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ORGANIZED MEDICAL STAFF SECTION

Governing Council Report A

Annual 2026 Meeting

Access full text of resolutions/reports in the [HOD meeting handbook](#).

Recommendations key

Instructions for the delegate and alternate delegate are designated as follows:

- *Strongly support* – the delegate/alternate delegate shall support the resolution as written and actively speak in favor of the resolution
- *Support* – the delegate/alternate delegate shall support the resolution as written
- *Monitor* – the delegate/alternate delegate is not instructed to take any action, however, may if they believe it is in the best interest of the OMSS
- *Refer* – the delegate/alternate delegate shall move to refer (the item goes to a Council) or refer for decision (item goes to the Board)
- *Amend* – the delegate/alternate delegate shall move to amend the resolution in the manner prescribed in Report A
- *Oppose* – the delegate/alternate delegate shall oppose the resolution as written
- *Strongly oppose* – the delegate/alternate delegate shall oppose the resolution as written and actively speak in opposition of the resolution

Some items may contain specific instructions not included among those listed above. In such cases, instructions to the delegate/alternate delegate are described in detail alongside the item of business.

Note: Items highlighted in blue have been recommended for reaffirmation.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
1	E&B	CEJA 03 – Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	<p>RECOMMENDATIONS</p> <p>The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of the report be filed:</p> <p>1. That Opinion 1.2.10 be amended by addition and deletion with a change in title as follows:</p> <p><u>Advocacy and Collective Actions by Physicians</u> Political Action by Physicians</p> <p>Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law, or policy, or practice are contrary to the best interests of patients. However, <u>advocacy actions should not put the wellbeing of patients in jeopardy.</u></p> <p><u>Collective action is one means by which physicians can advocate for patients, the health of communities, the profession, and their own health. Physicians have a responsibility to avoid disruption to patient care when engaging in any</u></p>	Delegate instructed to strongly support.

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			<p><u>collective action. When considering collective actions that have the potential to be disruptive, whether aimed at changing the policies of government, the private sector, or their own institutions, there are additional considerations that should be addressed. These include avoiding harm to patients, minimizing the impact of actions on patient access to care, maintaining trust in the patient-physician relationship, fulfilling the responsibility to improve patient care, avoiding mental and physical harms to physicians, promoting physician wellbeing, upholding the values and integrity of the profession, and considering alternative measures that could reasonably be expected to achieve similar results with less potential effect on patient and physician wellbeing.</u></p> <p><u>When considering participation Physicians who participate in advocacy activities, including collective actions:</u></p> <p><u>(a) Ensure that the health of patients is not jeopardized, and that patient care is not compromised. Physicians should recognize that, in pursuing their primary commitment to patients, physicians can, and at times may have an obligation to, engage in collective political action to advocate for changes in law and institutional policy aimed at promoting patient care and wellbeing.</u></p> <p><u>(b) Avoid using disruptive means to press for reform. Strikes and other collective actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice. Physicians may also engage in collective action to advocate for changes within their institutions, including changes in patient care practices, physician work conditions, health and wellbeing, and/or institutional culture that negatively affect patient care.</u></p> <p><u>(i) Physicians should refrain from collective action that would likely jeopardize the health of patients or compromise patient care.</u></p> <p><u>(ii) Physicians may, if non-disruptive actions fail, consider engaging in disruptive forms of collective action that do not compromise patient care, with the primary objective to improve patient care and outcomes by calling attention to and/or</u></p>	

