MEMORIAL RESOLUTIONS
ADOPTED UNANIMOUSLY

Haddon Christopher Alexander, MD
Introduced by: Virginia

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

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

Whereas, he honorably served his country as a Captain in the United States Air Force during the Vietnam War era, exemplifying dedication to both his nation and his profession; and
Whereas, Dr. Alexander was an astute clinician, practicing rheumatology in Roanoke, Virginia, for over 30 years until January 2000 and continuing to receive calls from grateful patients long after retirement; and

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

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

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

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

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

Whereas, he was preceded in death by his wife, Mary Alexander, and his parents, Haddon C. Alexander, Jr., M.D., and Judith Watson Alexander. He is survived by his children, Susan Campbell Alexander of Bern, Switzerland, H. Christopher Alexander IV of Egg Harbor, WI, and Margaret Alexander Johnson of Richmond; and his grandchildren, Sophie Lynn Johnson, Mary Lucille Johnson and Evelyn Lee Alexander; therefore be it

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

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

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David E.J. Bazzo, MD
Introduced by: California

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

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

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

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

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

Whereas, Dr. Bazzo shared his talents and gifts by serving in many leadership roles for the San Diego County Medical Society, including as President and Chair of the SDCMS Physician Wellness Committee; and
Whereas, Dr. Bazzo was always an example of what a physician should be, and epitomized extraordinary professional competence, dedication, hard work, and community involvement; and

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

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

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

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

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

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Russell Dougherty Evett, MD
Introduced by: Virginia

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

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

Whereas, he honorably served his country as a General Medical Officer in the United States Navy aboard the USS Boxer, demonstrating a lifelong commitment to service; and
Whereas, Dr. Evett completed his residency in internal medicine at the Mayo Clinic and went on to become a founding member of Consultants in Internal Medicine, dedicating more than three decades to the practice of medicine in Norfolk, Virginia, where he viewed caring for patients as both a privilege and a sacred responsibility; and

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

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

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

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

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

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

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

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Virginia "Ginny" Ettinger Hall, MD
Introduced by: Pennsylvania, Senior Physician Section

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Edwin James Harvie, MD
Introduced by: Virginia

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

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

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

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

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

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

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

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

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

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

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

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Leonard J. Morse, MD
Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

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

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

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

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

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

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

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

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

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

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

Robert W. Panton, MD
Introduced by: Illinois

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

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

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

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

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

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

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

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

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

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

Thomas E. Sullivan, MD
Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

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

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

Whereas, Dr. Sullivan was a visionary leader in healthcare information technology, serving over 20 years at Dr First — including as Chief Strategy Officer and Chief Privacy Officer from 2004 to 2022, and later as Senior Advisor for Clinical Innovation & Vendor Strategy — helping shape national standards for interoperability and clinical summaries; and Whereas, he served as President of the Massachusetts Medical Society (MMS) from 2003 to 2004, during which time the MMS became one of the first state medical societies to endorse e-prescribing, demonstrating his early leadership in advancing clinical technology for patient safety; and

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

Whereas, Dr. Sullivan's national engagement in organized medicine included service to the American Medical Association, including roles as a founding chair of the AMA e-Medicine Advisory Committee, past Chair of the AMA Council on Medical Service; and Whereas, Dr. Sullivan served admirably as Alternate Delegate for the Senior Physician Section during Covid, applying his wisdom and experience gained from leading the MMS, AMA CMS, and MMS Committee on Senior Physicians to advance the goals of the AMA SPS, resulting in passage of many resolutions of importance to seniors and to the profession; and

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

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

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

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

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

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

Kenneth Douglas Tuck, MD
Introduced by: Virginia

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

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

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

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

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

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

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

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

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

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

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

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

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RESOLUTIONS

Note: Testimony on each item is summarized in the reference committee reports.

Alternate resolutions are considered to have been introduced by the reference committee.

REFERENCE COMMITTEE ON ETHICS & BYLAWS

1. ETHICAL GUIDANCE ON POSTMORTEM SAMPLE COLLECTION FOR GENETIC TESTING
Introduced by American College of Medical Genetics and Genomics, Medical Student Section

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: **ADOPTED**
See Policy D-140.943

RESOLVED, that our American Medical Association study the ethical responsibility of physicians in the collection and storage of postmortem biological samples for genetic testing and research when clinically indicated and aligned with existing specialty guidelines.

2. PHYSICIAN WORKLOAD AND SCHEDULING
Introduced by Florida, American Academy of Emergency Medicine

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policies D-450.946 and H-450.917

RESOLVED, that our American Medical Association affirm that physicians have the professional right and authority, notwithstanding extraordinary situations such as mass casualty incidents and disasters, to decline, modify, or limit administratively determined patient volume expectations, scheduling mandates, and staffing conditions when the physician, utilizing clinical judgment, believes these conditions would harm patients or negatively impact patient-centered care.

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.

3. ARTIFICIAL INTELLIGENCE TO BOLSTER PHYSICIAN-LED TEAM-BASED CARE
Introduced by American Academy of Ophthalmology

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: **ADOPTED**
See Policy H-478.971

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;

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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;

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.

4. ETHICAL REPRODUCTIVE CARE FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies H-90.959 and H-90.968

RESOLVED, that our American Medical Association affirm that individuals with intellectual and developmental disabilities (IDD) have the right to meaningful participation in all reproductive healthcare decisions to the maximum extent of their abilities.

RESOLVED, that our AMA amend H-90.968 "Medical Care of Persons with Disabilities" by addition to read as follows:

1. Our American Medical Association encourages:
    a. clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses.
    b. medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with disabilities.
    c. medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care.
    d. education of physicians on how to provide and/or advocate for developmentally appropriate and accessible medical, social and living support for patients with disabilities so as to improve health outcomes.
    e. medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound disabilities and multiple co-morbid medical conditions in any setting.
    f. medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the disabled.
    g. cooperation among physicians, health & human services professionals, and a wide variety of adults with disabilities to implement priorities and quality improvements for the care of persons with disabilities.
2. Our AMA seeks:
    a. legislation to increase the funds available for training physicians in the care of individuals with disabilities, and to increase the reimbursement for the health care of these individuals.
    b. insurance industry and government reimbursement that reflects the true cost of health care of individuals with disabilities.
3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be guided by the following principles:
    a. All people with disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives.

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   b. An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound disabilities, that there are resources available to them.

4. Our AMA will collaborate with appropriate stakeholders to create a model general curriculum/objective that
   a. incorporates critical disability studies.
   b. includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction.
5. Our AMA recognizes the importance of managing the health of children and adults with developmental and intellectual disabilities as a part of overall patient care for the entire community.
6. Our AMA supports efforts to educate physicians on health management of children and adults with intellectual and developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with intellectual and developmental disabilities.
7. Our AMA encourages the Liaison Committee on Medical Education, Commission of Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a curriculum on the care and treatment of people with a range of disabilities.
8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of disabilities.
9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing programs that focus on the care and treatment of people with a range of disabilities.
10. Our AMA will advocate that the Health Resources and Services Administration include persons with disabilities as a medically underserved population.
11. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages:
    a. Medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental and intellectual disabilities, to improve quality in clinical education.
    b. Medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for individuals with developmental and intellectual disabilities.
    c. Cooperation among physicians, health and human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities.
    d. Clinicians to obtain direct, task-specific informed consent from individuals with intellectual and developmental disabilities, including discussing genetic diagnoses, whenever they demonstrate capacity for the decision at hand and, when legally required, the consent of a guardian or other authorized decision-maker.

RESOLVED, that our AMA support clinician education on disability-competent reproductive care, including accessible communication strategies, historical context, and best practices for ethical contraceptive counseling for individuals with intellectual and developmental disabilities.

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5. IMPERSONATION OF A PHYSICIAN
Introduced by Indiana

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-270.948

RESOLVED, that our American Medical Association recognizes physician impersonation as a significant threat to public health and patient safety.

RESOLVED, that our AMA support the creation and enforcement of state laws prohibiting physician impersonation.

RESOLVED, that our AMA encourage the development of clear public reporting mechanisms and collaboration among medical boards, law enforcement, and legislative bodies to ensure accurate identification and record of physician impersonation and effective, enforceable consequences.

RESOLVED, that our AMA promote improved coordination among regulatory bodies to prevent and address impersonation of licensed physicians.

6. INVESTIGATING MORAL INJURY RELATED TO ORGAN PROCUREMENT PRACTICES
Introduced by Indiana

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association study the national scope and causes of physician moral injury related to organ procurement, and to develop ethical guidelines and best practices that prioritize patient dignity and physician integrity in organ procurement practices.

7. SUPPORTING PRIVACY IN THE USE OF ARTIFICIAL INTELLIGENCE BASED SCRIBE SOFTWARE
Introduced by Indiana

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-478.955

RESOLVED, that our American Medical Association pursue federal regulation of artificial intelligence (AI) scribe technologies that protects clinician and patient privacy.

8. SENIOR PHYSICIANS IMPROVING PATIENT ACCESS
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: ADOPTED
See Policy D-405.963

RESOLVED, that our American Medical Association look for innovative approaches to help alleviate the workload of actively practicing physicians while at the same time providing late-career physicians with opportunities for fulfilling part-time work.

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RESOLVED, that our American Medical Association study programs [such as WIN CUBED[1]] that enable timely follow-up after hospital discharge or ambulatory services by providing meaningful part-time work opportunities to late-career physicians (both semi-retired and retired).

9. PRESERVING ACCESS TO CARE FOR UNDOCUMENTED INDIVIDUALS
Introduced by Resident and Fellow Section and Underrepresented in Medicine Advocacy Section

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: **ADOPTED**
See Policy H-290.948

RESOLVED, that our American Medical Association study the impacts of the One Big Beautiful Bill on Medicaid-expansion and health safety net programs and insurance coverage for undocumented people with recommendations to improve healthcare coverage for undocumented individuals with a report back.

10. FATIGUE MITIGATION: SUPPORTING FULLY-FUNDED TRANSPORTATION FOR TRAINEE PHYSICIANS AFTER EXTENDED OR OVERNIGHT SHIFTS

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: **ALTERNATE RESOLUTION 010**
ADOPTED IN LIEU OF RESOLUTION 010
See Policy H-405.943

RESOLVED, that our American Medical Association supports sponsoring institutions providing access to financially-supported transportation assistance and other appropriate fatigue-mitigation resources for trainee physicians following extended duty periods when fatigue may impair safe travel, with consideration given to local resource availability, geographic constraints, and institutional capacity.

11. PHYSICIAN ABILITY TO RENDER EMERGENCY MEDICAL AID DURING IMMIGRATION ENFORCEMENT
Introduced by

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: **ADOPTED**
See Policy D-140.942

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

12. TAKING ACTION ON DEATHS IN CUSTODY
Introduced by

Reference committee hearing: see report of Reference Committee on Ethics & Bylaws.

HOD ACTION: **REFERRED**

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

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REFERENCE COMMITTEE A

101. PAYER COVERAGE OF NON-STIGMATIZING LANGUAGE IN ICD-10-CM
Introduced by Washington

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-70.939

RESOLVED, that our American Medical Association will advocate to the Centers for Medicare & Medicaid Services and other payers to utilize equivalent, ICD-10-CM codes that are patient-centered, neutral, and non-stigmatizing for payment, quality measures, and risk adjustment.

102. Study for EMTALA Relief in Psychiatric Facilities
Introduced by Pennsylvania

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association perform a study to determine whether it would be appropriate to seek EMTALA relief, exemption, or modifications for exclusively psychiatric hospital facilities.

103. SUPPORTING NON-INSURANCE DIRECTED SALES OF PHARMACEUTICALS TO PATIENTS
Introduced by Florida, Oklahoma, Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-110.954

RESOLVED, that our American Medical Association advocate for legislation and regulation to ensure that when a patient with health insurance purchases an FDA-approved prescription medication pursuant to a valid prescription through a lawful cash-pay, coupon-based, direct-to-consumer pharmacy, or direct manufacturer-to-patient sales platform, the patient's out-of-pocket payment for that medication shall be credited toward the patient's deductible and annual out-of-pocket maximum to the same extent as if the medication had been obtained through the patient's insurance-arranged pharmacy or distribution channel.

RESOLVED, that our AMA advocate that health insurers, pharmacy benefit managers, pharmacies, and affiliated distribution entities should ensure that when a patient is using their insurance benefits, they cannot be charged more than the lowest publicly available cash price for the same drug, strength, dosage form, and quantity available through a valid prescription, whether offered through the patient's insurance benefit, a coupon-based retail program, a direct-to-consumer pharmacy, or a direct manufacturer-to-patient sales channel.

RESOLVED, that our AMA advocate that patients and prescribing physicians receive transparent point-of-sale disclosure of the patient's expected out-of-pocket cost through the insurance benefit and any lower lawful cash or direct-purchase price available for the prescribed medication.

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104. IMPROVING CHOICE, COMPETITION, AND AFFORDABILITY IN THE ACA MARKETPLACES
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: **ADOPTED**
See Policy H-165.824

RESOLVED, that our American Medical Association support expanding choice and competition on ACA Marketplaces, including by allowing ACA premium tax credits to be applied to the entire premium for qualifying Marketplace health plans, including the portion of the premium attributable to benefits that are not considered Essential Health Benefits;

RESOLVED, that our AMA support improving the benchmark plan on the ACA Marketplaces from the second-lowest cost silver plan to at least the second-lowest cost gold plan.

105. OPPOSE MEDICARE ADVANTAGE AUTO ENROLLMENT
Introduced by

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: **ADOPTED**
See Policy H-285.905

RESOLVED, that our American Medical Association oppose efforts to force Medicare recipients to be auto enrolled into Medicare Advantage plans, thus making Medicare Advantage plans the default option.

106. INSURANCE COVERAGE FOR SCALP COOLING (COLD CAPPING) THERAPY

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: **ALTERNATE RESOLUTION 106**
ADOPTED IN LIEU OF RESOLUTIONS 106 AND 111
See Policy H-55.964

RESOLVED, that our American Medical Association encourage insurance coverage, and reduced cost-sharing, for scalp cooling therapy for patients undergoing chemotherapy regimens for which scalp cooling is supported by evidence-based clinical guidelines to prevent chemotherapy-induced alopecia.

RESOLVED, that our AMA work with interested national medical specialty societies to support the development of clinical guidance on appropriate patient selection criteria for scalp cooling therapy, promote broad and equitable access to scalp cooling therapy, advance public awareness and legislative advocacy supporting insurance coverage of scalp cooling, and encourage research into additional evidence-based interventions for chemotherapy-induced alopecia.

107. OVERSIGHT OF MEDICARE ADVANTAGE PLAN
Introduced by Indiana

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: **REFERRED**

RESOLVED, that our American Medical Association support equivalence in treatment and prior-authorization guidelines between Medicare Advantage plans and Traditional Medicare.

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RESOLVED, that our AMA support and seek legislation that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions.

RESOLVED, that our AMA support the revision of Medicare Advantage risk adjustment formulas to ensure that claims data is based on the actual cost of providing care.

RESOLVED, that our AMA lobby in support of Medicare Payment Advisory Commission recommendations to develop an improved risk adjustment model and change the current benchmark policy to one that bases federal payments to Medicare Advantage organizations and Medicare Advantage payments to physicians/healthcare centers on more accurate fee-for-service-derived benchmarks.

RESOLVED, that our AMA support the allocation of federal funds to study how financial savings generated through enactment of Medicare Payment Advisory Commission recommendations and AMA policies for reform of the Medicare Advantage program can be used to improve Traditional Medicare.

108. ENSURING PHYSICIAN INPUT IN THE DEVELOPMENT OF CMMI MODELS
Introduced by Integrated Physician Practice Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-385.938

RESOLVED, that our American Medical Association seek meaningful and transparent involvement of actively practicing physicians, nominated by relevant national specialty societies, in the development of Center for Medicare and Medicaid Innovation (CMMI) models throughout the model development process, prior to approval for testing or implementation.

109. INSURANCE COVERAGE FOR PEDIATRIC INTRACRANIAL NEUROMODULATION FOR DRUG-RESISTANT EPILEPSY
Introduced by American Association of Neurological Surgeons, Congress of Neurological Surgeons

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: **ADOPTED**
See Policy D-185.905

RESOLVED, that our American Medical Association advocate for insurance coverage of intracranial neuromodulation as an acceptable treatment for appropriate pediatric patients with drug-resistant epilepsy.

