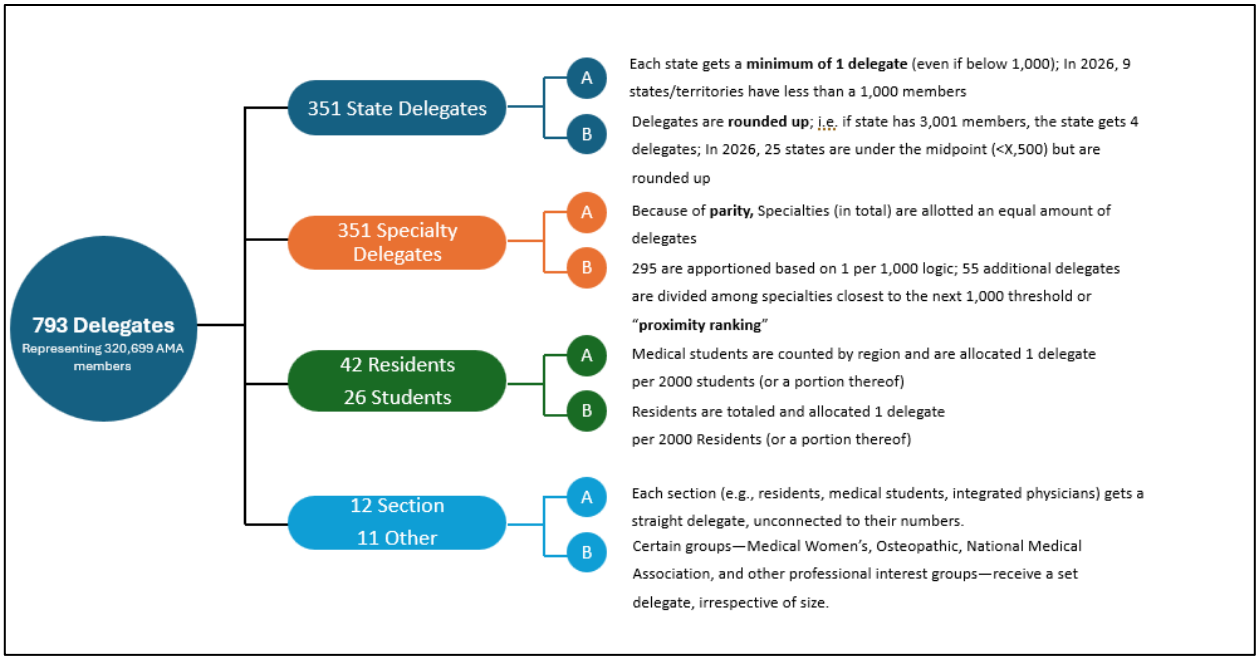
APPENDIX A



Graphic 1. Delegate Growth Timeline and Related Policy Decisions 1990-2026



Graphic 2. Delegate Growth Forecast Scenarios



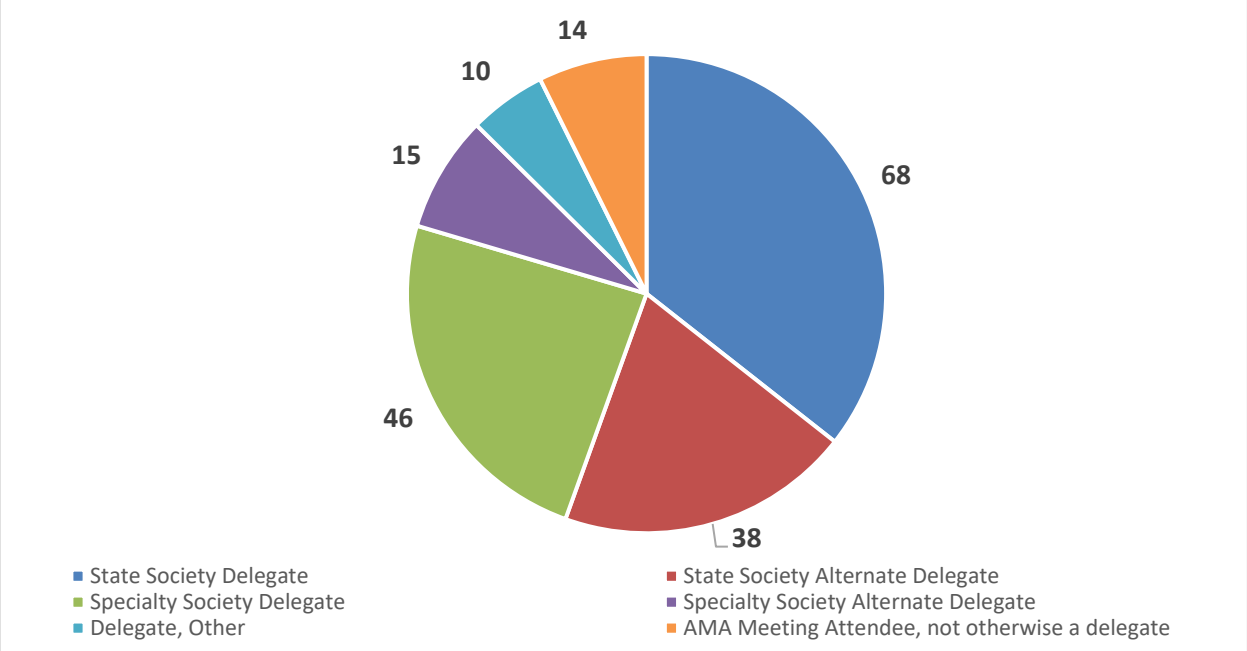
Graphic 3. Delegate Allocation (2026)

APPENDIX B

Summary of Survey of AMA Meeting Attendees on Size of HOD
Developed in part using AMA AI

Summary of Respondents by Role

Role	Number	Percent
State Society Delegate	68	36%
State Society Alternate Delegate	38	20%
Specialty Society Delegate	46	24%
Specialty Society Alternate Delegate	15	8%
Delegate, Other	10	5%
AMA Meeting Attendee, not otherwise a delegate	14	7%
Total	**191**	**100%**



Sentiment Descriptions for the Questions Presented at I-25 Open Forum and Follow-Up Survey

- **Positive**: Constructive, supportive, or forward-looking suggestions/remarks.
- **Somewhat Positive**: Mild positivity, constructive with some reservations/conditions.
- **Neutral**: Pure questions, factual statements, or comments without discernible sentiment.
- **Somewhat Negative**: Mild criticism or concern, not strongly worded.
- **Negative**: Strong opposition, criticism, or clear negativity about current structure/issues.

Q2: Could a House of Delegates with a fixed size help to address the cost, venue, and efficiency challenges?

Sentiment	Count	Percent	Description
Positive	4	2.14%	Enthusiastic support for fixed size, focus on benefits
Somewhat Positive	20	10.70%	Supportive, but often with caveats about diversity or flexibility
Neutral	91	48.66%	States ("Maybe," "It depends," asks for data, or provides balanced pros/cons)
Somewhat Negative	56	29.95%	Concerned about loss of representation/diversity, but not absolute opposition
Negative	16	8.56%	Strong opposition, e.g. "fixed size is a bad idea," prefer growth/expansion

Q2: Common Themes

- Those in favor highlight efficiency, administrative manageability, and cost/venue flexibility.
- Those opposed emphasize the need for inclusiveness, diversity, growth, and the risk of disenfranchising small groups or young/trainee voices.
- Growth & Policy: Strong opinions both for and against fixed, capped, or reduced size. Calls to balance state/specialty representation and apportionment formulas.
- Many “neutral” responses caution about unintended consequences or say "yes, but only with safeguards for representation/engagement/etc."
- Some suggest alternate reforms: hybrid/virtual options for participation, changes/expansion of venues, or incremental reforms rather than a strict cap.

Q3: How would our House of Delegates be impacted if the number of duplicative apportionments were reduced?

Sentiment	Count	Percent	Description
Positive	11	6.15%	Strong endorsement of reduction, believe it would improve fairness/efficiency
Somewhat Positive	68	37.99%	Generally supportive, express some reservations (e.g., want careful implementation)
Neutral	45	25.14%	Factual/informational or very balanced/mixed effects, sometimes "depends"
Somewhat Negative	26	14.53%	Express concern for engagement/small group participation, not total opposition
Negative	29	16.20%	Strong worry about loss of voices/diversity, pipeline, smaller specialties harmed

Q3: Common Themes

- Many favor reforms to reduce duplicative counting (especially for multiple specialties), reduce delegate inflation, and improve efficiency, but urge data-driven, carefully phased implementation to avoid unintended exclusion of smaller or marginalized groups.
- Some favor requiring/re-evaluating minimum society size for delegate eligibility.
- Some respondents suggest considering a process for members to pick one state and one specialty society and some suggest re-examining/limiting growth formulas or delegate allocation ratios (e.g., is 1/1000 members still an appropriate ratio?).
- Key recommendations include regularly reviewing apportionment, reducing number of alternate delegates, and allowing hybrid/virtual engagement and alternative forums for non-delegates or underrepresented voices.
- Most agree changes should be flexible, with exceptions or protections for key sections and ongoing monitoring to rebalance as needed.

Q4: Is the current structure of our House of Delegates representative and proportional to our membership?

Sentiment	Count	Percent	Description
Positive	3	1.66%	Strong assertions that the structure is representative/proportional
Somewhat Positive	8	4.42%	Vague or qualified positivity ("sort of," "more or less")
Neutral	93	51.38%	Factual, ambiguous, or "it depends" responses
Somewhat Negative	48	26.52%	Mild criticism, "not really," or "needs tweaking"
Negative	29	16.02%	Strongly believes it's not representative or proportional

Q4: Common Themes

- Many believe the current structure is not truly proportional, with duplicative counting and overrepresentation of small specialties, subspecialties, students, and residents diluting the voice of practicing physicians.
- There is widespread concern about whether delegate apportionment accurately reflects true membership, and several call for using real membership numbers or dues when considering apportionment.
- Some wish for more seats for underrepresented groups, mid-career, individual physicians, and states.
- Most respondents seek recalibration rather than status quo, with frequent suggestions to cap or reduce the size of the House.
- A minority value increased seats for broadening diversity, but overall, there are strong calls for greater transparency and clearer data on delegate allocation.

Q5: What other topics or questions related to the size and structure of our HOD have not been addressed yet by CLRPD, but should be?

Sentiment	Count	Percent	Description
Positive	53	43.09%	New constructive suggestions, affirmations, solution-seeking
Somewhat Positive	8	6.50%	Mildly constructive, positive with reservations
Neutral	38	30.89%	Factual or general "other questions," unclear sentiment
Somewhat Negative	7	5.69%	Mild critique of process, e.g. "should have addressed..."
Negative	17	13.82%	Strongly critical of "missed" issues by CLRPD

Q5: Common Themes

- Greater emphasis on the HOD's mission, long-term vision, and representative function—not just logistics.
- Calls for re-examination of venue policies, i.e., larger/more diverse and flexible venues (including convention centers), hybrid/remote options for participation, accessibility issues related to current venues.
- Concerns about delegate allocation: over-representation of certain groups (e.g., small specialties, medical students, and residents), duplicative counting, and the need for fair and periodically reviewed apportionment formulas.
- Support for diversity, equity, and leadership opportunities for all specialties, trainees, and underrepresented groups, including consideration of term limits.
- Calls to streamline meeting structure and duration, utilize remote participation, and reduce redundancies (e.g., virtual and in-person reference committee sessions)
- Improved accessibility for disabilities and more practical solutions for cost, member engagement, and transparency—especially regarding delegate numbers, allocation, venues, and costs.
- Stronger outreach and engagement with mid-career physicians, trainees, and non-AMA members.

APPENDIX C

Seat Allocation Methods for the American Medical Association House Of Delegates Using Mathematical Models

SUMMARY

This report outlines the process involved with transitioning the AMA House of Delegates (HOD) from the current delegate apportionment rule—one delegate per 1,000 AMA members or fraction thereof—to the Method of Equal Proportions (MEP).

While the current system is simple, it creates distortions in representation. A constituency with 1,001 members receives two delegates, the same as a constituency with 1,999 members, despite nearly double the membership. This produces "cliffs" in representation and inconsistent proportionality.

The Method of Equal Proportions, used by the U.S. House of Representatives since 1941, assigns seats based on mathematically neutral priority values rather than arbitrary thresholds. It is fair, transparent, and eliminates stepwise distortions.

Adopting MEP would modernize AMA representation and align it with a long-standing, nationally accepted apportionment standard.

BACKGROUND

The AMA's current apportionment rule awards one delegate per 1,000 AMA members, with upward rounding for any partial thousand. This distorts proportional representation and can advantage or disadvantage constituencies purely depending on where their membership falls relative to threshold lines.

Historical Origin of the Method of Equal Proportions

In the early 20th century, Congress faced similar representational inconsistencies when apportioning U.S. House seats among states after each Census. Earlier apportionment methods—Jefferson, Webster, Adams—each had biases favoring either large or small states.
To solve these problems, Joseph A. Hill (U.S. Census Bureau statistician) and Edward V. Huntington (Harvard mathematician) developed the Method of Equal Proportions, a purely mathematical, bias-minimized system.

Congress adopted MEP in 1941, and it has remained the federal standard for more than 80 years because:

- It is mathematically neutral
- It prevents disproportionate representation
- It does not systematically advantage large or small groups
- It ensures smooth scaling of representation without threshold cliffs

The same benefits would apply within the AMA HOD.

HOW THE METHOD OF EQUAL PROPORTIONS WORKS

The priority value used to decide who receives the next available delegate seat is:

$$\text{Priority} = \frac{\text{Membership}}{\sqrt{n(n+1)}}$$

Where:

- **Membership** = constituency's total AMA members
- **n** = number of seats already assigned
- **sqrt(n(n+1))** = geometric mean of the next two seat numbers

Plain-Language Explanation

- Every constituency begins with 1 seat.
- Additional seats become progressively harder to earn, unless membership increases proportionally.
- Each potential new seat is evaluated using the formula above.
- The next delegate seat goes to the constituency with the highest priority value.
- This is repeated until all HOD seats are assigned.

This prevents the abrupt "cliffs" caused by the current 1:1000 system.

WORKED EXAMPLE: THREE GROUPS, TEN TOTAL SEATS

Membership:

- Group A: **6,000 members**
- Group B: **3,000 members**
- Group C: **1,000 members**

Each group begins with **1 seat**.

Compute priority values:

$$A = \frac{6000}{\sqrt{1 \times 2}} = 4243$$

$$B = \frac{3000}{\sqrt{1 \times 2}} = 2121$$

$$C = \frac{1000}{\sqrt{1 \times 2}} = 707$$

Group A receives the next seat.
Recompute for A's third seat:

$$A = \frac{6000}{\sqrt{2 \times 3}} = 2449$$

Repeat until all 10 seats are assigned.
The final distribution closely tracks proportional membership.

Constituency	Members	Current Seats (1:1000)	Seats Under MEP
California Medical Assoc.	21,000	21	20
Texas Medical Assoc.	16,500	17	17
ACOG (OB/GYN)	10,500	11	11
Emergency Physicians	7,200	7	8
Small State Society (mock)	1,500	2	2
Dermatology Society	2,150	2	3

FRAMEWORK FOR A FULL MEP SIMULATION USING AMA MEMBERSHIP DATA

To conduct the complete apportionment calculation, AMA staff will need to:

1. Compile membership totals for all AMA constituencies:
    - State medical associations
    - National medical specialty societies
    - Sections, PIMAs, and other seated groups
2. Enter all membership numbers into the AMA MEP Excel Seat Calculator.