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			<p><u>making needed changes in practices, protocols, incentives, expectations, structures, and/or institutional culture.</u></p> <p><u>(iii) Physicians should avoid disruptive collective actions that could directly compromise patient care, including strikes, due to their potential to undermine physicians' primary duty to patient welfare, and should not use such actions primarily for physician self-interest.</u></p> <p>(c) Physicians should avoid forming workplace <u>or other</u> alliances, such as unions, with workers <u>colleagues and others</u> who do not share physicians' primary and overriding commitment to patients.</p> <p>(d) <u>Physicians should</u> refrain from using undue influence or pressure <u>colleagues punitive or coercive means to force others</u> to participate in advocacy activities or collective actions, or to <u>penalize others</u> and should not punish colleagues, overtly or covertly, for deciding not to participate <u>in such activities.</u></p> <p>2. That Policy H-405.946(2) be rescinded as having been accomplished by this report. (Rescind AMA Policy)</p>	
2	E&B	<p>Res. 002 – Physician Workload and Scheduling (Florida)</p>	<p>RESOLVED, that our American Medical Association adopt policy affirming that physicians have the professional right and authority to decline, modify, or limit patient volume expectations, scheduling mandates, and staffing conditions that compromise patient safety or their ability to provide safe, thorough, and patient-centered care (New HOD Policy)</p> <p>RESOLVED, that our AMA advocate for and support state and federal legislation or regulation that ensures local practicing physicians direct and control the development and implementation of patient scheduling protocols, workload standards, patient panel limits, and clinical staffing models within their practices and health systems, based on clinical complexity, time required for direct and indirect care, and safe practice standards rather than productivity or revenue targets. (Directive to Take Action)</p>	<p>Delegate instructed to support the intent of maintaining physician autonomy and satisfaction. Would recommend this be added to AMA guidance on employment contracting.</p>
3	E&B	<p>Res. 003 – Artificial Intelligence to Bolster Physician-Led Team-Based Care</p>	<p>RESOLVED, that our American Medical Association make efforts to educate physicians on evidence-based artificial intelligence (AI) tools that can strengthen collaboration with non-physician clinicians through improved interdisciplinary communication, decision support, and workflow integration (Directive to Take Action)</p>	<p>Delegate instructed to listen.</p>

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		(American Academy of Ophthalmology)	<p>RESOLVED, that our AMA support the development and dissemination of best practices for AI integration into physician-led care teams, with emphasis on safety monitoring, transparency, cyber hygiene, and preserving physician leadership in clinical decision-making (New HOD Policy)</p> <p>RESOLVED, that our AMA encourage further research on AI interventions that demonstrate how AI can enhance physician-led team effectiveness, reduce misalignment of clinical risk perception, and improve coordination of care.</p>	
4	B	BOT 25 – Federal Legislation to Prohibit the Corporate Practice of Medicine	<p>The Board recommends that the following be adopted in lieu of Resolution 225-I-25 and that the remainder of this report be filed:</p> <ol style="list-style-type: none"> 1. That the American Medical Association, in order to protect physician autonomy and strengthen the physician-patient relationship, support federal legislation prohibiting lay entities, including but not limited to insurance companies, private equity firms, non-physician individual licensed health care professionals and other non-physician-owned entities or individuals, from interfering with, controlling, or otherwise directing 1) the independent professional judgment or clinical decisions of a physician, or 2) the operational authority of physicians within their practices, provided that any such legislation include a specific saving clause clarifying an intent to preserve the right of states to enact and enforce more stringent state laws. (New HOD Policy) 2. That the AMA support whistleblower programs that allow individuals to report knowledge of violations of a law prohibiting lay entities from interfering with, controlling, or otherwise directing the professional judgment, clinical decisions, or operational authority of a physician to the appropriate enforcement agency. (New HOD Policy) 3. That the AMA support the implementation and enforcement of strong state laws or regulations that prohibit the corporate practice of medicine (New HOD Policy) 	Delegate instructed to support.

