

**AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION
(Annual 2026)**

Report of the Medical Student Section Reference Committee

Vignesh Senthilkumar and Yasmin Alamdeen, Co-Chairs

1 Your Reference Committee recommends the following consent calendar for acceptance:
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3 **RECOMMENDED FOR ADOPTION**
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- 5 1. Resolution 010 - Government Support of Adaptive Sports Programming
- 6 2. Resolution 217 - Ending Subminimum Wages for Workers with Disabilities
- 7 3. Resolution 318 - Transparent Visiting Rotation Fee Disclosure
- 8 4. CGSH Report A - Recognition of Intersex Individuals and their Human Rights
- 9 5. CPH Report A - Confidential Remote Reporting Systems for Domestic Violence Victims
- 10 6. CHEC Report A - Support for Covering Genetic Surveillance for High-Risk Patients
- 11 7. GC Report D - JAMA Collab

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13 **RECOMMENDED FOR ADOPTION AS AMENDED**
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- 15 8. Resolution 110 - Protecting Physician Autonomy and Promoting Biosimilar Utilization
- 16 9. Resolution 201 - Physician Ability to Render Emergency Medical Aid During Immigration
17 Enforcement
- 18 10. Resolution 215 - Missing Indigenous People Crisis in Medical Education
- 19 11. Resolution 316 - Artificial Intelligence use in Assessment Development During Medical
20 Education
- 21 12. Resolution 319 - Transparency in AI-Assisted Admissions
- 22 13. Resolution 419 - Set-Aside Federal Funding for Tribal Health Programs
- 23 14. Resolution 435 - Amending MSS Policy to Support Telehealth-Based Initiation of
24 Methadone for Opioid Use Disorder
- 25 15. Resolution 505 - Affirming Support for the National Institutes of Health Advisory Councils
- 26 16. Resolution 601 - Opposing and Restricting Federal Operations at AMA Events and Harm
27 to Lawful Non-Target Individuals
- 28 17. Resolution 602 - IOP Review and Recurring Annual Report of AMA-MSS Elections and
29 Appointments
- 30 18. CHJ Report B - Improving Access to Phenotype-Matched Blood for Transfusion-
31 Dependent Patients
- 32 19. CST Report A - Public Emergency Alert Reporting Requirements on Private Platforms
- 33 20. RTF Report - Annual 2026 Report of the Resolution Taskforce (RTF)
- 34 21. GC Report F - Development of Sustainable Guidelines for the MSS Strategic Plan and
35 Reporting Process
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RECOMMENDED FOR ADOPTION IN LIEU OF

22. Resolution 216 - Support Expanding Indigenous Adolescent Suicide Prevention to Include Native Hawaiian Youth
- Resolution 422 - Addressing Sexual Violence and Improving Health Outcomes for Native Hawaiian Women
23. Resolution 416 - Regulation of Organ Transplant Open Offers
24. Resolution 418 - Integrating Drowning Prevention Counseling and Resource Referral Into Pediatric Preventive Care
25. Resolution 431 - Establishing Menstrual Products as a Standard of Inpatient Care

RECOMMENDED FOR REFERRAL

26. Resolution 114 - Procedural Safeguards for Payer SIU Actions
27. Resolution 211 - Expanding Recognition of Indigenous Americans to Support Health Outcomes
28. Resolution 302 - Privacy and Protection of Trainee Educational Data in AI-Enabled Medical Education
29. Resolution 502 - Supporting “Right to Repair” for Hospital Equipment and Durable Medical Equipment
30. CPH Report B - National Database for Civilian Injuries by Law Enforcement
31. GC Report B - Annual Sunset and Consolidation Report
32. GC Report E - MSS Study of Assembly Representation

RECOMMENDED FOR NOT ADOPTION

33. Resolution 005 - Promoting Neurocognitive Screening and Accommodations in the Carceral Setting
34. Resolution 007 - Time and Care Burden in Geriatrics
35. Resolution 122 - Improving the External Appeals Process for Denied Claims
36. Resolution 123 - Short-Term Childcare for Patients
37. Resolution 204 - Evidence-Based Guidance for Federal Health Confirmations
38. Resolution 212 - Expanding Physicians' Collective Bargaining Rights
39. Resolution 218 - Medical Technology Access in Incarcerated Settings
40. Resolution 308 - Supporting Residency Pathways for F-1 Physicians Nationwide
41. Resolution 309 - STOP THE CAP! Protect Physician Diversity and Equitable Access to Federal Financing
42. Resolution 310 - Tribal Self-Determination in Medical School Enrollment
43. Resolution 311 - Strengths-Based Indigenous Medical School Curriculum
44. Resolution 401 - Rapid Response Framework for Unsupported Medical Claims by Public Officials
45. Resolution 420 - Indian Health Service Pharmaceutical Acquisition Parity
46. Resolution 425 - Preserving Evidence-Based Air Pollution Regulatory Analysis

- 1 47. Resolution 427 - Establishing a National Healthcare Carbon Budget and Market
- 2 48. Resolution 606 - Improving Alignment of AMPAC Activity and AMA Stances
- 3 49. CHJ Report A - Ensuring Multilingual Pediatric Access Points for Undocumented
- 4 Patients
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6 **RECOMMENDED FOR FILING**

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- 8 50. GC Report A - MSSAI Report
- 9 51. GC Report C - Annual Membership Report
- 10 52. SD Report - Delegate Report: Policy Proceedings of the Interim 2025 House of
- 11 Delegates Meeting
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RECOMMENDED FOR ADOPTION

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3 (1) RESOLUTION 010 - GOVERNMENT SUPPORT OF ADAPTIVE SPORTS
4 PROGRAMMING

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6 **RECOMMENDATION:**

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8 **Resolution 010 be adopted.**

9
10 RESOLVED, that our American Medical Association supports increased public funding and
11 governmental incentives, including, but not limited to, tax breaks and grants for the
12 development, expansion, accessibility, and sustainability of adaptive sports programming,
13 particularly in low-income and rural communities.

14
15 VRC testimony was unanimously supportive. Your Reference Committee agrees with testimony
16 that the resolution provides a novel addition to existing AMA policy H-470.952 which does not
17 include support for programming or any initiatives beyond community recreational fitness facilities.
18 We agree with testimony that the resolution has a strong evidence-base and a clear federal
19 advocacy target. Your Reference Committee recommends Resolution 010 be adopted.

- 20
21 (2) RESOLUTION 217 - ENDING SUBMINIMUM WAGES FOR WORKERS WITH
22 DISABILITIES

23
24 **RECOMMENDATION:**

25
26 **Resolution 217 be adopted.**

27
28 RESOLVED, that our AMA-MSS support federal efforts to ensure equitable compensation for
29 workers with disabilities, including policies that phase out the use of subminimum wage
30 certificates and promote transitions to competitive integrated employment; and be it further

31
32 RESOLVED, that our AMA-MSS support efforts to ensure federal Medicaid funds are directed
33 toward competitive integrated employment supports for workers with disabilities, rather than
34 employment programs utilizing FLSA Section 14(c) subminimum wage certificates.

35
36 VRC testimony was generally supportive. Your Reference Committee agrees with testimony that
37 the asks of the resolution to create an internal position will be helpful to support future policy
38 efforts. Your Reference Committee recommends Resolution 217 be adopted.

- 39
40 (3) RESOLUTION 318 - TRANSPARENT VISITING ROTATION FEE DISCLOSURE

41
42 **RECOMMENDATION:**

43

1 **Resolution 318 be adopted.**

2
3 RESOLVED, that our American Medical Association supports efforts to ensure transparent
4 preapplication disclosure of all mandatory fees associated with visiting student rotations,
5 including fees assessed through centralized application platforms and by host institutions, such
6 that those fees are specific, well-defined, and available to applicants before application
7 submission.

8
9 VRC testimony was unanimously supportive. Your Reference Committee agrees with testimony
10 that the AMA already has policy regarding medical education affordability, but current policy does
11 not specifically address the undisclosed participation fees of visiting rotations that can be an
12 inequitable barrier for many students. Your Reference Committee recommends Resolution 318
13 be adopted.

14
15 (4) CGSH REPORT A - RECOGNITION OF INTERSEX INDIVIDUALS AND THEIR
16 HUMAN RIGHTS

17
18 **RECOMMENDATION:**

19
20 **CGSH Report A be adopted.**

21
22 Your Committee on Gender and Sexual Health recommends that the following
23 recommendation be adopted in lieu of Resolution 211 and the remainder of this
24 report be filed:

25
26 RESOLVED, that the American Medical Association support the right of intersex
27 individuals, including individuals with Differences of Sex Development (DSD) and
28 variations in sexual characteristics (VSC), to have “intersex” or other inclusive
29 alternatives, such as “X,” beyond the sex binary available as a sex designation at
30 birth or selected later in medical and legal documentation at both the federal and
31 state levels.

32
33 VRC testimony was supportive. Your Reference Committee agrees with testimony that the report
34 was well researched. Additionally, we agree with testimony that the recommendations made by
35 the Committee on Gender and Sexual Health address a gap in existing policy, support improved
36 patient-centered care, and reduce stigma by allowing patients who identify as intersex to do so.
37 Your Reference Committee recommends CGSH Report A be adopted.

38
39 (5) CPH REPORT A - CONFIDENTIAL REMOTE REPORTING SYSTEMS FOR
40 DOMESTIC VIOLENCE VICTIMS

41
42 **RECOMMENDATION:**

43

1 **CPH Report A be adopted.**

2
3 Your Committee on Public Health (CPH) recommends that Resolution 426 not be
4 adopted and the remainder of this report be filed.

5
6 VRC testimony was unanimously supportive. Your Reference Committee agrees there are legal
7 and ethical concerns with creating a system as requested in the referred resolution. We also agree
8 with testimony that this is a sensitive topic and given the lack of current evidence, the referred
9 resolution should not be adopted in any form. Therefore, your Reference Committee recommends
10 CPH Report A be adopted.

11
12 (6) CHEC REPORT A - SUPPORT FOR COVERING GENETIC SURVEILLANCE
13 FOR HIGH-RISK PATIENTS

14
15 **RECOMMENDATION:**

16
17 **CHEC Report A be adopted.**

18
19 Your Committee on Health Economics and Coverage (CHEC) recommends that
20 Resolution 109 not be adopted and the remainder of this report be filed.

21
22 VRC testimony was unanimously supportive. Your Reference Committee agrees that this report
23 from the Committee on Health Economics and Coverage is well written and researched. We agree
24 with testimony and the conclusions of this report that the asks of the referred resolution are
25 covered under existing AMA policies H-185.919 and H-460.908. Therefore, your Reference
26 Committee recommends CHEC Report A be adopted.

27
28 (7) GC REPORT D - JAMA COLLAB

29
30 **RECOMMENDATION:**

31
32 **GC Report D be adopted.**

33
34 Your MSS Governing Council recommends that the recommendations of ATF
35 Report F not be adopted and the remainder of this report be filed.

36
37 VRC testimony was limited and supportive. Your Reference Committee agrees with testimony
38 that the referred resolution should not be codified since the asks can be accomplished outside of
39 the policymaking process. We agree that the referred resolution is too prescriptive and
40 recommend not adopting the referred resolution. Therefore, your Reference Committee
41 recommends GC Report D be adopted.

42
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RECOMMENDED FOR ADOPTION AS AMENDED

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3 (8) RESOLUTION 110 - PROTECTING PHYSICIAN AUTONOMY AND PROMOTING
4 BIOSIMILAR UTILIZATION

5
6 **RECOMMENDATION A:**

7
8 **The first Resolve of Resolution 110 be amended by deletion:**

9
10 **~~RESOLVED, that our AMA support physician autonomy to prescribe either a~~**
11 **~~reference biologic or biosimilar product without interference from payers,~~**
12 **~~including insurers or pharmacy benefit managers; and be it further~~**

13
14 **RECOMMENDATION B:**

15
16 **The second Resolve of Resolution 110 be amended by addition and deletion:**

17
18 **RESOLVED, that our AMA support state and federal oversight of payer and**
19 **PBM formulary and reimbursement practices that ~~may discourage biosimilar~~**
20 **~~utilization, including preferential formulary placement of favor higher-priced~~**
21 **~~reference biologics over lower-cost biosimilars when biosimilar use is safe,~~**
22 **~~clinically appropriate, and agreed upon by the patient and physician.~~**

23
24 **RECOMMENDATION C:**

25
26 **Resolution 110 be adopted as amended.**

27
28 **RESOLVED, that our AMA support physician autonomy to prescribe either a reference biologic**
29 **or biosimilar product without interference from payers, including insurers or pharmacy benefit**
30 **managers; and be it further**

31
32 **RESOLVED, that our AMA support state and federal oversight of payer and PBM formulary and**
33 **reimbursement practices that may discourage biosimilar utilization, including preferential**
34 **formulary placement of higher-priced reference biologics.**

35
36 VRC testimony was mixed. Your Reference Committee agrees with testimony that the first resolve
37 is covered by existing AMA policy. Additionally, we agree with testimony that the second resolve
38 is a very specific carveout that can be clarified through the above amendments to make the ask
39 actionable. Therefore, your Reference Committee recommends Resolution 110 be adopted as
40 amended.

- 41
42 (9) RESOLUTION 201 - PHYSICIAN ABILITY TO RENDER EMERGENCY MEDICAL
43 AID DURING IMMIGRATION ENFORCEMENT

1 **RECOMMENDATION A:**

2
3 **The first Resolve of Resolution 201 be amended by addition and deletion:**

4
5 **RESOLVED, that our American Medical Association study the ethical**
6 **responsibilities of physicians to render emergency medical care as**
7 **bystanders when such care is obstructed for patients in legal custody ~~by law~~**
8 **enforcement, including immigration enforcement activities.**

9
10 **RECOMMENDATION B:**

11
12 **Resolution 201 be amended by the addition of a Resolve:**

13
14 **RESOLVED, that our AMA-MSS immediately forward this resolution to the**
15 **House of Delegates.**

16
17 **RECOMMENDATION C:**

18
19 **Resolution 201 be adopted as amended.**

20
21 RESOLVED, that our American Medical Association study the ethical responsibilities of
22 physicians to render emergency medical care as bystanders when such care is obstructed by law
23 enforcement, including immigration enforcement activities.

24
25 VRC testimony was mixed. Your Reference Committee agrees with testimony that this is a very
26 important topic, and we sought clarification that this ask would fit in well with an upcoming AMA
27 Council on Ethics and Judicial Affairs report. We agree with testimony to amend the resolve clause
28 to focus on patients in legal custody so that this ask fits in with the ongoing efforts from CEJA.
29 Thus, we recommend adding an immediate forwarding clause so that this can be included in the
30 CEJA report in advance of the HOD I-26 Meeting. Your Reference Committee recommends
31 Resolution 201 be adopted as amended.