Use this calculator as an example:
https://btror.github.io/apportionment.github.io/huntingtonhill.html
(Jefferson's, Adam's, Webster's, Hamilton's, and Hill's Equal Proportions methods)

3. The calculator automatically computes priority values using:

$$\frac{\text{Membership}}{\sqrt{n(n+1)}}$$

4. Seats are awarded to the highest remaining priority value until all seats are assigned.
5. Staff compare MEP-generated seats to current allocations to identify representation shifts.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(A-26)

Introduced by: Medical Student Section

Subject: Physician Ability to Render Emergency Medical Aid During Immigration Enforcement

Referred to: Reference Committee on Ethics and Bylaws

Whereas, during the January 7, 2026, shooting of Renée Good in Minneapolis, a bystander identifying himself as a physician was prevented by immigration enforcement officers from approaching the injured person to render emergency aid while awaiting EMS, and reports also describe delayed ambulance access due to scene obstruction[1,2]; and

Whereas**,** during the January 24, 2026, shooting of Alex Pretti in Minneapolis, a physician and an emergency medical technician at the scene attempted to render emergency medical aid but were initially prevented by immigration enforcement agents from providing medical aid, delaying assessment and resuscitation efforts[3]; and

Whereas, reports concerning an incident outside an Immigration and Customs Enforcement (ICE) facility in the Portland, Oregon area describe immigration enforcement agents delaying an ambulance's departure while transporting an injured person for emergency evaluation, including allegations that armed agents physically blocked the ambulance and threatened EMS personnel[4-6]; and

Whereas, healthcare workers have reported immigration enforcement agents physically interfering with emergency department triage and bedside assessment, including a reported incident at a major academic medical center in Los Angeles in which an immigration enforcement agent allegedly blocked an experienced emergency nurse from evaluating a distressed patient brought in on a gurney[7-9]; and

Whereas, health care workers have raised concerns that the presence of immigration enforcement officers within hospitals is disruptive and may interfere with patient care, with reports describing situations in which individuals injured during arrests were not permitted to explain the circumstances of their injuries to clinicians, potentially compromising the delivery of appropriate medical evaluation and treatment[10-12]; and

Whereas, reporting from multiple outlets describes a broader pattern of immigration enforcement practices that healthcare workers state has disrupted patient care processes and impeded clinicians' ability to provide timely evaluation and treatment[1]; and

Whereas, interruption or delay of time-sensitive prehospital care is associated with worse outcomes in acute injury, and even incremental increases in total prehospital time have been associated with clinically meaningful increases in poor functional outcomes[13]; and

Whereas, reports of clinicians being threatened, intimidated, or harmed while attempting to render emergency medical aid may deter physicians and other health professionals from providing life-saving assistance in future emergencies[14]; and

Whereas, the AMA Code of Medical Ethics recognizes physicians' ethical obligation to provide care in cases of medical emergency, including for individuals who present without a prior patient-physician relationship[15]; and

Whereas, AMA recognizes that immigration enforcement activity in and around health care facilities can undermine access to care and impede physicians' ability to render care[16-17]; and

Whereas, AMA policy H-130.937 supports bystander physicians, as Good Samaritans, to voluntarily render emergency medical assistance within existing EMS systems, including appropriate coordination with EMS authority and reasonable self-identification[18]; and

Whereas, notwithstanding existing Good Samaritan policy, there remains a policy gap regarding what constitutes permissible law-enforcement obstruction of emergency medical aid at enforcement scenes, the minimum safeguards required to protect patient survival and clinician safety, and the need for clear guidance when clinicians offering emergency aid are delayed, intimidated, or threatened with retaliation[19]; therefore be it

RESOLVED, that our American Medical Association study the ethical responsibilities of physicians to render emergency medical care as bystanders when such care is obstructed for patients in legal custody, including immigration enforcement activities. (Directive to Take Action)

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

Received: 06/5/26

REFERENCES

1. Vargas RA. Federal officers blocked medics from scene of ICE shooting, witnesses say. *The Guardian*. January 9, 2026. Accessed March 13, 2026. https://www.theguardian.com/us-news/2026/jan/09/federal-officers-blocked-medics-from-scene-of-ice-shooting-witnesses-say
2. Collins J, MPR News Staff. Renee Macklin Good shot and killed by ICE agent, eyewitnesses say she posed "no threat." *MPR News*. January 7, 2026. Accessed March 13, 2026. https://www.mprnews.org/story/2026/01/07/shooting-south-minneapolis-ice-agents-federal-operation
3. Mackey R. Alex Pretti did not brandish gun, witnesses say in sworn testimony. *The Guardian.* January 24, 2026. Accessed March 13, 2026. https://www.theguardian.com/us-news/2026/jan/24/alex-pretti-killing-witness-testimony
4. Schwartz A. Documents allege a federal agent at Portland ICE threatened to shoot an ambulance driver. *Willamette Week*. October 12, 2025. Accessed March 13, 2026. https://www.wweek.com/news/2025/10/12/documents-allege-a-federal-agent-at-portland-ice-threatened-to-shoot-an-ambulance-driver/
5. KGW Staff. Federal agents delayed ambulance from leaving Portland ICE facility with injured protester. *KGW8 News.* October 14, 2025. Accessed March 13, 2026. https://www.kgw.com/article/news/local/protests/federal-agents-delayed-ambulance-leaving-portland-ice-facility-injured-protester/283-e6220b29-4ecc-4d47-985b-979c1eba9469
6. Park V. Federal agent threatened to shoot and arrest ambulance driver at ICE facility, report says. *KATU News.* October 14, 2025. Updated October 16, 2025. Accessed March 13, 2026. https://katu.com/news/local/federal-agent-threatened-shoot-arrest-amr-american-medical-response-ambulance-driver-immigration-customs-enforcement-ice-facility-willamette-week-says
7. Levin S. California nurses decry ICE presence at hospitals: "Interfering with patient care." *The Guardian*. September 16, 2025. Accessed March 13, 2026. https://www.theguardian.com/us-news/2025/sep/16/california-ice-hospitals-patient-care
8. Hwang L, Jones K. Nurses mobilize to oppose ICE presence in facilities. *National Nurses United.* November 3, 2025. Accessed March 13, 2026. https://www.nationalnursesunited.org/article/nurses-mobilize-to-oppose-ice-presence-in-facilities
9. Caro P. Hospital staff want ICE out of hospitals: "It is a threat to public health." *El País.* February 23, 2026. Accessed March 13, 2026. https://english.elpais.com/usa/2026-02-23/hospital-staff-want-ice-out-of-hospitals-it-is-a-threat-to-public-health.html
10. Boyd-Barrett C. How an ICE hospital incident sparked alarm about the patient rights of immigrants. *Los Angeles Times*. November 28, 2025. Accessed March 13, 2026. https://www.latimes.com/california/story/2025-11-28/socal-hospital-highlights-patient-rights-amid-immigration-crackdown
11. Pross K. Minnesota man hospitalized with life-threatening injuries after ICE arrest. *Sahan Journal*. January 20, 2026. Accessed March 13, 2026. https://sahanjournal.com/health/ice-detainee-hospitalized-head-injury-lawsuit/
12. Vue K. Health care workers say ICE agents inside Hennepin County Medical Center are "disruptive." Sahan Journal. January 13, 2026. Accessed March 13, 2026. https://sahanjournal.com/health/ice-agents-hospitals-hennepin-county-medical-center/
13. Chen CH, Shin SD, Sun JT, et al. Association between prehospital time and outcomes of trauma patients: a systematic review and meta-analysis. *PLoS Med*. 2020;17(9):e1003384. doi:10.1371/journal.pmed.1003384

14. Maguire BJ, O'Neill BJ. Emergency medical service personnel's risk from violence while serving the community. *American journal of public health.* 2017;107(11):1770-5.
15. American Medical Association. Prospective patients. In: *Code of Medical Ethics*. American Medical Association. Accessed March 13, 2026. https://code-medical-ethics.ama-assn.org/ethics-opinions/prospective-patients
16. American Medical Association. AMA statement on immigration enforcement at hospitals. *AMA Press Release*. January 26, 2026. Accessed March 13, 2026. https://www.ama-assn.org/press-center/ama-press-releases/ama-statement-immigration-enforcement-hospitals
17. Murphy B. Immigration enforcement shouldn't happen at health facilities. *American Medical Association*. April 25, 2018. Accessed March 13, 2026. https://www.ama-assn.org/public-health/population-health/immigration-enforcement-shouldn-t-happen-health-facilities
18. American Medical Association. Delivery of health care by Good Samaritans. AMA Policy H-130.937. American Medical Association House of Delegates. Accessed March 13, 2026. https://policysearch.ama-assn.org/policyfinder/detail/H-130.937?uri=%2FAMADoc%2FHOD.xml-0-237.xml
19. National Immigration Law Center. Health care providers and immigration enforcement: Know your rights, know your patients' rights. National Immigration Law Center. Updated January 24, 2025. Accessed March 13, 2026. https://www.nilc.org/resources/healthcare-provider-and-patients-rights-imm-enf/

RELEVANT AMA POLICY

Delivery of Health Care by Good Samaritans H-130.937
Our AMA supports…(b) A reasonable policy should be established whereby a bystander physician may assist in an emergency situation, while working within area-wide EMS protocols. Since EMS providers (non-physicians) are responsible for the patient, bystander physicians should work collaboratively, and not attempt to wrest control of the situation from EMS providers, and (d) Where voice communication with the medical oversight facility is available, and the EMS provider and the bystander physician are collaborating to provide care on the scene, both should interact with the local medical oversight authority, where practicable. Our AMA will develop model principles on Good Samaritan protections for physicians under state and federal laws that would encourage the prompt rendering of emergency care. [CCB/CLRPD Rep. 3, A-14; Appended: BOT Rep. 06, I-23; Modified: Speakers Rep. 02, I-24]

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
Our AMA opposes: (a) any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants. Our AMA opposes any legislative proposals that would criminalize the provision of health care to undocumented residents. [Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14' Modified: BOT Rep. 09, A-24; Modified: Res. 011, A-25]

911 Good Samaritan Laws D-95.977
Our AMA: (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level; and (3) will work with the relevant organizations and state societies to raise awareness about the existence and scope of Good Samaritan Laws. [Res. 225, A-14; Appended: Res. 203, I-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 248
(A-26)

Introduced by: Organized Medical Staff Section

Subject: Medical Staff Oversight of Hospital Augmented Intelligence

Referred to: Reference Committee B

Whereas, the core mission of the American Medical Association (AMA) is to promote the art and science of medicine and the betterment of public health; the organization focuses on empowering physicians to improve patient care, advancing medical science, and enhancing the professional lives of doctors; and

Whereas, the evolution and insertion of augmented/artificial intelligence tools is accelerating and already having a direct impact on the provision of health care with "cause for both optimism and caution, as no one can predict with certainty how life will be changed a decade from now due to AI's vast potential;"[1] and

Whereas, the American Hospital Association has communicated to the U.S. Department of Health and Human Services (HHS), including the following: "However, it is important that the ongoing expansion and adoption of AI in health care be handled carefully, and that policymakers balance the need for flexibility to foster innovation with the right policy guardrails to ensure patient safety and improve patient experience…We recommend policies that ensure clinicians are included in the decision loop for algorithms that may impact access to care or care delivery, such as prior authorizations, consistent privacy and security standards for third-party vendors, and post-development standards for health care AI developers to ensure ongoing integrity of tools;"[2] and

Whereas, the AMA has extensive policy related to augmented/artificial intelligence; and

Whereas, in particular, reference is made to the role physicians should play in quality control, such that: "…our AMA will advocate that…national medical specialty societies and state medical associations 1. Identify areas of medical practice where AI systems would advance the quadruple aim, 2. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts, 3. Outline new professional roles and capacities required to aid and guide health care AI systems, 4. Develop practical guidelines for clinical applications of AI systems;"[3] and

Whereas, the AMA has provided general guidance that "health care AI requires a risk-based approach where the level of security, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce" and "Generative AI should (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks;"[4] and

Whereas, medical departmental and specialty meetings are an established process by which hospital care and patient safety are assessed; therefore be it

RESOLVED, that our American Medical Association recommends medical staffs of hospitals and other healthcare facilities include physician reviews of all augmented intelligence tools and applications, including but not limited to recommendations that impact patient care. (New HOD Policy)

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

Received: 6/5/26

REFERENCES

1. "Tapping Into AI's Potential for Supporting Great Patient Care," Apr 03, 2026 - 08:18 AM by Rick Pollack, President and CEO, American Hospital Association; https://www.aha.org/news/perspective/2026-04-03-tapping-ais-potential-supporting-great-patient-care
2. *Ibid*
3. AMA Policy H-480.939, "Augmented Intelligence in Health Care" https://policysearch.ama-assn.org/policyfinder/detail/Augmented%20Intelligence%20in%20Health%20Care%20H-480.940?uri=%2FAMADoc%2FHOD.xml-H-480.940.xml
4. AMA Policy H-480.931, "Assessing the Intersection Between AI and Health Care" https://policysearch.ama-assn.org/policyfinder/detail/Assessing%20the%20Intersection%20Between%20AI%20and%20Health%20Care%20H-480.931?uri=%2FAMADoc%2FHOD.xml-H-480.931.xml

RELEVANT AMA POLICY

Augmented Intelligence in Health Care H-480.940
As a leader in American medicine, our American Medical Association has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
    a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
    b. is transparent;
    c. conforms to leading standards for reproducibility;
    d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
    e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

Citation: BOT Rep. 41, A-18; Reaffirmed: CMS Rep. 01, A-24; Reaffirmed; CSAPH Rep. 08, A-25

Augmented Intelligence in Health Care H-480.939

Our American Medical Association supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. 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.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on
    a. clinical validation.
    b. alignment with clinical decision-making that is familiar to physicians.
    c. high-quality clinical evidence.
4. Payment and coverage for health care AI systems must
    a. be informed by real world workflow and human-centered design principles.
    b. enable physicians to prepare for and transition to new care delivery models.
    c. support effective communication and engagement between patients, physicians, and the health care team.
    d. seamlessly integrate clinical, administrative, and population health management functions into workflow.
    e. seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
    a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
    b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
    a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
    b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations:
    a. Identify areas of medical practice where AI systems would advance the quadruple aim.
    b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts.
    c. Outline new professional roles and capacities required to aid and guide health care AI systems.

   d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders 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 stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

Citation: BOT Rep. 21, A-19; Reaffirmed: A-22; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed: Res. 226, A-25

Assessing the Intersection Between AI and Health Care H-480.931

Augmented Intelligence Development, Deployment, and Use in Health Care

1. General Governance
   a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
   b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
   c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
   d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
   e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce [See also Augmented Intelligence in Health Care H-480.939 at (1)]
   f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
   g. Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
   h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.
   i. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]
2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
   a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.

i. AI disclosure should align and meet ethical standards or norms.
ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.

b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.
c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.

3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies
   a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
      i. Regulatory approval status.
      ii. Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.
      iii. Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.
      iv. Intended population and intended practice setting.
      v. Clear description of any limitations or risks for use, including possible disparate impact.
      vi. Description of how impacted populations were engaged during the AI lifecycle.
      vii. Detailed information regarding data used to train the model:
         1. Data provenance.
         2. Data size and completeness.
         3. Data timeframes.
         4. Data diversity.
         5. Data labeling accuracy.
      viii. Validation Data/Information and evidence of:
         1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
         2. Constraint to evidence-based outcomes and mitigation of "hallucination"/"confabulation" or other output error.
         3. Algorithmic validation.
         4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
         5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
         6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.

7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.

ix. Data Use Policy:
1. Privacy.
2. Security.
3. Special considerations for protected populations or groups put at increased risk.

x. Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.

xi. Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.

b. Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

4. Generative Augmented Intelligence
   a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).
   b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
      i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
      ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
      iii. Lack of regulatory or clinical oversight to ensure performance of the tool.
      iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
      v. Data privacy.
      vi. Cybersecurity.
      vii. Physician liability associated with the use of generative AI tools.
   c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
   d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
   e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
   f. Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.

5. Physician Liability for Use of Augmented Intelligence-Enabled Technologies
   a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]

i. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
ii. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
iii. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.

b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.
c. Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.

6. Data Privacy and Augmented Intelligence
   a. Entity Responsibility:
      i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.
      ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
      iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.
   b. User Education:
      i. Users should be provided with training specifically on generative AI. Education should address:
         1. Legal, ethical, and equity considerations.
         2. Risks such as data breaches and re-identification.
         3. Potential pitfalls of inputting sensitive and personal data.
         4. The importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

7. Augmented Intelligence Cybersecurity
   a. AI systems must have strong protections against input manipulation and malicious attacks.
   b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
   c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
   d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.
8. Mitigating Misinformation in AI-Enabled Technologies
   a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training dat Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.

b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.

9. Payor Use of Augmented Intelligence and Automated Decision-Making Systems
a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate

claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

Citation: BOT Rep. 01, I-24; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed in lieu of the first resolve: Res. 226, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 249
(A-26)

Introduced by: Resident and Fellow Section

Subject: Bringing Physicians' Voices to the Implementation of AI Prescribers

Referred to: Reference Committee B

Whereas, in January 2026, Doctronic, an AI health technology platform launched a pilot program in collaboration with the state of Utah's Office of Artificial Intelligence Policy (OAIP) to "simplify the prescription refill process … [by striving to] automate routine, guideline-based prescription refills" for chronic conditions such as hypertension, diabetes, and depression;[2,14] and

Whereas, the Utah Medical Licensing Board issued a letter on April 20, 2026, demanding that "this program be immediately suspended pending further discussion because they recognize that overseeing "prescription refills is a task reserved for properly licensed medical practitioners";[11] and

Whereas, the state of Utah and Doctronic have responded on April 21, 2026, that they will not suspend the program because "the pilot is currently in Phase One—where a licensed physician reviews every refill decision, ensuring the program is already operating safely at the standard of care";[4,13] and

Whereas, the preprint non-peer-reviewed article submitted by Doctronic is a retrospective cohort of 500 telehealth urgent care appointments in which all authors have equity in Doctronic and the study does not directly evaluate the AI prescribing ability of Doctronic causing significant legal murkiness, especially if the Doctronic system contributed to a harmful outcome;[5] and

Whereas, Legion Health, a startup company in San Francisco, announced that they will also be launching a program in Utah that will allow AI to prescribe what they consider “lower-risk psychiatric maintenance medications” such as Zoloft, Trazodone, and Wellbutrin;[7,12] and

Whereas, although augmented intelligence (AI) can benefit physicians by reducing medical error and alleviating administrative and cognitive burdens associated with prescribing, the limitations of AI and its impact on patient care, existing laws, safety, privacy, and ethics must be considered before implementation;[1] and

Whereas, such considerations include evidence that the use and implementation of AI in health care can negatively impact physician decision-making through deskilling and cognitive offloading, which creates ramifications on patient care;[6] and

Whereas, additional risks accompanied by AI in healthcare are system biases and inequality, and in the matter of prescriptions, AI may recommend the wrong medication thus requiring significant physician oversight and engagement during system development and utilization;[9] and

Whereas, AI adoption by governments and healthcare entities has left out important stakeholders, including physicians; and

Whereas, the Joint Commission and the Coalition for Health AI formed a multidisciplinary group containing physician, industry, and hospital stakeholders that released guidelines urging development of AI policies for oversight, implementation, and enforcement;[8] and

Whereas, the AMA has established the AMA Center for Digital Health and AI specifically to advocate for physicians being at the center of AI and digital health implementation;[3] and

Whereas, there is growing interest in Congress in legally recognizing AI and machine learning technologies as practitioners, such as via the U.S. House Health Technology Act (H.R. 238)[10]; and

Whereas, there is no explicit AMA policy related to AI prescribing medications despite the escalating nature of the aforementioned developments; therefore be it

RESOLVED, that our American Medical Association advocate that autonomous clinical artificial/augmented intelligence (AI) including AI prescription services, be regulated and licensed by an appropriate body, as well as be developed with physician input and operated under direct physician supervision. (Directive to Take Action)