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5	B	<p>Res. 202 – Using and Defining “Unsupervised Practice of Medicine” (Florida)</p>	<p>RESOLVED, that our American Medical Association use the term “Unsupervised Practice of Medicine” (UPM) when describing statutory or regulatory efforts that allow nonphysician practitioners to diagnose, treat, and prescribe without physician oversight, and reaffirm that physician-led, team-based care with appropriate physician supervision remains the gold standard for patient safety and quality care (New HOD Policy);</p> <p>RESOLVED, that our AMA incorporate the term “Unsupervised Practice of Medicine” in its advocacy materials, public communications, testimony, and educational resources, where appropriate, to clarify the distinction between physician licensure and nonphysician scope expansion (Directive to Take Action);</p> <p>RESOLVED, that our AMA continue to advocate for truth in advertising, transparency in professional identification, and clear communication to patients regarding differences in education, training, and licensure between physicians and nonphysician practitioners. (Directive to Take Action)</p>	<p>Delegate instructed to seek referral – ask for a less confrontational or offensive term than “unsupervised” if used as an official definition.</p>
6	B	<p>Res. 203 – Support for Independent Evaluation of Outcomes Associated with Unsupervised Nurse Practitioner Practice (Florida)</p>	<p>RESOLVED, that our American Medical Association advocate for and support funding of independent, academically rigorous studies comparing patient outcomes between unsupervised nurse practitioner care and physician-led team-based care, including measures of patient safety, quality, utilization, access, and health outcomes, with a goal of publication in peer-reviewed literature. (Directive to Take Action)</p>	<p>Delegate instructed to support.</p>
7	B	<p>Res. 206 – Overall Hospital Quality Star Ratings/CMS Star Ratings (American Association of Clinical Urologists)</p>	<p>RESOLVED, that our American Medical Association advocate to CMS that the Overall Hospital Quality Star Ratings (CMS Star Ratings) include a 6th measured group defined as Physician Experience which would include those physicians who have membership on the hospital medical staff. (Directive to Take Action)</p>	<p>Delegate instructed to extract if included in reaffirmation and strongly support.</p>

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Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
8	B	<p>Res. 211 – Preventing Hospital-Based 340B Programs from Unfairly Competing with Independent Physicians</p> <p>(Mississippi)</p>	<p>RESOLVED, that our American Medical Association advocate for the patients of any physician practicing in the same county (or equivalent region) that contains a covered 340B entity to receive reduced cost medications under the 340b program through the covered entity’s contracted pharmacy. (Directive to Take Action)</p>	<p>Delegate instructed to support intent of resolution with a change in title to better reflect the resolve clause.</p>
9	B	<p>Res. 216 – Protecting Healthcare as a Sensitive Location</p> <p>(New York)</p>	<p>RESOLVED, that our American Medical Association reaffirm its policies Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare (D-160.921), Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients (H-440.876), Mass Deportation as a Public Health Issue (H-440.793), and Patient and Physician Rights Regarding Immigration Status (H-315.966) (Reaffirm HOD Policy);</p> <p>RESOLVED that our AMA collaborate with state societies where immigration enforcement in health care facility guidance has been developed, and with the AMA Advocacy Resource Center, to develop model legislation and regulation for states to adopt to better protect patients and health care workers from inappropriate intrusion of federal immigration agents in health care facilities (Directive to Take Action);</p> <p>RESOLVED, that our AMA collaborate with relevant stakeholders, including accrediting bodies, to develop health care facility standards related to immigration enforcement. (Directive to Take Action)</p>	<p>Delegate instructed to support.</p>
10	B	<p>Res. 220 – Reverse CMS Cuts to Facility-Based Practice Expense Payments for Physicians</p> <p>(Ohio)</p>	<p>RESOLVED, that our American Medical Association write and promote federal legislation to reverse CY 2026 Physician Fee Schedule (CME-1832-F) reductions to facility-based practice expenses payments for physicians – retroactive to 01/01/2026 – and codify future payment updates by linking these payments to the Medicare Economic Index (MEI). (Directive to Take Action)</p>	<p>Delegate instructed to listen.</p>
11	B	<p>Res. 224 – Clarity of Signage: Distinguishing</p>	<p>RESOLVED, that our American Medical Association advocate for federal regulatory or legislative action that would require clear and standardized</p>	<p>Delegate instructed to support.</p>