32
33 (10) **RESOLUTION 215 - MISSING INDIGENOUS PEOPLE CRISIS IN MEDICAL**
34 **EDUCATION**

35
36 **RECOMMENDATION A:**

37
38 **The first Resolve of Resolution 215 be amended by addition and deletion:**

39
40 **RESOLVED, that our American Medical Association will collaborate with the**
41 **American Association of American Medical Colleges and American**
42 **Association of Colleges of Osteopathic Medicine to encourage medical**
43 **schools to integrate education on the Missing and Murdered Indigenous**

1 **Persons (MMIP) crisis, trauma-informed care for Indigenous populations,**
2 **violence screening protocols, and recognition of human trafficking**
3 **indicators into medical education curricula;** ~~and be it further~~

4
5 **RECOMMENDATION B:**

6
7 **The second Resolve of Resolution 215 be amended by deletion:**

8
9 ~~**RESOLVED, that our AMA supports the implementation of trauma-informed**~~
10 ~~**and culturally responsive violence screening, health care, and provider**~~
11 ~~**education in healthcare settings which serve American Indians, Alaska**~~
12 ~~**Natives, and Native Hawaiians.**~~

13
14 **RECOMMENDATION C:**

15
16 **Resolution 215 be adopted as amended.**

17
18 **RESOLVED, that our American Medical Association will collaborate with the American**
19 **Association of Medical Colleges to encourage medical schools to integrate education on the**
20 **MMIP crisis, trauma-informed care for Indigenous populations, violence screening protocols, and**
21 **recognition of human trafficking indicators into medical education curricula; and be it further**

22
23 **RESOLVED, that our AMA supports the implementation of trauma-informed and culturally**
24 **responsive violence screening, health care, and provider education in healthcare settings which**
25 **serve American Indians, Alaska Natives, and Native Hawaiians.**

26
27 VRC testimony was mixed. Your Reference Committee agrees with testimony that the first resolve
28 can be strengthened and agreed with testimony to incorporate friendly amendments to the first
29 resolve clause to clarify the action of the ask. We additionally agreed with testimony that the
30 second resolve is covered by existing AMA policy D-350.985. Therefore, your Reference
31 Committee recommends Resolution 215 be adopted as amended.

32
33 (11) **RESOLUTION 316 - ARTIFICIAL INTELLIGENCE USE IN ASSESSMENT**
34 **DEVELOPMENT DURING MEDICAL EDUCATION**

35
36 **RECOMMENDATION A:**

37
38 **The first Resolve of Resolution 316 be amended by addition:**

39
40 **RESOLVED, that our American Medical Association supports disclosure to**
41 **students along the medical education continuum regarding the use of**
42 **generative augmented intelligence (AI) in the development and evaluation of**
43 **performance on assessments.**

1 **RECOMMENDATION B:**

2
3 **Resolution 316 be adopted as amended.**

4
5 RESOLVED, that our American Medical Association supports disclosure to students along the
6 medical education continuum regarding the use of generative AI in the development and
7 evaluation of performance on assessments.

8
9 VRC testimony was largely supportive. Your Reference Committee agrees with testimony that the
10 resolution is well researched and is a novel ask for the AMA. We agree with testimony from staff
11 to ensure we align with the AMA's recommended use of AI as "augmented intelligence" so a minor
12 amendment has been recommended by the committee. Therefore, your Reference Committee
13 recommends Resolution 316 be adopted as amended.

14
15 (12) **RESOLUTION 319 - TRANSPARENCY IN AI-ASSISTED ADMISSIONS**

16
17 **RECOMMENDATION A:**

18
19 **The first Resolve of Resolution 319 be amended by addition and deletion:**

20
21 **RESOLVED, that our American Medical Association study and report back**
22 **on the ethical, equitable, and transparent use of artificial augmented**
23 **intelligence (AI) in medical school and residency application review**
24 **processes, ~~consistent with existing AMA policy on augmented intelligence,~~**
25 **~~health equity, and ethics of health information technology,~~ including**
26 **potential standards for notice and disclosure of artificial intelligence AI**
27 **involvement to applicants such as what stage AI is involved and to what**
28 **extent; and be it further; mechanisms for meaningful human oversight,**
29 **explainability, and routine bias auditing; and approaches to promote**
30 **fairness, accountability, and applicant due process, including access to**
31 **human reevaluation and avenues to appeal or contest decisions influenced**
32 **by such systems.**

33
34 **RECOMMENDATION B:**

35
36 **Resolution 319 be amended by addition of a Resolve:**

37
38 **RESOLVED, that our American Medical Association support approaches to**
39 **promote fairness, accountability, and applicant due process, including**
40 **access to human reevaluation and avenues to appeal or contest decisions**
41 **influenced by such systems.**

42
43 **RECOMMENDATION C:**

1 **Resolution 319 be adopted as amended.**

2
3 RESOLVED, that our American Medical Association study and report back on the ethical,
4 equitable, and transparent use of artificial intelligence in medical school and residency application
5 review processes, consistent with existing AMA policy on augmented intelligence, health equity,
6 and ethics of health information technology, including potential standards for notice and disclosure
7 of artificial intelligence involvement to applicants; mechanisms for meaningful human oversight,
8 explainability, and routine bias auditing; and approaches to promote fairness, accountability, and
9 applicant due process, including access to human reevaluation and avenues to appeal or contest
10 decisions influenced by such systems.

11
12 VRC testimony was supportive. Your Reference Committee agrees with testimony that the
13 resolution has strong evidence base and would benefit from amendments to address clarity and
14 structure. We agree with testimony to amend the first resolve clause to clarify the study and
15 reduce any prescriptive language. Additionally, we agreed with testimony to separate the resolve
16 clauses into a study and a position stance so that the second resolve clause can move forward
17 while the study is completed. Therefore, your Reference Committee recommends Resolution 319
18 be adopted as amended.

19
20 (13) **RESOLUTION 419 - SET-ASIDE FEDERAL FUNDING FOR TRIBAL HEALTH**
21 **PROGRAMS**

22
23 **RECOMMENDATION A:**

24
25 **The first Resolve of Resolution 419 be amended by addition and deletion:**

26
27 **RESOLVED, that our American Medical Association ~~encourages the federal~~**
28 **~~government to supports set aside~~ dedicated set aside appropriations for**
29 **American Indian, Native Hawaiian, and Alaska Native governments and their**
30 **associated healthcare entities that do not compete with states and other**
31 **municipalities, ~~and that these funding streams be tailored to identified tribal~~**
32 **~~health needs and proportional to the population served~~; and be it further**

33
34 **RECOMMENDATION B:**

35
36 **The second Resolve of Resolution 419 be amended by addition and deletion:**

37
38 **RESOLVED, that our AMA supports that and ~~will advocate for the long-held~~**
39 **~~tribal position that appropriations to the Indian Health Service, the Native~~**
40 **Hawaiian Health Care Systems, and related federal agencies administering**
41 **American Indian, Native Hawaiian, and Alaska Native health programs**
42 **~~should~~ be transitioned from discretionary to mandatory appropriations**
43 **~~allowing for funding stability and long-term sustainability planning.~~**

1 **RECOMMENDATION C:**

2
3 **Resolution 419 be adopted as amended.**

4
5 RESOLVED, that our American Medical Association encourages the federal government to set
6 aside dedicated appropriations for American Indian and Alaska Native governments and their
7 associated healthcare entities that do not compete with states and other municipalities, and that
8 these funding streams be tailored to identified tribal health needs and proportional to the
9 population served; and be it further

10
11 RESOLVED, that our AMA supports and will advocate for the long-held tribal position that
12 appropriations to the Indian Health Service and related federal agencies administering American
13 Indian and Alaska Native health programs should be transitioned from discretionary to mandatory
14 appropriations allowing for funding stability and long-term sustainability planning.

15
16 VRC testimony was mixed. Your Reference Committee agrees with testimony to amend the
17 resolve clauses to clarify that the AMA support these appropriations for health systems including
18 the Native Hawaiian population. We agree with testimony that this resolution is well researched
19 and is novel compared to existing AMA policy H-350.976. Therefore, your Reference Committee
20 recommends Resolution 419 be adopted as amended.

21
22 (14) RESOLUTION 435 - AMENDING MSS POLICY TO SUPPORT TELEHEALTH-
23 BASED INITIATION OF METHADONE FOR OPIOID USE DISORDER

24
25 **RECOMMENDATION A:**

26
27 **The first Resolve of Resolution 435 be amended by addition and deletion:**

28
29 **RESOLVED, that our AMA-MSS amend Policy 120.018, “Methadone**
30 **Maintenance Therapy Dispensation in Community Pharmacy Settings,” to**
31 **include support for telehealth-based initiation and maintenance of**
32 **methadone for opioid use disorder:**

33
34 **AMA-MSS supports federal and state efforts to allow evidence-based**
35 **methadone treatment for opioid use disorder to be prescribed in the office-**
36 **based setting and initiated and/or maintained via telehealth by clinicians with**
37 **appropriate expertise, and dispensed in community pharmacies for patients**
38 **to take at home, in order to expand access outside of Opioid Treatment**
39 **Programs.**

40
41 **RECOMMENDATION B:**

42
43 **Resolution 435 be adopted as amended.**

1 RESOLVED, that our AMA-MSS amend Policy 120.018, “Methadone Maintenance Therapy
2 Dispensation in Community Pharmacy Settings,” to include support for telehealth-based initiation
3 and maintenance of methadone for opioid use disorder (new language underlined):
4

5 AMA-MSS supports federal and state efforts to allow evidence-based
6 methadone treatment for opioid use disorder to be prescribed in office-
7 based settings and initiated and/or maintained via telehealth by clinicians
8 with appropriate expertise, and dispensed in community pharmacies for
9 patients to take at home, in order to expand access outside of Opioid
10 Treatment Programs.
11

12 VRC testimony was supportive with amendment. Your Reference Committee agrees with
13 testimony that the ask of this resolution should be contained only to “maintaining” treatment via
14 telehealth. We agree with testimony sharing concerns to balance access to telehealth and
15 ensuring proper care. Therefore, your Reference Committee recommends Resolution 435 be
16 adopted as amended.
17

18 (15) RESOLUTION 505 - AFFIRMING SUPPORT FOR THE NATIONAL INSTITUTES
19 OF HEALTH ADVISORY COUNCILS
20

21 **RECOMMENDATION A:**
22

23 **The first Resolve of Resolution 505 be amended by addition and deletion:**
24

25 **RESOLVED, that our American Medical Association supports initiatives to**
26 **ensure continuity and stability in scientific advisory councils, including the**
27 **timely and appropriate replacement of members on NIH Advisory Councils**
28 **and review panels and other HHS agencies with equally qualified members**
29 **to prevent the delay, interruption, or cessation of NIHHHS-funded research**
30 **initiatives; and be it further**
31

32 **RECOMMENDATION B:**
33

34 **The second Resolve of Resolution 505 be amended by deletion:**
35

36 **~~RESOLVED, that our AMA support the timely and appropriate replacement~~**
37 **~~of members on NIH Advisory Councils and review panels with equally~~**
38 **~~qualified members, or the adherence to [a 180-day] term extension of current~~**
39 **~~members if suitable replacements have not yet been appointed; and be it~~**
40 **~~further~~**
41

42 **RECOMMENDATION C:**
43

1 **The third Resolve of Resolution 505 be amended by addition:**

2
3 **RESOLVED, that our AMA opposes the active removal of qualified scientists**
4 **from NIH advisory councils and review panels as well as qualified leaders in**
5 **other HHS agencies without documented proof of wrongdoing or**
6 **misconduct in accordance with established federal or state legal statutes.**

7
8 **RECOMMENDATION D:**

9
10 **Resolution 505 be adopted as amended.**

11
12 RESOLVED, that our American Medical Association supports initiatives to ensure continuity and
13 stability in scientific advisory councils to prevent the delay, interruption, or cessation of NIH-
14 funded research initiatives; and be it further

15
16 RESOLVED, that our AMA support the timely and appropriate replacement of members on NIH
17 Advisory Councils and review panels with equally qualified members, or the adherence to [a 180-
18 day] term extension of current members if suitable replacements have not yet been appointed;
19 and be it further

20
21 RESOLVED, that our AMA opposes the active removal of qualified scientists from NIH advisory
22 councils and review panels without documented proof of wrongdoing or misconduct in accordance
23 with established federal or state legal statutes.

24
25 VRC testimony was largely in support of this resolution with amendments. Your Reference
26 Committee agrees with testimony that the resolution is novel, actionable, and timely. We agree
27 with testimony that the asks of the first and second resolves overlap and an amendment to strike
28 the second resolve and strengthen the first resolve will clarify the language. Furthermore, we
29 agreed with testimony on expanding the scope of the resolution to address all appointments of
30 councils and committees under the purview of HHS. Therefore, your Reference Committee
31 recommends Resolution 505 be adopted as amended.

32
33 (16) **RESOLUTION 601 - OPPOSING AND RESTRICTING FEDERAL OPERATIONS**
34 **AT AMA EVENTS AND HARM TO LAWFUL NON-TARGET INDIVIDUALS**

35
36 **RECOMMENDATION A:**

37
38 **The first Resolve of Resolution 601 be amended by deletion:**

39
40 **RESOLVED, that our American Medical Association opposes ~~and restricts~~**
41 **federal immigration operations without a judicial warrant at AMA events; and**
42 **be it further**

43

1 **RECOMMENDATION B:**

2
3 **The second Resolve of Resolution 601 be amended by deletion:**

4
5 ~~**RESOLVED, that our AMA opposes federal immigration operational**~~
6 ~~**practices that compromise the safety, dignity, or well-being of individuals**~~
7 ~~**not lawfully targeted by such actions, including acts of unnecessary force or**~~
8 ~~**intimidation; and be it further**~~

9
10 **RECOMMENDATION C:**

11
12 **Resolution 601 be amended by addition of a Resolve:**

13
14 **RESOLVED, that our American Medical Association supports federal, state,**
15 **and institutional policies that prevent immigration enforcement actions from**
16 **interfering with the ability of physicians, trainees, and other health care**
17 **professionals to attend conferences, complete training, or provide patient**
18 **care, except where required by a valid judicial order; and be it further**

19
20 **RECOMMENDATION D:**

21
22 **Resolution 601 be adopted as amended.**

23
24 RESOLVED, that our American Medical Association opposes and restricts federal immigration
25 operations without a judicial warrant at AMA events; and be it further

26
27 RESOLVED, that our AMA opposes federal immigration operational practices that compromise
28 the safety, dignity, or well-being of individuals not lawfully targeted by such actions, including acts
29 of unnecessary force or intimidation; and be it further

30
31 RESOLVED, that our AMA supports the use of visible identification by federal immigration
32 enforcement personnel as a measure to uphold ethical standards, public trust, transparency, and
33 accountability in cases where their actions may result in health-related harms; and be it further

34
35 RESOLVED, that our AMA-MSS immediately forward this resolution to the House of Delegates.

36
37 VRC testimony was largely in support of this resolution with amendments. Your Reference
38 Committee agrees with testimony that the first resolve should be amended to ensure that the ask
39 is actionable and within the scope of the AMA. We agree with testimony to strike the second
40 resolve clause as the ask is too broad and not within the AMA's scope. Additionally, we agree
41 with testimony to amend by addition of a resolve clause to support policies that prevent
42 immigration enforcement actions that interfere with the ability to attend AMA events or provide
43 patient care, except where required by a judicial warrant. Additionally, we agree with testimony

1 regarding the inclusion of visible identification for immigration enforcement personnel and agree
2 the timeliness of this resolution warrants an immediate forward clause. Therefore, your Reference
3 Committee recommends Resolution 601 be adopted as amended.