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

Received: 6/5/26

REFERENCES

1. Aaron DG, Robertson C. The First AI Drug Prescriber. JAMA. 2026;335(18):1567–1568. doi:10.1001/jama.2026.3533
2. AI Doctronic - commerce.utah.gov. commerce.utah.gov. Published May 21, 2026. Accessed May 27, 2026. https://commerce.utah.gov/ai/regulatory-relief/authorized-ai-pilots/doctronic/
3. AMA Center for Digital Health and AI. Accessed May 16, 2026. https://www.ama-assn.org/amaone/ama-center-digital-health-and-ai
4. DOPL and OAIP Response to Board Concerns with Doctronic AI Regulatory Mitigation Pilot. State of Utah. April 21, 2026. Accessed May 17, 2026. https://commerce.utah.gov/wp-content/uploads/2026/04/Medical-Board-Doctronic-Response.pdf
5. Hayat H, Kudrautsau M, Makarov E, et al. Toward the Autonomous AI Doctor: Quantitative Benchmarking of an Autonomous Agentic AI Versus Board-Certified Clinicians in a Real World Setting. Published online July 16, 2025. doi:10.1101/2025.07.14.25331406
6. Heudel PE, Crochet H, Filori Q, Bachelot T, Blay JY. Artificial intelligence in medicine: A scoping review of the risk of deskilling and loss of expertise among physicians. ESMO Real World Data and Digital Oncology. 2026/06/01/ 2026;12:100693. doi:https://doi.org/10.1016/j.esmorw.2026.100693
7. Moynihan L. Artificial intelligence will see you now: Bots to prescribe mental health drugs. New York Post. March 27, 2026. Accessed May 17, 2026. https://nypost.com/2026/03/27/business/artificial-intelligence-can-now-prescribe-mental-health-drugs/
8. Palmieri S, Robertson CT, Cohen IG. New Guidance on Responsible Use of AI. JAMA. 2026;335(3):207–208. doi:10.1001/jama.2025.23059
9. Price II WN. Risks and remedies for artificial intelligence in health care. Brookings Institution. November 14, 2019. Accessed May 26, 2026. https://www.brookings.edu/articles/risks-and-remedies-for-artificial-intelligence-in-health-care/
10. Schweikert D. H.R.238 - Healthy Technology Act of 2025. US House of Representatives. Accessed May 17, 2026. https://www.congress.gov/bill/119th-congress/house-bill/238
11. State of Utah Utah Medical Licensing Board. April 20, 2026. Accessed May 17, 2026. https://commerce.utah.gov/wp-content/uploads/2026/04/doctronic-letter-from-medical-board.pdf
12. Tangerman V. Startup approved to let AI system prescribe psychiatric medication. Futurism. April 6, 2026. Accessed May 17, 2026. https://futurism.com/health-medicine/startup-ai-system-prescribe-psychiatric-medication
13. Utah News Dispatch. Suspension denied after health professionals call for pause of Utah AI medication refill pilot program. KPCW. May 4, 2026. Accessed May 17, 2026. https://www.kpcw.org/state-regional/2026-05-04/medical-licensing-board-calls-for-suspension-of-utah-pilot-program-using-ai-to-refill-prescriptions
14. Utah Steps into Autonomous AI Medicine with Prescription Renewal Pilot. Stanford.edu. Published March 19, 2026. Accessed May 27, 2026. https://healthpolicy.fsi.stanford.edu/news/utah-steps-autonomous-ai-medicine-prescription-renewal-pilot-program

RELEVANT AMA POLICY

Augmented Intelligence in Health Care H-480.940
As a leader in American medicine, our American Medical Association has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.
To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
    - is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
    - is transparent;
    - conforms to leading standards for reproducibility;
    - identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
    - safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
2. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
3. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

Assessing the Intersection Between AI and Health Care H-480.931
Augmented Intelligence Development, Deployment, and Use in Health Care

1. General Governance
    - Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
    - Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
    - Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
    - AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
    - 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 [See also Augmented Intelligence in Health Care H-480.939 at (1)]
    - AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
    - 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.

- Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

2. When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care

- 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.
    - AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician’s consent and final review.
    - When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
    - 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.

2. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies
    - When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the

purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:

- Regulatory approval status.
- Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.
- Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.
- Intended population and intended practice setting.
- Clear description of any limitations or risks for use, including possible disparate impact.
- Description of how impacted populations were engaged during the AI lifecycle.
- Detailed information regarding data used to train the model:
    1. Data provenance.
    2. Data size and completeness.
    3. Data timeframes.
    4. Data diversity.
    5. Data labeling accuracy.
- Validation Data/Information and evidence of:
    1. Clinical expert validation in intended population and practice setting and intended clinical outcomes.
    2. Constraint to evidence-based outcomes and mitigation of “hallucination”/“confabulation” or other output error.
    3. Algorithmic validation.
    4. External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
    5. Comprehensiveness of data and steps taken to mitigate biased outcomes.
    6. Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
    7. Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.
- Data Use Policy:
    1. Privacy.
    2. Security.
    3. Special considerations for protected populations or groups put at increased risk.

- Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.
- Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.

- Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

0. Generative Augmented Intelligence
    a. Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use

and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).

b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
    - Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
    - 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.
    - Lack of regulatory or clinical oversight to ensure performance of the tool.
    - Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
    - Data privacy.
    - Cybersecurity.
    - Physician liability associated with the use of generative AI tools.

c. Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]

d. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.

e. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.

f. Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.

0. Physician Liability for Use of Augmented Intelligence-Enabled Technologies

a. Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
    - Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
    - Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    - Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.

b. When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.

c. Liability protections for physicians using AI-enabled technologies should align with both current and future AMA medical liability reform policies.

0. Data Privacy and Augmented Intelligence
   a. Entity Responsibility:
      i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.
      ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
      iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.
   b. User Education:
      i. Users should be provided with training specifically on generative AI. Education should address:
         1. Legal, ethical, and equity considerations.
         2. Risks such as data breaches and re-identification.
         3. Potential pitfalls of inputting sensitive and personal data.
         4. The importance of transparency with patients regarding the use of generative AI and their data.

         [See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

7. Augmented Intelligence Cybersecurity
   a. AI systems must have strong protections against input manipulation and malicious attacks.
   b. Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
   c. Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
   d. Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.

0. Mitigating Misinformation in AI-Enabled Technologies
   a. AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training dat Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
   b. Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
   c. Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
   d. Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.

e. Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
f. Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.

0. Payor Use of Augmented Intelligence and Automated Decision-Making Systems
    a. Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
    b. Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
    c. Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
    d. Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
    e. Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
    f. Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
    g. Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics

to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

Augmented Intelligence in Health Care H-480.939
Our American Medical Association supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. 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.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. 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.
2. Payment and coverage for health care AI systems must
   a. be informed by real world workflow and human-centered design principles.
   b. enable physicians to prepare for and transition to new care delivery models.
   c. support effective communication and engagement between patients, physicians, and the health care team.
   d. seamlessly integrate clinical, administrative, and population health management functions into workflow.
   e. seek end-user feedback to support iterative product improvement.
3. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
4. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
   a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
   b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
5. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
   a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
   b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this

liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
6. Our AMA, national medical specialty societies, and state medical associations:
    a. Identify areas of medical practice where AI systems would advance the quadruple aim.
    b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts.
    c. Outline new professional roles and capacities required to aid and guide health care AI systems.
    d. Develop practice guidelines for clinical applications of AI systems.
7. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders 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 stakeholders. (New HOD Policy)
8. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

Augmented Intelligence and Organized Medical Staff H-225.940
Our American Medical Association recognizes that organized medical staff should be an integral part at the outset of choosing, developing and implementing augmented intelligence and digital health tools in hospital care. That consideration is consistent with organized medical staff's primacy in overseeing safety of patient care, as well as assessing other negative unintended consequences such as interruption of, or overburdening, the physician in delivery of care.

Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms D-480.954
1. To maximize the impact and trustworthiness of augmented intelligence and machine-learning (AI/ML) tools in clinical settings, our AMA recognizes that:
    a. Explainable AI with safety and efficacy data should be the expected form of AI tools for clinical applications, and exceptions should be rare and justified and require at minimum safety and efficacy data prior to their adoption or regulatory approval;
    b. To be considered "explainable," an AI device's explanation of how it arrived at its output must be interpretable and actionable by a qualified human. Claims that an algorithm is explainable should be adjudicated only by independent third parties, such as regulatory agencies or appropriate specialty societies, rather than by declaration from its developer;
    c. Explainability should not be used as a substitute for other means of establishing safety and efficacy of AI tools, such as through randomized clinical trials; and
    d. Concerns of intellectual property (IP) infringement, when provided as rationale for not explaining how an AI device created its output, does not nullify a patient's right to transparency and autonomy in medical decision-making. While intellectual property should be afforded a certain level of protection, concerns of infringement should not outweigh the need for explainability for AI with medical applications.
2. 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.

Ensuring Transparency and Accountability in Clinical Use of Augmented Intelligence D-480.952
1. Our AMA recognizes the need for clear disclosure to the healthcare provider whenever artificial intelligence (AI) is used in the delivery of clinical care, in order to ensure the safe, transparent, and accountable use of AI-generated content in clinical and public-health settings.
2. Our AMA advocates that entities developing or deploying artificial-intelligence systems—including, but not limited to, generative AI, foundation models, neural networks, and other machine-learning approaches—in healthcare:

a. establish and maintain a risk-based governance approach proportionate to the system's intended use and potential harm;
b. implement relevant security measures and privacy protections;
c. provide for clinically useful transparency, such as clear labeling of AI-generated outputs for end users, including disclosure of the algorithm's level of confidence in those outputs; and
d. implement risk management approaches throughout the AI lifecycle with particular emphasis on appropriate monitoring of the system for safety, clinical effectiveness, accuracy, and reliability, to help ensure ethical and regulatory alignment across all deployment contexts.

Use of Augmented Intelligence for Prior Authorization D-480.956

1. Our American Medical Association will work with stakeholders to advocate for legislative and/or regulatory action for greater regulatory oversight related to the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers and/or contracted third parties are using a thorough and fair process that:
    a. is based on accurate and up-to-date clinical criteria derived from national medical specialty societies' evidence-based guidelines and peer-reviewed clinical literature.
    b. includes reviews by physicians and other health care professionals who are not incentivized to deny care and with expertise for the service under review.
    c. provides for transparency and accountability over the use of augmented intelligence for all medical service denials, to include a direct review of patient records by a qualified clinician.
    d. requires direct review of the patient record by a qualified clinician of all medications flagged for denial by augmented intelligence platforms that were previously approved by payers.
    e. provides robust appeals processes and guardrails to prevent algorithmic discrimination and ensure equitable access to care.
2. Our AMA will report on actions taken by the 2026 Annual Meeting of the AMA House of Delegates.

Safe and Efficient Prescribing H-120.921

Our AMA encourages health care stakeholders to improve electronic prescribing practices in meaningful ways that will result in increased patient safety, reduced medication error, improved care quality, and reduced administrative burden associated with e-prescribing processes and requirements. Specifically, the AMA encourages:

a. E-prescribing system implementation teams to conduct an annual audit to evaluate the number, frequency and user acknowledgment/dismissal patterns of e-prescribing system alerts and provide an audit report to the software vendors for their consideration in future releases.
b. Health care organizations and implementation teams to improve prescriber end-user training and on-going education.
c. Implementation teams to prioritize the adoption of features like structured and codified Sig formats that can help address quality issues, allowing for free text when necessary.
d. Implementation teams to enable functionality of pharmacy directories and preferred pharmacy options.
e. Organizational leadership to encourage the practice of inputting a patient's preferred pharmacy at registration, and re-confirming it upon check-in at all subsequent visits.
f. Implementation teams to establish interoperability between the e-prescribing system and the EHR to allow prescribers to easily confirm continued need for e-prescription refills and to allow for ready access to pharmacy choice and selection during the refill process.
g. Implementation teams to enhance EHR and e-prescribing system functions to require residents assign an authorizing attending physician when required by state law.
h. Organizational leadership to implement e-prescribing systems that feature more robust clinical decision support, and ensure prescriber preferences are tested and seriously considered in implementation decisions.
i. Organizational leadership to designate e-prescribing as the default prescription method.

j. The DEA to allow for lower-cost, high-performing biometric devices (e.g., fingerprint readers on laptop computers and mobile phones) to be leveraged in two-factor authentication.
k. States to allow integration of PDMP data into EHR systems.
l. Health insurers, pharmacies and e-prescribing software vendors to enable real-time benefit check applications that enable more up to date prescription coverage information and allow notification when a patient changes health plans or a health insurer has changed a pharmacy's network status.
m. Functionality supporting the electronic transfer and cancellation of prescriptions. (BOT Rep. 20, A-19)

DVA Non-Physician Prescribing Authority
Our AMA will continue to pursue appropriate regulatory, legislative and legal means to oppose any efforts to permit non-physician health care professionals to prescribe medications. (Sub. Res. 220, A-99) (Reaffirmed: CMS Rep. 11, I-99) (Reaffirmed: BOT Rep. 23, A-09) (Reaffirmed: BOT Rep. 09, A-19)

Use of Physician and Patient Prescribing Data in the Pharmaceutical Industry D-315.988
Our American Medical Association will work to control the use of physician-specific prescribing data by the pharmaceutical industry as follows:

1. Implement a suitable "opt-out" mechanism for the AMA Physician Masterfile governing the release of physician-specific prescribing data to pharmaceutical sales reps by including appropriate restrictions in the AMA data licensing agreements.
    a. Communicate to physicians the resources available to them in reporting inappropriate behavior on the part of pharmaceutical sales representatives and the work the AMA has done and will continue to do on their behalf.
    b. Work with Health Information Organizations (HIOs) to describe to physicians how their prescribing data are used and work to create access for physicians to view reports on their own prescribing data to enhance their clinical practice.
2. Support continued updating of Prescribing Data Code of Conduct for the Pharmaceutical Industry that dictates appropriate use of pharmaceutical data, behavior expectations on the part of industry, and consequences of misuse or misconduct. (BOT Rep. 24, I-04) (Reaffirmed in lieu of Res. 624, A-05) (Reaffirmation A-09) (Reaffirmed: Res. 233, A-11) (Modified: CEJA Rep. 1, A-21)

Code of Medical Ethics E-9.6.6 Prescribing & Dispensing Drugs & Devices
In keeping with physicians' ethical responsibility to hold the patient's interests as paramount, in their role as prescribers and dispensers of drugs and devices, physicians should:

a. Prescribe drugs, devices, and other treatments based solely on medical considerations, patient need, and reasonable expectations of effectiveness for the particular patient.
b. Dispense drugs in their office practices only if such dispensing primarily benefits the patient.
c. Avoid direct or indirect influence of financial interests on prescribing decisions by:
    i. declining any kind of payment or compensation from a drug company or device manufacturer for prescribing its products, including offers of indemnification;
    ii. respecting the patient's freedom to choose where to fill prescriptions. In general, physicians should not refer patients to a pharmacy the physician owns or operates. (Issued 2016)

Drug Abuse Related to Prescribing Practices H-95.990

1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:
    a. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and

"dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.

b. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.

2. Our AMA:
    a. promotes physician training and competence on the proper use of controlled substances;
    b. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;
    c. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and
    d. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.
3. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances. (CSA Rep. C, A-81) (Reaffirmed: CLRPD Rep. F, I-91) (Reaffirmed: Sunset Report, I-01) (Reaffirmed: CSAPH Rep. 1, A-11) (Appended: Res. 907, I-11) (Appended: Res. 219, A-12) (Reaffirmation A-15) (Reaffirmed: BOT Rep. 12, A-15) (Reaffirmed: BOT Rep. 5, I-15) (Reaffirmed: BOT Rep. 17, A-18) (Modified: Speakers Rep., A-18)

Internet Prescribing H-120.956

1. Our AMA supports the use of the Internet as a mechanism to prescribe medications with appropriate safeguards to ensure that the standards for high quality medical care are fulfilled.
2. Our AMA will work with state medical societies in urging state medical boards to ensure high quality medical care by investigating and, when appropriate, taking necessary action against physicians who fail to meet the local standards of medical care when issuing prescriptions through Internet web sites that dispense prescription medications.
3. Our AMA will work with the Federation of State Medical Boards and others in endorsing or developing model state legislation to establish limitations on Internet prescribing.
4. Our AMA will continue to work with the National Association of Boards of Pharmacy and support their digital pharmacy accreditation program so that physicians and patients can easily identify legitimate Internet pharmacy practice sites.
5. Our AMA will work with federal and state regulatory bodies to close down Internet web sites of companies that are illegally promoting and distributing (selling) prescription drug products in the United States.
6. Our AMA will keep pace with changes in technology by continually updating standards of practice on the Internet. (BOT Rep. 35, A-99) (Reaffirmed: BOT Rep. 3, I-04) (Reaffirmed: Sub. Res. 522, A-05) (Modified: CSAPH Rep. 1, A-15) (Modified: CSAPH Rep. 01, A-25)

Non-Physician Prescribing H-120.955

1. Our AMA advocates that prescriptive authority include the responsibility to monitor the effects of the medication and to attend to problems associated with the use of the medication. This responsibility includes the liability for such actions.
2. Our AMA supports the development of methodologically valid research on the relative impact of non-physician prescribing on the quality of health care. (CMS Rep. 11, I-99) (Reaffirmed: CMS Rep. 5, A-09) (Reaffirmed: CMS Rep. 9, A-15) (Reaffirmed: BOT Rep. 09, A-25)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 250
(A-26)

Introduced by: Resident and Fellow Section

Subject: Protecting Resident Physicians with Pending Immigration Status and Ensuring Safe Participation in Professional Activities

Referred to: Reference Committee B

Whereas, recent federal directives have frozen or delayed visa and work authorization processing for nationals of certain countries whose Temporary Protected Status (TPS) expired on October 3, 2025, and by Presidential Proclamation 10998 (January 1, 2026), disrupting the employment and legal status of thousands of non-U.S. citizen physicians and trainees working in the US[1-4]; and

Whereas, visa processing delays or suspensions could result in lawful status non-U.S. citizen physicians and trainees to be detained or have other immigration consequences despite ongoing compliance with applicable requirements[5]; and

Whereas, two Venezuelan-born resident physicians in Texas were detained by immigration enforcement in April 2026 while traveling within the US despite actively working to maintain lawful status and transition visa categories, resulting in disrupted continuity of care and coverage[6-9]; and

Whereas, fear of detention or immigration consequences may discourage non-U.S. citizen physicians and trainees from traveling to professional meetings, educational conferences, and/or advocacy events[10]; and

Whereas, these fears have been recognized by several professional societies to impact international medical graduates, who represent 25% of all US physicians, and may exacerbate workforce shortages and inequities, stifle professional and career development, reduce diversity and representation, and silence advocacy within medicine; and