RESOLVED, that our AMA advocate for insurance coverage of chronic pain neuromodulation therapies such as intracranial, spinal cord and peripheral stimulation, as acceptable treatment for appropriate pediatric patients with chronic refractory pain.

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110. MEDICAID COVERAGE FOR INCARCERATED INDIVIDUALS
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-430.986

RESOLVED, that our American Medical Association advocate such that Medicaid programs ensure continued financial coverage for ongoing medications during incarceration.

111. ADVOCATING FOR INSURANCE COVERAGE OF SCALP COOLING THERAPY TO PREVENT CHEMOTHERAPY-INDUCED ALOPECIA

Resolution 111 was considered with Resolution 106. See Resolution 106.

RESOLVED, that our American Medical Association advocate for all payers to provide insurance coverage for scalp cooling systems for patients receiving chemotherapy who are at risk of chemotherapy-induced alopecia.

RESOLVED, that our AMA engage in continued national advocacy to promote broad and equitable access to scalp cooling therapy through public and private health insurance plans.

RESOLVED, that our AMA collaborate with relevant dermatology organizations (such as the American Academy of Dermatology), oncology organizations (such as the American Society of Clinical Oncology), and other appropriate medical societies and patient advocacy groups to advance public awareness and legislative action supporting insurance coverage for scalp cooling therapy.

112. ENSURING COVERAGE AND ACCESS TO ADULT STRABISMUS SURGERY
Introduced by Illinois

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED
See Policy D-185.904

RESOLVED, that our American Medical Association advocate for national insurer recognition of adult strabismus surgery as medically necessary, and to oppose insurer policies that misclassify such surgery as cosmetic.

113. HEALTH INSURANCE COVERAGE OF HEARING DEVICES AND RELATED SERVICES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association support public and private health insurance coverage of hearing services and devices, including digital hearing aids and routine replacements, for hearing-impaired adults aged 18-64.

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114. OPPOSING ALTERNATIVE FUNDING PROGRAMS
Introduced by Medical Student Section, Florida, Oklahoma, South Carolina, Tennessee

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-110.953

RESOLVED, that our American Medical Association oppose the use of Alternative Funding Programs (AFPs) and similarly functioning benefit designs including but not limited to those that condition patient access to covered medications on enrollment in third-party assistance programs or reclassify covered drugs as non-essential health benefits to avoid plan payment.

RESOLVED, that our AMA advocate for federal and state legislation or regulation prohibiting insurance benefit designs that condition patient access to a covered medication on enrollment in a third-party assistance program or that reclassify a covered prescription drug as a non-essential health benefit to avoid plan payment obligations.

115. PATIENT CONTINUITY PROTECTIONS DURING PAYER, PBM CHANGES
Introduced by Association for Clinical Oncology, American Society of Hematology, American College of Rheumatology

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-120.918

RESOLVED, that our American Medical Association seek federal and state legislation and regulation mandating a minimum 90-day transition-of-care grace period for patients with chronic or life-threatening conditions during which their existing treatment plan, including treatment location, physician/non-physician provider, prior authorizations, utilization management strategies, and formulary status, must be honored without interruption and that patients be notified of any changes in a clear and timely manner.

RESOLVED, that our AMA advocate that 90-day transition-of-care protections specifically apply to instances where a patient's health plan or pharmacy benefit manager undergoes structural changes, including but not limited to corporate mergers, acquisitions, or pharmacy benefit manager contract transitions, to prevent non-medical switching and ensure continuity of care.

116. STUDY OF COST IMPLICATIONS OF MEDICAID MANAGED CARE ORGANIZATIONS COMPARED WITH STATE-ADMINISTERED MEDICAID PROGRAMS
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-290.949

RESOLVED, That our American Medical Association study and report back to the HOD at A-27 on Medicaid managed care organizations and state-administered Medicaid programs, including:

- The comparative fiscal implications of programs administered through Medicaid managed care organizations versus those administered directly by states, including administrative costs, medical expenditures, and program oversight costs.
- Whether Medicaid managed care arrangements result in net cost savings, increased costs, or cost neutrality compared with state-administered models.
- The administrative impact of Medicaid managed care participation on physicians and health systems, including prior authorization requirements, network contracting, and claims administration.

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- Whether Medicaid managed care arrangements result in increased payments to physicians, including achievement of Medicare-to-Medicaid payment parity.
- Whether Medicaid managed care impacts patient access to care, including in rural areas.

117. UNIVERSAL OUT OF NETWORK BENEFITS
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: POLICIES D-165.989, D-285.958, D-285.963, H-165.838, H-180.952, H-285.904, H-285.907 and H-285.908 REAFFIRMED IN LIEU OF RESOLUTION 117

RESOLVED, that our American Medical Association will advocate for state and federal laws and regulations that require all insurers to offer plans that include out-of-network benefits.

118. ADDRESSING PROPOSALS TO IMPLEMENT INTERNATIONAL REFERENCE PRICING FOR PHYSICIAN-ADMINISTERED DRUGS
Introduced by American College of Rheumatology

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association remain committed to the position that international price indices or averages should not be used in isolation to set or determine prescription drug prices or payments.

RESOLVED, that our AMA work with state medical societies and specialty societies to educate policymakers on the risks of misaligned reimbursement under international reference pricing models and to promote approaches that reduce drug costs without jeopardizing patient access or practice sustainability.

RESOLVED, that our AMA amend policy H-110.980 by addition to read as follows:

1. Our American Medical Association will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
    a. The arbitration process should be overseen by objective, independent entities.
    b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel.
    c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process.
    d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question.
    e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision.
    f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer.
    g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases.
    h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision.
    i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.

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2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
    a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation.
    b. The use of any international drug price index or average should preserve patient access to necessary medications.
    c. The use of any international drug price index or average should limit burdens on physician practices by:
    1. Ensuring reimbursement at or above acquisition cost for physician-administered drugs.
    2. Protecting patient access to in-office treatments.
    3. Avoiding shifting care to higher-cost settings.
    4. Minimizing administrative and financial burdens on physician practices.
    d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.

3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.

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REFERENCE COMMITTEE B

201. PROHIBIT AND REGULATE 7-HYDROXYMITRAGYNINE (7-OH) KRATOM PRODUCTS TO PROTECT PUBLIC HEALTH AND YOUTH SAFETY

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ALTERNATE RESOLUTION 201 ADOPTED IN LIEU OF RESOLUTION 201 AND RESOLUTION 233
See Policy D-95.945 and H-95.903

RESOLVED, that our American Medical Association our AMA amend policy H-95.903 by addition, Regulate Kratom and Ban Over-The-Counter Sales, to read:

1. Our American Medical Association recommends the safety and efficacy of kratom, and its derivatives, should be determined through research and clinical trials and subsequently evaluated by the relevant regulatory entities for its appropriateness for sale and potential oversight via the Controlled Substances Act, before it can be marketed, purchased, or prescribed.
2. Our AMA recommends individuals who are currently using kratom, and its derivatives, for pain management or other conditions should have access to appropriate medical care to manage their conditions and withdrawal symptoms, if needed.
3. Our AMA recommends individuals who are using kratom, and its derivatives, only for personal use should not face criminal consequences.
4. Our AMA recommends kratom, and its derivatives, should be regulated by the FDA, and its safety and efficacy should be determined through clinical trials before it can be marketed or prescribed as treatment for any condition.

RESOLVED, that our American Medical Association pursue legislation banning synthesized, purified or derivative products from kratom for marketing, distribution, promotion and sale including but not limited to the unregulated mitragynine along with the 7-hydroxymitragynine and MGM-15 market.

RESOLVED, that our AMA urges the FDA and state legislatures to classify 7-OH kratom products as adulterated or misbranded when sold in child-appealing forms, prohibit their availability in physical retail stores and online platforms accessible to minors.

RESOLVED, that our AMA advocate for public education campaigns by physicians warning parents and youth of 7-OH kratom risks, including adverse cutaneous effects, and support research into pediatric exposures and optimal regulatory frameworks.

202. USING AND DEFINING "UNSUPERVISED PRACTICE OF MEDICINE"
Introduced by Florida, Texas, Oklahoma and South Carolina

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

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.

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.

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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.

203. SUPPORT FOR EVALUATION OF OUTCOMES ASSOCIATED WITH NON-PHYSICIAN PRACTITIONER PRACTICE
Introduced by Florida, Texas, Oklahoma and South Carolina

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy D-160.903

RESOLVED, that our American Medical Association fund independent, academically rigorous studies performing comparative effectiveness analyses of patient outcomes between autonomous non-physician practitioners and physician-led (MD/DO or foreign equivalent) care models, including measures of patient safety, quality, utilization, access, cost, and health outcomes, with a goal of publication in peer-reviewed scientific journals.

204. D-400.982 REVISION
Introduced by Florida, New York, Texas, Oklahoma

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-400.982

RESOLVED, that our American Medical Association reaffirm D-400.982:

1. Our American medical Association will increase media awareness around the 2024 AMA Annual Meeting about the need for Medicare payment reform eliminating budget neutrality reductions, and instituting annual cost of living increases.
2. Our AMA will step up it's public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
3. Our AMA will increase awareness to all physicians about the efforts of our AMA on Medicare payment reform.
4. Our AMA will advocate for abolition of all MIPS penalties in light of current inadequacies of Medicare payments.

RESOLVED, that our AMA will report back on a biannual basis to AMA members via open forum on Medicare Payment Reform initiatives and advocacy on Medicaid.

205. REPEAL OF THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)
Introduced by Florida, New York, Texas, Oklahoma

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **POLICIES D-390.949, D-395.999, D-400.982, H-385.905, H-390.838, and H-478.986 RAFFIRMED IN LIEU OF RESOLUTION 205**

RESOLVED, that our American Medical Association support full repeal of the Merit-Based Incentive Payment System (MIPS).

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RESOLVED, that our AMA advocates for immediate administrative relief in MIPS, including expanded low-volume and hardship exemptions for rural and small practices, shortened/streamlined reporting requirements, and reduction of reporting complexity until MIPS is repealed.

206. OVERALL HOSPITAL QUALITY STAR RATINGS / CMS STAR RATINGS
Introduced by American Association of Clinical Urologists

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

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.

207. ADDRESSING RURAL CARE DESERTS THROUGH THE CONRAD 30 WAIVER PROGRAM
Introduced by American College of Obstetricians and Gynecologists, The American Association of Gynecologic Laparoscopists

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policies D-255.966, D-255.980, D-255.985, and H-255.961

RESOLVED, that our American Medical Association update existing policy D-255.985 "Conrad 30-J1 Visa Waivers" to address current challenges and modernize the program by addition as follows:

- advocate for the redistribution (or recapture) of unused waivers.

RESOLVED, That policies D-255.980, D-255.966, and H-255.961 be reaffirmed.

208. INCORPORATING CRITICAL MEDICAL TREATMENT PLANNING INTO EMERGENCY/DISASTER PREPAREDNESS
Introduced by Virginia

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-130.924

RESOLVED, that our American Medical Association support the development of legislation and/or guidelines that incorporate critical medical treatment planning into emergency/disaster preparedness plans.

RESOLVED, that our AMA support interdisciplinary cooperative planning agreements to ensure continuity of critical medical treatments during emergencies.

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209. PROTECTING MENTAL HEALTH TREATMENT PRIVACY IN LEGAL PROCEEDINGS
Introduced by Virginia and Resident and Fellow Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association develop model state legislation ensuring that mental health treatment records are protected from discoverability in civil and criminal trials, thereby fostering a safe and supportive environment for healthcare professionals to seek necessary mental health care.

210. ELIMINATING PRESCRIPTION DRUG ADHERENCE (PDA) AS A QUALITY METRIC TIED TO PHYSICIAN RATINGS OR COMPENSATION
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICIES D-180.976 and D-450.958
REAFFIRMED IN LIEU OF RESOLUTION 210

RESOLVED, that our American Medical Association advocate against the use of patient Prescription Drug Adherence (PDA) as a quality metric tied in any manner to physician ratings or compensation.

211. PREVENTING HOSPITAL-BASED 340B PROGRAMS FROM UNFAIRLY COMPETING WITH INDEPENDENT PHYSICIANS
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

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.

212. PROTECTING PATIENT ACCESS TO CLINICAL TRIALS AND MITIGATING ADMINISTRATIVE DISRUPTIONS TO NIH FUNDING
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies D-460.960 and D-460.961

RESOLVED, that our American Medical Association amend Policy D-460.960 by addition and deletion to read as follows:

2. Our AMA advocates against reorganization, consolidation or re-prioritization of the NIH when such action:
   a. lacks transparency or is implemented without meaningful input from the biomedical research and physician communities;~~ and~~
   b. results in a reduction of funding that jeopardizes ongoing or long-term research through premature cancellation of grants, contracts, or programs essential to public health, biomedical innovation, or patient care<u>; or</u>
   c. <u>is driven by frameworks that bypass validated, merit-based scientific peer-review processes or violate ethical obligations to human subjects.</u>

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RESOLVED, that our AMA advocate against (1) any delay or inappropriate interference by the Office of Management and Budget (OMB), or any other entity within the Executive Branch, in the approval, apportionment, or distribution of funds appropriated to the NIH, and (2) any other administrative actions that restrict or impound biomedical research funding.

RESOLVED, that our AMA advocate against the mandatory "forward-funding" or "front-loading" of multi-year NIH grants, which is the practice of distributing the entire multi-year total value of a grant upfront out of a single fiscal year's limited appropriation rather than the historical practice of disbursing annual grant allowances from the appropriations of those individual years, to prevent drastic reductions to the total number of potential new grants and clinical trials that can be awarded.

RESOLVED, that our AMA reaffirm Policy D-460.961, which opposes arbitrary and unilateral caps on indirect costs in federal grants.

213. PROHIBITING PHARMACY BENEFIT MANAGERS FROM OWNING PHARMACIES
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED**
See Policy D-120.914

RESOLVED, that our American Medical Association develop model state legislation empowering state insurance regulating bodies to regulate pharmacy benefits managers (PBMs) and prevent PBMs from owning or operating pharmacies**.**

214. MEDICAL STUDENT LOANS SHOULD NOT BE CAPPED
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **POLICIES H-305.924 and H-305.925**
REAFFIRMED IN LIEU OF RESOLUTION 214

RESOLVED, that our American Medical Association oppose the caps on medical student debt as a result of the H. R. 1 - One Big Beautiful Bill Act.

215. OPPOSE MEDICARE EFFICIENCY ADJUSTMENTS
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **POLICIES D-400.982, H-390.849 and H-400. 972**
REAFFIRMED IN LIEU OF RESOLUTION 215

RESOLVED, that the American Medical Association support all efforts, whether by legislation or regulation, to restrict the use of arbitrary new factors such as the efficiency adjustment used in the 2026 Medicare Physician Payment Schedule.

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216. PROTECTING HEALTHCARE AS A SENSITIVE LOCATION
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies D-160.921, D-440.900, H-315.966, H-440.793, and H-440.876

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).

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 intrusion of federal immigration agents in health care facilities.

RESOLVED, that our AMA collaborate with relevant stakeholders, including accrediting bodies, to develop health care facility standards related to immigration enforcement.

217. ENSURING PROPORTIONAL ACCOUNTABILITY FOR HOSPITAL EXPENDITURES ATTRIBUTED TO MEDICARE ACOS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICY H-160.915
REAFFIRMED IN LIEU OF RESOLUTION 217

RESOLVED, that our American Medical Association advocate that the Centers for Medicare & Medicaid Services establish policies requiring hospitals that receive substantial expenditures attributable to ACO-assigned beneficiaries to enter defined participation and financial accountability agreements with the relevant ACO contracting entity.

RESOLVED, that our AMA advocate that, absent such defined participation and accountability agreements, hospital expenditures for ACO-assigned beneficiaries not be included in total cost of care reconciliation calculations under the Medicare Shared Savings Program or other advanced alternative payment models.

RESOLVED, that our AMA advocate for enhanced transparency of hospital facility spending attributable to ACO-assigned beneficiaries within benchmarking and reconciliation methodologies.

RESOLVED, that our AMA to study and report on policy mechanisms to ensure equitable financial accountability for hospital expenditures attributed to Medicare ACOs, including mechanisms addressing site-of-service payment differentials and facility fee impacts.

218. OPPOSING THE PRACTICE OF JURY ANCHORING IN MEDICAL LIABILITY CASES
Introduced by Kansas

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy H-435.939

RESOLVED, that our American Medical Association opposes the practice of jury anchoring in medical liability litigation, specifically as it related to non-economic damages.