4
5 (17) RESOLUTION 602 - IOP REVIEW AND RECURRING ANNUAL REPORT OF
6 AMA-MSS ELECTIONS AND APPOINTMENTS

7
8 **RECOMMENDATION A:**

9
10 **The first Resolve of Resolution 602 be amended by addition and deletion:**

11
12 **RESOLVED, that our AMA-MSS maintain a centralized and publicly**
13 **accessible mechanism, like a website, through which, with consent,~~their~~**
14 **~~approval, current and former AMA-MSS leaders elected and appointed~~**
15 **~~positions they have held, including, where feasible, relevant information~~**
16 **regarding past and current AMA-MSS leaders such as the individual's name,**
17 **position title, and term of service be published, so as to support accurate**
18 **recognition, documentation, and verification of service for residency,**
19 **employment, and other professional purposes; and be it further**

20
21 **RECOMMENDATION B:**

22
23 **The second Resolve of Resolution 602 be amended by addition and deletion:**

24
25 **RESOLVED, that our AMA-MSS Governing Council develop and present a**
26 **recurring annual elections and appointments procedural summary to the**
27 **AMA-MSS Assembly at each AMA-MSS Interim Meeting, summarizing all**
28 **~~elections and appointments to AMA-MSS positions during the preceding~~**
29 **~~year, including but not limited to the positions filled, the number of~~**
30 **~~applicants or candidates when appropriate, and the outcomes of election or~~**
31 **~~appointment processes, as well as a brief description of any substantive~~**
32 **changes from prior years in the interpretation or application of relevant AMA-**
33 **MSS Internal Operating Procedures, bylaws, or speakers' rulings governing**
34 **these election and appointment processes, in order to promote transparency**
35 **and support equitable and consistent practices; and be it further**

36
37 **RECOMMENDATION C:**

38
39 **Resolution 602 be amended by addition of a Resolve:**

40
41 **RESOLVED, that our AMA-MSS maintain an easily accessible archive**
42 **through which information on election and appointment outcomes, including**
43 **but not limited to relevant candidate information, the number of candidates,**

1 **regions represented, positions filled, and election results, are published**
2 **after each meeting in which elections are held; and be it further**

3
4 **RECOMMENDATION D:**

5
6 **Resolution 602 be adopted as amended.**

7
8 RESOLVED, that our AMA-MSS maintain a centralized and publicly accessible mechanism, like
9 a website, through which, with their approval, current and former AMA-MSS leaders elected and
10 appointed positions they have held, including, where feasible, the individual's name, position title,
11 and term of service, so as to support accurate recognition, documentation, and verification of
12 service for residency, employment, and other professional purposes; and be it further

13
14 RESOLVED, that our AMA-MSS Governing Council develop and present a recurring annual
15 elections and appointments summary to the AMA-MSS Assembly at each AMA-MSS Interim
16 Meeting, summarizing elections and appointments to AMA-MSS positions during the preceding
17 year, including but not limited to the positions filled, the number of applicants or candidates when
18 appropriate, and the outcomes of election or appointment processes, as well as a brief description
19 of any substantive changes from prior years in the interpretation or application of relevant AMA-
20 MSS Internal Operating Procedures, bylaws, or speakers' rulings governing those processes, in
21 order to promote transparency and support equitable and consistent practices; and be it further

22
23 RESOLVED, that our AMA-MSS 2026–2027 Internal Operating Procedures Task Force have a
24 subcommittee/workgroup to review and provide recommendations on the sections of our IOPs
25 pertaining to elections and appointments, with specific attention to clarity of language, equitable
26 application, consistent enforcement of rules, transparency, and mechanisms for accountability
27 and reporting, to support clearer and more consistent implementation of those provisions.

28
29 VRC testimony was limited and in support. Your Reference Committee agrees that the first
30 resolve clause can be strengthened by amendments to clarify the ask. We agreed to add a resolve
31 clause asking for an archive resource that includes election and appointment data versus
32 including this ask in the summary requested in the original second resolve clause. Additionally,
33 your Reference Committee agrees with testimony to amend the second resolve clause and
34 address any redundancies in the language based on the added resolve. Therefore, your
35 Reference Committee recommends Resolution 602 be adopted as amended.

36
37 (18) CHJ REPORT B - IMPROVING ACCESS TO PHENOTYPE-MATCHED BLOOD
38 FOR TRANSFUSION-DEPENDENT PATIENTS

39
40 **RECOMMENDATION A:**

41
42 **The first Recommendation of CHJ Report B be amended by addition and**
43 **deletion:**

1 Your Committee on Health Justice (CHJ) recommends that the following
2 recommendations are adopted in lieu of Resolution 007 and the remainder
3 of this report be filed:
4

5 **RESOLVED**, that our AMA adopt Policy H-50.977 as amended to read as
6 follows:
7

- 8 1. Our American Medical ~~Association~~Association supports the
9 establishment of a national volunteer blood donor education and
10 recruitment campaign to assure an adequate and readily available blood
11 supply
- 12 2. ~~Our AMA supports scientifically-based policies that ensure the safety of~~
13 ~~the nation's blood supply. Our AMA supports initiatives to expanding~~
14 recruitment and retention of racially and ethnically diverse blood donors
15 to improve access to phenotype-matched blood for high-needs patients
16 with high transfusion requirements, including those with sickle cell
17 disease, while supporting scientifically-based policies that ensure a safe
18 national blood supply~~the safety of our nation's blood supply.~~

19
20 **RECOMMENDATION B:**

21 **CHJ Report B be adopted as amended.**

22
23
24 Your Committee on Health Justice (CHJ) recommends that the following recommendations are
25 adopted in lieu of Resolution 007 and the remainder of this report be filed:
26

27 **RESOLVED**, that our AMA amend Policy H-50.977 to read as follows:
28

- 29 1. Our American Medical Association supports the establishment of a national volunteer
30 blood donor education and recruitment campaign to assure an adequate and readily
31 available blood supply
- 32 2. Our AMA supports scientifically-based policies that ensure the safety of the nation's
33 blood supply. Our AMA supports initiatives to expand recruitment and retention of
34 racially and ethnically diverse blood donors to improve access to phenotype-matched
35 blood for patients with high transfusion requirements, including those with sickle cell
36 disease, while supporting scientifically-based policies that ensure the safety of our
37 nation's blood supply.

38
39 VRC testimony was supportive. Your Reference Committee agrees with testimony to clarify the
40 amendment to existing AMA policy through minor re-structuring of the proposed changes. We
41 agree with testimony that the report is well researched and the recommendation is novel.
42 Therefore, your Reference Committee recommends CHJ Report B be adopted as amended.

1 (19) CST REPORT A - PUBLIC EMERGENCY ALERT REPORTING
2 REQUIREMENTS ON PRIVATE PLATFORMS
3

4 **RECOMMENDATION A:**

5
6 **The first Recommendation of CST Report A be amended by deletion:**

7
8 ~~RESOLVED that our American Medical Association discourage the use of~~
9 ~~social media platforms as a standalone medium or replacement in lieu of~~
10 ~~more widely accessible public emergency alert systems at the federal, state,~~
11 ~~and local levels; and be it further~~

12
13 **RECOMMENDATION B:**

14
15 **The second Recommendation of CST Report A be amended by deletion:**

16
17 ~~RESOLVED, that our AMA support efforts by federal, state, and local~~
18 ~~emergency management agencies to ensure data transparency on account-~~
19 ~~restricted social media platforms to ensure that any time-sensitive alerts~~
20 ~~from federal, state, or local emergency responder organizations are~~
21 ~~immediately publicly visible to all individuals, without requiring account~~
22 ~~creation, paywalls, or other additional verification steps; and be it further~~

23
24 **RECOMMENDATION C:**

25
26 **The third Recommendation of CST Report A be amended by deletion:**

27
28 ~~RESOLVED that our American Medical Association encourages social media~~
29 ~~platforms to be used only as supplementary tools, and not as a replacement~~
30 ~~for established, universally accessible public emergency alert systems at~~
31 ~~the federal, state, and local levels; and be it further~~

32
33 **RECOMMENDATION D:**

34
35 **The fourth Recommendation of CST Report A be amended by deletion:**

36
37 ~~RESOLVED that our American Medical Association support policies that~~
38 ~~promote equitable and unrestricted public access to emergency~~
39 ~~communications disseminated by official agencies on digital platforms,~~
40 ~~including efforts to ensure that time-sensitive alerts are publicly viewable~~
41 ~~without account creation, paywalls, or algorithmic restriction; and be it~~
42 ~~further~~

43

1 **RECOMMENDATION E:**

2
3 **The sixth Recommendation of CST Report A be amended by deletion:**

4
5 ~~**RESOLVED that our American Medical Association support research and**~~
6 ~~**policy development evaluating the impact of social media use in emergency**~~
7 ~~**communication on health outcomes, misinformation spread, and access**~~
8 ~~**disparities.**~~

9
10 **RECOMMENDATION F:**

11
12 **CST Report A be adopted as amended.**

13
14 The Committee on Science and Technology recommends that the following recommendations
15 are adopted in lieu of Resolution 432 and the remainder of this report be filed:

16
17 RESOLVED that our American Medical Association discourage the use of social media platforms
18 as a standalone medium or replacement in lieu of more widely accessible public emergency alert
19 systems at the federal, state, and local levels; and be it further

20
21 RESOLVED, that our AMA support efforts by federal, state, and local emergency management
22 agencies to ensure data transparency on account-restricted social media platforms to ensure that
23 any time-sensitive alerts from federal, state, or local emergency responder organizations are
24 immediately publicly visible to all individuals, without requiring account creation, paywalls, or other
25 additional verification steps; and be it further

26
27 RESOLVED that our American Medical Association encourages social media platforms to be
28 used only as supplementary tools, and not as a replacement for established, universally
29 accessible public emergency alert systems at the federal, state, and local levels; and be it further

30
31 RESOLVED that our American Medical Association support policies that promote equitable and
32 unrestricted public access to emergency communications disseminated by official agencies on
33 digital platforms, including efforts to ensure that time-sensitive alerts are publicly viewable without
34 account creation, paywalls, or algorithmic restriction; and be it further

35
36 RESOLVED that our American Medical Association encourages collaboration between public
37 health agencies, emergency management systems, and private technology companies to
38 improve the reliability, accessibility, and transparency of emergency information dissemination
39 across both public alert systems and digital platforms; and be it further

40
41 RESOLVED that our American Medical Association support research and policy development
42 evaluating the impact of social media use in emergency communication on health outcomes,
43 misinformation spread, and access disparities.

44
45 VRC testimony was mixed. Your Reference Committee agrees with testimony that the report
46 recommendations 1-4 are redundant and the sixth recommendation is not actionable as written.
47 We agree with testimony that the fifth recommendation is most novel and could lead to meaningful

1 AMA advocacy. Additionally, we agreed that all current literature has been compiled in this report
2 and that the fifth recommendation would not benefit from further study. Therefore, your Reference
3 Committee recommends CST Report A be adopted as amended.

4
5 (20) RTF REPORT - ANNUAL 2026 REPORT OF THE RESOLUTION TASKFORCE
6

7 **RECOMMENDATION A:**

8
9 **The fourth Recommendation of RTF Report be amended by addition and**
10 **deletion:**

11
12 **RESOLVED, that 645.033MSS “Additional MSS Caucus Operations” be**
13 **amended by addition and deletion as follows:**

- 14
15 1. **The MSS Section Delegates have the ability to nominate existing**
16 **~~policies~~positions in the MSS ~~Digest of Actions~~Positions Compendium to the**
17 **queue to be transmitted to a future HOD meeting, based on strategic**
18 **considerations. These nominations must be approved by a ~~majority~~two-**
19 **thirds (2/3) vote of the MSS Caucus.**
20 2. **The MSS Caucus can co-sponsor resolutions in the name of the MSS with**
21 **another HOD delegation.**
22 a. **Co-sponsoring a resolution authored by another delegation must be**
23 **approved by a $\frac{2}{3}$ vote of the MSS Caucus.**
24 b. **The MSS Section Delegates have the authority to add other**
25 **delegations as co-sponsors of MSS-authored resolutions.**
26 3. **The MSS Caucus can decide by a $\frac{2}{3}$ vote in any given election cycle whether**
27 **it wants to offer the opportunity to seek an MSS endorsement to candidates**
28 **for elections in the AMA House of Delegates, and this vote shall apply to all**
29 **candidates in all elections for that cycle. Once a candidate for an election in**
30 **the AMA House of Delegates confirms they are seeking an MSS**
31 **endorsement, the MSS Caucus can endorse that candidate by a $\frac{2}{3}$ up or**
32 **down vote specific for that candidate. The number of endorsements given**
33 **for a race shall not exceed the number of open seats. If more candidates**
34 **surpass the 2/3 threshold than there are open seats, available endorsements**
35 **will be given to the candidates receiving the highest vote percentage. The**
36 **MSS Caucus may also withdraw an endorsement of a candidate by a $\frac{2}{3}$ vote.**

37
38 **RECOMMENDATION B:**

39
40 **RTF Report be adopted as amended.**

41
42 **RESOLVED, that 645.032MSS “MSS Policy Process” be amended by addition and deletion as**
43 **follows:**
44

1 1. The MSS Section Delegates will ensure that all items of business
2 submitted for consideration to each MSS Assembly meeting undergo a
3 comprehensive review process evaluating their impact, feasibility,
4 timeliness, and evidence basis.

5 ...

6 5. Per the MSS IOPs, submitted resolutions will be sent to the MSS
7 Reference Committee, which will make recommendations to the Assembly
8 for disposition of its items of business. The Reference Committee Report
9 will use a consent calendar format. In order for an item to be heard by the
10 MSS Assembly, it must be extracted from the Reference Committee
11 Consent Calendar. The Order of Business for each MSS Assembly meeting
12 will follow the order listed in the MSS Reference Committee report for that
13 meeting. Items of business will be categorized by Reference Committee
14 recommendations for “adoption,” “adoption as amended,” “adoption in lieu
15 of,” “referral,” “not adoption,” “reaffirmation in lieu of,” etc. The order of
16 items in each category will be randomized based on the resolution number
17 assigned at the beginning of the policy process. The MSS Reference
18 Committee must include a meaningful rationale for their recommendations
19 made on each item of business. Any MSS member may extract any item
20 from the Reference Committee Report for debate at the MSS Assembly.
21 No other requirements, such as testimony or votes, are necessary for an
22 item to be extracted. The Section Delegates shall provide opportunities for
23 extraction both in advance of the MSS Assembly remotely and at the
24 beginning of the Assembly. Extractions made in advance of the MSS
25 Assembly should be published in real-time as they are submitted.

26 ~~6. The AMA MSS Internal Operating Procedures (IOPs) and Digest of
27 Actions will be made available on the AMA MSS Web site, with updates
28 made prior to the beginning of the Policy Cycle for each Annual and Interim
29 Meeting of the Assembly.~~

30 ~~7. A resolution template will be made publicly available to assist resolution
31 authors in formatting their resolutions.~~

32 8. Upon final submission to the MSS for consideration by the Assembly,
33 MSS resolutions, including the “whereas” and “resolve” clauses and
34 footnotes, may not be altered by staff or any MSS leader, member,
35 committee, or other entity prior to the MSS Assembly Meeting without the
36 consent of the author, with the exception of retyping and reformatting.

37 9. The MSS Section Delegates (when they agree) may make grammatical
38 or syntax changes to the resolve clauses of MSS resolutions after they are
39 adopted by the Assembly and before they are forwarded to the House of
40 Delegates, but in no circumstances can the meaning or intent of the resolve
41 clauses be altered. Further, the MSS Speaker and Vice Speaker must be
42 advised of any change made to resolve clauses before the resolution is
43 forwarded to the House of Delegates and must concur that the change in
44 grammar or syntax does not alter the meaning or intent of the resolve
45 clauses. The MSS Speaker or Vice Speaker, may not, under any
46 circumstance, initiate the change in grammar or syntax on any MSS
47 resolution.