Whereas, by impacting international medical graduates' ability to work and train, visa processing disruptions disproportionately limit patient access to care in underserved and rural communities[11]; and

Whereas, USCIS has recognized a national interest in physicians for medically underserved regions by reviewing and endorsing the Green Card Through a Physician National Interest Waiver (NIW) as of July 8, 2025[12]; therefore be it

RESOLVED, that our American Medical Association urgently advocate for the Department of Homeland Security (DHS) and other relevant federal agencies to temporarily cease immigration enforcement for non-US citizen physicians and trainees with pending visa adjudication, including those who have recently matched (Directive to Take Action); and be it further

RESOLVED, that our AMA develop and disseminate a list of federal and national resources for medical schools and residency and fellowship programs in helping medical students, residents, and fellows with indeterminate visa statuses. (Directive to Take Action)

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

Received: 6/5/26

References:

1. Bustillo X. Stuck in limbo: millions of professionals risk losing legal status under Trump pause. *NPR*. Updated April 28, 2026. Accessed May 25, 2026. https://www.npr.org/2026/04/28/nx-s1-5775869/trump-travel-ban-pause-limbo-professionals
2. U.S. Citizen and Immigration Services. Temporary Protected Status Designated Country: Venezuela. Updated October 23, 2025. Accessed April 17, 2026. https://www.uscis.gov/humanitarian/temporary-protected-status/temporary-protected-status-designated-country-venezuela
3. Department of State. Suspension of Visa Issuance to Foreign Nationals to Protect the Security of the United States. Updated February 2, 2026. Accessed April 17, 2026. https://travel.state.gov/content/travel/en/News/visas-news/suspension-of-visa-issuance-to-foreign-nationals-to-protect-the-security-of-the-united-states.html
4. Hseih C, Girn J. United States – USCIS halts immigration processing for 19 countries and suspends all asylum applications. KPMG. Updated December 9, 2026. Accessed May 25, 2026. https://kpmg.com/xx/en/our-insights/gms-flash-alert/flash-alert-2025-259.html
5. CiberCuba Editorial Team. ICE detiene médico venezolano en Texas por violar los términos de su visa. *CiberCuba*. Published 2026 April 9. Accessed April 12, 2026. https://www.google.com/url?q=https://en.cibercuba.com/noticias/2026-04-09-u1-e135253-s27061-nid325475-ice-detiene-medico-venezolano-texas-violar-terminos?utm_source%3Dchatgpt.com&sa=D&source=docs&ust=1779760954324303&usg=AOvVaw2VgGHRbUMajHkjFFgsL3Oj
6. Jordan M. Doctor in South Texas Community Detained by Border Patrol. *New York Times*. Published 2026 April 7. Accessed April 12, 2026 https://www.google.com/url?q=https://www.nytimes.com/2026/04/11/us/second-venezuelan-doctor-detained-in-south-texas-by-immigration-agents.html&sa=D&source=docs&ust=1779760954318577&usg=AOvVaw3LuTdRNIigmQrSs2y9nlzG
7. Jordan M. Second Venezuelan Doctor Detained in South Texas by Immigration Agents. *New York Times*. Published April 11, 2026. Accessed April 12, 2026. https://www.google.com/url?q=https://www.nytimes.com/2026/04/07/us/texas-doctor-detained-border-patrol-visa-freeze.html&sa=D&source=docs&ust=1779760954320459&usg=AOvVaw1r0v76wmMAgbcZNs19JvHC
8. Jordan M. Trump's immigration policy sidelines foreign doctors amid shortage. *New York Times*. Published April 4, 2026. Accessed April 12, 2026. https://www.nytimes.com/2026/04/04/us/trumps-immigration-policy-sidelines-foreign-doctors-amid-shortage.html?unlocked_article_code=1.IVA.NOo6.AngNvUDpN7zL&smid=url-share
9. Jordan M. Second Venezuelan doctor is released from immigration custody. *New York Times*. Published May 13, 2026. Accessed May 25, 2026. https://www.nytimes.com/2026/05/13/us/venezuelan-doctor-released-from-immigration-custody-texas.html?unlocked_article_code=1.IVA.Ks9f.dW8uP1fJvVXN&smid=url-share
10. ACEP. Request for National Interest Exceptions and Expedited Processing for Physicians and Medical Trainees. Published April 8, 2026. Accessed April 17, 2026. https://www.acep.org/siteassets/new-pdfs/advocacy/joint-letter-requesting-national-interest-exceptions-and-expedited-processing-for-physicians.pdf
11. Al Ghoula F. My Libyan nationality shouldn't make me a 'high risk' doctor. *MedPage Today*. Published April 16, 2026. Accessed May 25, 2026. https://www.medpagetoday.com/opinion/second-opinions/120816
12. USCIS. Green Card Through a Physician National Interest Waiver (NIW). Updated July 8, 2026. Accessed May 28, 2026. https://www.uscis.gov/green-card/green-card-eligibility/green-card-through-a-physician-national-interest-waiver-niw

RELEVANT AMA POLICY:

Support Progress of Science by Addressing Travel Visa Problems D-250.988
Our American Medical Association will send a letter to the US Department of State explaining the negative impact current visa practices are having on medical and scientific progress and urging policy changes that remove unnecessary barriers in the business and travel visa process that prevent international physicians and scientists seeking to attend US-based medical and scientific conferences. [Res. 214, I-11; Reaffirmed: BOT Rep. 7, A-21]

Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs D-255.966
Our American Medical Association will work with all relevant federal agencies to support timely J-1 visa appointments and expedited processing for international medical graduates matched into U. S. residency and fellowship programs. [Res. 216, I-25]

Physician Visa Protection and Pathway to U.S. Permanent Residency D-255.967

1. Our American Medical Association advocates for a viable, expedited, and separate pathway for physicians to obtain permanent residence in the United States.
2. Our AMA advocates for the federal government to work to ensure physicians are exempt from unreasonable increases in H-1B visa fees.
3. Our AMA advocates for the creation of a dedicated visa pathway specifically for physicians. [Res. 213, I-25]

Urgent Advocacy to Restore J-1 Visa Processing for International Medical Graduate Physicians D-255.969

1. Our American Medical Association publicly advocates to resume the scheduling of new J-1 visa appointments affecting International Medical Graduates.
2. Our AMA will issue urgent advocacy communications to Congress, the Department of Homeland Security, the Department of State, and other relevant agencies, calling for the immediate resumption of J-1 visa processing for International Medical Graduates.
3. Our AME will collaborate with key parties, including program directors, Designated Institutional Officers, medical schools, and healthcare organizations to monitor the impact of visa appointment suspensions on patient care and physician workforce stability.
4. Our AMA will work proactively and transparently to reverse policies harmful to IMGs and mitigate future disruptions, emphasizing the essential contributions of International Medical Graduates to healthcare delivery in the United States. [Res. 237, A-25]

Employment of Non-Certified IMGs H-255.970

1. Our American Medical Association will oppose efforts to employ graduates of foreign medical schools who are neither certified by the ECFMG (a member of Intealth) nor have met state criteria for full licensure.
2. Our AMA encourages states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J-1 or other visa waiver programs. [Res. 309, A-03; Reaffirmed: CME Rep. 2, A-13; CME Rep. 01, A-23]

Addressing Work Requirements for J-1 Visa Waiver Physicians D-255.972

Our American Medical Association advocates for federal visa and visa waiver policies to include time for administrative tasks, professional development opportunities, and other professional responsibilities within the federally mandated work week requirements for direct patient care. [BOT Rep. 04, I-24]

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S. [Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 210, A-23;

Visa Complications for IMGs in GME D-255.991

1. Our American Medical Association will
    a. work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice.

   b. promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates.
   c. work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care. [Res. 844, I-03; Reaffirmation A-09; Reaffirmation I-10; Appended: CME Rep. 10, A-11; Appended: Res. 323, A-12; Reaffirmation: A-19; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 312, A-25]

J-1 Visa and Waivers D-255.993

1. Our American Medical Association shall encourage HHS and other interested government agencies to continue sponsorship of the J-1 visa waiver program.
2. Our AMA will work with federal agencies to ensure better coordination of federal, state, and local agencies in monitoring the placement and enforcement of physicians' service requirements through the J-1 waiver and Conrad-30 programs.
3. Our AMA will work towards regulation and/or legislation to allow physicians on H-1B waiver visas, who are limited to serving in medically underserved areas, to continue to care for their patients who require hospitalization in the closest appropriate medical facility which may not be in the underserved area.
4. Our AMA supports a national data repository of J-1 Visa Waiver statistics so that J-1 Visa Waiver unoffered positions can be transferred to states as needed to treat underserved communities and to monitor the success of this program. [BOT Rep. 11, I-02; Appended: Res. 324, A-11; Appended: Res. 904, I-11; Reaffirmation A-14; Modified: BOT Rep. 09, A-24]

Timely Issuance of Social Security Number D-310.960

Our AMA will work with the United States government to provide a social security number in a timely fashion to foreign physicians with a work-related visa, upon lawful entry to the United States, for any purposes. [Res. 304, A-09; Reaffirmed: CME Rep. 01, A-19]

AMA Principles on International Medical Graduates H-255.988

1. Our AMA supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.

7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:
    a. completion of medical school and residency training outside the U.S.;
    b. extensive U.S. medical practice; and
    c. evidence of good standing within the local medical community.
13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. Our AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. Our AMA membership outreach to IMGs to include
    a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
    b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
    c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
    d. expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.

21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
24. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
25. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.
26. Our AMA will uphold its commitment to opposing discrimination against IMGs in all aspects of medical education and training. [BOT Rep. Z, A-86; Reaffirmed: Res. 312, I-93; Modified: CME Rep. 2, A-03; Reaffirmation I-11; Reaffirmation: CME Rep. 1, I-13; Modified: BOT Rep. 25, A-15; Modified: CME Rep. 01, A-16; Appended: Res. 304, A-17; Modified: CME Rep. 01, I-17; Reaffirmation: A-19; Modified: CME Rep. 2, A-21; Modified: CME Rep. 1, A-22; Modified: CCB/CLRPD Rep. 1, A-22; Reaffirmed: CME Rep. 03, A-23; Reaffirmed: Res. 312, A-25; Reaffirmed in lieu of the first resolve: Res. 234, A-25; Reaffirmed: Res. 241, A-25; Appended: Res. 304, I-25]

Reducing the Harmful Impacts of Immigration Status on Health H-65.932

1. Our AMA supports protecting the human right to seek asylum.
2. Our AMA supports pathways to citizenship for undocumented immigrants who entered the US as minors, including Deferred Action for Childhood Arrivals (DACA), temporary protected status (TPS) recipients, and Dreamers.
3. Our AMA supports family reunification pathways for children and adult immigrants from other countries if their parent/guardian, spouse, or child/dependent has documented status in the U.S.
4. Our AMA supports deferral of deportation (and if applicable, employment authorization, driver's licenses, and identification documents) for people with disabilities and significantly limiting chronic illness, people who work in healthcare and social care, and relatives of people with documented or DACA status, and people without violent felonies.
5. Our AMA supports federal and state efforts to remove immigration enforcement from workplaces and employment consideration, including the removal of E-Verify mandates. [Res. 004, A-25]

Mass Deportation as a Public Health Issue H-440.793

1. Our American Medical Association recognizes mass deportation of immigrants, asylum seekers, refugees, and others with or seeking an immigration benefit as a public health issue, and recognizes the long-term mental and physical health implications of deportation on individuals, families, and communities.
2. Our AMA opposes deportation of health care workers and medically vulnerable patients solely based on their documentation status.
3. Our AMA opposes the large-scale internment of individuals targeted for deportation efforts. [Res. 931, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 251
(A-26)

Introduced by: Resident and Fellow Section

Subject: Minimum Standards for Public Health Leaders

Referred to: Reference Committee B

Whereas, candidates or nominees for positions in the federal government who explicitly oppose medical practice and science can be reasonably described as anti-medicine; and

Whereas, candidates or nominees who persistently refuse to take vocal and evidence-based positions on vaccination can be accurately described as anti-medicine; and

Whereas, anti-medicine individuals do not constitute those who produce valid evidence or assertions that depart from the scientific consensus, but rather those who clearly misjudge the totality of the evidence or produce false or misleading evidence or statements that risk harming the public; and

Whereas, the tenure of RFK, Jr. has harmed trust in public health, as he has cut billions in medical research funding, systematically undermined confidence in vaccination, downplayed vaccines in response to a major and deadly resurgence in measles, and reduced transparency in the Department of Health and Human Services[1-6]; and

Whereas, ensuring that our public health leaders are not anti-medicine is clearly within the scope of the AMA as an organization whose mission is "to promote the art and science of medicine and the betterment of public health"[7]; therefore be it

RESOLVED, that our American Medical Association vocally oppose federal government nominees or appointees to health policy leadership positions who demonstrate a pattern of nonadherence to high-quality scientific evidence, including evidence-based vaccination policy, or who do not have appropriate medical or scientific qualifications (New HOD Policy); and be it further

RESOLVED, that our AMA work with relevant entities to provide good faith vaccine education, counseling, and informational resources to federal candidates, nominees, or appointees for health policy leadership positions who do not openly take evidence-based positions on vaccination. (Directive to Take Action)

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

Received: 6/5/26

References

1. Late, M. (2026, February 10). *One year in, RFK Jr.'s leadership has endangered public health, report says*. American Public Health Association.
2. NPR. (2025, March 7). *Measles, RFK, West Texas outbreak*. NPR.
3. NBC News. (n.d.). *RFK Jr. vowed to restore public trust in health. It's not working, new survey suggests*. NBC News.
4. Swenson, A. (2026, January 2). *In a tumultuous year, U.S. health policy transforms under RFK Jr.* PBS NewsHour.
5. Santhanam, L. (2025, September 26). *12 ways RFK Jr. has undercut vaccine confidence as health secretary*. PBS NewsHour.

6. Stobbe, M. (n.d.). *RFK Jr. pledged more transparency. Here's what the public doesn't know anymore*. AP News.
7. American Medical Association. About the AMA. American Medical Association. Accessed June 5, 2026. https://www.ama-assn.org/about

RELEVANT AMA POLICY

Addressing Public Health Disinformation Disseminated by Health Professionals D-440.914
Our American Medical Association will collaborate with relevant health professional societies and other stakeholders:

1. On efforts to combat public health disinformation disseminated by health professionals in all forms of media.
2. Address disinformation that undermines public health initiatives.
3. Implement a comprehensive strategy to address health-related disinformation disseminated by health professionals that includes:
    1. Maintaining our AMA as a trusted source of evidence-based information for physicians and patients.
    2. Ensuring that evidence-based medical and public health information is accessible by engaging with publishers, research institutions and media organizations to develop best practices around paywalls and preprints to improve access to evidence-based information and analysis.
    3. Addressing disinformation disseminated by health professionals via social media platforms and addressing the monetization of spreading disinformation on social media platforms.
    4. Educating health professionals and the public on how to recognize disinformation as well as how it spreads.
    5. Considering the role of health professional societies in serving as appropriate fact-checking entities for health-related information disseminated by various media platforms.
    6. Encouraging continuing education to be available for health professionals who serve as fact-checker to help prevent the dissemination of health-related disinformation.
    7. Ensuring licensing boards have the authority to take disciplinary action against health professionals for spreading health-related disinformation and affirms that all speech in which a health professional is utilizing their credentials is professional conduct and can be scrutinized by their licensing entity.
    8. Ensuring specialty boards have the authority to take action against board certification for health professionals spreading health-related disinformation.
    9. Encouraging state and local medical societies to engage in dispelling disinformation in their jurisdictions.