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		Urgent Cares from Emergency Rooms (Indiana)	signage for urgent care centers to distinguish them from hospital emergency departments. (Directive to Take Action)	
12	B	Res. 230 – Exemption of International Medical Graduates from Presidential Proclamations Restricting Entry into the United States (International Medical Graduates Section)	RESOLVED, that our American Medical Association advocate for policies that ensure appropriate consideration and avoidance of undue delays in visa processing, issuance, and entry into the United States for fully vetted international medical graduates entering to participate in accredited graduate medical education or provide patient care, while maintaining necessary security and vetting procedures (Directive to Take Action); and be it further RESOLVED, that our AMA monitor and report on the impact of such policies on International Medical Graduate participation, physician workforce supply, patient access to care; and develop recommendations for ongoing advocacy. (Directive to Take Action)	Delegate instructed to support.
13	B	Res. 238 – Prohibiting the Independent Practice of Medicine by Artificial Intelligence (Texas)	RESOLVED, that our American Medical Association advocate for legislation and regulation prohibiting the use of artificial intelligence (AI) as an independent diagnostic or prescriptive tool or as a care management substitute for a physician. (Directive to Take Action)	Delegate instructed to strongly support – would like to see provision included in any AMA guidance on medical staff bylaws.
14	B	Res. 241 – Strengthening Our AMA Efforts Toward CPOM Prohibition (American Academy of Emergency Medicine)	RESOLVED, that our American Medical Association amend AMA Policy H-160.891 by deletion and addition in section 1 as follows: “1. Our American Medical Association encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under ‘friendly’ physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines: <u>supports policies that preserve physician ownership, governance, and independent medical judgment in physician practices and opposes corporate ownership or contractual arrangements that permit non-licensed entities to exercise control over the practice of medicine.</u> ” (Modify Current HOD Policy); and be it further	Delegate instructed to support intent, but seek referral given the volume of edits proposed to existing policy – ask that the Board take a close look at specific language.

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			<p>RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in the introductory clause preceding subsections (a)–(c) as follows: “Physicians who are contemplating corporate investor partnerships or corporate entity relationships <u>Physicians and policymakers evaluating corporate investment in physician practices</u> should consider the following principles to ensure that any such relationships <u>remain subordinate to physician ownership, governance, and professional medical judgment</u>” (Modify Current HOD Policy); and be it further</p> <p>RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in subsection (d) as follows: “(d) Physicians should ensure that contractual arrangements preserve physician autonomy in clinical decision making. <u>Physician practices delivering medical care should be majority owned by licensed physicians who are actively practicing in the entity, and those licensed physicians must retain final authority over clinical decision making and over operational and administrative decisions that affect patient care, including clinical staffing, scope of services, clinical policies and standards, compensation structures tied to clinical services, coding and billing policies, payer contracting, and practice governance.</u>” (Modify Current HOD Policy); and be it further</p> <p>RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in subsection (e) as follows: “(e) Physicians should carefully review contractual provisions governing governance structures, compensation arrangements, and management responsibilities when entering relationships with corporate investors. Our AMA opposes stock transfer restriction agreements, “friendly PC” arrangements, succession rights, compelled sale provisions, management agreements, or other contractual mechanisms that permit non-licensed entities to exercise direct or de facto control over physician practices or over physicians’ professional medical judgment. Physicians should review contractual provisions governing governance structures, compensation arrangements, and management responsibilities to ensure that such arrangements do not transfer</p>	