48 ~~10. Our AMA MSS will reevaluate 645.032MSS, 645.033MSS, and the
49 MSS Policy Process in general in a Governing Council report to be
50 presented to the MSS A-26 Assembly.~~

1 RESOLVED, that 630.078MSS “Optimizing MSS Communications” be amended by addition as
2 follows:

3
4 1. AMA-MSS will continue to support and explore strategies to optimize
5 communications with general members, including at minimum:

6 (1) Production of an electronic newsletter;

7 ...

8 (10) The AMA-MSS Internal Operating Procedures (IOPs) and Positions
9 Compendium will be made available on the AMA-MSS Web site, with
10 updates made prior to the beginning of the Policy Cycle for each Annual
11 and Interim Meeting of the Assembly.

12 (11) A resolution template will be made publicly available to assist
13 resolution authors in formatting their resolutions.

14
15 2. Development and implementation of strategy regarding effective
16 communication to the general membership will be based on the core
17 guiding principles of accessibility, clarity, and transparency, with an end
18 goal of ensuring all MSS members are easily able to locate and access the
19 information necessary to support policy, advocacy, and other MSS goals.

20
21 RESOLVED, that 645.031MSS “MSS Action Items” be amended by addition and deletion as
22 follows:

23
24 1. Medical Student Section Action Items (MSSAIs) are formal, non-binding
25 requests from MSS members for the MSS Governing Council to take action
26 on issues that are currently supported by current MSS positions and AMA
27 policy.

28
29 2. MSSAIs may be submitted at any time in accordance with procedures
30 set by the MSS Governing Council.

31
32 3. The MSS Governing Council has the sole discretion on what, if any,
33 actions are taken on behalf of the MSS in response to submitted MSSAIs

34
35 4. The MSS Governing Council shall review and provide a formal response
36 to each MSSAI author on a reasonable timeframe determined by the MSS
37 Governing Council. The Governing Council, at their discretion, may choose
38 to provide further updates to the author and solicit additional information.

39
40 5. A list of all MSS Action Items received during the period between MSS
41 national meetings, any actions taken by the MSS Governing Council in
42 response, any resulting public AMA actions, and any subsequent advocacy
43 impacts shall be made publicly available to MSS members at each
44 business meeting of the MSS Assembly, will be included in the Meeting
45 Handbook as official MSS Actions, along with their Disclosure of additional
46 information regarding the implementation status of MSSAIs shall be at the
47 sole discretion of the MSS Governing Council. Additionally, the MSS should
48 create an opportunity for the Governing Council to discuss MSS Action Item
49 implementation status with interested students.
50

1 6. The MSS Governing Council shall maintain archives of all MSSAIs and
2 actions and shall make them available to any MSS member upon request,
3 subject to the disclosure restrictions above.

4
5 RESOLVED, that 645.033MSS “Additional MSS Caucus Operations” be amended by addition
6 and deletion as follows:

7
8 4. The MSS Section Delegates have the ability to nominate existing
9 ~~policies~~positions in the MSS ~~Digest of Actions~~Positions Compendium to the
10 queue to be transmitted to a future HOD meeting, based on strategic
11 considerations. These nominations must be approved by a majority vote of
12 the MSS Caucus.

13 5. The MSS Caucus can co-sponsor resolutions in the name of the
14 MSS with another HOD delegation.

15 a. Co-sponsoring a resolution authored by another delegation must be
16 approved by a $\frac{2}{3}$ vote of the MSS Caucus.

17 b. The MSS Section Delegates have the authority to add other
18 delegations as co-sponsors of MSS-authored resolutions.

19 6. The MSS Caucus can decide by a $\frac{2}{3}$ vote in any given election cycle
20 whether it wants to offer the opportunity to seek an MSS endorsement to
21 candidates for elections in the AMA House of Delegates, and this vote shall
22 apply to all candidates in all elections for that cycle. Once a candidate for
23 an election in the AMA House of Delegates confirms they are seeking an
24 MSS endorsement, the MSS Caucus can endorse that candidate by a $\frac{2}{3}$
25 up or down vote specific for that candidate. The number of endorsements
26 given for a race shall not exceed the number of open seats. If more
27 candidates surpass the $\frac{2}{3}$ threshold than there are open seats, available
28 endorsements will be given to the candidates receiving the highest vote
29 percentage. The MSS Caucus may also withdraw an endorsement of a
30 candidate by a $\frac{2}{3}$ vote.

31
32 RESOLVED, that 640.015MSS “Standing Committee Task Force Report” be amended by addition
33 as follows:

34
35 (1) That the AMA-MSS Governing Council (a) implement the
36 recommendations adopted by the MSS Assembly from the Standing
37 Committee Task Force to restructure the Standing Committee framework
38 and leadership model, (b) clarify Standing Committee responsibilities and
39 objectives, and (c) enhance operational efficiency;

40 ...
41 (12) Self-Generated and Governing Council Requested Standing Committee
42 Reports:

43 (a) MSS standing committees may self-generate reports for
44 presentation to the MSS Assembly with the concurrence of the MSS
45 Governing Council.

46 (b) The MSS Governing Council may request reports from standing
47 committees beyond those mandated by MSS Assembly actions. Standing
48 committees may choose to decline these reports.

49 (c) Once a report request has been submitted and has received
50 approval from both the standing committee and the Governing Council,

1 these reports shall be subject to the same timeline, deadlines, and content
2 requirements as other standing committee reports per the MSS policy
3 process.

4 (d) MSS standing committees may withdraw approved self-generated
5 reports with the concurrence of the MSS Governing Council, subject to the
6 rules governing the policy process. Requests for self-generated reports
7 may be unilaterally withdrawn at any point before approval by the MSS
8 Governing Council.

9 (e) The MSS Governing Council may withdraw requested reports at
10 any time with the concurrence of the relevant standing committee, subject
11 to the rules governing the policy process. Governing Council Requested
12 reports may be unilaterally withdrawn at any point before approval by the
13 relevant standing committee.

14 (f) These procedures shall not apply to any report directly arising from
15 an action of MSS Assembly.

16
17 RESOLVED, that our AMA-MSS amend 630.079MSS MSS Archives Task Force Report by title
18 change, addition, and deletion as follows:

19
20 ~~630.079MSS MSS Archives Task Force Report~~ MSS Policy Archiving and Outcomes Tracking

21 That our AMA-MSS

- 22 (1) maintain a MSS Positions Compendium containing (a) all current MSS
23 positions, outcomes of resolutions that were sent to the AMA House of
24 Delegates, and actions taken by the AMA as a result of AMA Policy
25 originally proposed by the MSS and (b) a separate section for rescinded
26 MSS positions with accompanying rationale for their rescission;
27 (2) maintain a MSS ~~Positions~~ Resolutions Outcomes Archive that will include
28 at minimum authorship information, links to the original resolution, final
29 language adopted by the MSS, final language adopted by the HOD, links
30 to the HOD Policy Finder, implementation notes regarding AMA actions,
31 and other links to media coverage, actions taken by the AMA and other
32 parties resulting from the resolution;
33 (3) identify MSS big policy wins after each annual and interim meeting as
34 relevant at other timepoints;
35 (4) provide information to the MSS regarding how to find and track outcomes
36 of resolutions forwarded to HOD and implementation of associated
37 adopted AMA policy;
38 (5) collaborate with appropriate stakeholders including MSS standing
39 committees, MSS regions, and AMA staff to create and promote MSS
40 notable success and advocacy wins to medical students and the public;
41 (6) produce an annotated reference committee report indicating the final MSS
42 assembly outcome at each meeting;
43 (7) produce and maintain confidential archives of notes on information
44 gathered regarding other delegations stances on MSS items and actions
45 taken by the MSS Caucus at HOD
46 (8) maintain an Archiving Team to oversee ~~prospective archiving efforts,~~ the
47 completion of the historical policy archives, ~~and refinement of best~~
48 ~~practices for communication of outcomes~~ which will be disbanded by the
49 A-27 MSS Assembly meeting, after which this clause will be rescinded as
50 having been accomplished.

1 (9) review and formally define the roles and responsibilities of archiving entities
2 as part of the A-26 Resolution Task Force Report.
3

4 RESOLVED, that our AMA-MSS ask the MSS Governing Council to, at the A-30 MSS Assembly
5 meeting, re-evaluate the need to convene another Resolution Task Force for evaluation of the
6 MSS policy process.
7

8 VRC testimony was supportive. Your Reference Committee thanks the Resolutions Task Force
9 for a well written and comprehensive report. Your Reference Committee agrees with testimony
10 that the fourth recommendation of the report should be amended to clarify the voting threshold
11 for nominating MSS positions to be forwarded to the AMA House of Delegates from a majority
12 vote to a two-thirds vote. Therefore, your Reference Committee recommends RTF Report be
13 adopted as amended.
14

15 (21) GC REPORT F - DEVELOPMENT OF SUSTAINABLE GUIDELINES FOR THE
16 MSS STRATEGIC PLAN AND REPORTING PROCESS
17

18 **RECOMMENDATION A:**
19

20 **The first Recommendation of GC Report F be amended by deletion:**
21

22 ~~Your MSS Governing Council recommends that Resolution 602 not be~~
23 ~~adopted and the remainder of this report be filed.~~
24

25 **RECOMMENDATION B:**
26

27 **GC Report F be amended by addition of a Resolve:**
28

29 **Our AMA-MSS Governing Council shall maintain a strategic plan aligned with**
30 **the AMA mission and the Section's Purpose and Objectives, utilizing a**
31 **process that includes the following components:**

32 **a) Annual Review: Annual review and revision by the MSS Governing Council**
33 **to ensure alignment with AMA and MSS priorities;**

34 **b) Structured Process: Internal mechanisms and timelines, as defined by the**
35 **MSS Governing Council, for plan development including solicitation of MSS**
36 **member input, implementation, progress reporting, and archiving to**
37 **promote continuity and institutional memory;**

38 **c) Measurable Outcomes: Measurable objectives and outcomes to guide**
39 **Section initiatives and evaluate progress; and**

40 **d) Transparency and Reporting: Publication of strategic plan objectives**
41 **and tactics to MSS members and presentation of progress reports at each**
42 **Assembly meeting.**
43

44 **RECOMMENDATION C:**

GC Report F be adopted as amended.

Your MSS Governing Council recommends that Resolution 602 not be adopted and the remainder of this report be filed.

VRC testimony was limited and supportive. Your Reference Committee agrees with testimony that language should be codified to hold the MSS Governing Council accountable to the strategic planning process. While your Reference Committee agrees with testimony that the Strategic Planning process is informally integrated into MSS Governing Council campaigns, procedures, and transition of leadership between terms, we disagree that this removes the need for the proposed processes to be codified for MSS governance and transparency. Thus, your Reference Committee recommends GC Report F be adopted as amended.

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RECOMMENDED FOR ADOPTION IN LIEU OF

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2
3 (22) RESOLUTION 216 - SUPPORT EXPANDING INDIGENOUS ADOLESCENT
4 SUICIDE PREVENTION TO INCLUDE NATIVE HAWAIIAN YOUTH
5 RESOLUTION 422 - ADDRESSING SEXUAL VIOLENCE AND IMPROVING
6 HEALTH OUTCOMES FOR NATIVE HAWAIIAN WOMEN
7

8 **RECOMMENDATION:**
9

10 **Alternate Resolution 216 be adopted in lieu of Resolutions 216 and 422:**
11

12 **RESOLVED, that our American Medical Association supports culturally**
13 **grounded prevention programs and explicit inclusion of Native Hawaiian**
14 **youth in Indigenous suicide prevention efforts at the state and national**
15 **levels by amending Policy D-350.988, “American Indian / Alaska Native**
16 **Adolescent Suicide,” as follows; and be it further**
17

18 **American Indian / Alaska Native / Native Hawaiian Adolescent Suicide, D-**
19 **350.988**

- 20 1. **Our American Medical Association will provide active testimony in**
21 **Congress for suicide prevention and intervention resources to be**
22 **directed towards American Indian/Alaska Native/Native Hawaiian**
23 **communities.**
24 2. **Our AMA will encourage significant funding to be allocated to**
25 **research the causes, prevention, and intervention regarding**
26 **American Indian/Alaska Native/Native Hawaiian adolescent suicide**
27 **and make these findings widely available.**
28 3. **Our AMA will lobby the Senate Committee on Indian Affairs on the**
29 **important issue of American Indian/Alaska Native/Native Hawaiian**
30 **adolescent suicide; and be it further**
31

32 **RESOLVED, that our American Medical Association amend Policy D-**
33 **350.985, “Addressing Sexual Violence and Improving American Indian**
34 **and Alaska Native Women’s Health Outcomes,” to read as follows; and be**
35 **it further**
36

37 **Addressing Sexual Violence and Improving American Indian, Alaska**
38 **Native, and Native Hawaiian Women’s Health Outcomes D-350.985**
39

- 40 1. **Our AMA advocates for mitigation of the critical issues of**
41 **American Indian/Alaska Native/Native Hawaiian women's health**
42 **that place Native women at increased risk for sexual violence, and**
43 **encourages allocation of sufficient resources to the clinics**

1 **serving this population to facilitate health care delivery**
2 **commensurate with the current epidemic of violence against**
3 **Native women.**

- 4 **2. Our AMA will collaborate with the Indian Health Service, Centers**
5 **for Disease Control and Prevention (CDC), Tribal authorities,**
6 **community organizations, and other interested stakeholders to**
7 **develop programs to educate physicians and other health care**
8 **professionals about the legal and cultural contexts of their**
9 **American Indian, and Alaska Native, and Native Hawaiian female**
10 **patients as well as the current epidemic of violence against Native**
11 **women and the pursuant medical needs of this population.**
- 12 **3. Our AMA will collaborate with the Indian Health Service, CDC,**
13 **Tribal authorities, and community organizations to obtain or**
14 **develop appropriate American Indian, and Alaska Native, and**
15 **Native Hawaiian women's health materials for distribution to**
16 **patients in the spirit of self-determination to improve responses**
17 **to sexual violence and overall health outcomes.**

18
19 *Resolution 216*

20
21 RESOLVED, that our American Medical Association supports culturally grounded prevention
22 programs and explicit inclusion of Native Hawaiian youth in Indigenous suicide prevention efforts
23 at the state and national levels by amending Policy D-350.988, "American Indian / Alaska Native
24 Adolescent Suicide," as follows; and be it further

25 **American Indian / Alaska Native / Native Hawaiian Adolescent Suicide,**
26 **D-350.988**

27 Our American Medical Association will provide active testimony in
28 Congress for suicide prevention and intervention resources to be directed
29 towards American Indian/Alaska Native/Native Hawaiian communities. Our
30 AMA will encourage significant funding to be allocated to research the
31 causes, prevention, and intervention regarding American Indian/Alaska
32 Native/Native Hawaiian adolescent suicide and make these findings widely
33 available. Our AMA will lobby the Senate Committee on Indian Affairs on
34 the important issue of American Indian/Alaska Native/Native Hawaiian
35 adolescent suicide.

36
37 RESOLVED, that our AMA supports and advocates for the disaggregation of Asian American,
38 Native Hawaiian, and Pacific Islander (AA/NHPI) data in all federal, state, and local public health
39 reporting, research, and funding allocation, in order to accurately identify and address the distinct
40 mental health needs and suicide risk of Native Hawaiian youth.