Medical and Public Health Misinformation Online D-440.915

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 252
(A-26)

Introduced by: Resident and Fellow Section

Subject: Immediate Action to Prevent Further Immigrant Deaths

Referred to: Reference Committee B

Whereas, inhumane conditions of detention and mass deportation policies exacerbate chronic health problems, spread infectious disease, and disrupt continuity of care, including life-saving care[1-10]; and

Whereas, this is deadliest year of immigration detention in over 20 years, and this fiscal year's deaths surpassed the prior months ago[1]; and

Whereas, the population being held in Immigration and Customs Enforcement (ICE) is at a record-high and reporting has demonstrated a pattern of illegal or deadly conditions in detention[2]; and

Whereas, there has been a massive increase in children detained by ICE[3]; and

Whereas, ICE detention centers have seen measles outbreaks related to the conditions of these facilities[4]; and

Whereas, US citizens, including children with cancer undergoing treatment, have been deported, and pregnant women have been harmed repeatedly in immigration detention[5-6]; and

Whereas, many patients, including US citizens, avoid care and face serious health deterioration due to mass deportation policies, with health care workers stepping up to provide home visits and meet the needs of immigrant families[7-8]; and

Whereas, the avoidance of care is amplified by the sharing of data from health programs with immigration enforcement agencies[9]; and

Whereas, health professionals, including resident physicians (as unfortunately exemplified by the detainment of a Texas family medicine resident in April 2026) have been targeted by immigration enforcement[10]; and

Whereas, in January 2025, the administration rescinded a previously longstanding federal policy designating certain locations including hospitals, churches, and schools as sensitive locations[11-12]; and

Whereas, states have begun to take action to protect immigrants in health care facilities since the rescission of the sensitive locations policy[13-14]; and

Whereas, health care facilities have the ability to set policies on, for instance, where law enforcement agents can go within the nonpublic areas of their facilities and create protocols to

ensure a warrant is presented prior to entering these premises and states can require and standardize these policies in health care facilities[13-14]; and

Whereas, AMA's code of medical ethics honors the role of physicians and nurses in providing care and advocacy to those in need as moral acts that foster patient trust in health professionals[15-16]; therefore be it

RESOLVED, that our American Medical Association support efforts to ensure health care facilities effectively serve as sensitive locations, without deterring immigrants seeking care, by actively and vocally advocating for and endorsing policies that:

- make immigration status and place of birth protected health information
- prohibit immigration agents from entering nonpublic, patient-sensitive areas of health care facilities without a warrant signed by a judge
- require health care facilities to adopt minimum enforceable guidelines for interactions with immigration enforcement authorities
- oppose mandated inquiries about patient immigration status in health care facilities; (Directive to Take Action) and be it further

RESOLVED, that our AMA supports physician and other health care worker efforts to organize in support of immigrants' right to safe and high-quality health care in medical settings (New HOD Policy); and be it further

RESOLVED, that our AMA reaffirm policies H-440.793, D-350.983, H-65.932, D-160.921 and H-315.966, and will advocate in an urgent, timely manner all HOD policies related to the deportation, detention, and health and safety for all immigrants, migrants, refugees, detainees, and asylum seekers. (Reaffirm HOD Policy)

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

Received: 6/5/26

REFERENCES

1. NPR. “Immigration Detention Deaths in Custody.” *NPR*, https://www.npr.org/2026/03/10/g-s1-111238/immigration-detention-deaths-custody.
2. PBS NewsHour. “Migrants Face Dire Conditions and Prolonged Waits in U.S. Detention Centers.” *PBS NewsHour*, https://www.pbs.org/newshour/nation/migrants-face-dire-conditions-and-prolonged-waits-in-u-s-detention-centers.
3. The Marshall Project. “ICE Kids Detention Over 6200 Under Trump.” *The Marshall Project*, https://www.themarshallproject.org/2026/04/06/ice-kids-detention-over-6200-trump.
4. *Scientific American*. “Measles Outbreak Erupts in One of U.S.’s Largest ICE Detention Centers.” https://www.scientificamerican.com/article/measles-outbreak-erupts-in-one-of-u-s-s-largest-ice-detention-centers/.
5. BBC News. “Three US Citizen Children, One With Cancer, Deported to Honduras, Lawyers Say.” *BBC News*, https://www.bbc.com/news/articles/c4g8yj2n33yo.
6. Center for Reproductive Rights. “Pregnant, Postpartum, and Nursing Women in ICE Custody.” https://reproductiverights.org/news/pregnant-postpartum-nursing-women-ice-custody/.
7. KFF. “Potential Chilling Effects of Public Charge and Other Immigration Policies on Medicaid and CHIP Enrollment.” *KFF*, https://www.kff.org/medicaid/potential-chilling-effects-of-public-charge-and-other-immigration-policies-on-medicaid-and-chip-enrollment/.
8. KFF Health News. “Minneapolis Immigration Crackdown Underground Medical Care Networks.” *KFF Health News*, https://kffhealthnews.org/news/article/minneapolis-immigration-crackdown-underground-medical-care-networks/.
9. Stateline. “States Say ICE Pulled Medicaid Data Despite Court Order.” *Stateline*, https://stateline.org/2026/03/31/states-say-ice-pulled-medicaid-data-despite-court-order/.
10. *MySA*. “ICE Detains South Texas Doctors.” *MySA*, https://www.mysanantonio.com/news/local/politics/article/ice-detains-south-texas-doctors-22203495.php.
11. Health Care Providers warn of impacts of increased ice presence at Health Care Facilities. Health Care Providers Warn of Impacts of Increased ICE Presence at Health Care Facilities. January 22, 2026. Accessed June 5, 2026. https://www.kff.org/quick-insights/health-care-providers-warn-of-impacts-of-increased-ice-presence-at-health-care-facilities/.
12. Statement from a DHS spokesperson on Directives Expanding Law Enforcement and ending the abuse of Humanitarian Parole | homeland security. Accessed June 5, 2026. https://www.dhs.gov/news/2025/01/21/statement-dhs-spokesperson-directives-expanding-law-enforcement-and-ending-abuse .

13. Stateline. “Health Care Workers Want ICE Out of Hospitals, and Blue States Are Responding.” *Stateline*, https://stateline.org/2026/02/09/health-care-workers-want-ice-out-of-hospitals-and-blue-states-are-responding/.
14. Know Your Rights: Health Care Providers & Immigration Enforcement. National Immigration Law Center. Accessed June 5, 2026. https://www.nilc.org/resources/healthcare-provider-and-patients-rights-imm-enf/.
15. American Medical Association. “E-1.1.1 Patient-Physician Relations.” *AMA*, https://share.google/JG0MhqP9bq6daEO1I.
16. American Medical Association. “E-10.4.” *AMA*, https://share.google/ohFQAaQsugp71b6Vq.

RELEVANT AMA POLICY

Mass Deportation as a Public Health Issue H-440.793
1. Our American Medical Association recognizes mass deportation of immigrants, asylum seekers, refugees, and others with or seeking an immigration benefit as a public health issue, and recognizes the long-term mental and physical health implications of deportation on individuals, families, and communities.
2. Our AMA opposes deportation of health care workers and medically vulnerable patients solely based on their documentation status.
3. Our AMA opposes the large-scale internment of individuals targeted for deportation efforts.

Improving Medical Care in Immigrant Detention Centers D-350.983
Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.
Citation: Res. 017, A-17;

Reducing the Harmful Impacts of Immigration Status on Health H-65.932
1. Our AMA supports protecting the human right to seek asylum.
2. Our AMA supports pathways to citizenship for undocumented immigrants who entered the US as minors, including Deferred Action for Childhood Arrivals (DACA), temporary protected status (TPS) recipients, and Dreamers.
3. Our AMA supports family reunification pathways for children and adult immigrants from other countries if their parent/guardian, spouse, or child/dependent has documented status in the U.S.
4. Our AMA supports deferral of deportation (and if applicable, employment authorization, driver's licenses, and identification documents) for people with disabilities and significantly limiting chronic illness, people who work in healthcare and social care, and relatives of people with documented or DACA status, and people without violent felonies.
5. Our AMA supports federal and state efforts to remove immigration enforcement from workplaces and employment consideration, including the removal of E-Verify mandates.
Citation: Res. 004, A-25;

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921
1. Our American Medical Association advocates for and supports legislative efforts to designate healthcare facilities as protected areas by law.
2. Our AMA will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as protected areas where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur.
3. Our AMA encourages healthcare facilities to clearly demonstrate and promote their status as protected areas.
4. Our AMA opposes the presence of ICE enforcement at healthcare facilities.
Citation: Res. 232, I-17; Reaffirmed in lieu of the first resolve: Res. 234, A-25; Modified: Res. 218, I-25;

Patient and Physician Rights Regarding Immigration Status H-315.966
1. Our American Medical Association supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records, Medicaid, Children's Health Insurance Program (CHIP), or other health program data, including but not limited to Emergency Medicaid and related immigrant-specific programs, for immigration enforcement purposes.
2. Our AMA supports efforts by interested parties to educate physicians, medical students, and patients about existing privacy protections to safeguard confidential health information, and to help ensure that this information reaches immigrant and mixed-status families.
Citation: Res. 018, A-17; Modified: Res. 229, I-25;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 435
(A-26)

Introduced by: Organized Medical Staff Section

Subject: Supporting Regulations for More Stringent Safety Measures for Micromobility

Referred to: Reference Committee D

Whereas, E-scooters and e-bikes create serious injuries, leading to excessive healthcare costs for everyone with the injuries being often severe involving neurosurgical, orthopedic, and maxillofacial problems and requiring multiple specialty surgeries with riders and pedestrians often suffer the worst—even fatal—injuries, especially among children; and

Whereas, E-bicycle injuries doubled every year from 2017 to 2022, from 751 injuries in 2017 to 23,493 injuries in 2022 while e-scooter injuries rose by 45 percent each year, from 8,566 injuries in 2017 to 56,847 injuries in 2022; average costs for an e-scooter injury was $95,710 while median costs for e-bike injuries in certain regions exceeded $14,000 with long ICU/hospital stays; and

Whereas, safety issues with e-bikes and e-scooters are multi-faceted; they include being made with poor quality lithium-ion batteries that can spark fires that are exceptionally difficult to control and can reignite days or weeks after burning due to energy that remains stored inside damaged battery cells, rechargeable batteries that must be changed often and present a higher risk of fire and explosion, and extra care and maintenance of the device in order to keep it operating properly; and

Whereas, e-bikes are currently classified into three classes that come not from the federal legislation but mostly from federal land management regulations written for off-road use—Class 1, a pedal-assisted e-bike with a motor that provides assistance only when the rider is pedaling and only up to a speed of 20 miles per hour; Class 2, equipped with a motor that can be used exclusively to propel the bicycle with the use of a throttle and a maximum speed of 20 miles per hour; and Class 3, a pedal-assist bike with a motor that provides assistance up to 28 miles per hour; and

Whereas, there is very limited federal law regarding micromobility devices with the most significant being a 2002 law establishing that e-bikes with a top speed of 20 mph are consumer products, but not motor vehicles, meaning most low-speed micromobility devices do not share the same regulatory environment as cars and motorcycles and leaving states to regulate these devices on their own; therefore be it

RESOLVED, that our American Medical Association better define and expand AMA policy to help improve safety for micromobility (e-bikes and e-scooters) usage by endorsing the following positions:

1. Helmets, certified by the US Consumer Safety Product Commission and rated for speed, should be worn for all and be mandatory for Class 3 e-bikes and all scooters;
2. Additional gear should include elbow pads, knee pads, wrist guards, closed-toe footwear and high-visibility or reflective gear for use at nighttime;
3. Headphones should be avoided during use;

4. E-scooters and Class 3 e-bikes should have a minimum age of 16 to operate;
5. Require education and training for Class 3 e-bikes;
6. Define where e-bikes can be ridden both on and off-road, including speed limits on shared paths and no operation allowed on sidewalks;
7. No distractions while operating;
8. No passengers while operating;
9. Regulate out-of-class products and anti-tampering;
10. Training required to operate devices, including smooth and consistent braking at high speeds and basic traffic rules;

(Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for standardized injury surveillance and reporting of micromobility-related injuries at the state and national level, including integration into existing trauma registries and public health reporting systems (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage and advocate for accelerated research into the root causes of e-bike and e-scooter related injuries in the United States, with the goal of defining actionable best practices to prevent and/or minimize serious injury associated with operation of various classes of such vehicles, as well as the relevant demographics of the operators thereof. (New HOD Policy)

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

Received: 6/5/26

REFERENCES

1. Financial impact of electric scooters: a review of injuries over 27 months at an urban level 1 trauma center (cost of e-scooter injuries at an urban level 1 trauma center) – PMC https://pmc.ncbi.nlm.nih.gov/articles/PMC7831709/
2. Evidence Synthesis on E-Bike and E-Scooter Injuries, Safety Interventions, and Policies https://acrobat.adobe.com/id/urn:aaid:sc:US:a0bc5c8f-c926-47e0-96e0-b125a2ec7a11
3. Electric Bikes Are Emerging As Public Health Hazard / ACS https://www.facs.org/for-medical-professionals/news-publications/news-and-articles/bulletin/2024/julyaugust-2024-volume-109-issue-7/electric-bikes-are-emerging-as-public-health-hazard/
4. Safety with E-Bikes and E-Scooters https://www.nfpa.org/education-and-research/electrical/ebikes
5. Are Electric Bikes Safe For Children? https://www.healthychildren.org/English/tips-tools/ask-the-pediatrician/Pages/are-electric-bikes-e-bikes-safe-for-children.aspx?gad_source=1&gad_campaignid=69654055&gbraid=0AAAADyMpZEGO4TZXQlMPm79w5d0QauWs&gclid=Cj0KCQjws83OBhD4ARIsACblj18bxHjn784tAcnzLWsKpN-8DGgLUWurQANHiFMNAemP2poxdYRjKcMaAkOREALw_wcB
6. The E-Bike Problem Is an E-Moto Problem https://www.peopleforbikes.org/news/the-e-bike-problem-is-an-e-moto-problem
7. Safe and Successful E-Bike Policies with PeopleForBikes' New Tool Kit https://www.peopleforbikes.org/news/peopleforbikes-ebike-legislative-toolkit?gad_source=1&gad_campaignid=847353551&gbraid=0AAAADvTKtq_Jk0lymhS7OjLSupR7N4G5&gclid=Cj0KCQjws83OBhD4ARIsACblj1_JJme-JCzUjfCr_HmYEnSxyTgPkKyhaZGXlDiTINT9b8-xLh3y89oaAu56EALw_wcB
8. Electric Scooter and Bike Accidents Are Soaring Across the U.S. https://www.ucsf.edu/news/2024/07/428096/electric-scooter-and-bike-accidents-are-soaring-across-us#:~:text=2018:%201%2C615%20individual%20injuries%20and,individual%20injuries%20and%206%2C317%20hospitalizations.
9. Understanding Electric Scooter Risks Dangers https://www.lawfirmdavidoff.com/queens-electric-scooter-accident-lawyer/electric-scooter-risks-dangers/
10. Why Kids Should Not Ride E-Scooters https://www.luriechildrens.org/en/blog/why-kids-should-not-ride-e-scooters/

11. Why scooters and e-bikes are the newest travel hazard you didn't see coming https://www.usatoday.com/story/travel/columnist/2025/06/23/why-cities-rethinking-scooters/84284420007/
12. Micromobility in the US: How States are Regulating the Boom https://micromobility.io/news/micromobility-in-the-us-how-states-are-regulating-the-boom

RELEVANT AMA POLICY

Helmets for Riders of Motorized and Non-motorized Cycles H-10.964

General Helmet Use: Our AMA: (1) encourages physicians to counsel their patients who ride motorized and non-motorized cycles to use approved helmets and appropriate protective clothing while cycling; (2) encourages patients and families to inform and train children about safe cycle-riding procedures, especially on roads and at intersections, the need to obey traffic laws, and the need for responsible behavior; (3) encourages community agencies, such as those involving law enforcement, schools, and parent-teacher organizations, to promote training programs for the responsible use of cycles; (4) urges manufacturers to improve the safety and reliability of the vehicles they produce and to support measures to improve cycling safety; (5) advocates further research on the effectiveness of helmets and on the health outcomes of community programs that mandate their use; (6) encourages efforts to investigate the impact of helmet use by riders of motorcycles and all bicycles, in order to establish the risk of major medical trauma from not wearing helmets, the costs added to the health care system by such behavior, and the payers of these added costs (i.e., private insurance, uncompensated care, Medicare, Medicaid, etc.); (7) supports the exploration of ways to ensure the wearing of helmets through the use of disincentives or incentives such as licensing fees, insurance premium adjustments and other payment possibilities.

Bicycles: Our AMA: (1) actively supports bicycle helmet use and encourages physicians to educate their patients about the importance of bicycle helmet use; (2) encourages the manufacture, distribution, and utilization of safe, effective, and reasonably priced bicycle helmets; and (3) encourages the availability of helmets at the point of bicycle purchase.

Scooters: Our AMA: (1) recommends the use of protective gear (certified helmets, elbow and knee pads, closed-toe shoes) for riders of scooters, especially children and adolescents; (2) encourages physicians to counsel patients, and their parents when appropriate, that full protective equipment should be worn and appropriate safety measures should be taken to prevent scooter injuries (e.g., riding away from traffic, and close supervision of riders under the age of eight); and (3) urges companies that manufacture or sell scooters to include appropriate information about the safe use of scooters on the scooters themselves, on or inside scooter packaging, on their web sites, and at the point of sale.

Motorcycles: Our AMA: (1) encourages physicians to be aware of motorcycle risks and safety measures and to counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs; (2) endorses the concept of legislative measures to require the use of helmets when riding or driving a motorcycle; (3) supports federal regulatory rules to make the receipt of federal highway funds by a state dependent on passage of mandatory motorcycle helmet laws by that state; (4) urges constituent societies to support the enactment or preservation of state motorcycle helmet laws; and (5) supports rider education legislation, which is more easily implemented and more effective than legislation requiring manufacturers to emphasize the dangers of operating motorcycles.
Citation: CCB/CLRPD Rep. 3, A-14

Motor Vehicle and Bicycle Safety H-15.960

The AMA supports legislation that would make safety belt non-use by any occupants in automobiles and other enclosed motor vehicles a "primary offense" in all states; supports extension of motorcycle helmet laws to include motorized vehicles such as mopeds, scooters and all-terrain vehicles, and to cover all age groups; and supports legislation that would require helmet usage for riders of bicycles, including passengers.
Citation: Res. 226, A-95; Reaffirmed: BOT Rep. 12, A-05; Reaffirmed: CSAPH Rep. 1, A-15

Options for Improving Motorcycle Safety D-15.999

Our AMA encourages physicians to: (a) be aware of motorcycle risks and safety measures; and (b) counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs.

Citation: CSA Rep. 6, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 1, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 436
(A-26)

Introduced by: Organized Medical Staff Section

Subject: Protecting Children from Potential Harms of Caffeinated Products

Referred to: Reference Committee D

Whereas, there is a positive correlation between age and consumption of caffeinated products in children and youth aged 10-26; and

Whereas, children and young people, especially males, consume energy drinks to fit in or emulate behaviors and they are often targeted by advertisements with themes of extreme sports or gaming; and

Whereas, over 80 percent of children and youth consume energy drinks, often leading to caffeine overdose, which is linked to adverse health effects including sleep disorders, anxiety, nervousness, irritability, depression, ADHD symptoms, nausea, headaches, high blood pressure, arrhythmia, and, in severe cases, emergency department visits; and

Whereas, there are links between high energy drink consumption and risky behaviors, such alcohol, tobacco, and non-prescribed drug use; therefore be it

RESOLVED, that our American Medical Association amend existing policy H-150.988 by addition to read:

> The AMA (1) supports a continued review of the safety of dietary caffeine intake; (2) supports continued efforts to disseminate information to the public and physicians on the caffeine content of food and beverages; and (3) will work with the FDA to ensure that, when caffeine is added to a product, the label reflects this in prominent letters and the amount of caffeine in the product be written on the label; also, that children under the age of 12 years old should avoid caffeinated products entirely and those under the age of 18 should limit intake to <100mg per day as supported by evidence-based research and guidelines.

(Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend existing policy D-150.976 by addition to read:

1. Our American Medical Association will seek necessary regulatory action through the US Food and Drug Administration to regulate potentially hazardous energy beverages (like Red Bull (TM), Rockstar (TM), Monster (TM), Full Throttle (TM)) with special attention to scientific evidence of harm to children below ages 12 and 18.

2. Our AMA will seek federal regulation to implement warning labels about the side effects of the contents of energy drinks, particularly when combined with alcohol with specific warning of harm to children below the age of 18.