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219. Incorporating Evidence-Based Lifestyle Medicine into Rural Health Transformation Programs
Introduced by American College of Lifestyle Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-165.817

RESOLVED, that our American Medical Association encourage State Medical Associations to work collaboratively with their State Departments of Health to incorporate the principles and practices of lifestyle medicine into their State's Rural Health Transformation Program initiatives.

RESOLVED, that our AMA encourage State Medical Associations to work collaboratively with their State Departments of Health to offer nutrition continuing medical education as part of the Rural Health Transformation Program.

220. REVERSE CMS CUTS TO FACILITY-BASED PRACTICE EXPENSE PAYMENTS FOR PHYSICIANS
Introduced by Ohio

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICIES D-330.891, D-400.982, D-405.965, H-385.916, H-390.849 and H-400.972 REAFFIRMED IN LIEU OF RESOLUTION 220

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).

221. UNIVERSAL NEWBORN CONGENITAL CYTOMEGALOVIRUS SCREENING
Introduced by American Academy of Otolaryngology – Head and Neck Surgery, American Academy of Pediatrics, Minnesota Medical Association

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association support state legislation and policies requiring universal newborn screening for congenital cytomegalovirus (cCMV);

RESOLVED, that our AMA support federal legislation and policies that expand newborn screening for congenital cytomegalovirus (cCMV) and increase funding for public awareness, prevention, and research related to congenital cytomegalovirus infection.

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222. ADVOCATING FOR A CENTRALIZED MEDICARE ENROLLMENT PLATFORM TO PRESERVE PATIENT CHOICE

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ALTERNATE RESOLUTION 220
ADOPTED IN LIEU OF RESOLTUION 220
See Policies D-330.930, H-285.902, H-315.983, H-330.860, H-330.862, H-330.878, and H-330.913

RESOLVED, that our American Medical Association advocate for the development and maintenance of a centralized, official Medicare enrollment platform overseen by the Centers for Medicare & Medicaid Services that provides clear, neutral, accurate, and easily understandable comparisons of coverage options under Traditional Medicare, Medicare Advantage, and supplemental coverage, including information on provider networks, prior authorization requirements, benefits, and out-of-pocket costs (Directive to Take Action); and be it further

RESOLVED, that existing AMA policies D-330.930, H-330.862, H-330.878, H-285.902, H-330.913, and H-315.983 be reaffirmed.

223. ENSURING DUE PROCESS, TRANSPARENCY, AND HUMAN CLINICAL OVERSIGHT IN THE USE OF ARTIFICIAL INTELLIGENCE FOR HEALTH INSURANCE COVERAGE AND ELIGIBILITY DETERMINATIONS
Introduced by Georgia

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association oppose the use of artificial intelligence, algorithms, or automated decision-making systems as the sole basis for any adverse health insurance determination, including denials, delays, or limitations of coverage and adverse eligibility, underwriting, or enrollment determinations affecting health insurance applicants or insured patients.

RESOLVED, that our AMA advocate that when artificial intelligence or automated decision-making systems are used in adverse health insurance determinations, any required human review must be conducted through the independent judgment of a licensed physician in accordance with existing AMA peer review policy, and must not be overridden, dictated, or unduly influenced by the output of such systems.

RESOLVED, that our AMA advocate for policies requiring that patients and physicians be provided a clear and accessible explanation when artificial intelligence or automated decision-making systems materially contributed to an adverse health insurance determination, including an explanation of the role of the system in the decision, in both coverage determinations and eligibility, underwriting, or enrollment decisions.

RESOLVED, that our AMA support and advocate for payer-specific regulatory standards governing the use of artificial intelligence and automated decision-making systems in adverse health insurance determinations, including requirements for auditable records of AI-assisted decisions, independent validation, regular testing for accuracy, bias, and clinical validity, and oversight by appropriate regulatory bodies.

RESOLVED, that our AMA advocate for the uniform application of safeguards governing artificial intelligence and automated decision-making systems across all payer types and markets, including commercial insurance, individual and small-group markets, employer-sponsored coverage, and government insurance, with particular attention to applicant-facing eligibility, underwriting, and enrollment decisions.

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224. CLARITY OF SIGNAGE: DISTINGUISHING URGENT CARES FROM EMERGENCY ROOMS
Introduced by Indiana

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICY H-160.888
REAFFIRMED IN LIEU OF RESOLUTION 224

RESOLVED, that our American Medical Association advocate for federal regulatory or legislative action that would require clear and standardized signage for urgent care centers to distinguish them from hospital emergency departments.

225. REQUIRING PERIODIC FACE-TO-FACE VISITS BY BOARD-CERTIFIED SPECIALISTS WHO DELEGATE VISITS TO NON-PHYSICIAN PRACTITIONERS FOR NURSING HOME PATIENTS
Introduced by Indiana

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association support federal legislation or regulation to require a minimal standard for specialist care for patients in nursing homes, such that, when a board-certified medical specialist delegates visits to nonphysician practitioners in a nursing home setting, the physician specialist must personally conduct a face-to-face evaluation of the patient either in person or via telehealth no less than every third visit.

226. EXEMPTION OF INTERNATIONAL MEDICAL GRADUATES FROM PRESIDENTIAL PROCLAMATIONS RESTRICTING ENTRY INTO THE UNITED STATES

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ALTERNATE RESOLUTION 226
ADOPTED IN LIEU OF RESOLUTION 226 AND RESOLUTION 230
See Policies D-255.965, D-255.966, D-255.967, D-255.980, D-255.991, H-255.961 and H-255.988

RESOLVED, that our AMA monitor and report on the impact of Presidential Proclamations restricting entry into the United States and how such policies affect International Medical Graduate participation, physician workforce supply, and patient access to care; and develop recommendations for ongoing advocacy.

RESOLVED, that existing AMA policies D-255.966, D-255.967, D-255.980, D-255.991, H-255.961, H-255.988 be reaffirmed.

227. STANDBY CAPACITY PAYMENTS AND HEALTH IT FOR HOSPITALS IN RURAL AREAS
Introduced by California, Hawaii, Idaho, Oregon, Washington, Wyoming and Resident and Fellow Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICIES D-290.970, D-305.967, D-465.998, D-478.994, D-478.996, H-290.951, H-350.937, H-465.972, H-478.980, AND H-480.937
REAFFIRMED IN LIEU OF RESOLUTION 227

RESOLVED, that our American Medical Association assist state medical associations, specialty societies and physician practices with the implementation of H.R. 1, to mitigate the negative impact of the Medicaid, ACA and student loan cuts to physicians and patients, particularly in rural areas.

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RESOLVED, that our AMA support the provision and payment of physician-to-physician virtual telehealth consultations as an option to increase access to primary and specialty care in rural communities, acknowledging that significant investments in rural telehealth broadband must be made in order to effectively deliver telehealth services.

RESOLVED, that our AMA encourage the development of programs and financial assistance models for rural physician practices in need of health information technology and other technological modernization and security, as well as access to specialty equipment to provide quality care.

RESOLVED, that our AMA urge the Centers for Medicare and Medicaid Services and others to provide funding for standby capacity payments to sustain obstetric services at hospitals at risk of closing access to maternity care.

228. DEPARTMENT OF DEFENSE HEALTH CARE INVESTMENT AT MILITARY BASES IN MATERNITY CARE HEALTH PROFESSIONAL SHORTAGE AREAS
Introduced by California, Hawaii, Oregon, Washington, Wyoming

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy H-420.942

RESOLVED, that our American Medical Association urge the Department of Defense to provide comprehensive reproductive health care coverage, funding and improved access to labor and delivery services for military personnel, military families, and non-military individuals working on military bases in maternity care health professional shortages areas.

RESOLVED, that our AMA continue to research and distribute successful state and specialty society models that have improved access to comprehensive reproductive care and maternal care in rural areas and reduced maternal mortality rates.

229. PHYSICIANS ARE NOT PROVIDERS
Introduced by Colorado, Arizona, Idaho, Utah, Washington, Wyoming

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-405.942

RESOLVED, that our American Medical Association take further advocacy actions to implement Policy H-405.968 which prioritizes the use of the term “physician” when discussing those with an MD or DO.

RESOLVED, that our AMA Oppose the use of the term “provider” when used to include physicians.

RESOLVED, that our AMA believes that the use of the term “provider” when used to include physicians negatively impacts patient education and awareness, transparency and the ethical responsibilities of physicians to patient safety and professionalism.

RESOLVED, that our AMA refer the issue of “Physicians are not Providers” for possible consideration by the American Medical Association’s Council on Ethical and Judicial Affairs (CEJA).

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230. EXEMPTION OF INTERNATIONAL MEDICAL GRADUATES FROM PRESIDENTIAL PROCLAMATIONS RESTRICTING ENTRY INTO THE UNITED STATES
Introduced by International Medical Graduates Section

Resolution 230 was considered with Resolution 226. See Resolution 226.

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;

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.

231. PROTECTING AND PROMOTING LONG TERM CARE WORKFORCE AMIDST IMMIGRATION CHALLENGES
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED**
See Policy H-255.959

RESOLVED, that our American Medical Association oppose administrative or regulatory actions that exacerbate staffing shortages or threaten access to long term care when such actions are not accompanied by adequate workforce supply and training, immigration pathways, and funding support.

RESOLVED, that our AMA support immigration policies that protect, retain, and expand the long-term care workforce, including timely work authorization, efficient visa processing, and protections against abrupt workforce disruptions for immigrant health care workers.

232. BANNING FLAVORED CANNABIS E-CIGARETTES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-95.944

RESOLVED, that our American Medical Association advocate and support a complete ban on the production, marketing, and sale of Cannabis based ECIG flavored devices and cartridges throughout all regulated cannabis dispensaries (medical and adult-use) along with any outlet selling intoxicating hemp products.

RESOLVED, that our AMA pursue legislative changes supporting a comprehensive ban on the production, marketing and sale of cannabis-based ECIG flavored devices and cartridges in the United States.

233. BANNING SYNTHESIZED, PURIFIED OR DERIVATIVE PRODUCTS FROM KRATOM
Introduced by Illinois

Resolution 233 was considered with Resolution 201. See Resolution 201.

RESOLVED, that our American Medical Association pursue legislation banning synthesized, purified or derivative products from kratom for marketing, distribution, promotion and sale including but not limited to the unregulated mitragynine along with the 7-hydroxymitragynine and MGM-15 market.

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234. PHYSICIAN UNITY IN ADVOCACY REGARDING PHYSICIAN REIMBURSEMENT
Introduced by International College of Surgeons

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association reaffirm that physician payment reform should prioritize the sustainability of the entire physician workforce and the protection of patient access to care.

RESOLVED, that our AMA adopt policy stating that physicians and physician organizations should refrain from advocating for reductions in reimbursement specifically targeted at other physician specialties or physician groups.

RESOLVED, that our AMA encourage physician organizations to pursue payment reform through approaches that improve overall fairness, adequacy, and stability of physician reimbursement rather than redistribution among physician specialties.

RESOLVED, that our AMA affirm that physicians should advocate collectively against reimbursement cuts affecting any group of physicians and support efforts to protect the financial sustainability of all physician practices in order to preserve patient access to care.

235. ESTABLISHING HEALTHCARE MONITORING AND ACCOUNTABILITY IN IMMIGRATION DETENTION FACILITIES
Introduced by Medical Student Section, Underrepresented in Medicine Advocacy Section and Resident and Fellow Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy H-160.879

RESOLVED, that our American Medical Association support independent, transparent, unannounced inspections of all ICE detention facilities, with anti-retaliation protections for detainees and health staff who participate.

RESOLVED, that our AMA supports efforts to reform ICE's waiver system by requiring that all waivers include clear expiration dates, transparent public reporting, and standardized criteria that limit their use to cases of demonstrated necessity.

236. EXTENDING AND EXPANDING THE AMA TASK FORCE TO PRESERVE THE PATIENT-PHYSICIAN RELATIONSHIP TO ENSURE ACCESS AND REGULATORY CLARITY IN GENDER-AFFIRMING CARE
Introduced by LGBTQ+ Section, Medical Student Section, American College of Physicians and FLMA: Health Professionals Advancing LGBQ+ Equality

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: FIRST, THIRD, FOURTH AND FIFTH RESOLVES ADOPTED
SECOND RESOLVE REFERRED WITH REPORT BACK AT I-26
See Policy D-605.981

[Editor's note: the following resolve clause was adopted]
RESOLVED, that our American Medical Association extend and expand the work of the Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted to include a formalized and sustained focus on legislative and regulatory actions to protect access to and education in gender-affirming care;

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[Editor's note: the following resolve clause was referred with a report back at I-26]
RESOLVED, that our AMA direct the Task Force to develop, launch, and maintain a comprehensive, centralized digital resource hub—modeled on the Reproductive Health Resource Navigator—specifically dedicated to gender-affirming care no later than the 2026 Interim Meeting, including but not limited to:

1. State-specific legal summaries and regulatory guidance;
2. Shield law analyses and cross-state practice considerations;
3. Privacy and HIPAA compliance best practices;
4. Risk-mitigation guidance addressing civil, criminal, and professional liability;
5. Documentation and informed consent templates consistent with evolving legal standards;
6. Coding, billing, and reimbursement guidance;
7. Institutional policy templates and sample protocols;
8. Educational and training resources for undergraduate and graduate medical education;
9. Telehealth and interstate licensure guidance; and
10. Information regarding legal assistance and physician defense resources;

[Editor's note: the following resolve clause was adopted]
RESOLVED, that our AMA strengthen its advocacy efforts at the federal and state levels to oppose criminalization and punitive actions against physicians providing evidence-based gender-affirming care and to support legal protections safeguarding the patient-physician relationship, with guidance by the Task Force;

[Editor's note: the following resolve clause was adopted]
RESOLVED, that our AMA identify gaps in information and resources and develop a comprehensive advocacy and policy blueprint to prevent, counter, and mitigate restrictions on safe, evidence-based, and medically appropriate health care;

[Editor's note: the following resolve clause was adopted]
RESOLVED, that our AMA report annually to the House of Delegates regarding progress on these deliverables, including metrics on resource utilization, physician engagement, and identified advocacy outcomes.

237. GUARANTEED 30-DAY TRANSITION FILL OF CURRENTLY PRESCRIBED INSULIN AT THE BEGINNING OF EACH YEAR PLAN

Introduced by Texas

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED**
See Policy D-120.913

RESOLVED, that our American Medical Association adopt as policy and advocate that beneficiaries of ERISA-governed health plans be allowed a 30-day transition fill of insulin at the beginning of each plan year to allow time for the formulary preference to be determined by the patient and prescriber.

238. PROHIBITING THE INDEPENDENT PRACTICE OF MEDICINE BY ARTIFICIAL INTELLIGENCE

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ALTERNATE RESOLUTION 238**
ADOPTED IN LIEU OF RESOLUTIONS 238, 246 and 249
See Policy D-480.947

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RESOLVED, that our American Medical Association advocate for legislation and regulation related to the use of augmented and/or artificial intelligence (AI) in autonomous or semiautonomous circumstances in healthcare (including diagnostics, prescriptions, care management, or other functions) requiring that such tools must:

1. integrate with the physician-led team and be used at the direction of the treating physician,
2. respect the continuity of care and best practices related to transitions of care,
3. have transparent, auditable data demonstrating safety and efficacy,
4. be subject to relevant and appropriate regulations (including but not limited to those related to liability and documentation), and
5. adhere to our AMA policy on Augmented Intelligence in Health Care.

RESOLVED, that our AMA will study emerging concepts around the regulation and licensure of autonomous and semiautonomous augmented and/or artificial intelligence performing clinical functions, and their potential impact on the profession and the physician-patient relationship.