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			<p><u>control of clinical decision making, physician employment conditions affecting patient care, or other core professional functions to non-licensed entities.</u>" (Modify Current HOD Policy); and be it further</p>	
15	B	<p>Res. 242 – Reducing Emergency Department Boarding through Payment Reform (American Academy of Emergency Medicine)</p>	<p>RESOLVED, that our American Medical Association advocates for the Centers for Medicare & Medicaid Services (CMS) and other payors to tie admitted patients' hospital reimbursement to emergency department boarding performance, including payment reductions or creation of a lower-reimbursed status when boarding of admitted patients exceeds four hours (Directive to Take Action); and be it further</p> <p>RESOLVED, that our AMA adopts policy and advocates for making emergency department boarding metrics mandatory quality measures incorporated into value-based payment programs, rather than reporting-only requirements without financial consequence. (Directive to Take Action)</p>	Delegate instructed to listen.
16	B	<p>Res. 246 – Artificial Intelligence Scope of Practice (Private Practice Physicians Section)</p>	<p>RESOLVED, that our American Medical Association will develop model legislation declaring that artificial intelligence will not be used as a prescriptive or care management substitute for a physician (Directive to Take Action); and be it further</p> <p>RESOLVED, that our AMA will develop model legislation prohibiting the Federation of State Medical Boards from enabling independent licensure be granted to artificial intelligence "providers." (Directive to Take Action)</p>	Delegate instructed to strongly support.
17	B	<p>Res. 247 – Comprehensive ERISA Reform (Texas)</p>	<p>RESOLVED, that our American Medical Association support federal regulation and/or legislation under ERISA to establish rules for prompt payment, refund and recoupment timelines, prepayment claims audits, penalties, and related matters, and that such be modeled after the Texas Prompt Pay laws and rules, requiring a report back at the following annual meeting. (New HOD Policy)</p>	Delegate instructed to listen.
18	C	<p>Res. 303 – Allowing Options for Certification Maintenance (Mississippi)</p>	<p>RESOLVED, that our American Medical Association encourage all hospitals and insurance programs in the United States to end the monopoly of MOC and accept NBPAS to accomplish any MOC requirements (New HOD Policy); and be it further</p>	Delegate instructed to listen.

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			RESOLVED, that our AMA request that the Accreditation Council for Graduate Medical Education (ACGME), the Liaison Committee on Medical Education (LCME), and the Commission on Osteopathic College Accreditation (COCA) accept this alternative route for MOC for all teachers of medical students and physicians in order to maintain quality and experienced instruction in residency programs and medical schools in this era of physician shortages. (Directive to Take Action)	
19	D	BOT 29 – Educational Materials Regarding Ultra-Processed Foods	<p>The Board of Trustees recommends:</p> <p>(1) That the second resolve of Resolution 601-A-25 not be adopted; and</p> <p>(2) That Policy H-150.914, “Addressing the Health Impacts of Ultraprocessed Foods” be amended by addition and deletion to read as follows:</p> <p>1. Our AMA supports and promotes public awareness and education, <u>among both the public and clinicians</u>, about the differences between healthy and unhealthy <u>ultraprocessed foods (UPF) and the benefits of minimally processed and unprocessed foods.</u></p> <p><u>2. Our AMA supports the development of multi-lingual patient educational materials with regard to the health impact of UPFs and will help disseminate available materials through relevant AMA platforms.</u></p> <p>2-3. Our AMA supports federal, state, and local policies that promote and incentivize the production and distribution of healthier, affordable, minimally-processed and unprocessed foods.</p> <p>3. <u>4.</u> Our AMA encourages the integration of nutrition education into all levels of medical education to empower clinicians to best counsel patients efficiently and effectively on reducing unhealthy UPF consumption.</p> <p>4. <u>5.</u> Our AMA supports increased funding to the FDA for research into the health impacts of ultraprocessed foods and strategies to mitigate their risks.</p>	Delegate instructed to listen.
20	D	Res. 401 – Partnership with the Administration to Reduce Harmful Chemicals in Food and Align with European Safety Standards	RESOLVED, that our American Medical Association advocates for the establishment of a joint task force comprising AMA representatives, FDA officials, USDA personnel, and relevant administration appointees to:	Delegate instructed to strongly support.