3. Our AMA supports a ban on the marketing of "high stimulant/caffeine drinks" to children/adolescents under the age of 18, including opposing commercial advertising,

sponsorships, and promotional practices that target or appeal to children and adolescents.

(Modify Current HOD Policy).

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

Received: 6/5/26

REFERENCES

1. Caffeine Use in Children: What we know, what we have left to learn, and why we should worry https://pmc.ncbi.nlm.nih.gov/articles/PMC2699625/pdf/nihms117089.pdf

2. Consumption of energy drinks by children and young people: a systematic review examining evidence of physical effects and consumer attitudes https://www.sciencedirect.com/science/article/pii/S0033350623003189#:~:text=Additional%20health%20effects%20noted%20in,caries%20and%20erosive%20tooth%20wear.
3. Effects of Caffeine and Caffeinated Beverages in Children, Adolescents and Young Adults: Short Review https://pmc.ncbi.nlm.nih.gov/articles/PMC8656548/pdf/ijerph-18-12389.pdf
4. Adolescent caffeine consumption slows brain development https://www.nature.com/articles/laban.431
5. For Kids and Teens, Energy Drinks May Have Harmful Side Effects https://www.uclahealth.org/news/article/teens-energy-drinks-side-effects (web page only)

RELEVANT AMA POLICY

Caffeine Labeling H-150.988
The AMA (1) supports a continued review of the safety of dietary caffeine intake; (2) supports continued efforts to disseminate information to the public and physicians on the caffeine content of food and beverages; and (3) will work with the FDA to ensure that, when caffeine is added to a product, the label reflects this in prominent letters and the amount of caffeine in the product be written on the label.Citation: CSA Rep. E, I-83; CLRPD Rep. 1, I-93; Modified: Res. 523, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Hazards of Energy Beverages - Their Abuse and Regulation D-150.976

4. Our American Medical Association will seek necessary regulatory action through the US Food and Drug Administration to regulate potentially hazardous energy beverages (like Red Bull (TM), Rockstar (TM), Monster (TM), Full Throttle (TM)).

5. Our AMA will seek federal regulation to implement warning labels about the side effects of the contents of energy drinks, particularly when combined with alcohol.

6. Our AMA supports a ban on the marketing of "high stimulant/caffeine drinks" to children/adolescents under the age of 18.

Citation: Res. 909, I-11; Appended: Res. 409, A-13; Reaffirmed: BOT Rep. 09, A-23

Prevention of Underage Drinking: A Call to Stop Alcoholic Beverages with Special Appeal to Youths D-60.973

1. Our AMA will advocate for a ban on the marketing of products such as flavored malt liquor beverages, gelatin-based alcohol products, food-based alcohol products, alcohol mists, and beverages that contain alcohol and caffeine and other additives to produce alcohol energy drinks that have special appeal to youths under the age of 21 years of age.

2. Our AMA supports state and federal regulations that would reclassify flavored malt liquor beverages as a distilled spirit so that it can be taxed at a higher rate and cannot be advertised or sold in certain locations.

Citation: Res. 435, A-07; BOT Action in response to referred for decision Res. 411, A-08; Reaffirmed in lieu of Res. 902, I-09; Modified: SCAPH Rep. 01, A-19

Augmented Intelligence and Organized Medical Staff H-225.940

Our American Medical Association recognizes that organized medical staff should be an integral part at the outset of choosing, developing and implementing augmented intelligence and digital health tools in hospital care. That consideration is consistent with organized medical staff's primacy in overseeing safety of patient care, as well as assessing other negative unintended consequences such as interruption of, or overburdening, the physician in delivery of care.
Citation: Res. 024, A-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 516
(A-26)

Introduced by: Resident and Fellow Section

Subject: FDA Regulation of Unapproved Synthetic Peptides

Referred to: Reference Committee E

Whereas, synthetic peptides backed by carefully conducted clinical research and studies, including insulin and GLP-1 receptor agonists (semaglutide, tirzepatide), positively impact health and medicine[1]; and

Whereas, unapproved synthetic peptides, including growth hormone, Body Protection Compound 157 (BPC-157), glycyl-l-histidyl-l-lysine copper (GHK-Cu), and immunomodulators, are increasingly promoted by wellness communities and influencers for purported benefits including "tissue repair", “skin health”, and “longevity”[2,3]; and

Whereas, growing public interest in synthetic peptides has led to the emergence of companies marketing untested or unapproved peptide formulations, such as oral tirzepatide, which has not been tested by its manufacturer Eli Lilly[4,5]; and

Whereas, patients and consumers are increasingly using synthetic peptides with unregulated manufacturing, often from international sources, even over well-studied and regulated medications like statins[6]; and

Whereas, unapproved synthetic peptides are often marketed without clear ingredient labeling, standardized dosing, or adequate disclosure of risks, especially that these peptides have never been tested in humans[7,8]; and

Whereas, the Food and Drug Administration (FDA) evaluates bulk drug substances, including peptides, that may be used in compounding under Section 503A and 503B of the Federal Food, Drug, and Cosmetic Act based on safety and clinical need, and has historically restricted or excluded certain synthetic peptide compounds from inclusion on this list due to safety concerns in human use; and

Whereas, in 2023 the FDA identified 19 synthetic peptide compounds as ineligible for use in compounding pharmacies[9]; and

Whereas, the Secretary of Health and Human Services announced that 14 of these peptides will be reclassified as eligible for use in licensed compounding pharmacies, and has set a FDA panel meeting in July 2026 to do so[10,11]; and

Whereas, adverse events associated with unapproved synthetic peptides remain underreported due to a lack of standardized surveillance, fragmented sourcing, and limited clinician awareness; and

Whereas, the chemical variability, contamination risk, and lack of Good Manufacturing Practice (GMP) oversight in many compounded or imported peptide products introduce significant risks including dosing inconsistency, immunogenic reactions, and unknown long-term effects; and

Whereas, the marketing of unapproved synthetic peptides frequently occurs through direct-to-consumer platforms and social media channels, often bypassing traditional medical oversight and contributing to misinformation regarding safety and efficacy[12]; and

Whereas, physicians and healthcare professionals may face increasing pressure from patients to prescribe or endorse unapproved peptide therapies despite insufficient evidence; and

Whereas, our American Medical Association has created policy for specific emerging substances of concern (e.g., for kratom), for working with the FDA to "appropriately oversee the dietary supplement sector" and for advising that the marketing of supplements be clear ["dietary supplement product…cannot be confused with pharmaceutical products"]; therefore be it

RESOLVED, that our American Medical Association supports appropriate FDA oversight of synthetic peptides, recommending that unapproved synthetic peptide products undergo regulatory review, third-party testing, and demonstration of safety and efficacy through well-conducted clinical trials before marketing or clinical use (New HOD Policy); and be it further

RESOLVED, that our AMA submit comments to the Food and Drug Administration (FDA) regarding the July 2026 Pharmacy Compounding Advisory Committee review of synthetic peptide products, advocating for evidence-based regulatory oversight, third-party testing, and demonstration of safety and efficacy prior to marketing, compounding, or clinical use. (Directive to Take Action)

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

Received: 6/5/26

REFERENCES:

1. Zheng B, Wang X, Guo M, Tzeng CM. Therapeutic Peptides: Recent Advances in Discovery, Synthesis, and Clinical Translation. *Int J Mol Sci*. 2025;26(11):5131. Published 2025 May 27. doi:10.3390/ijms26115131
2. Stone W. The wellness world is eager for RFK Jr.'s promised move on peptides. *NPR*. Published 2026 March 31. Accessed April 4, 2026. https://www.npr.org/2026/03/31/nx-s1-5768206/peptides-rfk-fda-compounding-pharmacies
3. Boden S. Influencers are promoting peptides for better health. What does the science say?. *NPR*. Published 2026 February 23. Accessed April 4, 2026. https://www.npr.org/2026/02/23/nx-s1-5716162/peptides-science-muscle-growth-longevity-wellness
4. Griffith E. How A.I. Helped One Man (and His Brother) Build a $1.8 Billion Company. *New York Times*. Published 2026 April 2. Accessed April 4, 2026. https://www.nytimes.com/2026/04/02/technology/ai-billion-dollar-company-medvi.html
5. Eli Lilly. Is Zepbound® (tirzepatide) available as an oral formulation?. Published 2025 September 23. Accessed April 4, 2026. https://medical.lilly.com/us/products/answers/is-zepbound-tirzepatide-available-as-an-oral-formulation-294847
6. Patel V. My patient would rather take a peptide than a statin. That reveals an uncomfortable truth in medicine. *StatNews*. Published 2026 April 3. Accessed April 4, 2026. https://www.statnews.com/2026/04/03/peptides-statins-research-trust-bpc-157/
7. Todd S. What the peptide craze reveals about Americans' relationship with risk. *Statnews*. Published 2026 April 6. Accessed April 20, 2026. https://www.statnews.com/2026/04/06/rfk-jr-apparent-contradiction-peptides-vaccines-medical-libertarianism/
8. Sun S. 'Chinese Peptides' Are the Latest Biohacking Trend in the Tech World. *New York Times*. Published 2026 January 3. Accessed April 20, 2026. https://www.nytimes.com/2026/01/03/business/chinese-peptides-silicon-valley.html?unlocked_article_code=1.b1A.2zjp.i7Gk0hlZz1W8&smid=url-share
9. Perrone M. FDA to weigh easing limits on unproven peptides favored by RFK Jr. and other MAHA figures. *AP News*. Published 2026 April 15. Accessed April 20, 2026. https://apnews.com/article/peptides-fda-kennedy-injection-bpc157-37bf2f94f0e8a57da76e67a03b58ff0f
10. Food and Drug Administration. Certain Bulk Drug Substances for Use in Compounding that May Present Significant Safety Risks. Published 2025 July 8. Accessed April 4, 2026. https://www.fda.gov/drugs/human-drug-compounding/certain-bulk-drug-substances-use-compounding-may-present-significant-safety-risks
11. Damon A. RFK Jr. May Reverse a Peptide Ban He Calls "Illegal." Former FDA Officials Say He Mischaracterized Their Work. *ProPublica*. Published 2026 April 3. Access April 5, 2026. https://www.propublica.org/article/peptide-safety-fda-compounding-pharmacies

12. Damon A. A Las Vegas Festival Promised Ways to Cheat Death. Two Attendees Left Fighting for Their Lives. *ProPublica*. Published 2025 July 29. Accessed April 20, 2026.

RELEVANT AMA POLICY

Herbal Products and Drug Interactions D-150.991
Our AMA supports the Food and Drug Administration's efforts to create a publicly accessible database of adverse event and drug interaction information on dietary supplements.
[Citation: Sub. Res. 518, A-04; Modified: CSAPH Rep. 1, A-14; Reaffirmation: A-19; Reaffirmed: CSAPH Rep. 3, I-20]

Regulate Kratom and Ban Over-The-Counter Sales H-95.903
1. Our American Medical Association recommends the safety and efficacy of kratom should be determined through research and clinical trials and subsequently evaluated by the relevant regulatory entities for its appropriateness for sale and potential oversight via the Controlled Substances Act, before it can be marketed, purchased, or prescribed.
2. Our AMA recommends individuals who are currently using kratom for pain management or other conditions should have access to appropriate medical care to manage their conditions and withdrawal symptoms, if needed.
3. Our AMA recommends individuals who are using kratom only for personal use should not face criminal consequences.
4. Our AMA recommends Kratom should be regulated by the FDA, and its safety and efficacy should be determined through clinical trials before it can be marketed or prescribed as a treatment for any condition.

[Citation: Res. 515, A-23]

Quantitative Labeling of All Drugs H-115.998
The AMA supports efforts to promote the qualitative labeling of all drugs and dietary supplements, requiring both active and inactive ingredients of over-the-counter and prescription drugs and dietary supplements to be listed on the manufacturer's label or package insert.
[Citation: Res. 96, A-84; Reaffirmed by CLRPD Rep. 3 - I-19; BOT Rep. 1, A-95; Reaffirmed: CSA Rep. 8, A-05; Modified: Sub. Res. 504, A-10; Reaffirmation: A-19]

Advertising for Herbal Supplements H-150.946
It is AMA policy that the naming, packaging, and advertising of dietary supplement products be such that they cannot be confused with pharmaceutical products. [Citation: Sub. Res. 504, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmation: A-19]

Dietary Supplements and Herbal Remedies H-150.954
(1) Our AMA supports efforts to enhance U.S. Food and Drug Administration (FDA) resources, particularly to the Office of Dietary Supplement Programs, to appropriately oversee the growing dietary supplement sector and adequately increase inspections of dietary supplement manufacturing facilities.
(2) Our AMA supports the FDA having appropriate enforcement tools and policies related to dietary supplements, which may include mandatory recall and related authorities over products that are marketed as dietary supplements but contain drugs or drug analogues, the utilization of risk-based inspections for dietary supplement manufacturing facilities, and the strengthening of adverse event reporting systems.
(3) Our AMA supports continued research related to the efficacy, safety, and long-term effects of dietary supplement products.
(4) Our AMA will work with the FDA to educate physicians and the public about FDA's Safety Reporting Portal (SRP) and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.
(5) Our AMA strongly urges physicians to inquire about patients' use of dietary supplements and engage in risk-based conversations with them about dietary supplement product use.
(6) Our AMA continues to strongly urge Congress to modify and modernize the Dietary Supplement Health and Education Act to require that:
a. dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy;

b. dietary supplements meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling;
c. FDA establish a mandatory product listing regime that includes a unique identifier for each product (such as a QR code), the ability to identify and track all products produced by manufacturers who have received warning letters from the FDA, and FDA authorities to decline to add labels to the database if the label lists a prohibited ingredient or new dietary ingredient for which no evidence of safety exists or for products which have reports of undisclosed ingredients; and
d. regulations related to new dietary ingredients (NDI) are clarified to foster the timely submission of NDI notifications and compliance regarding NDIs by manufacturers.

(7) Our AMA supports FDA postmarketing requirements for manufacturers to report adverse events, including drug interactions; and legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement.
(8) Our AMA will work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements and supports adequate funding and resources for FTC enforcement of violations of the FTC Act.
(9) Our AMA strongly urges that criteria for the rigor of scientific evidence needed to support a structure/function claim on a dietary supplement be established by the FDA and minimally include requirements for robust human studies supporting the claim.
10) Our AMA strongly urges dietary supplement manufacturers and distributors to clearly label all products with truthful and not misleading information and for the product labeling to:

a. not include structure/function claims that are not supported by evidence from robust human studies;
b. not contain prohibited disease claims;
c. eliminate “proprietary blends” and list and accurately quantify all ingredients contained in the product;
d. require advisory statements regarding potential supplement-drug and supplement-laboratory interactions and risks associated with overuse and special populations; and
e. include accurate and useful disclosure of ingredient measurement.

(11) Our AMA supports and encourages the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies.
(12) Our AMA urges that in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label.
(13) Our AMA will continue its efforts to educate patients and physicians about the risks associated with the use of dietary supplements and herbal remedies and supports efforts to increase patient, healthcare practitioner, and retailer awareness of resources to help patients select quality supplements, including educational efforts to build label literacy.
[Citation: Res. 513, I-98; Reaffirmed: Res. 515, A-99; Amended: Res. 501 & Reaffirmation I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 516, I-00; Modified: Sub. Res. 516, I-00; Reaffirmed: Sub Res. 518, A-04; Reaffirmed: Sub. Res. 405, A-05; Reaffirmation A-05; Reaffirmed in lieu of Res. 520, A-05; Reaffirmation I-09; Reaffirmed in lieu of Res. 501, A-10; Reaffirmation A-11; Reaffirmation I-14; Modified: Res. 511, A-16; Reaffirmation: A-17; Reaffirmation: A-19; Modified: CSAPH Rep. 3, I-20; Reaffirmed: Res. 510, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 619
(A-26)

Introduced by: Medical Student Section

Subject: Opposing Federal Immigration Operations at AMA Events and Harm to Lawful Non-Target Individuals

Referred to: Reference Committee F

Whereas, Immigration and Customs Enforcement (ICE) was created with a mission to preserve American security and public safety, mainly within U.S. borders, by enforcing immigration laws[1-5]; and

Whereas, excessive force has been utilized on several occasions by ICE/CBP agents, who are often unidentified and/or masked, leaving difficulty for accountability and litigation for medical costs incurred[6-10]; and

Whereas, immigration crackdown has impeded patients from arriving to appointments, such as in the case of the detainment of Aliya Rahman, who was en route to a traumatic brain injury center when ICE officers smashed her passenger side window, cut her seatbelt, and dragged her by her arms and legs to an ICE vehicle[11]; and

Whereas, under ICE custody, Aliya Rahman was brought to a center where she was denied medical care until she lost consciousness in her cell[12]; and

Whereas, immigration enforcement operations cause acute disruptions in healthcare utilization, as individuals delay or avoid seeking medical care and forego medication refills due to fear of arrest or deportation[13-14]; and

Whereas, such immigration enforcement-related avoidance of healthcare contributes to worsening control of chronic diseases such as diabetes and hypertension and overall deterioration in health status due to reduced access to timely and preventive medical care[15-16]; and

Whereas, ICE arrests have been shown to cause significant mental health harms, including increased rates of anxiety, depression, psychological distress, and suicide risk among adolescents and adults in affected communities[17-20]; and

Whereas, the use of violence on behalf of ICE has led to deaths of multiple U.S. citizens, including Alex Pretti and Renee Nicole Good, and the intentional delay of medical aid to these victims[21-22]; and

Whereas, the presence of ICE in hospitals has negatively impacted patient care through several means, such as entering private patient areas without warrants and denying patients from speaking privately with doctors[23]; and

Whereas, under the current administration, over 100,000 visas (including F1, H1, and J1 visas) have been revoked without prior notice or justification on the basis of vaguely articulated or minor infractions[24-25]; and

Whereas, international medical graduates (IMGs) constitute 25% of the practicing physicians having about 11,000 residents are sponsored annually by the H-1B program, 17,500 residents through the J1 visa program and about 1.5% of the medical students through F1 student visas[26]; and