41
42 *Resolution 422*

43

1 RESOLVED, that our American Medical Association amend Policy D-350.985, "Addressing
2 Sexual Violence and Improving American Indian and Alaska Native Women's Health Outcomes,"
3 to read as follows; and be it further
4

5 **Addressing Sexual Violence and Improving American Indian, Alaska
6 Native, and Native Hawaiian Women's Health Outcomes D-350.985**

7 1. Our AMA advocates for mitigation of the critical issues of
8 American Indian/Alaska Native/Native Hawaiian women's health that
9 place Native women at increased risk for sexual violence, and
10 encourages allocation of sufficient resources to the clinics serving this
11 population to facilitate health care delivery commensurate with the current
12 epidemic of violence against Native women.

13 2. Our AMA will collaborate with the Indian Health Service, Centers for
14 Disease Control and Prevention (CDC), Tribal authorities, community
15 organizations, and other interested stakeholders to develop programs to
16 educate physicians and other health care professionals about the legal
17 and cultural contexts of their American Indian, and Alaska Native, and
18 Native Hawaiian female patients as well as the current epidemic of
19 violence against Native women and the pursuant medical needs of this
20 population.

21 3. Our AMA will collaborate with the Indian Health Service, CDC, Tribal
22 authorities, and community organizations to obtain or develop appropriate
23 American Indian, and Alaska Native, and Native Hawaiian women's
24 health materials for distribution to patients in the spirit of self-
25 determination to improve responses to sexual violence and overall health
26 outcomes.
27

28 RESOLVED, that our AMA supports the development and implementation of culturally grounded,
29 trauma-informed programs for Native Hawaiian women affected by sexual violence, including but
30 not limited to the incorporation of Native Hawaiian cultural practices, community-led healing
31 approaches, and partnerships with Native Hawaiian-serving organizations.
32

33 VRC testimony was mixed. Your Reference Committee agrees with testimony that the most
34 actionable resolves of 216 and 422 are the proffered amendments to existing AMA policy. The
35 Reference Committee recommends Alternate Resolution 216 be adopted in lieu of Resolution
36 216 and 422.
37

38 (23) RESOLUTION 416 - REGULATION OF ORGAN TRANSPLANT OPEN OFFERS
39

40 **RECOMMENDATION:**

41
42 **Alternate Resolution 416 be adopted in lieu of Resolution 416:**
43

1 **RESOLVED, that our American Medical Association will support**
2 **increased oversight and regulation of open offers and other out-of-**
3 **sequence donor organ allocations; and be it further**

4
5 **RESOLVED, that our AMA support the creation of Organ Procurement and**
6 **Transplantation Network (OPTN) policies for open offers and out-of-**
7 **sequence deceased donor organ offers; and, be it further**

8
9 **RESOLVED, that our AMA support OPTN/Health Resources and Services**
10 **Administration-led evaluation and monitoring of open offer practices.**

11
12 RESOLVED, that our American Medical Association study the issue of out of sequence allocation
13 practices in transplant organ procurement and make recommendations concerning the ethics of
14 out-of-sequence allocations in cases of inequity.

15
16 VRC testimony was mixed between opposition and support for amendments. Your Reference
17 Committee agrees with testimony from the relevant specialty societies to amend the language to
18 strengthen the ask. We agree with testimony that this issue is nuanced and the resolution should
19 direct to the framework from the Organ Procurement and Treatment Network to be novel and
20 actionable. Your Reference Committee recommends Alternate Resolution 416 be adopted in lieu
21 of Resolution 416.

22
23 (24) RESOLUTION 418 - INTEGRATING DROWNING PREVENTION COUNSELING
24 AND RESOURCE REFERRAL INTO PEDIATRIC PREVENTIVE CARE

25
26 **RECOMMENDATION:**

27
28 **Alternate Resolution 418 be adopted in lieu of Resolution 418:**

29
30 **RESOLVED, that our American Medical Association amends Policy H-**
31 **10.983 entitled Swimming Safety by addition and deletion to read as**
32 **follows:**

33
34 ~~**1. Our American Medical Association strongly supports barrier**~~
35 ~~**fencing and pool covers for residential pools, early water safety, and**~~
36 ~~**water awareness programs.**~~

37 **1. Our American Medical Association support evidence-based**
38 **drowning prevention strategies consistent with national guidelines,**
39 **including but not limited to four-sided isolation fencing, use of U.S.**
40 **Coast Guard-approved life jackets, close and constant supervision,**
41 **and avoidance of ineffective or non-evidence-based interventions**

1 **2. Our AMA encourages swimming pool manufacturers and pool**
2 **chemical suppliers to distribute educational materials that promote**
3 **swimming and water safety.**

4 **3. Our American Medical Association support public education efforts**
5 **and anticipatory guidance by physicians on drowning prevention**
6 **across the lifespan, including promotion of formal swim lessons,**
7 **caregiver education, and targeted risk reduction for high-risk**
8 **populations.**

9 **4. Our American Medical Association advocate for policies and**
10 **community partnerships that expand access to water safety**
11 **education, swim instruction, and drowning prevention resources,**
12 **particularly in underserved and high-risk communities.**

13
14 RESOLVED, that our American Medical Association supports evidence-based drowning
15 prevention strategies consistent with national guidelines, including but not limited to four-sided
16 isolation fencing, use of U.S. Coast Guard-approved life jackets, close and constant supervision,
17 and avoidance of ineffective or non-evidence based interventions; and be it further

18
19 RESOLVED, that our AMA supports public education efforts and anticipatory guidance by
20 physicians on drowning prevention across the lifespan, including promotion of formal swim
21 lessons, caregiver education, and targeted risk reduction for high-risk populations; and be it
22 further

23
24 RESOLVED, that our AMA advocates for policies and community partnerships that expand
25 access to water safety education, swim instruction, and drowning prevention resources,
26 particularly in underserved and high-risk communities.

27
28 VRC testimony was mixed. Your Reference Committee agrees with testimony to amend the
29 resolution to address concerns of reaffirmation and scope. We agree that parts of the resolve
30 clauses are covered by existing AMA policy H-10.983 and agree with testimony and input from
31 the relevant specialty society that amending our current policy will be a more actionable and
32 feasible ask of the AMA. Your Reference Committee recommends Alternate Resolution 418 be
33 adopted in lieu of Resolution 418.

34
35 (25) RESOLUTION 431 - ESTABLISHING MENSTRUAL PRODUCTS AS A
36 STANDARD OF INPATIENT CARE

37
38 **RECOMMENDATION:**

39
40 **Alternate Resolution 431 be adopted in lieu of Resolution 431:**

41

1 **RESOLVED, that our American Medical Association encourages public and**
2 **private healthcare institutions as well as places of work and education to**
3 **provide free, readily available menstrual care products to patients.**
4

5 RESOLVED, that our American Medical Association support the inclusion of menstrual hygiene
6 products as routine inpatient hygiene supplies available at no cost to hospitalized patients who
7 menstruate, when clinically and logistically appropriate; and be it further

8
9 RESOLVED, that our AMA advocate with interested parties, including Centers for Medicare and
10 Medicaid Services (CMS), The Joint Commission (TJC), and hospital accrediting and regulatory
11 bodies, for recognition of timely access to menstrual hygiene products as an element of inpatient
12 dignity, privacy, and patient-centered care; and be it further

13
14 RESOLVED, that our AMA supports research and dissemination of best practices on inpatient
15 menstrual product provision, including identification of access barriers and evaluation of patient
16 experience and health equity impacts.

17
18 VRC testimony was largely supportive with numerous proffered amendments and a call for referral
19 to study. Your Reference Committee agrees with testimony that this resolution addresses a gap
20 in current policy by addressing the inpatient setting. Due to the lack of current research, your
21 Reference Committee does not believe a referral to study would yield much benefit. Your
22 Reference Committee agreed to propose an alternate resolution to clarify and mirror prior AMA
23 policy. Your Reference Committee recommends Alternate Resolution 431 be adopted in lieu of
24 Resolution 431.

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RECOMMENDED FOR REFERRAL

(26) RESOLUTION 114 - PROCEDURAL SAFEGUARDS FOR PAYER SIU ACTIONS

RECOMMENDATION:

Resolution 114 be referred.

RESOLVED, that our American Medical Association supports federal policies requiring continuity-of-care protections, notice to affected enrollees, and transition assistance for patients in an active course of treatment when a provider is removed from network participation or payment is suspended “for cause” based on SIUs or other payment-integrity program findings before final adjudication; and be it further

RESOLVED, that our AMA supports policies prohibiting recovery-linked compensation arrangements for SIU contractors or payment-integrity vendors when such arrangements may influence recommendations that result in provider removal or other actions that materially affect patient access to care.

VRC testimony was mixed. Your Reference Committee agrees with testimony that this resolution represents a novel addition to AMA policy. However, your Reference Committee also agrees with concerns that the evidence is not strong enough to pass the resolution as written; there is evidence for the first resolve but not sufficient evidence for the second. We agree there is general support for advocacy on this topic, but the language needs to be strengthened before moving forward. Your Reference Committee recommends the resolution be referred to address: How can the evidence and language be strengthened to oppose any strategies that interfere with the availability or continuity of care? Thus, your Reference Committee recommends Resolution 114 be referred.

(27) RESOLUTION 211 - EXPANDING RECOGNITION OF INDIGENOUS AMERICANS TO SUPPORT HEALTH OUTCOMES

RECOMMENDATION:

Resolution 211 be referred.

RESOLVED, that our American Medical Association recognize the identification of Indigenous Latin Americans as a marginalized group facing health inequities driven by historical and ongoing structural racism, colonization, and exclusion from legal recognition of indigenous status in the United States; and

1 RESOLVED, that our AMA recognize indigenous Mexicans as original inhabitants of land in the
2 United States and support implementation of public health initiatives that address historical
3 injustices resulting from the colonization of the Americas; and
4

5 RESOLVED, that our AMA support federal initiatives or policy that advocate for resources,
6 disaggregated data collection, and reporting into the colonization of indigenous Americans in the
7 Americas and its downstream effects on health on the modern population to better identify
8 inequities;
9

10 RESOLVED, that our AMA expand its existing support for pathways to U.S. citizenship due to
11 immigration status' known negative effect on health outcomes, with an emphasis on indigenous
12 Americans, and supports U.S. citizenship pathways for those seeking asylum from any country
13 in North, Central, or South America.
14

15 VRC testimony was mixed between support and opposition. Your Reference Committee agrees
16 with the spirit of this resolution. We also recognize that several of the resolved clauses, particularly
17 those related to demographic classification, historical context, and immigration-related advocacy,
18 raise complex questions regarding feasibility, implementation, terminology, and AMA scope. We
19 recommend that the referral focuses on the following questions: How can the referral incorporate
20 input from the communities outlined? How would the asks of this resolution be accomplished?
21 How can the language be clarified as even small language changes can make a big difference?
22 Thus, your Reference Committee recommends Resolution 211 be referred.
23

24 (28) RESOLUTION 302 - PRIVACY AND PROTECTION OF TRAINEE
25 EDUCATIONAL DATA IN AI-ENABLED MEDICAL EDUCATION
26

27 **RECOMMENDATION:**
28

29 **Resolution 302 be referred.**
30

31 RESOLVED, that our American Medical Association support institutional policies and regulatory
32 frameworks that require transparent disclosure of, and informed consent for, any secondary
33 use, commercialization, or non-educational application of trainee-generated educational data
34 collected through AI-enabled medical education technologies; and be it further
35

36 RESOLVED, that our AMA support the principle of data minimization in AI-enabled medical
37 education, encouraging that AI systems collect and retain only the minimum trainee data
38 necessary from medical students, residents, and fellows to fulfill clearly defined educational
39 purposes.
40

41 VRC testimony was mixed. Your Reference Committee agrees that there is sufficient evidence of
42 the problem but not sufficient evidence for the solution proposed. We agree with testimony that
43 the first resolve clause is covered by existing AMA policy. Additionally, your Reference Committee

1 agrees that the second resolve brings up questions about the scope of the ask that could be
2 further refined via a MSS study. We recommend that the committee studying this item take into
3 account the following questions: What data is collected during fellowship, residency, and medical
4 school and how does the data collected differ between training level? How long can the data
5 collected be stored and used? How is “minimum trainee data” defined in the second resolve
6 clause? Who defines “defined educational topics” as referenced in the second resolve clause?
7 Therefore, your Reference Committee recommends Resolution 302 be referred.

8
9 (29) RESOLUTION 502 - SUPPORTING “RIGHT TO REPAIR” FOR HOSPITAL
10 EQUIPMENT AND DURABLE MEDICAL EQUIPMENT

11
12 **RECOMMENDATION:**

13
14 **Resolution 502 be referred.**

15
16 RESOLVED, that our American Medical Association promote that the servicing and repair of
17 medical devices by qualified entities does not inherently compromise patient safety, software
18 integrity, security, or device function; and be it further

19
20 RESOLVED, that our AMA support federal and state legislation requiring medical device
21 manufacturers to make available to healthcare facilities, hospital-employed biomedical
22 engineers, and independent service organizations, on fair and reasonable terms: all
23 documentation, parts, software, and diagnostic tools necessary for the safe maintenance and
24 repair of medical equipment; and be it further

25
26 RESOLVED, that our AMA oppose the use of restrictive proprietary measures, including parts
27 pairing, software serialization, or digital locks, that limit device functionality or prevent durable
28 medical equipment owners, hospital-employed biomedical engineers, and qualified third-party
29 technicians from installing functional replacement components in medical equipment for the
30 purpose of repair and maintenance; and be it further

31
32 RESOLVED, that our AMA amends Policy H-185.912, “Expediting Repairs for Power and
33 Manual Wheelchairs,” as follows:

34
35 **Expediting Repairs for Power and Manual Wheelchairs, H-185.912**

- 36 1. Our American Medical Association supports health insurance coverage
37 to eliminate barriers for patients to obtain wheelchair repair; ensure that
38 repairs and services are safe, affordable, timely, and support mobility
39 and independence for those who utilize power and manual wheelchairs;
40 eliminate unnecessary paperwork and prior authorization requirements
41 for basic repairs, including proof of continuous need; cover temporary
42 rental of a substitute wheelchair when repairs require the primary
43 wheelchair to be taken out of the home; and would include preventive

- 1 maintenance and transporting the wheelchair between the patient's
- 2 home and the repair facility.
- 3 2. Our AMA will identify procedures for obtaining changes to Medicare and
- 4 other payers' current policies on repairing wheelchairs.
- 5 3. Our AMA supports suppliers of power and manual wheelchairs providing
- 6 preventive maintenance and repair services for wheelchairs they supply
- 7 to patients and permits consumers to perform self-repairs ~~as permitted~~
- 8 ~~by the manufacturer and when it does not void the warranty.~~

9

10 VRC testimony was mixed. Your Reference Committee agrees with concerns that the first
11 resolve is not actionable as written and the fourth resolve does not fit into the structure of
12 the resolution as it offers amendments to existing policy. We agree with testimony that this
13 resolution could benefit from amendments and concluded that a study would offer more
14 time to workshop the language. Your Reference Committee agrees there is sufficient
15 evidence to prove the problem, but further study is needed to provide actionable
16 recommendations for the resolved language. We recommend the study address the
17 following questions: How can the first resolve be workshopped to clearly identify the
18 problem? How can/should the resolution be expanded from "medical devices" to "including
19 durable medical equipment (DME)?" Thus, your Reference Committee recommends
20 Resolution 502 be referred.