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		(Organized Medical Staff Section)	<p>substances</p> <p>3. Develop a prioritized timeline for regulatory action on the most concerning additives</p> <p>4. Create transition pathways for food manufacturers to adopt safer alternatives (Directive to Take Action); and be it further</p> <p>RESOLVED, that our AMA will monitor the implementation of any resulting food additive regulation policies and provide ongoing medical and scientific guidance to ensure reforms achieve meaningful public health improvements. (Directive to Take Action)</p>	
21	D	<p>Res. 404 – Develop Climate-Conscious Resources for Physicians</p> <p>(New Jersey)</p>	<p>RESOLVED, that our American Medical Association support compiling and maintaining a resource for U.S. physicians, focused on education physicians and other healthcare professionals about the health impacts of climate change and the role of the healthcare sector in contributing to greenhouse gas emissions (New HOD Policy); and be it further</p> <p>RESOLVED, that our AMA support providing practical, evidence-based recommendations for reducing the environmental footprint of clinical practices and healthcare systems (New HOD Policy); and be it further</p> <p>RESOLVED, that our AMA support offering resources and tools to support physicians in advocating for environmentally sustainable policies and practices within their organization and communities (New HOD Policy); and be it further</p> <p>RESOLVED, that our AMA facilitates collaboration and sharing of best practices among healthcare professionals and institutions committed to addressing climate change and promoting sustainability. (Directive to Take Action)</p>	Delegate instructed to support.
22	D	<p>Res. 425 – Prioritizing, Measuring, and Preventing Workplace Violence in Health Care</p>	<p>RESOLVED, that our American Medical Association recognize workplace violence in health care as a national advocacy priority and expand existing AMA policy to support standardized reporting and data-driven prevention strategies (New HOD Policy); and be it further</p> <p>RESOLVED, that our AMA advocate for the development and implementation</p>	Delegate instructed to support.

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		(American College of Emergency Physicians)	<p>of standardized, mandatory reporting mechanisms for workplace violence incidents across all health care settings, with appropriate protections for patient and worker privacy (Directive to Take Action); and be it further</p> <p>RESOLVED, that our AMA advocate for policies that remove barriers to reporting workplace violence, including protections against retaliation, reduction of disincentives related to institutional liability or reputational concerns, and the establishment of a culture in which all acts of violence against health care workers are recognized as unacceptable and reportable regardless of patient condition (Directive to Take Action); and be it further</p> <p>RESOLVED, that our AMA support the aggregation and analysis of workplace violence data to inform research, benchmarking, and the development of national policies aimed at reducing violence in health care settings (New HOD Policy); and be it further</p> <p>RESOLVED, that our AMA advocate for the development, funding, and implementation of evidence-based, trauma-informed strategies to prevent workplace violence and protect the health care workforce (Directive to Take Action); and be it further</p> <p>RESOLVED, that our AMA rescind existing policies H-515.957 (Preventing Violent Acts Against Health Care Providers), D-515.983 (Preventing Violent Acts Against Health Care Providers), and H-515.966 (Violence and Abuse Prevention in the Health Care Workplace). (Rescind HOD Policy)</p>	
23	F	Res. 611 – Publicizing, Supporting, and Promoting (Appropriate) AMA Member Physicians and Physician Spouses as Candidates for Local and State Offices	RESOLVED, that our American Medical Association, to the extent permitted by applicable laws, collaborate with other interested organizations to facilitate opportunities for AMA physician-member and physician-spouse elected officials at the local and state levels to connect, exchange ideas, collaborate, and support each other to protect our patients and our practices, such as with a “National Meeting of Physician State Legislators” (Directive to Take Action); and be it further	Delegate instructed to strongly support.