Whereas, most IMGs practice in underserved areas within primary care, are integral to the U.S. healthcare workforce and a huge asset to mitigate projected clinician shortages, and aggressive enforcement causes undue distress, disrupts staffing and continuity of care[27]; and

Whereas, our AMA currently recognizes the negative health effects of the detention of families seeking safe haven and opposes the expansion of family immigration detention in the U.S.[28]; and

Whereas, the presence of federal enforcement operations in civic or advocacy spaces may create fear and deter participation, undermining the ability of physicians and trainees to engage in open dialogue and policy advocacy, as has been documented in other settings[29]; and

Whereas, the American Medical Association Code of Medical Ethics affirms physicians' responsibility to advocate for social and policy conditions that improve health, reduce suffering, and safeguard patient welfare and access to care[30]; therefore be it

RESOLVED, that our American Medical Association opposes federal immigration operations without a judicial warrant at AMA events (New HOD Policy); and be it further

RESOLVED, that our AMA supports federal, state, and institutional policies that prevent immigration enforcement actions from interfering with the ability of physicians, trainees, and other health care professionals to attend conferences, complete training, or provide patient care, except where required by a valid judicial order (New HOD Policy); and be it further

RESOLVED, that our AMA supports the use of visible identification by federal immigration enforcement personnel as a measure to uphold ethical standards, public trust, transparency, and accountability in cases where their actions may result in health-related harms. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 06/5/26

REFERENCES

1. History of ICE | ICE. August 17, 2020. Accessed April 12, 2026. https://www.ice.gov/history
2. What is Immigration and Customs Enforcement (ICE) and what does it do? USAFacts. Accessed April 12, 2026. https://usafacts.org/articles/what-is-ice-and-what-does-it-do/
3. CBP's 20th Anniversary History: The Establishment of U.S. Customs and Border Protection | U.S. Customs and Border Protection. Accessed April 12, 2026. https://www.cbp.gov/about/history/cbp-20-20-establishment
4. CBP History Through the Years | U.S. Customs and Border Protection. July 11, 2025. Accessed April 12, 2026. https://www.cbp.gov/about/history
5. About CBP | U.S. Customs and Border Protection. Accessed April 12, 2026. https://www.cbp.gov/about
6. Gabbatt A. US green card holder sues ICE over claims of 'violent assault.' The Guardian. December 15, 2025. Accessed April 12, 2026. https://www.theguardian.com/us-news/2025/dec/15/ice-lawsuit-violent-assault

7. ICE agents under scrutiny after man's legs allegedly crushed in Vancouver arrest. opb. November 14, 2025. Accessed April 12, 2026. https://www.opb.org/article/2025/12/06/vancouver-ice-alleged-crushing-legs/
8. News ABC. 79-year-old US citizen claims ICE agents body-slammed him at his business, seeks $50M. ABC News. Accessed April 12, 2026. https://abcnews.com/US/79-year-us-citizen-claims-ice-agents-body/story?id=125978834
9. Mustian J, Biesecker M, español JBL en. FBI, St. Paul police probing ICE arrest that resulted in skull fractures. AP News. February 18, 2026. Accessed April 12, 2026. https://apnews.com/article/immigration-enforcement-minneapolis-hospital-ice-beating-assault-eb305587f58dfc8b97d844d0073411c2
10. Espinoza-Madrigal I. Lawyers for Civil Rights. Lawyers for Civil Rights. June 5, 2025. Accessed April 12, 2026. https://lawyersforcivilrights.org
11. CBC. Woman dragged from car by ICE identified as U.S. citizen Aliya Rahman. CBC News. January 16, 2026. Accessed April 12, 2026. https://www.cbc.ca/news/world/aliya-rahman-citizen-ice-arrest-9.7047853
12. Oversight A. What We Know About How ICE is Being Trained on the Use of Force. American Oversight. February 17, 2026. Accessed April 12, 2026. https://americanoversight.org/what-we-know-about-how-ice-is-being-trained-on-the-use-of-force/
13. Herring J, Barnow B. Indirect effects of immigration enforcement on health care utilization among lawfully present older Hispanics. Social Science & Medicine. 2025;384:118540. doi:10.1016/j.socscimed.2025.118540
14. As Trump's raids ramp up, a Texas region's residents stay inside — even when they need medical care. AP News. July 21, 2025. Accessed April 12, 2026. https://apnews.com/article/trump-immigration-medicaid-health-illegal-985fb65ee53095d5cedf39bdac58500f
15. Friedman AS, Venkataramani AS. Chilling Effects: US Immigration Enforcement And Health Care Seeking Among Hispanic Adults. Health Affairs. 2021;40(7):1056-1065. doi:10.1377/hlthaff.2020.02356
16. Nwadiuko J, German J, Chapla K, et al. Changes in Health Care Use Among Undocumented Patients, 2014-2018. JAMA Netw Open. 2021;4(3):e210763. doi:10.1001/jamanetworkopen.2021.0763
17. Pinedo M, Valdez CR. Immigration Enforcement Policies and the Mental Health of US Citizens: Findings from a Comparative Analysis. American Journal of Community Psychology. 2020;66(1-2):119-129. doi:10.1002/ajcp.12464
18. Luo T, Kostandini G, Liu Y, Nie P. Deportation enforcement, mental health, and health risk behaviors of hispanic adolescents. Social Science & Medicine. 2026;388:118753. doi:10.1016/j.socscimed.2025.118753
19. Lopez WD, Kruger DJ, Delva J, et al. Health Implications of an Immigration Raid: Findings from a Latino Community in the Midwestern United States. J Immigrant Minority Health. 2017;19(3):702-708. doi:10.1007/s10903-016-0390-6
20. Heffernan S, Meagher T. How ICE and Border Patrol Keep Injuring and Killing People. The Marshall Project. January 26, 2026. Accessed April 12, 2026. https://www.themarshallproject.org/2026/01/26/ice-minneapolis-shooting-alex-pretti
21. News ABC. Minneapolis ICE shooting: A minute-by-minute timeline of how Renee Nicole Good died. ABC News. Accessed April 12, 2026. https://abcnews.com/US/minneapolis-ice-shooting-minute-minute-timeline-renee-nicole/story?id=129021809
22. OnLabor. Hospitals Become Sites of Confrontation for Healthcare Workers and Immigration Agents ✦ OnLabor. December 19, 2025. Accessed April 12, 2026. https://onlabor.org/hospitals-become-sites-of-confrontation-for-healthcare-workers-and-immigration-agents
23. Ansari H. Immigrants Detained by ICE Sue Immigration Detention Center for Medical Neglect and Other Conditions. American Civil Liberties Union. December 17, 2025. Accessed April 12, 2026. https://www.aclu.org/news/immigrants-rights/inside-an-ice-detention-center-detained-people-describe-severe-medical-neglect-harrowing-conditions
24. Psaledakis D, Psaledakis D. Trump administration has revoked over 100,000 visas, State Department says. Reuters. January 12, 2026. Accessed April 12, 2026. https://www.reuters.com/legal/government/trump-administration-has-revoked-over-100000-visas-state-department-says-2026-01-12/
25. ABIM. ABIM recommends preserving "duration of status" designation for physicians in training with J-1 visas in support of physician education and patient care | ABIM Blog. Accessed April 12, 2026. https://blog.abim.org/abim-recommends-preserving-duration-of-status-designation-for-physicians-in-training-with-j-1-visas-in-support-of-physician-education-and-patient-care/
26. 2024 Key Findings and Definitions. AAMC. Accessed April 12, 2026. https://www.aamc.org/data-reports/data/2024-key-findings-and-definitions
27. Muthukumar AV, Fong ZV, Buss R, et al. International students in United States allopathic medical education: a mixed-methods analysis of institutional policies. Med Educ Online. 2025;30(1):2471433. doi:10.1080/10872981.2025.2471433
28. H-350.955 Care of Women and Children in Family Immigration Dete | AMA. Accessed April 12, 2026. https://policysearch.ama-assn.org/policyfinder/detail/detention%20centers?uri=%2FAMADoc%2FHOD.xml-H-350.955.xml
29. Duret D, Bogan J. 'We Know Where You Live.' Protesters Say ICE Agents Retaliate With Threats, Investigations. The Marshall Project. February 4, 2026. Accessed April 12, 2026. https://www.themarshallproject.org/2026/02/04/ice-immigration-intimidation-tactics-protesters
30. AMA Principles of Medical Ethics. Accessed April 12, 2026. https://code-medical-ethics.ama-assn.org/principles

RELEVANT AMA POLICY

Disruptive Visits to Medical Offices by Government Investigators and Agents H-175.977
Our American Medical Association supports legislation and/or other appropriate means to ensure that State and Federal investigators, and/or agents, give a physician written notice prior to a visit to a medical office, so that such visit may be scheduled upon mutual agreement at a time when patients are not present in the medical office.
Our AMA, in any circumstances which lawfully permit a visit to a medical office without notice, such as a search warrant, arrest warrant or subpoena, investigators and/or agents should be required to initially identify themselves to appropriate medical staff in a quiet and confidential way that allows the physician an opportunity to comply in a manner that is least disruptive and threatening to the patients in the medical office.
Our AMA encourages physicians to report incidents of inappropriate intrusions into their medical offices to the AMA's Office of the General Counsel and consider development of a hotline for implementation. [Res. 211, A-99, Reaffirmation I-01, Reaffirmed: BOT Rep. 22, A-11, Reaffirmed: BOT Rep. 7, A-21]

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921
Our American Medical Association advocates for and supports legislative efforts to designate healthcare facilities as protected areas by law.
Our AMA will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as protected areas where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur.
Our AMA encourages healthcare facilities to clearly demonstrate and promote their status as protected areas.
Our AMA opposes the presence of ICE enforcement at healthcare facilities. [Res. 232, I-17, Reaffirmed in lieu of the first resolve: Res. 234, A-25, Modified: Res. 218, I-25]

Addressing Targeting and Workplace Restrictions and Barriers to Healthcare Delivery by International Medical Graduate (IMG) Physicians D-255.970
Our AMA will work with relevant stakeholders to develop model workplace policies to address unfair treatment or targeting of physicians and other healthcare workers, based upon migration status or country of origin, during the regular performance of their duties within healthcare systems.
Our AMA will study and develop model hospital and workplace policies to provide standardized procedures for addressing situations in which U.S. Immigration and Customs Enforcement (ICE) officers seek entry into “protected areas,” such as hospitals and healthcare settings to produce actions which may impact patient care or physician safety. [Res. 015, A-25]

Patient and Physician Rights Regarding Immigration Status H-315.966
Our American Medical Association supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records, Medicaid, Children’s Health Insurance Program (CHIP), or other health program data, including but not limited to Emergency Medicaid and related immigrant-specific programs, for immigration enforcement purposes.
Our AMA supports efforts by interested parties to educate physicians, medical students, and patients about existing privacy protections to safeguard confidential health information, and to help ensure that this information reaches immigrant and mixed-status families. [Res. 018, A-17, Modified: Res. 229, I-25]

Care of Women and Children in Family Immigration Detention H-350.955
Our AMA recognizes the negative health consequences of the detention of families seeking safe haven.
Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
Our AMA will advocate for access to health care for women and children in immigration detention.
Our AMA will advocate for the preferential use of alternatives to detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies.

Our AMA advocates for the implementation of evidence-based, child-centered, and trauma-informed policies across all detention centers, ensuring detained minors have access to developmentally appropriate socioemotional care, including physical contact, and for all detained people, free, unfettered communication access including regular in-person communication, phone calls, and letters.
Our AMA supports efforts to address and mitigate concerns and accusations of child abuse and neglect in detention centers. [Res. 002, A-17, Appended: Res. 218, A-21, Reaffirmed: Res. 234, A-22, Appended: Res. 415, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 620
(A-26)

Introduced by: Organized Medical Staff Section

Subject: Survey of Medical Staffs

Referred to: Reference Committee F

Whereas, the core mission of the American Medical Association (AMA) is to promote the art and science of medicine and the betterment of public health; the organization focuses on empowering physicians to improve patient care, advancing medical science, and enhancing the professional lives of doctors; and

Whereas, among the most relevant categories of concern that have impact on the quality of, cost, and access to medical care is the organizational structure of our hospitals and related institutions; and

Whereas, the Organized Medical Staff Section (OMSS) of the AMA serves as a representative forum for physicians practicing in, or affiliated with, organized medical staffs. OMSS focuses on issues related to hospitals and employed environments as well as independent physicians interacting with hospital organizations, and provides a dedicated voice within the AMA to advocate for, and address the unique needs of, these physicians and their patients; and

Whereas, within recent decades, the nature of the physician-hospital relationship and dynamic has evolved markedly. In order best to inform and direct the efforts of OMSS, and the AMA, to optimize the care given, and safety within, this aspect of the healthcare system; it is imperative better to understand the present constitution of medical staffs across the United States; and

Whereas, there is a spectrum of different models within and between hospital organizations and related caregiving institutions, which directly impacts on the influence physicians have over the practice and direction of evolving medical care; therefore be it

RESOLVED, that our American Medical Association work with the Organized Medical Staff Section to sponsor a survey of sufficient statistical power to determine the spectrum of composition and influence of the contemporary medical staff across the United States, including but not limited to information such as:

- Is your hospital owned by a system, is it independent, or is it affiliated with a system?
- Do you have your own medical staff with officers? If part of a system, is there one medical staff for the system or does each facility have its own?
- What are the categories of medical staff membership? Please define these.
- Are the officers appointed by the hospital or are they elected by the medical staff?
- Is there a medical staff executive committee (MEC) that meets regularly? How often? Does it meet with hospital leadership? Do non-medical staff members have a vote on the MEC?
- To what degree are independent physicians (solo, members of group organizations, etc) versus employed physicians active in the administration of medical staff, i.e. involvement in committees or ad hoc initiatives?

(Directive to Take Action).

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

Received: 6/5/26

Summary of Fiscal Notes (A-26)

Report(s) of the Board of Trustees

01	Annual Report	Minimal
02	New Specialty Organizations Representation in the House of Delegates	Minimal
03	2025 Grants and Donations	
04	AMA 2027 Dues	Minimal
05	Update on Corporate Relationships	
06	AMA Performance, Activities and Status in 2025	
07	Annual Update on Activities and Progress in Tobacco Control: March 2025 through February 2026	
08	Council on Legislation Sunset Review of 2016 House Policies	Minimal
09	American Medical Association Optimal Health Outcomes Annual Report	
10	AMA Efforts on Medicare Payment Reform	
11	AMA Public Health Strategy Update	
12	The Uniform Health-Care Decisions Act	Minimal
13	Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medicaid Purposes	Minimal
14	Binding Arbitration in Health Insurance Contracts	Minimal
15	Protecting the Prescriptive Authority of Plenary Licensed Physicians	Minimal
16	Demographic Report of the House of Delegates and AMA Membership	
17	Supporting the Integration of Blood Pressure Variability Data in Electronic Medical Records Report	Major
18	Report on the Preservation of Independent Medical Practice	
19	Root Cause Analysis of the Causes of the Decline of Private Medical Practice	Minimal
20	Mitigating the Impact of Excessive Prior Authorization Processes	Minimal
21	Abolishing Venue Shopping	Minimal
22	Comprehensive AMA Policy Publication Regarding Employed Physicians	Minimal
23	Liberalized Remorse Period for Medicare Advantage Plan Insureds	Minimal
24	AMA Advocacy to Mitigate Medicaid Cuts	Minimal
25	Federal Legislation to Prohibit the Corporate Practice of Medicine	Minimal

Summary of Fiscal Notes (A-26)

26	AMA Ethics Fellowships	
27	Update the Status of Virtual Credit Card Policy, EFT Fees, and Lack of Enforcement of Administrative Simplification Requirements by CMS	Minimal
28	Accountability in the Use of Augmented Intelligence for Prior Authorization	Minimal
29	Educational Materials Regarding Ultra-processed Foods	Minimal
30	AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates	
31	Establishing an Advisory Committee on AI/AN Affairs	
32	Disability Advisory Group	
33	Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted	
34	Discontinuation of AMA Citation for Distinguished Service	Minimal
35	Specialty Society Representation in the House of Delegates - Five-Year Review	Minimal
36	Update on the Report of the TRHT Task Force to the AMA Board of Trustees	
37	Project IMG Observer Status in the House of Delegates	
38	Project IMG Observer Status in the House of Delegates	Minimal

Report(s) of the Council on Constitution and Bylaws

01	Introducing CCB Reports 2-7 concerning Bylaw 2, House of Delegates	
02	HOD Representation and Composition	
03	Rights & Privileges of HOD Members	
04	Credentialing of HOD Delegates and Alternate Delegates	
05	Inclusion of Medical Students and Resident/Fellow Physicians in HOD Delegations	
06	Medical Student Regional Delegates and Alternate Delegates and Resident and Fellow Sectional Delegates and Alternate Delegates in the HOD	
07	HOD Delegate and Alternate Delegate Vacancies and Meeting Absences	
08	Business Meetings of the AMA Sections	
09	Continuity of AMA Resident and Fellow Section Governing Council Leadership	

Summary of Fiscal Notes (A-26)

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

01	Guidelines on Chaperones for Sensitive Exams	Minimal
02	Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure	Minimal
03	Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	Minimal
04	Carceral Systems and Practices in Behavioral Health Emergency Care	
05	CEJA's Sunset Review of 2016 House Policies	Minimal
06	Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report	

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

01	Amendment to Opinion 1.1.1 "Patient-Physician Relationships"	
02	Research Involving Pregnant and Lactating Individuals	

Report(s) of the Council on Medical Education

01	Council on Medical Education Sunset Review of 2016 House of Delegates' Policies	Minimal
02	Examining ABMS Processes for New Boards	Minimal
03	Support for the Establishment of Indigenous-Led Medical Schools in the United States	Major - $100,000 Non-staff travel and meeting expenses
04	Reflecting the Values and Priorities of Tribal Communities in Indigenous-Led Medical Schools in the United States	Major - $80,000 Non-staff travel and meeting expenses