239. MEDICARE ADMINISTRATIVE CONTRACTOR POLICY MODIFICATION
Introduced by American Academy of Physical Medicine and Rehabilitation, American Association of Neuromuscular & Electrodiagnostic Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-330.897, D-330.908 and D-330.918

RESOLVED, that our American Medical Association amend Policy D-330.897, Stakeholder Engagement in Medicare Administrative Contractor Policy, by addition to read:

1. Our American Medical Association opposes Medicare Administrative Contractors (MACs) using Local Coverage Articles (LCAs) that could have the effect of restricting coverage or access without providing data and evidentiary review or without issuing associated Local Coverage Determinations (LCDs) and following required stakeholder processes.
2. Our AMA will advocate and work with the Centers for Medicare and Medicaid Services (CMS) to improve the instructions to MACs regarding development of local coverage policies in such a manner as to prevent LCAs that could have the effect of restricting coverage or access from being adopted without the MAC providing public data, decision criteria, and evidentiary review and allowing comment, or without an associated LCD and the required LCD stakeholder review and input process.
3. Our AMA will work with specialty and state medical societies and other interested stakeholders to identify LCAs that potentially restrict coverage or access and that were issued without the MACs providing opportunities for stakeholder input, public data, decision criteria, and evidentiary review and advocate that CMS require MACs to revise the policies by taking any such proposed changes through an appropriate stakeholder engagement, public data, and evidentiary review.
4. Our AMA will advocate and work with CMS to require a minimum 90-day public comment period for new or revised LCDs.
5. Our AMA will advocate and work with CMS to require expedited reconsideration timelines for new or revised LCDs that involve patient access to an intervention that may preserve life and/or function.
6. Our AMA will advocate and work with CMS to require MACs to provide an explanation for the removal of diagnostic codes from the list of diagnoses included as medically necessary for any procedure in a proposed new or revised LCA;LCD Reference Article, or Billing and Coding Article, and to require MACs to allow a 90-day public comment period after this explanation has been provided.
7. Our AMA will support federal legislation to improve the LCD process, including to make the LCD process more transparent and responsive to stakeholders such as providers with subject matter expertise so that patients can receive medically necessary and appropriate care.

RESOLVED, that our AMA reaffirm policy D-330.918, Appropriateness of National Coverage Decisions;

RESOLVED, that our AMA reaffirm policy D-330.908, Improving the Local Coverage Determination Process.

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240. ENDING PRIVATE EQUITY DIVIDEND RECAPITALIZATION IN HEALTHCARE
Introduced by American Academy of Emergency Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-160.902

RESOLVED, that our American Medical Association will advocate that the practice of Dividend Recapitalization must be banned in all acquisitions of health care enterprises by Private Equity firms or other investors that permit any non-physician licensed entities to exercise control over the practice of medicine.

RESOLVED, that our AMA will develop model state legislation that would prohibit the practice of Dividend Recapitalization when health care enterprises are acquired by PE and other corporations.

241. STRENGTHENING OUR AMA EFFORTS TOWARD CPOM PROHIBITION
Introduced by American Academy of Emergency Medicine, Florida

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-160.891

[Editor's note: Upon final review of final HOD actions following the 2026 Annual Meeting, a discrepancy was found between existing policy language and the language used to proffer amendments to the policy in Resolution 241. The proffered language in the resolution included text that was being amended that did not appear in the existing policy. The Speakers reviewed the discrepancy and are providing clarification in Speakers Report 2 being brought at the 2026 Interim Meeting. The language below is what was adopted at A-26.]

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:~~ 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."

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~~ Physicians and policymakers evaluating corporate investment in physician practices should consider the following principles to ensure that any such relationships remain subordinate to physician ownership, governance, and professional medical judgment"

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.~~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

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structures tied to clinical services, coding and billing policies, payer contracting, and practice governance.";

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 control of clinical decision making, physician employment conditions affecting patient care, or other core professional functions to non-licensed entities.";

RESOLVED, that our AMA amend Policy H-160.891 by addition by inserting a new subsection (f) to read as follows, and renumbering the subsequent subsections accordingly:

"(f) Our AMA opposes management services organizations, private equity firms, and other non-licensed entities, and their owners, officers, directors, employees, or agents, from exercising governance authority or management control within a professional medical entity in a manner that directs, controls, or unduly influences clinical decision making, physician employment conditions affecting patient care, or other decisions reserved to licensed physicians.";

RESOLVED, that our AMA amend Policy H-160.891 by addition by inserting a new subsection (g) to read as follows, and renumbering the subsequent subsections accordingly:

"(g) Our AMA opposes noncompetition, nondisclosure, non-disparagement, and non-interference clauses that restrict a physician's ability to exercise independent professional judgment, advocate for patients, report unsafe or unethical conditions, or continue caring for patients consistent with ethical and legal obligations.";

RESOLVED, that our AMA amend Policy H-160.891 by deletion and addition in subsection (h) as follows:

"(h) ~~Physicians should seek transparency regarding the financial and ownership structures associated with corporate investors and related entities.~~ Our AMA supports clear disclosure of physician practice ownership, governance, management agreements, and contractual control rights so that physicians, patients, regulators, and policymakers can identify who holds financial and operational control over the practice entity.";

RESOLVED, that our American Medical Association amend AMA Policy H-160.891 by deletion and addition in item 2 as follows:

"2. Physicians should understand and evaluate the financial and governance implications of corporate investment in medical practices ~~before entering such arrangements~~ and ensure that any such arrangements do not transfer ownership, governance authority, or operational control over clinical decision making to non-licensed entities."

242. REDUCING EMERGENCY DEPARTMENT BOARDING THROUGH PAYMENT REFORM

Introduced by American Academy of Emergency Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

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;

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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.

243. STANDARDIZING MEDICAL FRAILTY TO STREAMLINE MEDICAID COMMUNITY ENGAGEMENT & WORK EXEMPTIONS
Introduced by Association for Clinical Oncology, American Society of Hematology and American Academy of Hospice and Palliative Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-290.969

RESOLVED, that our American Medical Association advocate that the Centers for Medicare & Medicaid Services and state Medicaid agencies establish a standard with which to define "medical frailty" and "complex medical conditions" to be adopted by state Medicaid agencies; this definition shall explicitly include, at a minimum, any individual currently undergoing diagnostic testing for, receiving treatment for, or under active surveillance or monitoring for a life-threatening or complex chronic medical condition, as well as conditions in which the disease or its treatment results in functional limitation or an ongoing need for medical care, while preserving the authority of states to expand these protections to additional populations.

RESOLVED, that our AMA advocate for federal and state Medicaid guidance to provide automatic exemptions from community engagement and work requirements for patients and primary caregivers of patients with complex medical conditions, utilizing evidence-based clinical data and claims-based algorithms to ensure treatment adherence and continuity of care.

RESOLVED, that our AMA continues to advocate for streamlined Medicaid community engagement and work requirement exemption verification by minimizing administrative burden for patients and physicians.

RESOLVED, that our AMA urge policymakers, in defining and operationalizing medical frailty exemptions, to adopt policies that encompass the full range of serious and complex conditions, including conditions associated with functional impairment, that are life-threatening, chronic, episodic, relapsing, co-occurring, not yet diagnosed but evidenced by significant healthcare utilization, or that require significant, ongoing interaction with the health care system.

244. ELIMINATE ADMINISTRATIVE BARRIERS TO APPEAL WRONGFUL DENIALS
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-285.954

RESOLVED, that our American Medical Association advocates to the United States Department of Labor to issue regulations to require that health plans honor signed patients' designations to submit and appeal denials without requiring plan-specific forms.

RESOLVED, that our AMA advocates that the US Department of Labor does not require additional and separate consent from the patient in order for a physician practice to file a complaint with the US Department of Labor against self-funded ERISA plans once the patient has assigned benefits to the physician.

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245. STATE REGULATION OF NON-PREEMPTED "NON-CENTRAL MATTERS" OF ERISA PLANS—RUTLEDGE V. PCMA
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association will examine the strategic and operational opportunities physicians should consider under the U.S. Supreme Court holding in Rutledge v. PCMA as they pertain to the Employment Retirement Income Security Act (ERISA) with a report back at the Annual 2027 meeting with recommendations for operational best practices.

RESOLVED, that our AMA will explore and, as appropriate, provide related educational programming at Interim and/or Annual Meetings and through other appropriate venues, including potential educational modules, regarding ERISA and its practical implications for private practice physicians.

RESOLVED, that our AMA with appropriate stakeholders will explore the possibilities of amending the Employment Retirement Income Security Act (ERISA) to revise the law in ways that can eliminate problems that some independent physicians experience, including:

1. Interest payments on overdue "clean" health insurance claims not otherwise addressed by ERISA's statutory mandate;
2. Administrative issues surrounding prior authorization, including but not limited to timeliness of responses and duty to obtain date records available from sources other than the physician so as not to waste physician resources;
3. Payment for Medicare co-insurance and deductibles when Medicare is primary and another plan is secondary and the physician is a Medicare-participating physician but non-participating with the secondary plan;
4. Payment for the administrative burden of prior authorization and successful denial appeals;
5. Parity for telehealth-delivered services;
6. Timely payment of "clean claims" when the insurer's obligation to pay the claim is reasonably distinct from timely determination of claims;
7. Enforcement of evaluation & management modifier code 25 use/payments as articulated under AMA policies D-385.956 and D-70.971 as well as analogous state medical society policies;
8. Requiring that when health plan payment recovery or recoupment is due to coordination of benefit failure, the health plan shall seek recovery from the patient and/or the correct payor.

246. ARTIFICIAL INTELLIGENCE SCOPE OF PRACTICE
Introduced by Private Practice Physicians Section

Resolution 246 was considered with Resolutions 238 and 249. See Resolution 238.

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;

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."

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247. COMPREHENSIVE ERISA REFORM
Introduced by Texas

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-285.953

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 states' Prompt Pay laws and rules, requiring a report back at the following annual meeting.

248. MEDICAL STAFF OVERSIGHT OF HOSPITAL AUGMENTED INTELLIGENCE
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-480.930

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

249. BRINGING PHYSICIANS' VOICES TO THE IMPLEMENTATION OF AI PRESCRIBERS
Introduced by Resident and Fellow Section

Resolution 249 was considered with Resolutions 238 and 246. See Resolution 238.

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

250. PROTECTING RESIDENT PHYSICIANS WITH PENDING IMMIGRATION STATUS AND ENSURING SAFE PARTICIPATION IN PROFESSIONAL ACTIVITIES
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-255.964

RESOLVED, that our American Medical Association (AMA) urgently advocate on behalf of non-US citizen physicians and trainees with pending visa adjudication, including those who have recently matched

RESOLVED, that our AMA support the development and dissemination of a list of federal and national resources for medical schools and residency and fellowship programs in helping medical students, residents, and fellows with indeterminate visa statuses.

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251. MINIMUM STANDARDS FOR PUBLIC HEALTH LEADERS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

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

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

252. IMMEDIATE ACTION TO PREVENT FURTHER IMMIGRANT DEATHS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies D-160.921, D-350.983, H-65.932, H-160.878, H-315.966 and H-440.793

RESOLVED, that our American Medical Association (AMA) support efforts to ensure health care facilities effectively serve as sensitive locations, without deterring immigrants seeking care, by supporting policies that:

- make immigration status and place of birth protected health information
- prohibit immigration agents from entering nonpublic, patient-sensitive areas of health care facilities without a warrant signed by a judge
- encourage health care facilities to adopt minimum enforceable guidelines for interactions with immigration enforcement authorities
- oppose mandated inquiries about patient immigration status in health care facilities.

RESOLVED, that our AMA supports physician and other health care worker efforts to organize in support of immigrants' right to safe and high-quality health care in medical settings.

RESOLVED, that our AMA reaffirm policies H-440.793, D-350.983, H-65.932, D-160.921 and H-315.966.

RESOLVED, That AMA advocate in an urgent, timely manner to protect immigrant health, safety, and access to care as directed by HOD policies related to the deportation, detention, and health and safety for all immigrants, migrants, refugees, detainees, and asylum seekers.

253. PROTECTION OF MEDICAID BENEFICIARIES FROM FEDERAL FUNDING DEFERRALS

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ALTERNATE RESOLUTION 253 ADOPTED
IN LIEU OF RESOLUTION 253
See Policy D-290.968

RESOLVED, that our AMA opposes withholding or deferral of Medicaid funding and other financial enforcement mechanisms in a manner that is arbitrary, disproportionate, inconsistent with established legal and administrative processes, or likely to cause undue disruption to patient care or state Medicaid program operations.

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RESOLVED, that our AMA advocates that 1) federal enforcement actions utilize deferral or withholding of state Medicaid funding only after a thorough and transparent administrative process, in accordance with federal laws and regulations, that provides states with meaningful notice and opportunity for corrective action and administrative and judicial review protections; 2) CMS restore or release withheld or deferred Medicaid funds when such administrative processes have not been followed; and 3) CMS carefully balance the benefits and harms of new program integrity actions and minimize harm to Medicaid beneficiaries, participating physicians, hospitals and other providers, and state program operations.

RESOLVED, that our AMA requests that the relevant congressional committees conduct timely and appropriate oversight of the Administration's use of the Medicaid deferral mechanism.

254. OMB PROPOSED RULE: REGULATION FOR FEDERAL FINANCIAL ASSISTANCE
Introduced by American Thoracic Society, American Academy of Allergy Asthma & Immunology

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-460.956

RESOLVED, that our American Medical Association expresses its strong support for the scientific peer review process, academic journal independence and the immense value of merit-based scientific investments unimpeded by political interference.

RESOLVED, that our AMA submit comments during the public comment period expressing our strong concerns with the proposed rule titled “Regulation for Federal Financial Assistance” (91 Federal Register 32198) issued on May 29, 2026.

RESOLVED, that our AMA consider taking legal action to challenge implementation of the proposed Office of Management and Budget (OMB) rule titled “Regulation for Federal Financial Assistance” (91 Federal Register 32198) issued on May 29, 2026.

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REFERENCE COMMITTEE C

301. EXPANDING RESIDENT AND FELLOW EXPOSURE TO DIVERSE HEALTHCARE PRACTICE MODELS TO FULFILL ACGME CORE COMPETENCIES
Introduced by Pennsylvania

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: POLICY H-295.864
REAFFIRMED IN LIEU OF RESOLUTION 301

RESOLVED, that our American Medical Association will advocate to the ACGME and other relevant accrediting and educational bodies for the formal inclusion and recognition of diverse practice model exposure as a vital component of Systems-Based Practice training.

302. EXCESSIVE COST OF MULTI-STATE DEA LICENSURE
Introduced by Michigan

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED
See Policies D-100.975 and D-100.980

RESOLVED, that our American Medical Association continue its support of person-specific rather than site-specific Drug Enforcement Administration (DEA) registration numbers and a one-time DEA registration fee by reaffirming existing AMA policies, "One Fee One Number D-100.975" and "One Fee, One Number D-100.980."

303. ALLOWING OPTIONS FOR CERTIFICATION MAINTENANCE
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: NOT ADOPTED

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;

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.

304. INCREASING THE USE OF RETIRED PHYSICIANS IN TEACHING STUDENTS AND RESIDENTS
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-295.295

RESOLVED, that our American Medical Association explore with the appropriate interested parties creative and innovative ways to increase opportunities for retired physicians to participate as medical faculty at medical schools and residency training programs.

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305. Leadership by Physicians for Physicians in Graduate Medical Education (GME)
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-310.894

RESOLVED, that our American Medical Association encourage the ACGME to examine minimum qualifications for Designated Institutional Officials to ensure physician leadership in the oversight of graduate medical education programs.

306. Competency-Based Portfolio Assessment of Medical Students, Interns, Residents, and Fellows
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED
See Policy D-295.318 and H-65.951

RESOLVED, that our American Medical Association amend D-295.318 "Competency-Based Portfolio Assessment of Medical Students" by addition and deletion to read as follows:

1. Our American Medical Association will work with the Association of American Medical Colleges, the American Osteopathic Association, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education, and other organizations to examine new and emerging approaches to medical student and trainee evaluations, including competency-based portfolio assessment.
2. Our AMA will work with the NRMP, ACGME and ~~the 11 schools in the AMA's Accelerating Change in Medical Education consortium~~ medical schools to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency and fellowship match process ~~and off-cycle entry into residency programs,~~ and transitions across the UME-GME practice continuum; including off-cycle entry pathways.

RESOLVED, that our AMA amend H-65.951 "Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions" by addition to read as follows:

Our American Medical Association recognizes that implicit biases in evaluations, including those related to gender, race, ethnicity, socioeconomic status, and/or personal background, may influence learner assessment, advancement, and professional opportunities across the medical education continuum.

Our American Medical Association adopted the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:

GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE

Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.

An effective healthcare anti-discrimination policy should:

- Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.

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- Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.
- Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.
- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Create anti-discrimination policies that:
- Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
- Define expected and prohibited behavior.
- Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.
- Ensure privacy and confidentiality to the reporter.
- Provide a confidential method for documenting and reporting incidents.
- Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.