21

22 (30) CPH REPORT B - NATIONAL DATABASE FOR CIVILIAN INJURIES BY
23 LAW ENFORCEMENT

24

25 **RECOMMENDATION:**

26

27 **CPH Report B be referred.**

28

29 Your Committee on Public Health (CPH) recommends that the following
30 recommendations are adopted in lieu of Resolution 411 and the remainder of this report
31 be filed:

32

33 RESOLVED, that our American Medical Association support increased federal
34 coordination and funding to establish mandatory reporting requirements for law
35 enforcement agencies and integrate data from existing surveillance systems including
36 the National Violent Death Reporting System, National Electronic Injury Surveillance
37 System, and law enforcement incident reporting into a comprehensive, publicly
38 accessible surveillance system for law enforcement-related civilian injuries and deaths;
39 and be it further

40

41 RESOLVED, that our AMA support the development and implementation of standardized
42 definitions of reportable law enforcement-related injuries and improved protocols for

1 clinical documentation and coding of such injuries in healthcare settings to enhance
2 case identification and data quality in public health surveillance systems.

3
4 VRC testimony was largely in support. Your Reference Committee agrees with concerns
5 that the first resolve is not actionable as written, and the second resolve would not result
6 in meaningful change as extensive standardized definitions already exist. We agreed with
7 testimony that additional evidence is needed to provide strong recommendations on this
8 topic. Your Reference Committee recommends the following questions for the committee's
9 consideration: How can the first resolve be re-written given that state reporting is
10 voluntary? What is the appropriate avenue for this ask given the variance from state to
11 state? How can the resolve clauses accurately reflect the intent laid out in the whereas
12 clauses? Your Reference Committee recommends CPH Report B be referred.

13
14 (31) GC REPORT B - ANNUAL SUNSET AND CONSOLIDATION REPORT

15
16 **RECOMMENDATION:**

17
18 **GC Report B be referred.**

19
20 Your AMA-MSS Governing Council recommends that the following be adopted and the
21 remainder of the report be filed:

- 22
23 1. That the recommendations for retention, retention including amendments, and
24 consolidation actions specified in Appendix A and Appendix B of this report be
25 retained as official, active positions of the AMA-MSS or rescinded as indicated.
26 2. That the recommendations regarding MSS positions in Appendix A and Appendix
27 B of this report be adopted.
28 3. That our AMA-MSS amend 630.044MSS by addition and deletion as follows:

29
30 **630.044MSS, "Sunset Mechanism for AMA-MSS Policy**

31 AMA-MSS will establish and use a sunset review mechanism for AMA-
32 MSS positions with a ten-year time horizon whereby MSS positions that
33 have not been actively rescinded by the MSS Assembly are reviewed
34 every ten years to determine if they maintain relevance and considered
35 for sunset, consolidation, retention, or retention with amendments. The
36 implementation of a sunset mechanism for AMA-MSS policy shall follow
37 the following procedures:

38 (1) review of positions will be the ultimate responsibility of the Governing
39 Council, whereby the report is authored by the Chair of the Governing
40 Council with initial position recommendations being solicited from relevant
41 Standing Committees as appropriate;

1 (2) The Governing Council will provide Standing Committees clear
2 guidance regarding criteria for recommendations of retention, retention
3 with amendments, or sunset;
4 (3) position recommendations will be reported to the AMA-MSS Assembly
5 at each Annual Meeting on the ten or nine and one-half year anniversary
6 of a policy's adoption, with a brief rationale accompanying each
7 recommendation;
8 (4) to gradually transition to the new timeline for sunset review, the 2025-
9 2029 Sunset Reports only review policies last reaffirmed at the Annual
10 Meeting five years prior (not the Interim Meeting 4.5 years prior), and then
11 the 2030 Sunset Report will begin the new 10- and 9.5-year timeline, at
12 which point this subclause will be automatically rescinded;
13 (5) a consent calendar format will be used by the Assembly in considering
14 the positions encompassed within the report;
15 (6) the MSS Governing Council should recommend policies for
16 consolidations of groups of related positions, whereby the report(s) are
17 authored by the MSS Chair with recommendations solicited from relevant
18 Standing Committees as appropriate;
19 (7) when MSS positions are reviewed via either the sunset or
20 consolidation mechanisms, the result of any positions submitted to HOD
21 and associated implementation actions will be reviewed and documented
22 for archival purposes if not already characterized;
23 (8) in their report on the previous HOD's proceedings, the Section
24 Delegates will recommend changes to any MSS positions that amend
25 AMA Policy and were considered by HOD, in order to summarize the
26 amendment's ask and simplify the language; and
27 ~~(9) any MSS positions written as "MSS will ask the AMA" will be~~
28 ~~automatically converted to past tense ("asked the AMA") after~~
29 ~~consideration by HOD as either a resolution or an amendment; and~~
30 (10) any MSS position (or portion of a position) requesting an AMA or
31 MSS study will automatically sunset after the study is completed by either
32 the AMA or MSS or after consideration of the study request by HOD.

33
34 VRC testimony was limited and in support. Your Reference Committee thanks the MSS
35 Governing Council and Standing Committee leaders for their work on this expansive
36 report. We agree with concerns on the review of MSS positions for sunset and the
37 proposed changes to 630.044MSS. Your Reference Committee agrees to refer this report
38 with the following questions: How can the sunset review training process be improved so
39 that the Standing Committee review is more standardized across committees? What is the
40 interpretation of the "ask accomplished" review recommendation and any unintended
41 consequences of its broad usage? Your Reference Committee recommends GC Report
42 B be referred.

43

1 (32) GC REPORT E - MSS STUDY OF ASSEMBLY REPRESENTATION

2
3 **RECOMMENDATION:**

4
5 **GC Report E be referred.**

6
7 Your MSS GC recommends that the following recommendations are adopted in
8 lieu of Resolution 604 and the remainder of this report be filed:

9
10 RESOLVED, that AMA MSS IOP 10.3.1.2 be amended by addition and deletion:

11
12 **10.3.1.2** Satellite Campuses. The AMA medical student members of
13 an educational program (AMA Bylaw 1.1.1) that has more than one
14 campus (a "satellite campus") may select one MSS Chapter Delegate
15 and one Alternate MSS Chapter Delegate from each campus. A
16 satellite campus is defined as an administrative campus separate
17 from the central campus where a minimum of ~~20~~ 70 members of the
18 student body are ~~assigned~~ enrolled independently of the main campus
19 ~~for some portion of their instruction over a period of time not less than~~
20 ~~an~~ 50% of the traditional 4 year medical school curriculum academic
21 year. For students in combined or dual-degree programs (e.g.,
22 MD/PhD, MD/MPH, MD/JD), this calculation applies only to the
23 traditional four-year medical education curriculum. MSS Chapter
24 Delegates and Alternate MSS Chapter Delegates credentialing under
25 the satellite campus provisions must, at the time of the meeting,
26 reside at the campus they will represent.

27
28 RESOLVED, that our AMA MSS establish a standardized Campus Verification
29 Process to operationalize MSS IOP 10.3.1.2, including a uniform Campus
30 Verification Form to be completed and certified by a Dean or authorized
31 institutional designee, documenting campus structure, total enrollment,
32 administrative enrollment status, and curricular distribution; and be it further

33
34 RESOLVED, that both main campus and satellite campus medical schools be
35 required to complete and submit the Campus Verification Form within six (6)
36 months of the conclusion of the Annual Meeting, with all submissions finalized
37 prior to the Interim Meeting to ensure accurate delegate credentialing; and be it
38 further

39
40 RESOLVED, that AMA MSS staff responsible for credentialing maintain a
41 centralized database of verified campus structures and delegate configurations,
42 and that any elements of submitted verification forms requiring interpretive review
43 be referred to the MSS Governing Council for determination; and be it further

1 RESOLVED, that medical schools failing to submit a completed Campus
2 Verification Form within the six-month timeframe be placed on provisional status
3 and granted a one-time grace period during the initial implementation year only,
4 during which the prior year's delegate configuration shall remain temporarily valid
5 for a period not to exceed one (1) year, with such schools required to complete
6 verification prior to the subsequent Interim Meeting in order to maintain
7 representation; and be it further

8
9 RESOLVED, that the Campus Verification Process operate on a two-year re-
10 verification cycle requiring full resubmission of the Campus Verification Form to
11 ensure continued accuracy of campus designations under MSS IOP 10.3.1.2.

12
13 VRC testimony was limited and in support. Your Reference Committee is concerned that
14 this report lacks data for the recommendations. We agreed that this report should be
15 referred to address and clarify with further evidence the following questions: How was the
16 threshold for satellite campuses established at 70 students and the instruction threshold
17 set to 50%? Can all MSS Local Campus Sections' enrollment be recorded so that the
18 report includes data on all campuses that this new threshold would affect? Can the report
19 differentiate between satellite campuses that have varying degrees of integration with their
20 respective main campuses? Your Reference Committee recommends GC Report E be
21 referred.

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RECOMMENDED FOR NOT ADOPTION

(33) RESOLUTION 005 - PROMOTING NEUROCOGNITIVE SCREENING AND ACCOMMODATIONS IN THE CARCERAL SETTING

RECOMMENDATION:

Resolution 005 not be adopted.

RESOLVED, that our American Medical Association work with state medical associations and other stakeholders to advocate for the implementation of standardized, evidence-based screening for neurocognitive disorders during intake for all juveniles entering detention and correctional facilities in the United States; and be it further

RESOLVED, that our AMA advocate for policies that ensure juveniles identified with neurocognitive disorders receive medically necessary accommodations during detention or incarceration, including but not limited to environmental modifications, visual or alternative communication supports, and structured scheduling supports.

VRC testimony was unanimously opposed. Your Reference Committee agrees with testimony that the asks of this resolution are either broadly covered by existing AMA policy or fall outside of the AMA's scope. We agree with testimony that the juvenile system is regulated at the state and county level, making these asks better suited for advocacy at those levels. AMA's existing policy H-60.986 covers these asks from a federal standpoint. Your Reference Committee recommends Resolution 005 not be adopted.

(34) RESOLUTION 007 - TIME AND CARE BURDEN IN GERIATRICS

RECOMMENDATION:

Resolution 007 not be adopted.

RESOLVED, that our American Medical Association advocate for increased federal funding to support research and demonstration projects on healthcare-related time and cumulative care burden in older adults with multimorbidity and its impact on patient outcomes, including through correspondence with the National Institute on Aging, Agency for Healthcare Research and Quality, and Centers for Medicare & Medicaid Services.

VRC testimony was largely opposed. Your Reference Committee agrees with testimony that the asks of the resolution are broadly covered under existing policy D-280.982, H-25.999, and H-295.981, and further, that there is not sufficient evidence outlined to support the resolved clause. While we agree with the spirit of the resolution, we do not think this

1 resolution would lead to a meaningful change in current AMA advocacy. Your Reference
2 Committee recommends Resolution 007 not be adopted.

3
4 (35) RESOLUTION 122 - IMPROVING THE EXTERNAL APPEALS PROCESS
5 FOR DENIED CLAIMS

6
7 **RECOMMENDATION:**

8
9 **Resolution 122 not be adopted.**

10
11 RESOLVED, that our American Medical Association supports policies eliminating
12 mandatory internal review requirements as a prerequisite for initiating independent
13 external review of insurance claim denials; and be it further

14
15 RESOLVED, that our AMA supports broadening patient access to independent external
16 review of insurance claim denials, including by removing restrictive eligibility
17 requirements that limit independent external review to cases involving medical judgment,
18 surprise billing, retrospective coverage cancellation, or determinations of experimental
19 treatment.

20
21 VRC testimony was mixed. Your Reference Committee agrees with testimony that there
22 are concerns about the ask of the first resolve clause being in opposition to existing AMA
23 policy H-320.952. Additionally, we agree that the second resolve clause is covered under
24 existing AMA policy H-320.952. Overall, we agreed that there is not enough evidence to
25 support the asks of the first resolve clause and the second resolve clause would not
26 change AMA advocacy. Therefore, your Reference Committee recommends Resolution
27 122 not be adopted.

28
29 (36) RESOLUTION 123 - SHORT-TERM CHILDCARE FOR PATIENTS

30
31 **RECOMMENDATION:**

32
33 **Resolution 123 not be adopted.**

34
35 RESOLVED, that our American Medical Association collaborate with relevant
36 professional organizations to provide physicians and healthcare staff with resources and
37 education on maintaining high-quality care when patients are accompanied by children;
38 and be it further

39
40 RESOLVED, that our AMA advocate for increased public and private support and
41 funding for hospitals to be able to provide no-cost, short-term childcare for patients
42 during outpatient appointments or inpatient stays; and be if further
43

1 RESOLVED, that our AMA encourage outpatients clinics as well as inpatient hospital
2 services, where feasible, to offer inexpensive or free childcare services to patients; and
3 be it further

4
5 RESOLVED, that our AMA supports collaboration with community-based organizations
6 offering free or inexpensive childcare as an option for patients seeking appointments or
7 in-patient stays with childcare needs.

8
9 VRC testimony was mixed. Your Reference Committee agrees with testimony that there
10 is not sufficient evidence included in the resolution and the asks of the resolution are too
11 broad as written and may result in unintended consequences for medical practices. We
12 agreed that there may not be enough evidence for a solution to this problem given the
13 sources included. Furthermore, the asks of this resolution are already broadly covered by
14 H-215.985 and H-60.917. Your Reference Committee recommends Resolution 123 not be
15 adopted.

16
17 (37) RESOLUTION 204 - EVIDENCE-BASED GUIDANCE FOR FEDERAL
18 HEALTH CONFIRMATIONS

19
20 **RECOMMENDATION:**

21
22 **Resolution 204 not be adopted.**

23
24 RESOLVED, that our American Medical Association study, develop, and make publicly
25 available a transparent, non-partisan framework for evaluating the professional
26 qualifications, scientific expertise, and public health leadership experience of nominees
27 for federal public health leadership positions, consistent with existing AMA policy on
28 professional standards and evidence-based public health governance; and be it further

29
30 RESOLVED, that our AMA use this framework to provide evidence-based evaluations of
31 such nominees and communicate those evaluations to the United States Senate during
32 relevant confirmation processes through written analyses, public statements, expert
33 testimony, or other appropriate engagement with congressional committees.

34
35 VRC testimony was mixed with proffered amendments. Your Reference Committee
36 agreed with concerns about this resolution's feasibility and worries it would not
37 meaningfully change AMA advocacy, while potentially limiting AMA's advocacy.
38 Therefore, your Reference Committee recommends Resolution 204 not be adopted.

39
40 (38) RESOLUTION 212 - EXPANDING PHYSICIANS' COLLECTIVE
41 BARGAINING RIGHTS

42
43 **RECOMMENDATION:**

1 **Resolution 212 not be adopted.**

2
3 RESOLVED, that our American Medical Association support efforts to expand
4 physicians' scope of and eligibility for collective bargaining rights and protections,
5 including but not limited to instituting policies such as default timelines for negotiation,
6 procedural rules that facilitate sectoral bargaining, equal time rules for union and
7 employer position meetings, and greater civil penalties for unfair labor practices.