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

01	Update on CLRPD Evaluation of the Structure of the House of Delegates	

Report(s) of the Council on Medical Service

01	Council on Medical Service Sunset Review of 2016 House Policies	
02	Study of the Federal Employees Health Benefits Program (FEHBP)	
03	Improving Patient Access to Pharmacies and Medications in Pharmacy Deserts	Minimal
04	Expanding Medicare Coverage of Medical Nutrition Therapy	Minimal
05	Inclusion of Discounted Prescription Medication in Patient Cost-Sharing	Minimal
06	Study of Practice Models for Physicians Performing Procedures Across State Lines	Minimal

Summary of Fiscal Notes (A-26)

07	Private Insurance Coverage of Anti-Obesity Medications	Minimal
08	Rural Health Transformation Program Update & Workforce Challenges	Minimal
09	Nonprofit Status	Minimal

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

01	Sunset Review of 2016 House Policies	
02	Setting Standards for Forensic Toxicology Laboratories Used in Litigation	Modest
03	Public Health Implications of Food Subsidies	Minimal
04	Improving Public Awareness of Lung Cancer Screening and CAD in Chronic Smokers	Minimal
05	Removing Artificial Turf in Schools, Parks, and Public Places	Minimal
06	Mitigating Air and Noise Pollution from Aviation in Minority Communities Disproportionately Impacted and Vulnerable Communities	Minimal
07	Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making	Minimal
08	Increased Transparency Among Psychotropic Drug Administration in Prisons	Minimal
09	In Support of a National Drug Checking Registry	Minimal
10	Standardizing Safety Requirements for Traditional and Rideshare Based Non-Emergency Medical Transportation	Modest

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

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

Resolutions

001	Ethical Guidance on Postmortem Sample Collection for Genetic Testing	Minimal
002	Physician Workload and Scheduling	Modest
003	Artificial Intelligence to Bolster Physician-Led Team-Based Care	Moderate
004	Ethical Reproductive Care for Individuals with Intellectual and Developmental Disabilities	Minimal
005	Impersonation of a Physician	Modest
006	Investigating Moral Injury Related to Organ Procurement Practices	Modest

Summary of Fiscal Notes (A-26)

007	Supporting Privacy in the Use of Artificial Intelligence Based Scribe Software	Modest
008	Senior Physicians Improving Patient Access	Modest
009	Preserving Access to Care for Undocumented Individuals	Modest
010	Fatigue Mitigation: Supporting Fully-Funded Transportation for Trainee Physicians After Extended or Overnight Shifts	Minimal
011	Physician Ability to Render Emergency Medical Aid During Immigration Enforcement	Modest
101	Revise the Use of Language Stigmatizing Obesity in ICD-10 Code E66.01"Morbid (Severe) Obesity Due to Excess Calories"	Modest
102	Study for EMTALA Relief in Psychiatric Facilities	Modest
103	Supporting Non-Insurance Directed Sales of Pharmaceuticals to Patients to Improve Access and Reduce Costs	Moderate
104	Improving Choice, Competition, and Affordability in the ACA Marketplaces	Modest
105	Oppose Medicare Advantage Auto Enrollment	Minimal
106	Insurance Coverage for Scalp Cooling (Cold Capping) Therapy	Minimal
107	Oversight of Medicare Advantage Plan	Moderate
108	Ensuring Physician Input in the Development of CMMI Models	Minimal
109	Insurance Coverage for Pediatric Intracranial Neuromodulation for Drug-Resistant Epilepsy	Modest
110	Medicaid Coverage for Incarcerated Individuals	Modest
111	Advocating for Insurance Coverage of Scalp Cooling Therapy to Prevent Chemotherapy-Induced Alopecia	Moderate
112	Ensuring Coverage and Access to Adult Strabismus Surgery	Modest
113	Health Insurance Coverage of Hearing Devices and Related Services	Minimal
114	Opposing Alternative Funding Programs	Modest
115	Patient Continuity Protections During Payer, PBM Changes	Moderate
116	Study of Cost Implications of Medicaid Managed Care Organizations Compared with State-Administered Medicaid Programs	Modest
117	Universal Out of Network Benefits	Modest
118	Addressing Proposals to Implement International Reference Pricing for Physician-Administered Drugs	Moderate

Summary of Fiscal Notes (A-26)

201	Prohibit and Regulate 7-Hydroxymitragynine (7-OH) Kratom Products to Protect Public Health and Youth Safety	Minimal
202	Using and Defining "Unsupervised Practice of Medicine"	Moderate
203	Support for Independent Evaluation of Outcomes Associated with Unsupervised Nurse Practitioner Practice	Modest
204	D-400.982 Revision	Moderate
205	Repeal of the Merit-Based Incentive Payment System (MIPS)	Moderate
206	Overall Hospital Quality Star Ratings / CMS Star Ratings	Modest
207	Addressing Rural Maternity Care Deserts Through the Conrad 30 Waiver Program	Minimal
208	Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness	Modest
209	Protecting Mental Health Treatment Privacy in Legal Proceedings	Modest
210	Eliminating Prescription Drug Adherence (PDA) as a Quality Metric Tied to Physician Ratings or Compensation	Modest
211	Preventing Hospital-Based 340B Programs from Unfairly Competing with Independent Physicians	Modest
212	Protecting Patient Access to Clinical Trials and Mitigating Administrative Disruptions to NIH Funding	Moderate
213	Prohibiting Pharmacy Benefit Managers from Owning Pharmacies	Modest
214	Medical Student Loans Should Not Be Capped	Minimal
215	Oppose Medicare Efficiency Adjustments	Modest
216	Protecting Healthcare as a Sensitive Location	Moderate
217	Ensuring Proportional Accountability for Hospital Expenditures Attributed to Medicare ACOs	Moderate
218	Opposing the Practice of Jury Anchoring in Medical Liability Cases	Minimal
219	Incorporating Evidence-Based Lifestyle Medicine into Rural Health Transformation Programs	Modest
220	Reverse CMS Cuts to Facility-Based Practice Expense Payments for Physicians	Moderate
221	Universal Newborn Congenital Cytomegalovirus Screening	Modest
222	Advocating for a Centralized Medicare Enrollment Platform to Preserve Patient Choice Between Traditional Medicare and Medicare Advantage	Moderate

Summary of Fiscal Notes (A-26)

223	Ensuring Due Process, Transparency, and Human Clinical Oversight in the Use of Artificial Intelligence for Health Insurance Coverage and Eligibility Determinations	Moderate
224	Clarity of Signage: Distinguishing Urgent Cares From Emergency Rooms	Modest
225	Requiring Periodic Face-to-Face Visits By Board-Certified Specialists Who Delegate Visits to Non-Physician Practitioners for Nursing Home Patients	Minimal
226	Impact of a Proposed $100,000 H-1B Visa Fee on the NRMP Match, the Physician Workforce, and the U.S. Health Care System	Moderate
227	Standby Capacity Payments and Health IT for Hospitals in Rural Areas	Moderate
228	Department of Defense Health Care Investment at Military Bases in Maternity Care Health Professional Shortage Areas	Moderate
229	Physicians are not Providers	Moderate
230	Exemption of International Medical Graduates from Presidential Proclamations Restricting Entry into the United States	Moderate
231	Protecting and Promoting Long Term Care Workforce Amidst Immigration Challenges	Modest
232	Banning Flavored Cannabis E-Cigarettes	Modest
233	Banning Synthesized, Purified or Derivative Products from Kratom	Modest
234	Physician Unity in Advocacy Regarding Physician Reimbursement	Modest
235	Establishing Healthcare Monitoring and Accountability in Immigration Detention Facilities	Minimal
236	Extending and Expanding the AMA Task Force to Preserve the Patient-Physician Relationship to Ensure Access and Regulatory Clarity in Gender-Affirming Care	Major - To Be Determined
237	Guaranteed 30-Day Transition Fill of Currently Prescribed Insulin at the Beginning of Each Year Plan	Minimal
238	Prohibiting the Independent Practice of Medicine by Artificial Intelligence	Moderate
239	Medicare Administrative Contractor Policy Modification	Moderate
240	Ending Private Equity Dividend Recapitalization in Healthcare	Moderate
241	Strengthening Our AMA Efforts Toward CPOM Prohibition	Minimal
242	Reducing Emergency Department Boarding through Payment Reform	Modest
243	Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions	Moderate

Summary of Fiscal Notes (A-26)

244	Eliminate Administrative Barriers to Appeal Wrongful Denials	Moderate
245	State Regulation of Non-Preempted “Non-Central Matters” of ERISA Plans—Rutledge v. PCMA	Major - $127,219 Legal analysis, creation of educational programming/module
246	Artificial Intelligence Scope of Practice	Moderate
247	Comprehensive ERISA Reform	Moderate
248	Medical Staff Oversight of Hospital Augmented Intelligence	Modest
249	Bringing Physicians' Voices to the Implementation of AI Prescribers	Modest
250	Protecting Resident Physicians with Pending Immigration Status and Ensuring Safe Participation in Professional Activities	Moderate
251	Minimum Standards for Public Health Leaders	Modest
252	Immediate Action to Prevent Further Immigrant Deaths	Moderate
301	Expanding Resident and Fellow Exposure to Diverse Healthcare Practice Models to Fulfill ACGME Core Competencies	Minimal
302	Excessive Cost of Multi-State DEA Licensure	Minimal
303	Allowing Options for Certification Maintenance	Minimal
304	Increasing the Use of Retired Physicians in Teaching Students and Residents	Minimal
305	Leadership by Physicians for Physicians in Graduate Medical Education (GME)	Minimal
306	Competency-Based Portfolio Assessment of Medical Students, Interns, Residents, and Fellows	Minimal
307	Recognizing Advocacy as a Component of Faculty Appointment and Promotion in Academic Medicine	Minimal
308	Impact of Federal and State Restrictive Actions on Gender-Affirming Care on Medical Education and Physician Workforce Development	Minimal
309	Osteoporosis Education, Awareness, and Musculoskeletal Health Optimization	Modest
310	Increasing Capacity and Access to Maternal Health Services in Rural Areas	Minimal
311	Changing the Paradigm of Medical Student Debt to address the Geriatric Physician Shortfall	Minimal
312	Advocating for Equitable Application Review in a Single Match System	Modest
313	Evaluation of Situational Judgement Tests in Medical School Admissions	Modest

314	Promoting Sex- and Gender-Inclusive Diagnostic Practices, Language, and Patient Education	Minimal
315	Expanding the Native Hawaiian Health Scholarship Program Eligibility	Minimal
316	Addressing Transitions Within GME Regarding Orientation Standards	Minimal
317	Support for Intern, Resident, and Fellow Jeopardy Pay and Additional Compensation for Gaps in Trainee Coverage	Minimal
401	Partnership with the Administration to Reduce Harmful Chemicals in Food and Align with European Safety Standards	Modest
402	Strengthening Public Health Protections Against Raw Milk–Associated Illness	Major - $69,695 Development and dissemination of education initiatives
403	AMA's continued support for COVID-19 vaccination in pregnant individuals and children	Minimal
404	Develop Climate-Conscious Resources for Physicians	Moderate
405	Studying the Environmental Impact of Ambient Clinical Intelligence Use	Modest
406	Reduce Environmental Impact of Medical Journals	Modest
407	Colorectal Cancer in Alaskan Native Patients	Modest
408	Addressing Rural Maternal Morbidity and Mortality through Collaboration and Intersectionality	Modest
409	Eliminate PFAS and Glyphosate in our Food and Environment	Minimal
410	Light Pollution	Minimal
411	Addressing the Myopia Epidemic, Public Education, and Insurance Coverage for Evidence-Based Myopia Control	Modest
412	Guiding Principles of Pandemic Prevention, Preparedness and Response	Minimal
413	Erosion of the Public Evidence Base for Health Policy	Modest
414	Restoring Balanced Scientific Perspective within the ACIP	Minimal
415	Advocacy for Restoration of the Endangerment Finding Regarding Greenhouse Gas Emissions	Modest
416	Clinical Laboratory Workforce Shortage and Sustainability	Modest
417	Respiratory Protection for Wildland Firefighters	Modest
418	Ensuring Access to Full HIV Post-Exposure Prophylaxis (PEP) Courses for Survivors of Sexual Assault	Minimal

Summary of Fiscal Notes (A-26)

419	Examining the Impact of Circadian Disruption from Shift Work During Pregnancy	Minimal
420	Expanding Support for Women Experiencing Homelessness	Minimal
421	Improving Access to Care and Support for Patients with Inflammatory Bowel Disease in the United States	Minimal
422	Expanding Access to High Resolution Anoscopy	Modest
423	Expanding Access to HIV Pre-Exposure Prophylaxis (PrEP)	Minimal
424	Supporting Education and Access to Postexposure Doxycycline (DoxyPEP)	Minimal
425	Prioritizing, Measuring, and Preventing Workplace Violence in Health Care	Modest
426	Integrating Nutrition into Health Care Delivery to Reduce Cardiovascular Risk and Food Insecurity (“Food is Medicine”)	Minimal
427	Infant Feeding Options for HIV-Seropositive Individuals	Minimal
428	Protecting Environmental Health Before, During, and After War	Minimal
429	Adolescent Dating Violence Comprehensive Screening Tool Development	Modest
430	Support Heavy Metal and Toxic Exposure Testing for Residents Affected by Wildfires	Minimal
431	Supporting Transportation Infrastructure Reform for Public Health	Minimal
432	Addressing Public Health Risks of Online Sports Betting	Minimal
433	Addressing the Epidemic of Fragility Fractures Through Improved Osteoporosis Screening and Treatment	Modest
434	Vaccinations in Physician Offices	Modest
435	Supporting Regulations for More Stringent Safety Measures for Micromobility	Modest
436	Protecting Children from Potential Harms of Caffeinated Products	Modest
501	Preregistration in Medical Research	Modest
502	Support for Rapid Methadone Inpatient Stabilization and Linkage to Care	Modest
503	Expansion of Psychedelic Assisted Therapy (PAT)	Modest
504	Strengthening U.S. Rubber Glove Production and Purchase While Reducing Foreign Forced-Labor Dependence	Modest
505	Avoiding misuse of artificial intelligence (AI) in clinical practice	Minimal

Summary of Fiscal Notes (A-26)

506	Access To Gender Affirming Healthcare Including Clinical Trials	Minimal
507	Pairing Behavioral and Lifestyle Medicine Principles and Practice with Glucagon-like Peptide-1 (GLP-1) Receptor Agonists and Other Anti-obesity Medications	Modest
508	Aligning Consistency and Credibility Of Direct-To-Consumer Gut Microbiome Testing Services	Modest
509	Preserving Gender-Affirming Surgical Care Access	Moderate
510	Exosome and Peptide Use in Healthcare	Moderate
511	Preserving Specialty Access to Anti-Cancer Agents	Modest
512	Medical Cannabis Use in Older Adults	Modest
513	Access, Affordability, and Safety of GLP-1 Receptor Agonists	Modest
514	Education, Screening, and Effective Treatment for Obstructive Sleep Apnea During Pregnancy	Modest
515	Transparency in AI-Driven Adverse Determinations & Clinical Logic Disclosure	Modest
516	FDA Regulation of Unapproved Synthetic Peptides	Modest
601	Board Chair Term Limits	Moderate
602	Protection of Healthcare and Humanitarian Aid Personnel in Conflict Zones	Minimal
603	Establish AMA Policy and Project to Compile and Distribute JAMA Patient Pages to Enhance Public Medical Literacy	Minimal
604	Annual Scorecard to Evaluate the AMA's Impact	Minimal
605	Review of Past Resolutions	Modest
606	Further Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations	Modest
607	Shortening the AMA House of Delegates Endorsement Process and Timeline	Minimal
608	Reinstitution of AMA Guides Editorial Panel	Major - $271,952 Annual Editorial Panel funding
609	American Medical Association Board Chair Term Limits	Moderate
610	Plant-Based Diets at AMA meetings	Modest
611	Publicizing, Supporting, and Promoting (Appropriate) AMA Member Physicians and Physician Spouses as Candidates for Local and State Offices	Major - $252,348 Legal study, meeting planning and execution

Summary of Fiscal Notes (A-26)

612	Increasing Expert Guidance in AMA Statements	Modest
613	Preserving Institutional Equity and Inclusivity Efforts	Minimal
614	Inclusive Policy Language for Older Adults	Minimal
615	Condemnation of Attacks on Healthcare Workers and Facilities in Gaza	Minimal
616	Humanitarian and Medical Aid Support to Palestine	Minimal
617	Reevaluation of AMA Policy Regarding Support for Specific National Medical Associations in the World Medical Association	Minimal
618	Ending AMA Investment in Weapons Manufacturers	Moderate
619	Opposing Federal Immigration Operations at AMA Events and Harm to Lawful Non-Target Individuals	Minimal
620	Survey of Medical Staffs	Moderate
701	The Crisis in the Availability of Primary Care: Halt the Required Participation of Small Practices in Value-Based Payment (VBP) Models	Minimal
702	Physicians Who Do Not Practice in Hospital Setting	Minimal
703	Parity in Pricing for Anti-Obesity Medications	Moderate
704	Advocating Against Automatic Refill Requests	Modest
705	Recognizing Physicians as Sexual Assault Forensic Examiners	Minimal
706	Discharge Summaries from Skilled Nursing Facilities	Minimal
707	Malpractice Insurance for Employed Physicians	Minimal
708	Oppose Imposition of Fees on Physicians for Electronic Payment Transfers	Modest
709	Requiring Transparency and Accountability When Insurers and Third-Party Administrators Require Utilization Review, Thereby Practicing Medicine	Moderate
710	Parity in Access to Evidence-Based Obesity Treatment	Modest
711	Oppose Denials Based on Origin of Referral	Minimal
712	Addressing the Commoditization of Medicine Through Recognition of the Full Scope of Physician Work and Contributions	Minimal
713	Reducing Prior Authorization Delays to Improve Access to Neuromodulation and Non-Opioid Pain Therapies	Moderate

Summary of Fiscal Notes (A-26)

714	Physician Case Log Portability	Modest
715	Oppose the Legal Position that Virtual Credit Cards are a Legal Method of Payment under HIPAA	Moderate
716	Equal Opportunity for Payment for “On Call” Duty	Modest
717	Advocacy for a Failure-Proof National Centralized Electronic Transaction Clearinghouse	Moderate