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		(Organized Medical Staff Section)	<p>RESOLVED, that our AMA study the:</p> <ol style="list-style-type: none"> 1. Feasibility of collaborating with state medical societies and specialty societies to assess appropriate AMA physician members and physician spouses running for state and local offices and creating a “master list” to publicize, support, and promote those individuals, and 2. Opportunities to publicize this list widely to support appropriate physicians and physician spouses who are aligned with our priorities and encourage financial and social medial support of those candidates, with a report back at the 2027 Annual Meeting. <p>(Directive to Take Action).</p>	
24	G	BOT 22 – Comprehensive AMA Policy Publication Regarding Employed Physicians	The Board of Trustees recommends that the first directive of Policy D-225.971, Comprehensive AMA Policy Publication Regarding Employed Physicians, be rescinded as having been accomplished by this report and that the remainder of the report be filed.	Delegate instructed to applaud the intent of the report, but seek referral back with an ask for a report that more closely meets the initial request.
25	G	CMS 06 – Study of Practice Models for Physicians Performing Procedures Across State Lines	<p>The Council on Medical Service recommends that the following be adopted in lieu of Resolution 711-A-25 and the remainder of the report be filed.</p> <ol style="list-style-type: none"> 1. That our American Medical Association (AMA) supports the following principles for physicians employed by ambulatory surgical centers (ASC) or office-based laboratories (OBL) who may travel from their primary practice location to provide patient care: <ol style="list-style-type: none"> a. A transfer agreement with a physician or physician group licensed in the patient’s state should be arranged to address in-person care needs that may arise from a patient receiving care from a physician who primarily practices out of state or out of the immediate area or from a physician with no admitting privileges to the local hospital. b. A referral system with a local physician, physician practice, or other facility for appropriate treatment should be established if a patient’s conditions or symptoms are beyond the scope of services provided by the ASC or OBL. c. Transfer agreements and backup plans should be coordinated between 	Delegate instructed to listen.

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			<p>physicians.</p> <p>i. In the event an institution coordinates these arrangements (i.e., a hospital system, an ASC, or an OBL), a physician that would be among those receiving the patient must give explicit consent to the agreement to provide follow-up care.</p> <p>ii. When patient transfer is required, a direct hand off of the patient and patient records should be completed.</p> <p>iii. Transfer and referral agreements should be evidence-based and risk-based to balance access to care and patient safety.</p> <p>d. Protocols for ensuring continuity of care with physicians in the local community should be established.</p> <p>e. Consent from the patient regarding preoperative assessment and postoperative care should be obtained prior to the provision of any procedure, with clarity on which physician will be providing care during each step of the process.</p> <p>f. Physicians entering into these arrangements should ensure that they are in keeping with ethical standards and legal requirements. (New HOD Policy)</p> <p>2. That our AMA reaffirm Policy H-475.984, which lists Core Principles for Office-Based Surgery Regulations, with a focus on Core Principle #4 which states that physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospitals or a transfer agreement with another physician who has admitting privileges at a nearby hospital, or to maintain an emergency transfer agreement with a nearby hospital. (Reaffirm HOD Policy)</p>	
26	G	CMS 09 – Nonprofit Status	<p>The Council on Medical Service recommends that the following be adopted in lieu of Resolution 221-I-25 and the remainder of the report be filed.</p> <p>1. That our American Medical Association amend Policy H-155.954 by addition and deletion to read as follows:</p> <p>NONPROFIT HOSPITAL CHARITY CARE POLICIES, H-155.954</p>	Delegate instructed to support.