These policies should include:

- Taking every complaint seriously.
- Acting upon every complaint immediately.
- Developing appropriate resources to resolve complaints.
- Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
- Communicating decisions and actions taken by the organization following a complaint to all affected parties.
- Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:

- Surveying staff, trainees and medical students, anonymously and confidentially to assess:
- Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Ideas about the impact of this behavior on themselves and patients.
- Integrating lessons learned from surveys into programs and policies.
- Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, bias or microaggressions.
- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions.
- Providing designated support person to confidentially accompany the person reporting an event through the process.

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307. RECOGNIZING ADVOCACY AS A COMPONENT OF FACULTY APPOINTMENT AND PROMOTION IN ACADEMIC MEDICINE
Introduced by Academic Physicians Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED**
See Policy G-615.103

RESOLVED, that our American Medical Association reaffirm AMA Policy G-615.103, Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy.

RESOLVED, that our AMA encourage medical education institutions and academic medical centers to recognize physician advocacy activities as a component of faculty appointment, promotion, and tenure criteria.

RESOLVED, that our AMA collaborate with relevant organizations representing medical school leadership, to promote best practices for incorporating advocacy efforts into protected non-clinical faculty effort and academic productivity models.

308. IMPACT OF FEDERAL AND STATE RESTRICTIVE ACTIONS ON GENDER-AFFIRMING CARE ON MEDICAL EDUCATION AND PHYSICIAN WORKFORCE DEVELOPMENT
Introduced by LGBTQ+ Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED**
See Policy D-295.294

RESOLVED, that our American Medical Association study the impact of federal and state restrictive actions on gender-affirming care on undergraduate medical education (UME), graduate medical education (GME), and continuing medical education (CME), including effects on: (1) clinical training opportunities, (2) accreditation standards and compliance, (3) federal funding streams for medical education and research, (4) faculty recruitment and retention, (5) trainee recruitment, retention, and geographic distribution, (6) academic freedom and curricular integrity, and (7) physician workforce preparedness to provide comprehensive, evidence-based care.

RESOLVED, that our AMA assess the implications of federal executive actions, agency guidance, regulatory changes, and funding conditions on academic medical centers and training programs that provide or teach gender-affirming care.

309. OSTEOPOROSIS EDUCATION, AWARENESS, AND MUSCULOSKELETAL HEALTH OPTIMIZATION

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ALTERNATE RESOLUTION 309**
ADOPTED IN LIEU OF RESOLTUION 309
See Policy H-425.959

RESOLVED, That our American Medical Association encourage development and promotion of physician education, continuing medical education (CME), multidisciplinary programming, research, and patient and physician awareness initiatives regarding osteoporosis and bone health optimization as components of musculoskeletal health, frailty prevention, mobility preservation, healthy aging, surgical risk optimization, and improvement of functional outcomes, including evidence-based strategies related to physical activity, nutrition, fall prevention, screening, and individualized clinical decision-making consistent with existing evidence.

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RESOLVED, that our AMA advocate for insurance coverage of evidence-based osteoporosis screening tests and osteoporosis therapies.

310. INCREASING CAPACITY AND ACCESS TO MATERNAL HEALTH SERVICES IN RURAL AREAS
Introduced by California, ACOG, Hawaii, Idaho, Oregon, Washington and Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED
See Policy H-200.944

RESOLVED, that our American Medical Association continue to address the nation's obstetrics and gynecology training and workforce needs, by supporting additional ways to increase physicians providing OB-GYN services in shortage areas.

RESOLVED, that our AMA support expansion of Family Medicine obstetrical care provided by family physicians who are trained and privileged to deliver such services.

RESOLVED, that our AMA support increased funding physicians providing obstetric care in Maternity Care Target Areas (MCTAs).

311. CHANGING THE PARADIGM OF MEDICAL STUDENT DEBT TO ADDRESS THE GERIATRIC PHYSICIAN SHORTFALL
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association (AMA) develop a platform supporting a 3-year medical school curriculum in order to help reduce medical student debt and reduce the coming physician shortage.

RESOLVED, that our AMA, in order to advance equity in the medical profession, work to ensure all specialties—especially primary care—can compete fairly, reduce the looming physician shortage especially those providing care to older patients.

RESOLVED, that our AMA advocate that the AAMC and Liaison Committee on Medical Education (LCME) begin steps to ensure that all medical schools offer a 3-year program by 2030 to help reduce student debt.

312. ADVOCATING FOR EQUITABLE APPLICATION REVIEW IN A SINGLE MATCH SYSTEM
Introduced by American College of Legal Medicine

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-295.848, H-295.876 and H-310.893

RESOLVED, that our American Medical Association support the removal of filters within medical student clinical elective application systems which differentiate between applicants' allopathic or osteopathic degree status.

RESOLVED, that our AMA oppose the use of filters within the residency and fellowship application systems which denote equivalent aspects such as allopathic and osteopathic degree status.

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RESOLVED, that our AMA provide a report at A-28 on the status of filtering by degree status within medical student clinical elective application systems.

RESOLVED, that our AMA reaffirm H-295.876: Equal Fees for Osteopathic and Allopathic Medical Students and H-295.848: Teaching and Assessing Osteopathic Manipulative Medicine and Osteopathic Principles and Practice.

313. EVALUATION OF SITUATIONAL JUDGEMENT TESTS IN MEDICAL SCHOOL ADMISSIONS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-295.834

RESOLVED, that our American Medical Association support relevant interested parties in their continued evaluation of the utilization of situational judgment tests, and other similar online decision-making assessments, in medical school admissions and residency and fellowship selection processes, to determine whether or not this style of examination meets the AMA's stated goal of holistic applicant review, unbiased by non-modifiable factors.

314. PROMOTING SEX- AND GENDER-INCLUSIVE DIAGNOSTIC PRACTICES, LANGUAGE, AND PATIENT EDUCATION
Introduced by Medical Student Section, LGBTQ+ Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED**
See Policy H-295.833

RESOLVED, that our American Medical Association supports discontinuing use of the term 'atypical' to describe sex- and gender-based differences in symptomatic presentations in medical education curriculum and reference materials.

315. EXPANDING THE NATIVE HAWAIIAN HEALTH SCHOLARSHIP PROGRAM ELIGIBILITY
Introduced by Medical Student Section, Underrepresented in Medicine Advocacy Section, Hawaii, Washington, Oregon

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED**
See Policy H-305.922

RESOLVED, that our American Medical Association encourage expanded funding and eligibility requirements for the Native Hawaiian Health Scholarship Program (NHHSP) or equivalent programs.

316. ADDRESSING TRANSITIONS WITHIN GME REGARDING ORIENTATION STANDARDS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED**
See Policy D-310.943

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RESOLVED, that our American Medical Association study mechanisms for training programs to provide residents and fellows with necessary benefits, including but not limited to health insurance, during transitions in undergraduate and graduate medical education.

RESOLVED, that our AMA study the benefits of flexible start dates as it relates to reducing logistical and financial burdens on trainees, including but not limited to the following transitions: (1) from medical school to residency; (2) from a transitional or preliminary year to residency; and (3) from residency into fellowship.

317. SUPPORT FOR INTERNS, RESIDENTS, AND FELLOWS DURING JEOPARDY CALL VIA IMPACT STUDY

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ALTERNATE RESOLUTION 317**
ADOPTED IN LIEU OF RESOLUTION 317
See Policy D-310.942

RESOLVED, That our American Medical Association study the impacts of jeopardy duty on resident and fellow trainees, including the frequency and causes of unscheduled coverage, variation across specialties and institutions, and the associated educational, wellness, and workload implications and report back to the House of Delegates with findings and recommendations to inform future policy on systems improvement and, if appropriate, recompense related to jeopardy coverage.

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REFERENCE COMMITTEE D

401. PARTNERSHIP WITH THE ADMINISTRATION TO REDUCE HARMFUL CHEMICALS IN FOOD
Introduced by Organized Medical Staff Section and American College of Lifestyle Medicine

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWs
TITLE CHANGED
See Policy H-150.998

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

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

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.

402. STRENGTHENING PUBLIC HEALTH PROTECTIONS AGAINST RAW MILK–ASSOCIATED ILLNESS
Introduced by Oklahoma, American Association of Public Health Physicians, Mississippi, Tennessee and American College of Medical Quality

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-150.980

RESOLVED, that our American Medical Association oppose the consumption, sale, and distribution of raw unpasteurized milk and dairy products, for protection of everyone, including but not limited to those at risk for Listeria complications.

RESOLVED, that our AMA urge congress and state legislatures to prohibit interstate sale of raw unpasteurized milk, strengthening current FDA regulation.

RESOLVED, that our AMA collaborate with like-minded organizations, possibly the AAP, to jointly develop and disseminate cost-efficient public education initiatives on the risks of raw, unpasteurized milk and dairy products for children and those who are pregnant, targeting parents, schools, and childcare providers.

RESOLVED, that our AMA support and advocate for, in jurisdictions where the sale or distribution of unpasteurized raw milk products cannot be prohibited, the implementation of labeling requirements that clearly warn consumers of the specific health risks associated with consumption of raw milk products, for general public and for members of vulnerable populations, including children and those who are pregnant.

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

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403. AMA'S CONTINUED SUPPORT FOR COVID-19 VACCINATION IN PREGNANT INDIVIDUALS AND CHILDREN
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-440.921

RESOLVED, that our American Medical Association calls on the U.S. Centers for Disease Control and Prevention, Health and Human Services, and the Department of Health and Human Services to restore evidence-based vaccine recommendations, including for COVID-19 vaccination of pregnant individuals and children aged 6 months to 17 years.

404. DEVELOP CLIMATE-CONSCIOUS RESOURCES FOR PHYSICIANS
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-135.897

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.

RESOLVED, that our AMA support providing practical, evidence-based recommendations for reducing the environmental footprint of clinical practices and healthcare systems.

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.

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

405. STUDYING THE ENVIRONMENTAL IMPACT OF AMBIENT CLINICAL INTELLIGENCE USE
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy D-135.960

RESOLVED, that our American Medical Association in collaboration with state medical societies, develop a framework to study the public health impact and ecological challenges posed by the growth of ambient clinical intelligence.

RESOLVED, that our AMA support efforts to require reporting of emissions, water use, and e-waste from data centers to allow for public health entities to anticipate care and coverage costs to affected populations.

RESOLVED, our AMA works with stakeholders to encourage ~~s~~state and federal legislatures to offer specific tax incentives to ambient clinical intelligence vendors to work toward using 100% sustainable energy sources.

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

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406. REDUCE ENVIRONMENTAL IMPACT OF MEDICAL JOURNALS
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association's medical journals be provided via electronic-only means by default, and that physicians and other recipients be required to opt in to receive print versions.

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

407. COLORECTAL CANCER IN ALASKA NATIVE PATIENTS
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-425.990

RESOLVED, that our American Medical Association advocates that the National Cancer Institute dedicate resources to the investigation of early-onset colorectal cancer in Americans younger than age 45.

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

408. ADDRESSING RURAL MATERNAL MORBIDITY AND MORTALITY THROUGH COLLABORATION AND INTERSECTIONALITY
Introduced by American College of Obstetricians and Gynecologists, The American Association of Gynecologic Laparoscopists

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-420.993

RESOLVED, that our American Medical Association publish a focused report examining the intersection of maternal mortality disparities, access to rural pregnancy care, workforce shortages, the effects of changes in Medicaid reimbursement, expansion and extension for maternity care, and reproductive health policy variability, with recommendations to reduce preventable maternal deaths, including during the postpartum period.

RESOLVED, that our AMA ensure that this report includes evidence-based recommendations to reduce preventable maternal mortality through the postpartum year, including strategies for optimized allocation of federal and state funding.

RESOLVED, that our AMA collaborate with specialty societies, academic medical institutions, and public health stakeholders to promote and disseminate innovative practice models—such as regional call-sharing systems, tele–

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maternal-fetal medicine support, and hospital–physician partnership structures—designed to reduce rural maternal morbidity and mortality, including during the postpartum period.

409. ELIMINATE PFAS AND GLYPHOSATE IN OUR FOOD AND ENVIRONMENT
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-150.912

RESOLVED, that our American Medical Association promote a safe and healthy food supply and environment by advocating to relevant regulatory bodies and stakeholders for reduction of PFAS and glyphosate chemicals from our food supply and environment to concentrations below which there have been no observed adverse effects demonstrated.

RESOLVED, that our American Medical Association oppose the use of PFAS-containing insecticides in industrial agriculture.

410. LIGHT POLLUTION
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: REFERRED FOR DECISION

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

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

411. ADDRESSING THE MYOPIA EPIDEMIC, PUBLIC EDUCATION, AND INSURANCE COVERAGE FOR EVIDENCE-BASED MYOPIA CONTROL
Introduced by American Academy of Ophthalmology

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-440.786

RESOLVED, that our American Medical Association recognize that myopia is a significant and increasing public health concern warranting public health outreach, improved screening in children, and prevention efforts.

RESOLVED, that our AMA advocate for public education initiatives to increase awareness among patients, caregivers, educators, and policymakers about the risks of progressive myopia and the availability of evidence-based interventions shown to slow myopia progression.

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RESOLVED, that our AMA support efforts to formally classify myopia as a disease to ensure that patients can receive appropriate treatment and insurance coverage for the treatment of this medical condition.

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

412. GUIDING PRINCIPLES OF PANDEMIC PREVENTION, PREPAREDNESS AND RESPONSE; SUPPORT FOR THE WORLD HEALTH ORGANIZATION PANDEMIC AGREEMENT
Introduced by New York

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: REFERRED

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

- Article 4, Pandemic prevention and surveillance;
- Article 5, One Health approach for Pandemic Prevention, Preparedness and Response;
- Article 6, Preparedness, readiness and health system resilience;
- Article 7, Health and care workforce;
- Article 8, Regulatory systems strengthening;
- Article 9, Research and development;
- Article 10, Sustainable and geographically diversified local production;
- Article 11, Transfer of technology and cooperation on related know-how for the production of pandemic-related health products;
- Article 12, Pathogen Access and Benefit-Sharing Systems;
- Article 13, Supply chain and logistics;
- Article 14, Procurement and distribution;
- Article 15, Whole-of-government and whole-of-society approaches;
- Article 16, Communication and public awareness;
- Article 17, International cooperation and support for implementation; - Article 18, Sustainable financing

413. EROSION OF THE PUBLIC EVIDENCE BASE FOR HEALTH POLICY
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-440.813

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

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

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414. RESTORING BALANCED SCIENTIFIC PERSPECTIVE WITHIN THE ACIP
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies D-440.902 and H-440.902

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

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

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

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

RESOLVED, that our AMA specifically notes the importance of representation from health economics experts, and from the medical specialty of Preventive Medicine, in vaccine policy development as was recognized in the original charter, but was eliminated in the April 2026 update of the charter.

RESOLVED, That our AMA immediately oppose any executive order or federal administrative action that changes or proposes to change the United States vaccine schedules without proper evidence and scientific review by an appropriately convened Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC) per the approved charter prior to June 2025.

RESOLVED, That our AMA oppose any alignment of the United States vaccine schedules with other international recommendations that do not strictly account for unique U.S. domestic data and demographics.

415. ADVOCACY FOR RESTORATION OF THE ENDANGERMENT FINDING REGARDING GREENHOUSE GAS EMISSIONS
Introduced by Colorado, Washington, Utah, American College of Physicians

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-135.923

RESOLVED, that our American Medical Association encourage the Litigation Center to monitor lawsuits against the rescinding of the endangerment finding and to consider submitting amicus curiae briefs in those with a likelihood of success on behalf of the HOD.

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RESOLVED, that our AMA advocate against the repeal of the endangerment finding and support its restoration.

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

416. CLINICAL LABORATORY WORKFORCE SHORTAGE AND SUSTAINABILITY
Introduced by American Society for Clinical Pathology, American Society of Cytopathology, American Society of Dermatopathology, College of American Pathologists, National Association of Medical Examiners

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-260.958

RESOLVED, that our American Medical Association recognize the unique and critical role of medical laboratory professionals in patient care and public health and the urgent need to address workforce shortages.

RESOLVED, that our AMA support advocacy efforts to sustain and strengthen clinical laboratory training and education programs, including assistance for faculty development and infrastructure, to address capacity and recruitment needs.

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

417. RESPIRATORY PROTECTION FOR WILDLAND FIREFIGHTERS
Introduced by American College of Occupational & Environmental Medicine

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-365.993

RESOLVED, that our American Medical Association advocate for the adoption of evidence based respiratory protection standards for wildland firefighting, including triggers based on PM2.5 or other exposure metrics, easy access to National Institute of Occupational Safety and Health (NIOSH) Approved respiratory protective devices and other exposure mitigation technologies appropriate for wildland operations; and operational protocols that balance respiratory protection with heat stress, physiological burden, communication, visibility, and exertional demands while maximizing incorporation of the performance objectives and protective elements described in National Fire Protection Association (NFPA) 1984 until fully NFPA 1984-certified products become commercially available.