8
9 VRC testimony was largely in opposition. Your Reference Committee agrees with
10 concerns that the resolution language is very broad and the AMA's Council on Ethics and
11 Judicial Affairs is working on a report on this topic, so a new policy would be premature.
12 Therefore, your Reference Committee recommends Resolution 212 not be adopted.

13
14 (39) RESOLUTION 218 - MEDICAL TECHNOLOGY ACCESS IN
15 INCARCERATED SETTINGS

16
17 **RECOMMENDATION:**

18
19 **Resolution 218 not be adopted.**

20
21 RESOLVED, that our American Medical Association support patient access to and
22 education on smart devices for health monitoring and treatment delivery in incarcerated
23 settings, including but not limited to prisons, jails, and detention centers; and be it further

24
25 RESOLVED, that our AMA support policies ensuring that patients in carceral settings
26 who use institution-provided digital tools for health-related purposes are afforded
27 meaningful privacy protections including transparency in data collection, limits on
28 secondary data use, and safeguards against unauthorized access, and that such use be
29 voluntary and based on informed consent with clear disclosure of privacy risks, data
30 sharing practices, and any limitations on confidentiality.

31
32 VRC testimony was largely in support. Your Reference Committee agrees with testimony
33 that individuals who are incarcerated should have access to proper healthcare services to
34 address their higher burden of chronic disease. While many found this policy addresses a
35 gap in advocacy, your Reference Committee resonates with the concerns of this resolution
36 overlapping with currently existing policy such as 3.1.1 covering privacy in healthcare and
37 concerns with the impact of technology access due to the current infrastructure of the
38 carceral system. Furthermore, your Reference Committee had additional concerns
39 regarding the lack of evidence supporting the proposed asks, as well as the predominantly
40 state and local control of carceral institutions. Therefore, your Reference Committee
41 recommends Resolution 218 not be adopted.

42

1 (40) RESOLUTION 308 - SUPPORTING RESIDENCY PATHWAYS FOR F-1
2 PHYSICIANS NATIONWIDE

3
4 **RECOMMENDATION:**

5
6 **Resolution 308 not be adopted.**

7
8 RESOLVED, that our American Medical Association (AMA) formally recognize U.S.-
9 trained medical graduates requiring work authorization as a distinct subgroup within
10 existing policy and advocacy efforts related to physician workforce and immigration
11 pathways; and be it further

12
13 RESOLVED, that our AMA work with the Association of American Medical Colleges
14 (AAMC) and other relevant stakeholders to study the specific barriers to residency entry
15 and the workforce retention of U.S.-trained medical graduates on F-1 student visas; and
16 be it further

17
18 RESOLVED, that our AMA support federal and state efforts, in collaboration with
19 relevant stakeholders, including the AAMC and the National Resident Matching
20 Program, to support efforts to develop and disseminate standardized guidance clarifying
21 visa pathways for U.S.-trained medical graduates requiring work authorization, including
22 distinctions between F-1, J-1, and H-1B processes.

23
24 VRC testimony was mixed. Your Reference Committee agrees with testimony that the
25 asks of this resolution are covered by current AMA policy and the AMA has advocated in
26 this space. Your Reference Committee recommends Resolution 308 not be adopted.

27
28 (41) RESOLUTION 309 - STOP THE CAP! PROTECT PHYSICIAN DIVERSITY
29 AND EQUITABLE ACCESS TO FEDERAL FINANCING

30
31 **RECOMMENDATION:**

32
33 **Resolution 309 not be adopted.**

34
35 RESOLVED, that our American Medical Association publicly oppose the transfer of the
36 federal student loan portfolio and its management from the Department of Education to
37 the Department of the Treasury; and be it further

38
39 RESOLVED, that our AMA actively advocate in support of H.R. 6677 and any
40 subsequent legislation that seeks to restore or expand federal loan limits to reflect the
41 actual cost of medical school attendance; and be it further

42

1 RESOLVED, that our AMA Council on Medical Education (CME) conduct an updated
2 study of the current “funding gap” and its projected impact on the primary care workforce
3 in rural and underserved urban areas, using these data points to produce a new report
4 analyzing the “funding gap” created by H.R. 1, with a specific focus on how the
5 Department of Treasury’s management of loans may impact the Public Service Loan
6 Forgiveness (PSLF) program and specialty choice for minoritized students; and be it
7 further

8
9 RESOLVED, that our AMA amend Policy H-305.924, “Restore and Enhance Federal
10 Loan Programs for Medical Education,” by addition and deletion to read as follows:
11 Restore and Enhance Federal Loan Programs for Medical Education, H-305.924

- 12 1. Our American Medical Association will continue to advocate for actively
13 pursue legislative, regulatory, and judicial remedies, such as support for
14 the Professional Degree Access Restoration Act (H.R. 6677), to ensure
15 federal student loan limits that accurately reflect the full cost of
16 attendance of graduate medical education programs.
- 17 2. Our AMA opposes the elimination of the Graduate PLUS loan program
18 and the implementation of arbitrary borrowing caps. Our AMA will
19 continue to support diverse and beneficial repayment plans for federal
20 student loans, including income-based repayment plans that are
21 favorable to individuals who took out loans for graduate medical
22 education.
- 23 3. Our AMA will continue to advocate for the protection of the Public Service
24 Loan Forgiveness (PSLF) Program for physicians.

25
26 RESOLVED, that our AMA amend Policy H-305.925, “Principles of and Actions to
27 Address Medical Education Costs and Student Debt” by an addition to read as follows:
28 Principles of and Actions to Address Medical Education Costs and Student Debt, H-
29 305.025

30 The costs of medical education should never be a barrier to the pursuit of
31 a career in medicine nor to the decision to practice in a given specialty. To
32 help address this issue, our American Medical Association (AMA) will:

33 1. Employ all available advocacy pillars, including the pursuit of judicial
34 intervention under the Administrative Procedure Act, to oppose the
35 implementation of financial policies—including federal borrowing caps or
36 interagency portfolio transfers—that create a financial barrier to entry for
37 the medical profession or disparately impact minoritized medical students.

- 38 1. Collaborate with members of the Federation and the medical education
39 community, and with other interested organizations, to address the cost of
40 medical education and medical student debt through public- and private-
41 sector advocacy.
- 42 2. Vigorously advocate for and support expansion of and adequate funding
43 for federal scholarship and loan repayment programs--such as those from

- 1 the National Health Service Corps, Indian Health Service, Armed Forces,
2 and Department of Veterans Affairs, and for comparable programs from
3 states and the private sector--to promote practice in underserved areas,
4 the military, and academic medicine or clinical research.
- 5 3. Encourage the expansion of National Institutes of Health programs that
6 provide loan repayment in exchange for a commitment to conduct targeted
7 research.
- 8 4. Advocate for increased funding for the National Health Service Corps Loan
9 Repayment Program to assure adequate funding of primary care within the
10 National Health Service Corps, as well as to permit:
 - 11 a. inclusion of all medical specialties in need, and
 - 12 b. service in clinical settings that care for the underserved but are not
13 necessarily located in health professions shortage areas.
- 14 5. Encourage the National Health Service Corps to have repayment policies
15 that are consistent with other federal loan forgiveness programs, thereby
16 decreasing the amount of loans in default and increasing the number of
17 physicians practicing in underserved areas.
- 18 6. Work to reinstate the economic hardship deferment qualification criterion
19 known as the "20/220 pathway," and support alternate mechanisms that
20 better address the financial needs of trainees with educational debt.
- 21 7. Advocate for federal legislation to support the creation of student loan
22 savings accounts that allow for pre-tax dollars to be used to pay for
23 student loans.
- 24 8. Work with other concerned organizations to advocate for legislation and
25 regulation that would result in favorable terms and conditions for borrowing
26 and for loan repayment, and would permit 100% tax deductibility of interest
27 on student loans and elimination of taxes on aid from service-based
28 programs.
- 29 9. Encourage the creation of private-sector financial aid programs with
30 favorable interest rates or service obligations (such as community- or
31 institution-based loan repayment programs or state medical society loan
32 programs).
- 33 10. Support stable funding for medical education programs to limit excessive
34 tuition increases, and collect and disseminate information on medical
35 school programs that cap medical education debt, including the types of
36 debt management education that are provided.
- 37 11. Work with state medical societies to advocate for the creation of either
38 tuition caps or, if caps are not feasible, pre-defined tuition increases, so
39 that medical students will be aware of their tuition and fee costs for the
40 total period of their enrollment.
- 41 12. Encourage medical schools to:
 - 42 a. study the costs and benefits associated with non-traditional instructional
43 formats (such as online and distance learning, and combined

- 1 baccalaureate/MD or DO programs) to determine if cost savings to medical
2 schools and to medical students could be realized without jeopardizing the
3 quality of medical education;
- 4 b. engage in fundraising activities to increase the availability of scholarship
5 support, with the support of the Federation, medical schools, and state and
6 specialty medical societies, and develop or enhance financial aid
7 opportunities for medical students, such as self-managed, low-interest loan
8 programs;
- 9 c. cooperate with postsecondary institutions to establish collaborative debt
10 counseling for entering first-year medical students;
- 11 d. allow for flexible scheduling for medical students who encounter financial
12 difficulties that can be remedied only by employment, and consider
13 creating opportunities for paid employment for medical students;
- 14 e. counsel individual medical student borrowers on the status of their
15 indebtedness and payment schedules prior to their graduation;
- 16 f. inform students of all government loan opportunities and disclose the
17 reasons that preferred lenders were chosen;
- 18 g. ensure that all medical student fees are earmarked for specific and well-
19 defined purposes, and avoid charging any overly broad and ill-defined
20 fees, such as but not limited to professional fees;
- 21 h. use their collective purchasing power to obtain discounts for their students
22 on necessary medical equipment, textbooks, and other educational
23 supplies;
- 24 i. work to ensure stable funding, to eliminate the need for increases in tuition
25 and fees to compensate for unanticipated decreases in other sources of
26 revenue; mid-year and retroactive tuition increases should be opposed.
- 27 13. Support and encourage state medical societies to support further
28 expansion of state loan repayment programs, particularly those that
29 encompass physicians in non-primary care specialties.
- 30 14. Take an active advocacy role during reauthorization of the Higher
31 Education Act and similar legislation, to achieve the following goals:
 - 32 a. Eliminating the single holder rule.
 - 33 b. Making the availability of loan deferment more flexible, including
34 broadening the definition of economic hardship and expanding the period
35 for loan deferment to include the entire length of residency and fellowship
36 training.
 - 37 c. Retaining the option of loan forbearance for residents ineligible for loan
38 deferment.
 - 39 d. Including, explicitly, dependent care expenses in the definition of the “cost
40 of attendance”.
 - 41 e. Including room and board expenses in the definition of tax-exempt
42 scholarship income.

- 1 f. Continuing the federal Direct Loan Consolidation program, including the
2 ability to “lock in” a fixed interest rate, and giving consideration to grace
3 periods in renewals of federal loan programs. Our AMA opposes the
4 elimination of the Graduate PLUS program as established by the One Big
5 Beautiful Bill Act (H.R. 1) and supports legislative efforts, such as the
6 Professional Degree Access Restoration Act (H.R. 6677), to restore
7 comprehensive federal financing for medical education.
- 8 g. Adding the ability to refinance Federal Consolidation Loans.
- 9 h. Eliminating the cap on the student loan interest deduction.
- 10 i. Increasing the income limits for taking the interest deduction.
- 11 j. Making permanent the education tax incentives that our AMA successfully
12 lobbied for as part of Economic Growth and Tax Relief Reconciliation Act
13 of 2001.
- 14 k. Ensuring that loan repayment programs do not place greater burdens upon
15 married couples than for similarly situated couples who are cohabitating.
- 16 l. Increasing efforts to collect overdue debts from the present medical
17 student loan programs in a manner that would not interfere with the
18 provision of future loan funds to medical students.
- 19 m. Opposing the transfer of the federal student loan portfolio and its
20 management from the Department of Education to the Department of the
21 Treasury, ensuring that medical education financing remains under the
22 purview of an education-focused agency rather than a revenue-focused
23 agency.
- 24 15. Continue to work with state and county medical societies to advocate
25 for adequate levels of medical school funding and to oppose legislative or
26 regulatory provisions that would result in significant or unplanned tuition
27 increases.
- 28 16. Continue to study medical education financing, so as to identify long-
29 term strategies to mitigate the debt burden of medical students, and
30 monitor the short-and long-term impact of the economic environment on
31 the availability of institutional and external sources of financial aid for
32 medical students, as well as on choice of specialty and practice location.
- 33 17. Collect and disseminate information on successful strategies used by
34 medical schools to cap or reduce tuition.
- 35 18. Continue to monitor the availability of and encourage medical schools
36 and residency/fellowship programs to:
 - 37 a. provide financial aid opportunities and financial planning/debt management
38 counseling to medical students and resident/fellow physicians;
 - 39 b. work with key stakeholders to develop and disseminate standardized
40 information on these topics for use by medical students, resident/fellow
41 physicians, and young physicians; and
 - 42 c. share innovative approaches with the medical education community.

1 19. Seek federal legislation or rule changes that would stop Medicare and
2 Medicaid decertification of physicians due to unpaid student loan debt. Our
3 AMA believes that it is improper for physicians not to repay their
4 educational loans, but assistance should be available to those physicians
5 who are experiencing hardship in meeting their obligations.

6 20. Related to the Public Service Loan Forgiveness (PSLF) Program, our
7 AMA supports increased medical student and physician participation in the
8 program, and will:

- 9 a. Advocate that all resident/fellow physicians have access to PSLF during
10 their training years.
- 11 b. Advocate against a monetary cap on PSLF and other federal loan
12 forgiveness programs.
- 13 c. Work with the United States Department of Education and the Department
14 of the Treasury to ensure that any cap on loan forgiveness under PSLF be
15 at least equal to the principal amount borrowed and that interagency
16 transfers do not result in the loss of qualifying payment records or
17 administrative barriers to forgiveness.
- 18 d. Ask the United States Department of Education to include all terms of
19 PSLF in the contractual obligations of the Master Promissory Note.
- 20 e. Encourage the Accreditation Council for Graduate Medical Education
21 (ACGME) to require residency/fellowship programs to include within the
22 terms, conditions, and benefits of program appointment information on the
23 employer's PSLF program qualifying status.
- 24 f. Advocate that the profit status of a physician's training institution not be a
25 factor for PSLF eligibility,
- 26 g. Encourage medical school financial advisors to counsel wise borrowing by
27 medical students, in the event that the PSLF program is eliminated or
28 severely curtailed.
- 29 h. Encourage medical school financial advisors to increase medical student
30 engagement in service-based loan repayment options, and other federal
31 and military programs, as an attractive alternative to the PSLF in terms of
32 financial prospects as well as providing the opportunity to provide care in
33 medically underserved areas.
- 34 i. Strongly advocate that the terms of the PSLF that existed at the time of the
35 agreement remain unchanged for any program participant in the event of
36 any future restrictive changes.
- 37 j. Monitor the denial rates for physician applicants to the PSLF.
- 38 k. Undertake expanded federal advocacy, in the event denial rates for
39 physician applicants are unexpectedly high, to encourage release of
40 information on the basis for the high denial rates, increased transparency
41 and streamlining of program requirements, consistent and accurate
42 communication between loan servicers and borrowers, and clear

1 expectations regarding oversight and accountability of the loan servicers
2 responsible for the program.

3 I. Work with the United States Department of Education to ensure that
4 applicants to the PSLF and its supplemental extensions, such as
5 Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are
6 provided with the necessary information to successfully complete the
7 program(s) in a timely manner.