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			<p>1. Our American Medical Association (AMA) advocates that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing.</p> <p>2. Our AMA advocates to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful.</p> <p>3. Our AMA advocates for the development of minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible.</p> <p>4. Our AMA advocates for a standardized definition of what is considered a “community benefit” when evaluating community health improvement activities <u>and eligibility for nonprofit status.</u></p> <p>5. Our AMA advocates for the development of a transparent, publicly available, standardized data sets <u>and/or reports on nonprofit hospital community benefit spending,</u> including consideration of charity care-to-expense ratios.</p> <p>6. Our AMA advocates for <u>transparency and consistency regarding the expansion of governmental oversight of nonprofit hospitals,</u> and enforcement of federal and/or state guidelines, and standards for community benefit requirements <u>and reporting,</u> including the ability to enact penalties and/or loss of tax-exempt status.</p> <p>7. <u>Our AMA encourages nonprofit hospitals to publicly share the results from assessments, such as the Community Health Needs Assessment (CHNA), including progress that has been made since the previous assessment, as well as areas where there is room for improvement.</u> (Modify Current HOD Policy)</p>	
27	G	<p>Res. 702 – Physicians Who Do Not Practice in Hospital Setting (Pennsylvania)</p>	<p>RESOLVED, that our American Medical Association amend D-230-981 as follows:</p> <p>1. Our American Medical Association advocates for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment or care of a patient at that hospital.</p>	Delegate instructed to support.

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Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendation
			<p>2. Our AMA will collaborate with specialty societies and state medical societies oppose unfair and/or coercive business practices which undermine patient access and/or physician practices.</p> <p>3. <u>Our AMA advocate that hospital privileges not be a requirement for insurance network participation.</u> (Modify Current HOD Policy)</p>	
28	G	<p>Res. 707 – Malpractice Insurance for Employed Physicians (New York)</p>	<p>RESOLVED, that our American Medical Association support a requirement for employers to purchase only occurrence malpractice insurance policies for their employed physicians, fellows and residents. (New HOD Policy)</p>	<p>Delegate instructed to strongly support.</p>
29	G	<p>Res. 712 – Addressing the Commoditization of Medicine Through Recognition of the Full Scope of Physician Work and Contributions (American Academy of Dermatology)</p>	<p>RESOLVED, that our American Medical Association advocate that health systems, hospitals, other physician employers, and third-party payors recognize that the profession of medicine is not a commoditized entity, is fundamentally anchored in the patient-physician relationship, and should not be reduced solely to productivity measures (Directive to Take Action); and be it further</p> <p>RESOLVED that our AMA encourage employers of physicians to utilize productivity benchmarks, performance expectations, and compensation structures that recognize and integrate the full scope of physician work, including clinical, administrative, educational, and operational responsibilities that may not be fully captured by traditional productivity metrics (New HOD Policy); and be it further</p> <p>RESOLVED, that our AMA advocate for regulatory, employer, and practice models that provide both employed and independent physicians with appropriate time, resources, compensation, support, and recognition for non-billable work that is essential to patient care, physician well-being, and health system function. (Directive to Take Action)</p>	<p>Delegate instructed to listen.</p>
30	G	<p>Res. 714 – Physician Case Log Portability</p>	<p>RESOLVED, that our American Medical Association advocates for federal and state policies requiring physician employers, regardless of type of employment, to provide physicians, free of charge, with complete and accurate copies of their</p>	<p>Delegate instructed to listen.</p>

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		(American Academy of Emergency Medicine)	<p>case logs in a deidentified, electronically transferrable, nonproprietary format when requested to do so (Directive to Take Action); and be it further</p> <p>RESOLVED, that such polices establish a mandatory and enforceable timeline for production of case logs, not to exceed five (5) business days (Directive to Take Action); and be it further</p> <p>RESOLVED, that procedures are in place for the immediate transfer of case logs to all physicians upon dissolution of the physician employer for any reason. (Directive to Take Action)</p>	
31	G	<p>Res. 716 – Equal Opportunity for Payment for “On Call” Duty</p> <p>(Private Practice Physicians Section)</p>	RESOLVED, that our American Medical Association will work with relevant stakeholders to advocate that all physicians, whether employed or independent, should be paid for “on call” responsibilities, whether or not patient care is separately billed. (Directive to Take Action)	Delegate instructed to support.

END