RESOLVED, that our AMA join the American College of Occupational and Environmental Medicine (ACOEM) in advocating for relevant federal and state fire agencies, forestry departments, and occupational safety organizations to research, develop, and field-test lightweight, low-breathing-resistance (<=80 mm H_2O at 150 L/min) respirators and related controls better suited for prolonged wildland use (8 or more hours).

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

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418. ENSURING ACCESS TO FULL HIV POST-EXPOSURE PROPHYLAXIS (PEP) COURSES FOR SURVIVORS OF SEXUAL ASSAULT
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-20.900

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

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

Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault, including minors, who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested ~~in six months~~ at least at recommended intervals consistent with current clinical guidelines if the initial test is negative or as appropriate per individual, and that strict confidentiality of test results be maintained; and

(2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, ~~and~~ (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use, and (c) encourages hospitals, health systems, and affiliated payers to consider policies ensuring provision of the full recommended course of HIV post-exposure prophylaxis for survivors of sexual assault at no cos to the survivor.

419. EXAMINING THE IMPACT OF CIRCADIAN DISRUPTION FROM SHIFT WORK DURING PREGNANCY
Introduced by Women Physicians Section, American College of Lifestyle Medicine

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-365.992

RESOLVED, that our American Medical Association study and report back by A-27 on evidence-informed scheduling and workplace accommodation principles to mitigate circadian disruption from shift work for people trying to conceive and pregnant people, including medical trainees, when feasible and consistent with patient care needs, applicable law, and local staffing realities.

420. EXPANDING SUPPORT FOR WOMEN EXPERIENCING HOMELESSNESS
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-160.903

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

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

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2. Our AMA recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless and recognizes that women experiencing homelessness may face distinct health and safety risks that warrant tailored approaches, in addition to considerations such as having minors in their care, and including women Veterans.
3. Our AMA recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis.
4. Our AMA supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance, and encourages attention to gender-specific health needs within such programs when feasible, including trauma-informed and military-informed approaches for women Veterans who may have experienced military sexual trauma (MST), post-traumatic stress disorder (PTSD), intimate partner violence, or challenges associated with transition from military to civilian life.
5. Our AMA recognizes the need for an effective, evidence-based national plan to eradicate homelessness.
6. Our AMA encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.
7. Our AMA will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of ~~homeless patients~~ individuals experiencing homelessness, including gender-specific health needs, the unique social determinants of health impacting women Veterans, and the impact of domestic and intimate partner violence on housing instability, and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs.
8. Our AMA encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital.
9. Our AMA encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients, including support for research to better understand health needs, barriers to care, and effective interventions among populations disproportionately affected by housing instability, and women Veterans and military-connected women.
10. Our AMA:
    a. supports laws protecting the civil and human rights of individuals experiencing homelessness, and
    b. opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available.
11. Our AMA recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.
12. Our AMA:
    a. supports training to understand the needs of housing-insecure individuals for those who encounter this vulnerable population through their professional duties, including trauma-informed approaches and awareness of domestic violence as a contributor to housing instability;
    b. supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and
    c. will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals; and
    d. encourages incorporation of military service history and Veteran status screening into healthcare and homelessness outreach settings in order to identify women Veterans at risk for homelessness and connect them with appropriate federal, state, local, and community-based resources.
13. Our AMA encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement, including educational components addressing Veteran health, military cultural competence, and the healthcare needs of women Veterans experiencing housing instability or homelessness.

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421. IMPROVING ACCESS TO CARE AND SUPPORT FOR PATIENTS WITH INFLAMMATORY BOWEL DISEASE IN THE UNITED STATES
Introduced by Georgia

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED**
See Policy H-55.963

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

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

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

422. EXPANDING ACCESS TO HIGH RESOLUTION ANOSCOPY
Introduced by LGBTQ+ Section, Washington State Medical Association, California Medical Association

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED**
See Policy H-55.962

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

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

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

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

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423. EXPANDING ACCESS TO HIV PRE-EXPOSURE PROPHYLAXIS (PREP)
Introduced by LGBTQ+ Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-20.894

RESOLVED, that our American Medical Association supports advocacy, research funding, and targeted programmatic support to address disparities in PrEP access among populations disproportionately affected by HIV, ensuring that strategies are tailored to the unique needs of these communities.

RESOLVED, that our AMA supports efforts to expand PrEP access to all individuals in alignment with evidence-based guidelines and shared decision making, including but not limited to innovative delivery models across various care settings and strategies to address social determinants of health that impede PrEP uptake such as housing instability, transportation barriers, and stigma.

424. SUPPORTING EDUCATION AND ACCESS TO POSTEXPOSURE DOXYCYCLINE (DOXYPEP)
Introduced by LGBTQ+ Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-425.960

RESOLVED, that our AMA supports physician and trainee education on Postexposure Doxycycline (DoxyPEP) and other anti-microbial postexposure treatments;

RESOLVED, that our AMA supports prescribing and insurance coverage of Postexposure Doxycycline (DoxyPEP) for sexually transmitted infection (STI) prevention.

425. PRIORITIZING, MEASURING, AND PREVENTING WORKPLACE VIOLENCE IN HEALTH CARE
Introduced by American College of Emergency Physicians

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-515.972

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.

RESOLVED, that our AMA advocate for the development and implementation of standardized, mandatory reporting mechanisms for workplace violence incidents across all health care settings, with appropriate protections for patient and worker privacy.

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.

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.

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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.

RESOLVED, that our AMA rescind existing policies D-515.983 (Preventing Violent Acts Against Health Care Providers), and H-515.966 (Violence and Abuse Prevention in the Health Care Workplace).

RESOLVED, that our American Medical Association seek legislation, and/or craft model state legislation, calling for civil and/or criminal penalties to be established for any healthcare institution or administrator that tries to discourage, or in any way disincentivize, the reporting of workplace violence

426. INTEGRATING NUTRITION INTO HEALTH CARE DELIVERY TO REDUCE CARDIOVASCULAR RISK AND FOOD INSECURITY ("FOOD IS MEDICINE")
Introduced by American College of Cardiology and American College of Lifestyle Medicine

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-150.911

RESOLVED, that our American Medical Association recognizes "food is medicine" interventions—including medically tailored meals, medically tailored groceries, and produce prescription programs—as promising evidence-informed strategies to improve health outcomes, reduce diet-related chronic disease, and address food insecurity, while supporting continued research and evaluation of these interventions.

RESOLVED, that our AMA supports federal efforts to integrate nutrition services into health care delivery as well as funding for "food is medicine" initiatives through the yearly Labor–HHS appropriations process.

RESOLVED, that our AMA encourages collaboration with relevant specialty societies, including the American College of Cardiology, and supports research, education, and implementation efforts to advance "food is medicine" interventions in clinical practice, with emphasis on improving cardiovascular outcomes, reducing health disparities, and lowering health care costs.

427. INFANT FEEDING OPTIONS FOR HIV-SEROPOSITIVE INDIVIDUALS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-20.916

RESOLVED, that the American Medical Association amend Policy H-20.916, "Breastfeeding and HIV Seropositive People," by addition and deletion as follows:

> Breastfeeding and HIV Seropositive People, H-20.916
> Our American Medical Association believes that, where safe and alternative nutrition is widely available, HIV seropositive people should receive evidence-based, patient-centered counseling to support shared decision-making about infant feeding. Patients living with HIV who are using antiretroviral therapy (ART) and have a sustained undetectable viral load and who choose to breastfeed should be supported in this decision. ~~be counseled not to breastfeed and not to donate breast milk.~~ HIV testing of all human milk donors should be mandatory, and milk from HIV-positive donors, even if the viral load is suppressed, should not be donated.

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428. PROTECTING ENVIRONMENTAL HEALTH BEFORE, DURING, AND AFTER WAR
Introduced by Medical Student Section and Resident and Fellow Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-135.896

RESOLVED, that our American Medical Association supports the inclusion of drinking water sources and sanitation facilities, agricultural land, fisheries, and nature reserves as protected zones during active conflict, weapons production, and military activities.

RESOLVED, that our AMA supports clean-up and restoration of, toxic exposures and environmental harm related to military activities, including armed conflict and weapons production, that lead to adverse health outcomes.

RESOLVED, that our AMA supports the development, availability, and use of continued medical education for clinicians to take exposure histories, counsel patients, and report sentinel events in displaced and conflict-affected populations impacted by environmental health harms

429. ADOLESCENT DATING VIOLENCE COMPREHENSIVE SCREENING TOOL DEVELOPMENT
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy D-515.980

RESOLVED, that our American Medical Association ask relevant stakeholders, including federal agencies, academic institutions, and professional societies, to support the development of validated, culturally sensitive, LGBTQ+ inclusive adolescent-specific screening tools for adolescent intimate partner violence that can be easily implemented in the clinic setting.

430. SUPPORT HEAVY METAL AND TOXIC EXPOSURE TESTING FOR RESIDENTS AFFECTED BY WILDFIRES
Introduced by Medical Student Section, Oregon, Washington

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-135.895

RESOLVED, that our American Medical Association supports the development, dissemination, and implementation of voluntary post-wildfire toxicant exposure screening protocols, covering heavy metals, polycyclic aromatic hydrocarbons (PAHs), and other dangerous air pollutants and toxic substances, for wildfire-impacted individuals and communities, in coordination with appropriate public health and environmental agencies, universities, public health schools and societies.

RESOLVED, that our AMA support federal and state efforts, in partnership with public health and environmental agencies, to ensure access to environmental monitoring, mobile health services, medical follow-up, and treatment for individuals exposed to toxic substances during or after wildfire events, with particular attention to frontline, vulnerable and disproportionately impacted communities.

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431. SUPPORTING TRANSPORTATION INFRASTRUCTURE REFORM FOR PUBLIC HEALTH
Introduced by Medical Student Section, American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-15.947

RESOLVED, that our American Medical Association support street design strategies that 1.) facilitate the construction of integrated, multimodal transportation infrastructure that prioritizes the health, safety, and accessibility of all road users using context-sensitive designs; 2.) prioritize developing a transportation system with zero deaths and zero serious injuries for all road users regardless of age or ability; and 3.) ensure everyone has the right to access roads that are designed with the safety of all users in mind, placing a special emphasis on addressing safety in underserved communities including but not limited to rural areas, low-income neighborhoods, and communities of color.

RESOLVED, that our AMA support reform of federal transportation non-motorized travel performance monitoring and funding formulas, to explicitly prioritize vulnerable road user metrics, accessibility to destinations and services such as transit, jobs, and healthcare, and other health outcomes alongside vehicle miles traveled and level-of-service when calculating success of roads.

432. ADDRESSING PUBLIC HEALTH RISKS OF ONLINE GAMBLING
Introduced by Medical Student Section, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Addiction Psychiatry, American Academy of Psychiatry and the Law

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-275.939

RESOLVED, that our American Medical Association support efforts to establish federal and state consumer protections for online gambling, including sports betting, prediction markets, and daily fantasy sports, to reduce harms associated with gambling disorder and other related behaviors;

RESOLVED, that our AMA support epidemiological research to characterize the health impacts of online gambling, including sports betting, prediction markets, and daily fantasy sports, with particular attention to adolescents, young adults, older adults, people with cognitive impairment, and other vulnerable populations.

433. ADDRESSING THE EPIDEMIC OF FRAGILITY FRACTURES THROUGH IMPROVED OSTEOPOROSIS SCREENING AND TREATMENT
Introduced by Texas

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-425.959

RESOLVED, that our American Medical Association recognize fragility fractures and untreated osteoporosis as a significant and urgent public health issue in the United States.

RESOLVED, that our AMA support expanded and evidence-based osteoporosis screening efforts, including improved access to dual-energy X-ray absorptiometry scanning and Fracture Risk Assessment Tool evaluations for at-risk populations.

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RESOLVED, that our AMA encourage health systems, hospitals, and physician groups to develop and implement coordinated fracture liaison services and secondary fracture prevention programs.

RESOLVED, that our AMA advocate for legislation or regulation for improved insurance coverage and payment policies for osteoporosis screening, diagnosis, pharmacologic treatment, and follow-up care.

RESOLVED, that our AMA support nationwide public and physician education initiatives aimed at increasing awareness of osteoporosis risk factors, prevention, and the importance of post-fracture evaluation.

434. VACCINATIONS IN PHYSICIAN OFFICES
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: POLICY H-440.860
REAFFIRMED IN LIEU OF RESOLUTION 434

RESOLVED, that our American Medical Association supports efforts to educate the public about the benefits of lifestyle changes that may reduce breast cancer risk, including regular physical activity, maintenance of a healthy body weight, a healthy plant-based diet, and limiting alcohol intake.

RESOLVED, that our AMA encourages physicians to regularly discuss with their individual patients the benefits of lifestyle changes that may reduce cancer risk;

435. SUPPORTING REGULATIONS FOR MORE STRINGENT SAFETY MEASURES FOR MICROMOBILITY
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy D-10.989

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

1. Helmets, certified by the US Consumer Safety Product Commission and rated for speed, should be worn for all and be mandatory for Class 3 e-bikes and all scooters;
2. Additional gear should include elbow pads, knee pads, wrist guards, closed-toe footwear and high-visibility or reflective gear for use at nighttime;
3. Headphones should be avoided during use;
4. E-scooters and Class 3 e-bikes should have a minimum age of 16 to operate;
5. Require education and training for Class 3 e-bikes;
6. Define where e-bikes can be ridden both on and off-road, including speed limits on shared paths and no operation allowed on sidewalks;
7. No distractions while operating;
8. No passengers while operating;
9. Regulate out-of-class products and anti-tampering;
10. Training required to operate devices, including smooth and consistent braking at high speeds and basic traffic rules;

RESOLVED, that our AMA advocate for standardized injury surveillance and reporting of micromobility-related injuries at the state and national level, including integration into existing trauma registries and public health reporting systems.

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

436. PROTECTING CHILDREN FROM POTENTIAL HARMS OF CAFFEINATED PRODUCTS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies D-150.976 and H-150.988

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

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

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

1. Our American Medical Association will seek necessary regulatory action through the US Food and Drug Administration to regulate potentially hazardous energy beverages (like Red Bull (TM), Rockstar (TM), Monster (TM), Full Throttle (TM)) with special attention to scientific evidence of harm to children less than 12 years old and adolescents between 12 and 18 years old.
2. Our AMA will seek federal regulation to implement warning labels about the side effects of the contents of energy drinks, particularly when combined with alcohol with specific warning of harm to children below the age of 18.
3. Our AMA supports a ban on the marketing of "high stimulant/caffeine drinks" to children/adolescents under the age of 18, including opposing commercial advertising, sponsorships, and promotional practices that target or appeal to children and adolescents.

437. ADDRESSING HOUSING NEEDS OF THE NATIVE HAWAIIAN AND THEIR DIASPORA
Introduced by Underrepresented in Medicine Advocacy Section, Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-350.931

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

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

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438. PRESERVING AND STRENGTHENING MATERNAL MORTALITY REVIEW COMMITTEES (MMRCS)

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ALTERNATE RESOLUTION 438 ADOPTED IN LIEU OF RESOLUTION 438
See Policy H-60.909

RESOLVED, that our American Medical Association strongly opposes actions that undermine the independence, transparency, or scientific integrity of maternal mortality review and condemns undue interference with state MMRCs.

RESOLVED, that our AMA urge Congress to:
a) Require that all states use centralized maternal child health surveillance and data systems, such as the Maternal Mortality Review Information Application, to ensure ability to aggregate US maternal data;
b) Ensure timely public reporting of findings and recommendations while maintaining individual case confidentiality; and
c) Create whistleblower protections for MMRC members who report undue influence or data suppression.

RESOLVED, that our AMA calls upon state medical societies and physician advocates to:
a) Monitor state MMRC activities for signs of interference or funding threats; and
b) Support MMRC recommendations that lead to quality improvement, reduction in preventable deaths, and address non-medical drivers of health.

RESOLVED, that our AMA reaffirm H-60.909, State Maternal Mortality Review Committees.

439. AGE VERIFICATION AND ENDS PRODUCTS
Introduced by American Thoracic Society

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-495.971

RESOLVED, that our American Medical Association opposes FDA's decision to authorize ENDS products with fruit characterizing flavors.