8 m. Work with the United States Department of Education to ensure that
9 individuals who would otherwise qualify for PSLF and its supplemental
10 extensions, such as TEPSLF, are not disqualified from the program(s)

11 21. Advocate for continued funding of programs including Income-Driven
12 Repayment plans for the benefit of reducing medical student load burden.

13 22. Strongly advocate for the passage of legislation to allow medical
14 students, residents and fellows who have education loans to qualify for
15 interest-free deferment on their student loans while serving in a medical
16 internship, residency, or fellowship program, as well as permitting the
17 conversion of currently unsubsidized Stafford and Graduate Plus loans to
18 interest free status for the duration of undergraduate and graduate medical
19 education.

20 23. Continue to monitor opportunities to reduce additional expense burden
21 upon medical students including reduced-cost or free programs for
22 residency applications, virtual or hybrid interviews, and other cost-
23 reduction initiatives aimed at reducing non-educational debt.

24 24. Encourage medical students, residents, fellows and physicians in
25 practice to take advantage of available loan forgiveness programs and
26 grants and scholarships that have been historically underutilized, as well
27 as financial information and resources available through the Association of
28 American Medical Colleges and American Association of Colleges of
29 Osteopathic Medicine, as required by the Liaison Committee on Medical
30 Education and Commission on Osteopathic College Accreditation, and
31 resources available at the federal, state and local levels.

32 25. Support federal efforts to forgive debt incurred during medical school
33 and other higher education by physicians and medical students, including
34 educational and cost of attendance debt.

35 26. Support that residency and fellowship application services grant fee
36 assistance to applicants who previously received fee assistance from
37 medical school application services or are determined to have financial
38 need through another formal mechanism.

39
40 RESOLVED, that our AMA amend Policy D-305.984, "Reduction in Student Loan
41 Interest Rates," by addition and deletion to read as follows:
42 Reduction in Student Loan Interest Rates, D-305.984

- 1 1. Our American Medical Association will actively lobby for legislation
2 aimed at establishing an affordable student loan structure with a variable
3 interest rate capped at no more than 5.0%.
- 4 2. Our AMA will work in collaboration with other health profession
5 organizations to advocate for a reduction of the fixed interest rate of the
6 Stafford student loan program and the Graduate PLUS loan program and
7 successor programs established under H.R. 1.
- 8 3. Our AMA will consider the total cost of loans including loan
9 origination fees and benefits of federal loans such as tax deductibility or
10 loan forgiveness when advocating for a reduction in student loan interest
11 rates.
- 12 4. Our AMA will advocate for policies which lead to equal or less
13 expensive loans (in terms of loan benefits, origination fees, and interest
14 rates) for Grad-PLUS loans as this would change the status quo of high-
15 borrowers paying higher interest rates and fees in addition to having a
16 higher overall loan burden for all graduate medical student borrowers.
- 17 5. Our AMA opposes the management of the student loan portfolio by the
18 Department of the Treasury or any agency whose primary mission is
19 revenue collection rather than educational equity, as such oversight
20 threatens the stability of interest rate subsidies and loan forgiveness
21 programs.

22
23 VRC testimony was largely in opposition. Your Reference Committee agrees with
24 concerns that this resolution is too specific and narrow as written. We agree with testimony
25 that adoption of this resolution would limit the AMA's advocacy efforts due to the specificity
26 and prescriptive nature of language proffered. Additionally, the AMA is not a primary
27 research-generating body and the Council on Medical Education does not have the scope
28 to collect primary data in this area. Therefore, your Reference Committee recommends
29 Resolution 309 not be adopted.

30
31 (42) RESOLUTION 310 - TRIBAL SELF-DETERMINATION IN MEDICAL
32 SCHOOL ENROLLMENT

33
34 **RECOMMENDATION:**

35
36 **Resolution 310 not be adopted.**

37
38 RESOLVED our American Medical Association will advocate for the expansion and
39 dedicated federal funding of workforce development grant programs (e.g., INMED:
40 Indians Into Medicine Program) to support the creation or expansion of new, additive
41 medical school training positions designated for academically qualified American Indian
42 and Alaska Native students who (1) are descendants or enrolled members of state and
43 federally recognized Tribal Nations as determined by each Tribal Nation's governing

1 body and (2) commit to service within the IHS and Tribal Health Programs. Such
2 programs should increase overall medical school training capacity (e.g., administrative
3 support, tuition coverage) rather than displace existing medical school applicants; and
4 be it further

5
6 RESOLVED our AMA will advocate for the incorporation of Tribal partnership in
7 admissions processes, including opportunities for representatives of Tribal Nations to
8 participate in outreach, admissions review, or advisory roles to ensure the selection
9 process aligns with Tribal health workforce needs and priorities.

10
11 VRC testimony was largely in opposition. Your Reference Committee agrees with
12 concerns that this resolution is already robustly covered by existing AMA policy H-
13 350.981. We agree with testimony that adoption of this resolution would not significantly
14 impact or change current AMA advocacy efforts in this area. Additionally, the committee
15 shared concerns surrounding AMA defining who falls under tribal identity, when this is
16 currently being debated within the community. Therefore, your Reference Committee
17 recommends Resolution 310 not be adopted.

18
19 (43) RESOLUTION 311 - STRENGTHS-BASED INDIGENOUS MEDICAL
20 SCHOOL CURRICULUM

21
22 **RECOMMENDATION:**

23
24 **Resolution 311 not be adopted.**

25
26 RESOLVED, that our American Medical Association support incorporation of strengths-
27 based, community-informed American Indian and Alaska Native perspectives on health,
28 healing, and wellness into undergraduate, graduate, and continuing medical education,
29 in collaboration with relevant American Indian and Alaska Native-led organizations and
30 medical education stakeholders.

31
32 VRC testimony was largely in opposition. Your Reference Committee agrees with
33 concerns that this is premature given several AMA Council on Medical Education reports
34 on this and related topics coming forward. We agree with the spirit of the resolution, but
35 ultimately agreed the resolution is not novel enough to cause a meaningful change in AMA
36 advocacy. Therefore, your Reference Committee recommends Resolution 311 not be
37 adopted.

38
39 (44) RESOLUTION 401 - RAPID RESPONSE FRAMEWORK FOR
40 UNSUPPORTED MEDICAL CLAIMS BY PUBLIC OFFICIALS

41
42 **RECOMMENDATION:**

43

1 **Resolution 401 not be adopted.**

2
3 RESOLVED, that our American Medical Association study and report to the House of
4 Delegates on the feasibility of developing a transparent, time-bound evidence review
5 and response framework for evaluating and publicly responding to medical or public
6 health claims made by elected or appointed government officials outside formal
7 regulatory rulemaking that materially conflict with established scientific consensus or
8 misrepresent the strength or certainty of available evidence, including consideration of:
9 criteria for identifying high-impact claims warranting review, the responsible
10 organizational entity, and associated timelines and processes for evidence assessment
11 and public communication; and be it further

12
13 RESOLVED, that our AMA support the issuance of timely public clarifications, developed
14 in collaboration with relevant parties, when a government official's public claim materially
15 conflicts with established scientific consensus or misrepresents the strength or certainty
16 of available evidence, summarizing the relevant evidence and communicating areas of
17 uncertainty, without creating, endorsing, or modifying clinical practice guidelines; and be
18 it further

19
20 RESOLVED, that our AMA explore the feasibility of a consolidated, publicly accessible
21 evidence communication platform to support timely and transparent responses to
22 unsupported public health claims made by government officials, supported by trained
23 medical student volunteers under physician oversight, minimizing resource burden on
24 the AMA.

25
26 VRC testimony was largely opposed. Your Reference Committee agrees with concerns
27 that this resolution is broadly covered under existing AMA policy and these resolve clauses
28 are not feasible as written. We agree with testimony that the AMA can act in this space
29 under current policy and that the language as written is specific to an extent that could
30 actually hinder AMA's process for reviewing and responding. Therefore, your Reference
31 Committee recommends Resolution 401 not be adopted.

32
33 (45) RESOLUTION 420 - INDIAN HEALTH SERVICE PHARMACEUTICAL
34 ACQUISITION PARITY

35
36 **RECOMMENDATION:**

37
38 **Resolution 420 not be adopted.**

39
40 RESOLVED, that our American Medical Association support federal legislative and
41 regulatory efforts to protect and strengthen participation of Indian Health Service, Tribal,
42 and Urban Indian health programs in the 340B Drug Pricing Program, including efforts to
43 reduce administrative barriers, preserve access to contract pharmacy arrangements

1 where appropriate, and oppose policies that would shift substantial up-front drug
2 acquisition costs onto these covered entities.

3
4 VRC testimony was mixed. Your Reference Committee agrees with concerns that existing
5 AMA policy broadly covers the ask of this resolution and the resolve clause would not
6 cause a functional change in AMA advocacy. We agree that this resolution raises a timely
7 and important issue and advocacy can be pursued under existing AMA policy as written.
8 Therefore, your Reference Committee recommends Resolution 420 not be adopted.

9
10 (46) RESOLUTION 425 - PRESERVING EVIDENCE-BASED AIR POLLUTION
11 REGULATORY ANALYSIS

12
13 **RECOMMENDATION:**

14
15 **Resolution 425 not be adopted.**

16
17 RESOLVED, that our American Medical Association support federal regulatory cost-
18 benefit analyses that fully, consistently, and transparently quantify and incorporate both
19 mortality and morbidity outcomes - including lives saved and premature deaths avoided -
20 using the best available science and epidemiologic evidence.

21
22 VRC testimony was generally supportive. Your Reference Committee agrees with
23 testimony on the timeliness and sensitivity of this issue but believes that this resolution is
24 not supported by strong, current evidence, noting that the resolution as written is too broad
25 and not clear enough, and would benefit from further workshopping. However, we also
26 agree with AMA staff that overlap with existing policy may cause the resolution to not result
27 in meaningful advocacy. Therefore, your Reference Committee recommends Resolution
28 425 not be adopted.

29
30 (47) RESOLUTION 427 - ESTABLISHING A NATIONAL HEALTHCARE
31 CARBON BUDGET AND MARKET

32
33 **RECOMMENDATION:**

34
35 **Resolution 427 not be adopted.**

36
37 RESOLVED, that our AMA advocate for the establishment of a federally mandated
38 declining carbon budget specifically for the U.S. healthcare sector, with annual
39 emissions caps allocated to hospitals and large health systems that decrease in
40 alignment with national 2030 and 2050 climate goals; and be it further
41

1 RESOLVED, that our AMA support federal legislation to create a Healthcare Carbon
2 Market, allowing facilities that reduce emissions below their assigned cap to sell or trade
3 carbon credits exclusively to other higher-emitting facilities within the healthcare sector.

4
5 VRC testimony was unanimously opposed. Your Reference Committee agrees with
6 testimony that the asks of this resolution are broadly covered by existing policy, including
7 D-135.966, H-135.938, and H-135.923. A healthcare market-specific resolution is not
8 necessary and would not result in a meaningful change in advocacy. Therefore, your
9 Reference Committee recommends Resolution 427 not be adopted.

10
11 (48) RESOLUTION 606 - IMPROVING ALIGNMENT OF AMPAC ACTIVITY
12 AND AMA STANCES

13
14 **RECOMMENDATION:**

15
16 **Resolution 606 not be adopted.**

17
18 RESOLVED, that our American Medical Association define "commitment to democratic
19 governance" for the purpose of evaluating alignment between AMA policy and political
20 advocacy as support for and adherence to the following principles: (1) acceptance of
21 certified election outcomes and judicial determinations pertaining to elections, (2)
22 respect for the peaceful transfer of political power pursuant to elections, (3) support for
23 lawful election administration and protection of avenues for engagement with democratic
24 governance, including voter-enfranchisement, and (4) abstention from attempts to
25 overturn or otherwise invalidate election outcomes extrajudicially; and be it further

26
27 RESOLVED, that our AMA study mechanisms by which AMPAC can more consistently
28 align candidate endorsements, direct contributions, and independent expenditures with
29 established AMA stances, especially those related to the longevity of democratic
30 governance; and be it further

31
32 RESOLVED, that our AMA encourage AMPAC to develop and publish transparent
33 criteria incorporating the above principles when evaluating federal candidates for political
34 support; and be it further

35
36 RESOLVED, that our AMA study opportunities to improve transparency and alignment
37 between AMPAC activity and existing AMA stances related to democratic governance
38 and public health.

39
40 VRC testimony was limited and primarily in opposition. Your Reference Committee agrees
41 with testimony that the AMA and AMPAC are structurally and financially separate entities
42 and given how the AMA and AMPAC are required to interact with each other financially,
43 we are not convinced the resolution would meaningfully change how the AMPAC functions

1 in regard to transparency and disclosure of candidate selection criteria. Furthermore, we
2 see the first resolve clause as broadly covered under existing AMA policy, specifically H-
3 65.947. Your Reference Committee recommends Resolution 606 not be adopted.

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5 (49) CHJ REPORT A - ENSURING MULTILINGUAL PEDIATRIC ACCESS
6 POINTS FOR UNDOCUMENTED PATIENTS

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8 **RECOMMENDATION:**

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10 **CHJ Report A not be adopted.**

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12 Your Committee on Health Justice recommends that the following recommendations are
13 adopted in lieu of Resolution 212 and the remainder of this report be filed:

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15 RESOLVED, that our AMA studies the effects of dissemination of multilingual
16 educational resources in pediatric access points, including but not limited to schools,
17 School-Based Health Centers, and Telehealth Access Points, to better understand the
18 effects of this dissemination on healthcare delivery/outcomes, including but not limited to
19 understanding confidentiality protections, patient rights, diagnoses, treatments, and
20 available services.

21
22 VRC testimony was largely opposed. Your Reference Committee agrees with testimony
23 that the resolution topic is important but there is not enough evidence to provide a policy
24 recommendation on the referred resolution. We agree with testimony that an AMA study
25 would not lead to actionable steps since a study consists of a literature review which has
26 already been accomplished by the MSS Standing Committee. Your Reference Committee
27 recommends CHJ Report A not be adopted.

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RECOMMENDED FOR FILING

(50) GC REPORT A – MSSAI REPORT

RECOMMENDATION:

GC Report A be filed.

Your Governing Council recommends that no action be taken at this time and the remainder of this report be filed.

VRC testimony was limited but in support. Your Reference Committee thanks the Governing Council for this report on MSSAIs and their current status. Your Reference Committee recommends GC Report A be filed.

(51) GC REPORT C – ANNUAL MEMBERSHIP REPORT

RECOMMENDATION:

GC Report C be filed.

Your Governing Council recommends that no action be taken at this time and the remainder of this report be filed.

VRC testimony was limited but in support. Your Reference Committee thanks the Governing Council for this report and agrees with testimony to clarify the section on new school and student organization representation to future reports. Your Reference Committee recommends GC Report C be filed.

(52) SD REPORT– DELEGATE REPORT: POLICY PROCEEDINGS OF THE INTERIM 2025 HOUSE OF DELEGATES MEETING

RECOMMENDATION:

SD Report be filed.

Your MSS Section Delegates recommend the adoption of the recommendations for MSS positions outlined in Appendices A and B of this report and the remainder of the report be filed.

VRC testimony was limited in support. Your Reference Committee thanks the MSS Section Delegates for the comprehensive information report on I-25 proceedings. Your Reference Committee recommends SD Report be filed.