RESOLVED, that our AMA continues to oppose the authorization of any ENDS products with characterizing flavors, including but not limited to fruit, candy, dessert, mint, and menthol flavors, that may enhance the appeal of such products to youth.

RESOLVED, that our AMA advocate to FDA and others, that the sponsor of any electronic nicotine delivery system (ENDS) product considered for FDA authorization be required to product share the data used to prove the effectiveness and durability of age-verification used.

RESOLVED, that our AMA advocate that the FDA Committee on Tobacco Products require and implement effective post market surveillance data collection to measure the effectiveness and durability of any ENDS age-verification systems; and be it further

RESOVED, that our AMA urge FDA to take immediate action to remove authorized ENDS products from the market should age-verification technology prove to be insufficient to prevent youth initiation.

RESOLVED, that our AMA advocate that the FDA establish and maintain a high proof of effectiveness and durability threshold for age-verification systems for ENDS products to prevent youth access.

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REFERENCE COMMITTEE E

501. PREREGISTRATION IN MEDICAL RESEARCH
Introduced by Academic Physicians Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-460.941

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

Our AMA will:
(1) take every appropriate opportunity during the health system reform debate and implementation stages to educate the public, the Administration, and Congress about the importance of support for science and biomedical research and about the potential problems if these areas are not given sufficient consideration in health system reform;
(2) take steps to become the coordinating point for efforts, both within and outside of the Federation, to promote, enhance, and defend biomedical science;
(3) continue and expand its efforts to advocate for the primacy of science and biomedical research as the basis of quality medical care by working with and influencing both the private sector and the federal government, including the legislative, executive, and judicial branches;
(4) take necessary steps to monitor the scientific enterprise, establish programs and policies as appropriate, and initiate advocacy efforts as needed;
(5) consider and take the necessary steps to anticipate and establish guidelines to assist physicians and others in responding to the ethical issues emerging from the scientific revolution;
(6) increase its educational efforts to the public and to the profession to explain how science is critical to the future of the profession and to the future development of high quality medical care; and
~~(7) support preregistration in order to mitigate publication bias and improve the reproducibility of biomedical research.~~
(7) recognize the importance of preregistration in advancing rigorous and reproducible biomedical research; and
(8) study the use of preregistration in medical research, including standardized registries, education on preregistration practice, and alignment with transparency and accountability.

502. SUPPORT FOR RAPID INPATIENT STABILIZATION AND LINKAGE TO CARE FOR PREGNANT PATIENTS WITH OPIOID USE DISORDER
Introduced by Washington

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-95.946

RESOLVED, that our American Medical Association will advocate removal of barriers to the development and implementation of pregnancy-specific treatment pathways for pregnant patients with Opioid Use Disorder, including:
a. Encouraging treatment tailored for pregnancy and the individual patient (i.e. choice of medication, dosage, and frequency of dosing) informed by clinical evaluation, history, available resources, and patient and physician preference;
b. Advocating for medication take home flexibilities for pregnant patients;
c. Ensuring that institutions have care pathways in place to dispense adequate medication for 72 hours to allow time to link to ongoing treatment;
d. Encouraging the development of hospital-based medication initiation protocols that allow for faster dose titrations due to medical monitoring;

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e. Advocating for coverage for tailored treatment of opioid use disorder in pregnant patients; and
f. Ensuring linkage to prenatal care as well as addiction treatment (level of care based upon patient need) prior to discharge.

503. EXPANSION OF PSYCHEDELIC ASSISTED THERAPY (PAT)
Introduced by Pennsylvania

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED
See Policies H-100.943 and H-120.917

RESOLVED, that our American Medical Association reaffirm policies H-120.917 and H-100.943.

504. STRENGTHENING U.S. RUBBER GLOVE PRODUCTION AND PURCHASE WHILE REDUCING FOREIGN FORCED-LABOR DEPENDENCE
Introduced by Delaware

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: POLICIES H-100.956 and H-440.847 REAFFIRMED IN LIEU OF RESOLUTION 504

RESOLVED, that our American Medical Association advocate with the appropriate Federal agencies to prioritize production and procurement of domestically manufactured rubber gloves and their component materials consistent with the Buy American Act.

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

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

505. AVOIDING MISUSE OF ARTIFICIAL INTELLIGENCE (AI) IN CLINICAL PRACTICE
Introduced by New York

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies D-480.950, H-480.940 and H-480.931

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

RESOLVED, that Policy H-480.931 and Policy H-480.940 be reaffirmed.

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506. ACCESS TO GENDER AFFIRMING HEALTHCARE INCLUDING CLINCIAL TRAILS
Introduced by

Resolution 506 was considered with Resolution 509. See Resolution 509.

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

RESOLVED, that our AMA calls for continued research including clinical trials regarding the evidence of the effectiveness of puberty blockers (GnRH analogs) on transgender and non-binary youth.

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

507. PAIRING BEHAVIORAL AND LIFESTYLE MEDICINE PRINCIPLES AND PRACTICE WITH GLUCAGON-LIKE PEPTIDE-1 (GLP-1) RECEPTOR AGONISTS AND OTHER ANTI-OBESITY MEDICATIONS
Introduced by American College of Lifestyle Medicine, Underrepresented in Medicine Advocacy Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-440.901

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

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

RESOLVED, that our AMA advocate for coverage, reimbursement, and sustainable payment models that support the delivery of clinician-led, therapeutic, and structured lifestyle intervention programs as a component of glucagon-like peptide-1 receptor agonist's and other anti-obesity medication therapy, particularly for underserved, rural, and historically marginalized populations, to mitigate disparities in access and outcomes, provided that coverage of these medications shall not be conditioned upon participation in such lifestyle intervention programs..

508. ALIGNING CONSISTENCY AND CREDIBILITY OF DIRECT-TO-CONSUMER GUT MICROBIOME TESTING SERVICES
Introduced by American College of Lifestyle Medicine

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: REFERRED

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

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RESOLVED, that our AMA advocate for review and graded recommendation by the United States Preventive Services Task Force on the use of Direct-to-Consumer Gut Microbiome Testing Services with regard to quality, reliability, reproducibility and validity.

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

509. GENDER AFFIRMING HEALTHCARE AND RESEARCH

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ALTERNATE RESOLUTION 509
ADOPTED IN LIEU OF RESOLUTION 506 AND 509
See Policy D-460.957

RESOLVED, that our American Medical Association affirms that gender affirming healthcare (GAHC) includes social, medical and surgical GAHC with a shared decision-making process involving the physician, patient and legal guardians, when applicable.

RESOLVED, that our AMA advocate and support new and restored funding, as well as opportunities for GAHC research across modalities and age ranges, ensuring that such research and guideline development meaningfully involve clinicians who provide this care, researchers who study affected populations, and members of the impacted communities to strengthen the evidence base and uphold scientific integrity.

RESOLVED, that our AMA collaborate with relevant specialty societies and multidisciplinary experts to support education and promote educational resources for physicians and trainees on evidence-based, patient-centered, shared decision-making GAHC.

510. EXOSOME AND PEPTIDE USE IN HEALTHCARE
Introduced by North Carolina

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: REFERRED

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

1) Categorizing Exosomes and Peptides by their longevity, wound healing and regenerative potentials.
2) Encouraging the manufacture and processing of Exosomes and Peptides in the United States.
3) Work with the FDA to properly reclassify Exosomes and Peptides to allow Physicians to order and dispense Exosomes and Peptides properly sourced from FDA-approved pharmacies to patients to treat appropriate patient medical concerns including wound healing, improved health and longevity.
4) Work to advise Congress to propose an amendment to the NDAA for FY2027 that addresses appropriate use of Exosomes and Peptides within the Armed Services and VA system to improve Soldier and Veteran Healthcare, especially in acute and chronic wound healing.
5) Encourage additional trials and testing of Exosome and Peptide use protocols to firmly establish their efficacy as necessary.
6) Refer this issue to the AMA Council on Science and Public Health for study and report back at Interim 2026 due to the urgency of passing an amendment to the NDAA for FY2027.

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511. PRESERVING SPECIALTY ACCESS TO ANTI-CANCER MEDICATIONS

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ALTERNATE RESOLUTION 511
ADOPTED IN LIEU OF RESOLUTION 511
See Policy D-100.958

RESOLVED, that our AMA support multidisciplinary, evidence-based cancer care models and oppose single-specialty restrictions on physician prescribing and/or administering anti-cancer medications when their use falls within the physician's education, training and clinical practice and institutional safety and infrastructure standards are met.

RESOLVED, that our AMA support appropriate, targeted policies and protocols related to the safe transportation, administration, and proper disposal of anti-cancer medications.

RESOLVED, that our AMA advocate against policies that restrict physician use of anti-cancer medications based solely on specialty designation rather than clinical competency, training, and patient need.

512. CANNABIS USE IN OLDER ADULTS
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-95.893

RESOLVED, that our American Medical Association support the development and publication of educational resources on cannabis directed towards clinicians, including a virtual educational presentation that reviews the known effects of medical cannabis in older adults that highlights both its potential benefits and risks.

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

513. ACCESS, AFFORDABILITY, AND SAFETY OF GLP-1 RECEPTOR AGONISTS
Introduced by Texas

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-110.979

RESOLVED, that our American Medical Association advocate for legislation and/or regulation so that public and private health insurers provide GLP-1 receptor agonists for the treatment of type 2 diabetes and obesity at affordable formulary pricing, thereby reducing out-of-pocket costs for patients.

RESOLVED, that our AMA advocate for pricing transparency and cost-containment strategies among manufacturers, payers, and policymakers to improve affordability and access to evidence-based obesity and diabetes treatments.

RESOLVED, that our AMA encourage the use of GLP-1 receptor agonists in accordance with evidence based clinical indications and risk benefit analysis, within comprehensive care plans that include behavioral and lifestyle interventions.

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RESOLVED, that physicians and other prescribers of anti-obesity medications including GLP-1 receptor agonists evaluate individuals for body image concerns, weight history, history of prior and current eating disorders and prior or current treatment for eating disorders before prescribing such medications.

514. OBSTRUCTIVE SLEEP APNEA DURING PREGNANCY

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: **ALTERNATE RESOLUTION 514**
ADOPTED IN LIEU OF RESOLUTION 514
See Policy H-440.785

RESOLVED, that our AMA recognizes the potential negative outcomes of obstructive sleep apnea in pregnancy and supports education and training of physicians to engage patients about the potential impacts.

RESOLVED, that our AMA encourage continued research on the impact of obstructive sleep apnea on pregnancy and adverse pregnancy outcomes.

RESOLVED, that our AMA support insurance coverage and physician payment for screening and treatment of obstructive sleep apnea in pregnancy.

515. TRANSPARENCY IN AI-DRIVEN ADVERSE DETERMINATIONS & CLINICAL LOGIC DISCLOSURE

Introduced by Association for Clinical Oncology

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-480.949

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

RESOLVED, that our AMA advocate that any AI-driven or algorithmic tool used for clinical review must be transparently audited with re-audits triggered by material changes to the AI model, its training data, or applicable clinical guidelines, and with periodic comprehensive audits at minimum annually regardless of such changes, to ensure it reflects current evidence-based clinical guidelines and recognized standards of care.

516. FDA REGULATION OF UNAPPROVED SYNTHETIC PEPTIDES

Introduced by

Reference committee hearing: see report of Reference Committee E.

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HOD ACTION: FIRST RESOLVE ADOPTED AS FOLLOWS
SECOND RESOLVE REFERRED
See Policy H-100.939

RESOLVED, that our American Medical Association (AMA), recommends that unapproved synthetic peptide products undergo FDA regulatory review, third-party testing, and demonstration of safety and efficacy through well-conducted clinical trials before marketing or clinical use.

[Editor's note: The following resolve was referred]
RESOLVED, that our AMA submit comments to the Food and Drug Administration (FDA) regarding the July 2026 Pharmacy Compounding Advisory Committee review of synthetic peptide products, advocating for evidence-based regulatory oversight, third-party testing, and demonstration of safety and efficacy prior to marketing, compounding, or clinical use.

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REFERENCE COMMITTEE F

601. BOARD CHAIR TERM LIMITS
Introduced by Pennsylvania, Florida, New York, Texas

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: RESOLUTION 601 ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 609
See Policy G-605.008

RESOLVED, that our American Medical Association utilize an independent assessment by recognized nonprofit governance experts to evaluate best practices in board-chair term lengths, leadership continuity, and succession planning within large national nonprofit and professional membership organizations.

RESOLVED, that our AMA examine how board-chair tenure and leadership succession structures influence the Board of Trustees' ability to provide consistent oversight of senior management, monitor multi-year strategic and operational performance goals, preserve institutional knowledge, and maintain accountability to the House of Delegates and AMA membership.

RESOLVED, that our AMA provide the full report of the independent assessment, including benchmarking analyses and governance recommendations, to the House of Delegates no later than the 2027 Annual Meeting of the AMA.

RESOLVED, that our AMA Board of Trustees review the findings of the independent assessment and present to the House of Delegates at the 2027 Annual Meeting specific recommendations regarding governance best practices for board-chair tenure and leadership continuity, including any proposed amendments to the AMA Constitution and Bylaws for consideration by the House of Delegates.

602. PROTECTION OF HEALTHCARE AND HUMANITARIAN AID PERSONNEL IN CONFLICT ZONES
Introduced by Oregon

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-520.985

RESOLVED, that our American Medical Association will amend H-520.985 Protection of Healthcare and Humanitarian Aid Workers in all Areas of Armed Conflict by addition to read as follows:

a. Our American Medical Association supports peace in ~~Israel and Palestine~~ in the world in order to protect civilian lives and healthcare personnel.
b. Our American Medical Association supports the safety of healthcare and humanitarian aid workers along with safe access to healthcare, healthcare facilities, and humanitarian aid for all civilians in areas of armed conflict.
c. Our American Medical Association condemns targeting, detention, or attack of non-combatant healthcare workers and humanitarian personnel, and our AMA also condemns the use of healthcare workers, humanitarian personnel, and healthcare institutions for military purposes or as shields for military operations.

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603. ESTABLISH AMA POLICY AND PROJECT TO COMPILE AND DISTRIBUTE JAMA PATIENT PAGES TO ENHANCE PUBLIC MEDICAL LITERACY
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee F.
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HOD ACTION: ADOPTED AS FOLLOWS
See Policy G-630.009

RESOLVED, that our American Medical Association publicize the existence and value of JAMA Patient Pages as a resource for public health education and medical literacy.

RESOLVED, that our AMA explore opportunities to promote awareness, utilization and ease of use of JAMA Patient Pages among patients, physicians and healthcare institutions.

604. ANNUAL SCORECARD TO EVALUATE THE AMA'S IMPACT
Introduced by Michigan

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy G-625.009

RESOLVED, that our American Medical Association shall implement a comprehensive scorecard to measure its effectiveness in key areas including, but not limited to, the following specific metrics:

1. Medicare Impact: percent change in the Medicare Physician Fee Schedule;
2. Advocacy Impact: number of federal policies successfully influenced or implemented;
3. House of Delegates Impact: number of AMA policies translated into legislation or federal policy;
4. Financial Impact: percentage of revenue dedicated to advocacy; and,
5. Physician Engagement: total number of its member physicians directly engaged in advocacy efforts through contact with lawmakers.

RESOLVED, that our AMA shall review metric definitions and targets and provide a report by the 2027 AMA Annual Meeting. Any future updates to metrics or targets shall be recommended via a report to the AMA House of Delegates so that the AMA HOD can approve final metrics and targets for the subsequent year before or during the AMA Interim Meeting immediately preceding the year the metrics and targets are to take effect.

RESOLVED, that our AMA shall publish the AMA's scorecard performance for the prior year by the end of the first month of the following year, starting in January 2028.

605. REVIEW OF PAST RESOLUTIONS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: REFERRED WITH REPORT BACK AT A-27

RESOLVED, that our American Medical Association consider presenting, by the 2027 AMA Annual Meeting, a detailed and aggregate report that is easily accessible and includes the following data for the past 10 years; the total number of resolutions submitted and passed; the number of those resolutions specific to advocacy on the sustainability of medical practices; a breakdown of these resolutions by Annual and Interim meetings; and the percentage of resolutions that have been successfully implemented. The report shall be produced on an annual basis and included in the Annual meeting handbook.

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606. FURTHER ENABLING AMA BOT EXPEDIENCY FOR ACTIONS, ADVOCACY, AND RESPONSES DURING URGENT SITUATIONS
Introduced by American Society of Plastic Surgeons; American Association for Hand Surgery; American Society for Aesthetic Plastic Surgery; American Society for Maxillofacial Surgeons; American Society for Reconstructive Microsurgery; Michigan State Medical Society; Missouri State Medical Association

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association amend G.600.071, "Actions and Decisions by the AMA House and Policy Implementation" to read as follows:

8. Our AMA shall develop such processes as the BOT deems appropriate to ensure the BOT is apprised on a weekly basis of AMA activity related to the policy actions and directives adopted by the House of Delegates that occurred through:
    a. the formal meetings and notable informal meetings with stakeholders and policymaking entities;
    b. the formal correspondence, comments, or testimony submitted by the AMA
    c. notable informal correspondence exchanged between AMA management and policymakers or other stakeholders;
    d. the relevant correspondence received from the leadership of entities in organized medicine, the federal government, or any other relevant sector; and
    e. any developments with respect to new or existing policy concepts, policy negotiations, or policy proposals on transformational national health policies.
9. Our AMA BOT will be directly informed and consulted prior to the onset of and throughout the course of any negotiations between AMA management and federal policymakers on transformational changes to national health policies, such as alteration of the methodology for reimbursing physicians under any component of the public sector payer apparatus or the sunsetting or creation of any program that is likely to impact more than half of all Medicare participating providers.

607. SHORTENING THE AMA HOUSE OF DELEGATES ENDORSEMENT PROCESS AND TIMELINE
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED
See Policy G-610.090

RESOLVED, that our American Medical Association amend Policy G-610.090, "AMA Election Rules and Guiding Principles," by addition and deletion, effective immediate to the 2028 election endorsement cycle, to read as follows:

G-610.090 AMA Election Rules and Guiding Principles...
XI. Endorsements
1. Our American Medical Association requires all groups that endorse candidates turn in information about their endorsement process, the deadline, and a staff contact for applications in a timely and streamlined manner, no later than 30 days prior to the start of the Interim Meeting preceding the Annual Meeting at which the election is to take place.
2. Our AMA will then post this information on the election website in a timely manner, with the information being easily digestible and accessible.
3. Our AMA will not allow any group that fails to provide this information in a timely manner to offer an endorsement during that election cycle.
4. Our AMA will create a specific period (similar to virtual elections) during which endorsements may be sought, with the endorsement window opening at the commencement of the Interim Meeting immediately preceding the Annual Meeting at which the election is to take place.

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608. UPDATING THE AMA GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ALTERNATE RESOLUTION 608 ADOPTED IN LIEU OF RESOLUTION 608
See Policy H-365.987

RESOLVED, that our American Medical Association Board of Trustees develop, with input from physician stakeholders, relevant specialty societies, and users of the *AMA Guides to the Evaluation of Permanent Impairment*, a plan for ongoing updates, clinical oversight, transparency, governance, and sustainable funding of the AMA Guides to the Evaluation of Permanent Impairment with a goal of creating the most effective model to encourage the uptake of up-to-date information when evaluating impaired patients, and report back on that plan at the 2027 Annual Meeting.

RESOLVED, that our AMA continue the work of timely chapter updates for the *AMA Guides to the Evaluation of Permanent Impairment*, Sixth Edition 2025 that have not yet been addressed, in order to ensure that new evidence or diagnostic criteria is incorporated into chapter updates, ensuring the utilization of specialty-specific physician input in the evaluation of permanent impairment.

RESOLVED, that Policy H-365.987, which states that "It is the policy of the AMA: (1) to pursue the comprehensive revision and updating of the Guides to the Evaluation of Permanent Impairment with input from physicians in all appropriate specialty groups; and (2) to consider developing appropriate methods to facilitate the use of the Guides, including expansion of introductory instructions," be reaffirmed.

609. AMERICAN MEDICAL ASSOCIATION BOARD CHAIR TERM LIMITS

Introduced by New York

Resolution 609 as considered with Resolution 601. See Resolution 601.

RESOLVED, that our American Medical Association Board of Trustees commission an independent assessment by recognized nonprofit governance experts to evaluate best practices in board-chair term lengths, leadership continuity, and succession planning within large national nonprofit and professional membership organizations.

RESOLVED, that this independent assessment examine how board-chair tenure and leadership succession structures influence the Board of Trustees' ability to provide consistent oversight of senior management, monitor multi-year strategic and operational performance goals, preserve institutional knowledge, and maintain accountability to the House of Delegates and American Medical Association membership.

RESOLVED, that the Board of Trustees provide the full report of the independent assessment, including benchmarking analyses and governance recommendations, to the House of Delegates no later than the 2027 Annual Meeting of the American Medical Association.

RESOLVED, that the Board of Trustees review the findings of the independent assessment and present to the House of Delegates at the 2027 Annual Meeting specific recommendations regarding governance best practices for board-chair tenure and leadership continuity, including any proposed amendments to the American Medical Association Constitution and Bylaws for consideration by the House of Delegates.

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610. PLANT-BASED DIETS AT AMA MEETINGS
Introduced by New York and American College of Lifestyle Medicine

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy G-630.140

RESOLVED, that our American Medical Association encourages the use of evidence-based behavioral science strategies to promote healthier dietary choices at professional gatherings, while respecting individual autonomy.

RESOLVED, that our American Medical Association recognizes the importance of modeling prevention through food choices at its own meetings whenever possible, with an emphasis on increasing the plant-based food choice options which also contain minimal contributions from animal products, as an exemplary method for the promotion of individual and planetary health.

611. PUBLICIZING, SUPPORTING, AND PROMOTING (APPROPRIATE) AMA MEMBER PHYSICIANS AND PHYSICIAN SPOUSES AS CANDIDATES FOR LOCAL AND STATE OFFICES
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: FIRST AND SECOND RESOLVES REFERRED
THIRD RESOLVE ADOPTED AS FOLLOWS
See Policy G-640.004

[Editor's note: the following resolve was referred]
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".

[Editor's note: the following resolve was referred]
RESOLVED, that our AMA study the:

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.

[Editor's note: the following resolve was adopted]
RESOLVED, that the AMA will present for information via the AMA website an annual Physician+Alliance Election Report detailing the outcomes for physician and physician spouse candidates, beginning with the 2026 General Election in November, to include a scorecard identifying all such candidates who ran at the state or national level to include office sought, election district, party affiliation, any medical PAC endorsements, final election results with margins (+/-) and other pertinent details.

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612. INCREASING EXPERT GUIDANCE IN AMA STATEMENTS
Introduced by LGBTQ+ Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy G-605.007

RESOLVED, that our American Medical Association consult with multiple experts representing various disciplines when crafting specialist care focused statements, especially statements predominantly discussing care for vulnerable populations, to reduce the risk of harm to said populations.

613. PRESERVING INSTITUTIONAL EQUITY AND INCLUSIVITY EFFORTS
Introduced by LGBTQ+ Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: **ALTERNATE RESOLUTION 613**
ADOPTED IN LIEU OF RESOLUTION 613
See Policy G-630.008

RESOLVED, that our AMA preserve and maintain its "Optimal Health Outcomes"-focused resources on the AMA website and the AMA EdHub.

RESOLVED, that our AMA increase transparency regarding resource alterations or removal.

RESOLVED, that, when possible, our AMA limit substantive alterations to "Optimal Health Outcomes"-focused resources unless dictated by AMA policy.

614. INCLUSIVE POLICY LANGUAGE FOR OLDER ADULTS
Introduced by American Geriatrics Society

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: **NOT ADOPTED**
See Policy TBD

RESOLVED, that our American Medical Association will instruct all future policy language to use terms for those over the age of 65 to be "older persons", "older people", "older adults", "older patients", "older individuals", "persons 65 years and older", "the older population", or preferred terminology from a specific group of older adults (e.g., Native American elders), in order to avoid a connotation of discrimination and negative stereotypes.

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615. PROTECTION OF NON-COMBATANT HEALTHCARE WORKERS AND FACILITIES IN CONFLICT AREAS
Introduced by Resident and Fellow Section and Underrepresented in Medicine Advocacy Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-520.985

RESOLVED, that our American Medical Association recognize the deliberate targeting of non-combatant healthcare workers, medical students, and healthcare facilities in all areas of conflict as a violation of medical neutrality and AMA policy.

RESOLVED, that our AMA supports efforts to protect, release, and provide restitution to detained non-combatant healthcare workers in all areas of conflict.

616. HUMANITARIAN AND MEDICAL AID SUPPORT TO PALESTINE
Introduced by Resident and Fellow Section and Underrepresented in Medicine Advocacy Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association supports efforts to contribute funds to support the humanitarian crisis in Gaza.

RESOLVED, that our AMA advocate for continuous support of organizations providing humanitarian missions and medical care to Palestinian refugees in Palestine, in nearby countries, and/or in the US.

RESOLVED, that our AMA advocate for an early implementation of mental health measures and address war-related trauma and post-traumatic stress disorder when dealing with Palestinian refugees with special attention to vulnerable populations including but not limited to young children, their parents, pregnant people, and the elderly.

617. REEVALUATION OF AMA POLICY REGARDING SUPPORT FOR SPECIFIC NATIONAL MEDICAL ASSOCIATIONS IN THE WORLD MEDICAL ASSOCIATION
Introduced by Resident and Fellow Section and Underrepresented in Medicine Advocacy Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association rescind AMA policy D-250.990 “Israeli Medical Association” which states “Our AMA will oppose any efforts to expel the Israeli Medical Association from the World Medical Association.”

RESOLVED, that our AMA's position on business in the World Medical Association (WMA) related to applications for constituent membership, or discipline or termination for current constituent members shall be based on the prevailing evidence at the time.

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618. ENDING AMA INVESTMENT IN WEAPONS MANUFACTURERS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, that our American Medical Association divest from all companies that derive a majority of their revenue from the manufacturing of weapons, cluster munitions, chemical, biological, or nuclear weapons, or key component of these weapons.

RESOLVED, that our AMA report back to the House of Delegates at A-27 on what progress has been made towards divestment.

619. OPPOSING FEDERAL IMMIGRATION OPERATIONS AT AMA EVENTS AND HARM TO LAWFUL NON-TARGET INDIVIDUALS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy G-630.140

RESOLVED, that our American Medical Association opposes federal immigration operations without a judicial warrant at AMA events.

RESOLVED, that our AMA supports federal, state, and institutional policies that prevent immigration enforcement actions from interfering with the ability of physicians, trainees, and other health care professionals to attend conferences, complete training, or provide patient care, except where required by a valid judicial order.

RESOLVED, that our AMA supports the use of visible identification by federal immigration enforcement personnel at physician conferences, in medical training sites, or in patient care settings

620. SURVEY OF MEDICAL STAFFS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED
See Policy D-225.969

RESOLVED, that our American Medical Association work with the Organized Medical Staff Section to sponsor a survey of sufficient statistical power to determine the spectrum of composition and influence of the contemporary medical staff across the United States, including but not limited to information such as:

- Is your hospital owned by a system, is it independent, or is it affiliated with a system?
- Do you have your own medical staff with officers? If part of a system, is there one medical staff for the system or does each facility have its own?
- What are the categories of medical staff membership? Please define these.
- Are the officers appointed by the hospital or are they elected by the medical staff?
- Is there a medical staff executive committee (MEC) that meets regularly? How often? Does it meet with hospital leadership? Do non-medical staff members have a vote on the MEC?
- To what degree are independent physicians (solo, members of group organizations, etc) versus employed physicians active in the administration of medical staff, i.e. involvement in committees or ad hoc initiatives?

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REFERENCE COMMITTEE G

701. PARTICIPATION OF SMALL PRACTICES IN VALUE-BASED PAYMENT (VBP) MODELS
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy H-160.881

RESOLVED, that our American Medical Association advocate to exempt practices from mandatory participation in value-based programs (VBP), including associated reporting requirements and penalties, when such practices meet one or more criteria indicating limited capacity to participate. This includes but is not limited to small practice size, lower Medicare fee-for-service revenue, low attributed patient volume, or practice location in rural or Health Professional Shortage Areas, unless the physician or practice voluntarily elects to participate.

702. Physicians Who Do Not Practice in Hospital Setting
Introduced by Pennsylvania

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-230.981

RESOLVED, that our American Medical Association amend D-230-981 as follows:

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.
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.
3. Our AMA advocate and/or support state medical associations in advocating that hospital privileges not be a requirement for insurance network participation.

703. MEDICATION PRICING PARITY
Introduced by Obesity Medicine Association

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy H-110.952

RESOLVED, that our American Medical Association actively oppose preferential pricing strategies by pharmaceutical manufacturers that offer discounted medications exclusively to telehealth or online providers, as such practices undermine the established physician-patient relationship and the continuity of care.

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704. ADVOCATING AGAINST AUTOMATIC REFILL REQUESTS
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED
See Policy D-120.917

RESOLVED, that our American Medical Association communicate effectively with large pharmacy chains and conglomerates for the purpose of explaining the unnecessary administrative burden of automatic, non-patient-initiated refill requests and petitioning them to require all medication refill requests use a patient directed "opt-in" approach;

RESOLVED, that our AMA petition the Centers for Medicare and Medicaid Services to restrict participating pharmacies from sending medication refill requests to physicians unless the patient "opts-in" to using the refill request.

705. RECOGNIZING PHYSICIANS AS SEXUAL ASSAULT FORENSIC EXAMINERS
Introduced by American Academy of Family Physicians

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-80.999

RESOLVED, that our American Medical Association Policy H-80.999 be amended as follows:

SEXUAL ASSAULT SURVIVORS, H-80.999

1. Our American Medical Association supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing clinicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to:
    a. receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, drug testing for drug-facilitated assault, treatment of injuries, and collection of forensic evidence;
    b. preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation;
    c. notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation;
    d. be informed of these rights and the policies governing the sexual assault evidence kit; and
    e. access to emergency contraception information and treatment for pregnancy prevention free of charge.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased patient access to Sexual Assault Medical ~~Nurse~~ Forensic Examiners for sexual assault medical forensic examinations.
5. Our AMA will advocate at the state and federal level for;
    a. the timely processing of all sexual examination kits upon patient consent;
    b. timely processing of "backlogged" sexual assault examination kits with patient consent; and
    c. additional funding to facilitate the timely testing of sexual assault evidence kits.
6. Our AMA supports the implementation of a national database of ~~Sexual Assault Nurse Examiner and~~ Sexual Assault Medical Forensic Examiners ~~providers.~~

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706. DISCHARGE SUMMARIES FROM SKILLED NURSING FACILITIES
Introduced by New York

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-160.880

RESOLVED, that our American Medical Association educate physicians as to Centers for Medicare and Medicaid Services (CMS) Policy (8) regarding skilled nursing facilities' (SNF) responsibility to create and timely deliver a comprehensive patient discharge summary to a patient's outpatient primary care physician (PCP).

RESOLVED, that our AMA advocate that CMS enforce its existing regulations on timely and comprehensive discharge summaries.

707. MALPRACTICE INSURANCE FOR EMPLOYED PHYSICIANS
Introduced by New York

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: REFERRED

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.

708. OPPOSE IMPOSITION OF FEES ON PHYSICIANS FOR ELECTRONIC PAYMENT TRANSFERS
Introduced by New York

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED
See Policy D-190.964

RESOLVED, that our American Medical Association asks Centers for Medicare & Medicaid Services (CMS) to issue a legally-binding rules compliant with the Administrative Procedure Act with a notice and comment period preventing the use of virtual credit cards or imposition of electronic funds transfer (EFT) fees, or any fees on Health Insurance Portability and Accountability Act (HIPAA) standard electronic transactions.

709. REQUIRING TRANSPARENCY AND ACCOUNTABILITY WHEN INSURERS AND THIRD-PARTY ADMINISTRATORS REQUIRE UTILIZATION REVIEW, THEREBY PRACTICING MEDICINE
Introduced by New York

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-285.939

RESOLVED, that our American Medical Association seek legislation and/or regulation regarding insurance company utilization reviewers to require the person charged with authorization decisions to provide their full name, specialty and National Provider Identifier (NPI), in order to maintain transparency, fulfill the requirements of the Health Insurance Portability and Privacy Act (HIPAA), and allow for accountability should the decision be called into question.

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RESOLVED, that our American Medical Association seek legislation and/or regulation regarding utilization review so that the reviewing physician be licensed in the appropriate state or jurisdiction and therefore, accountable to appropriate state medical boards or regulatory authorities for the consequences of these clinically important decisions.

RESOLVED that our American Medical Association amend their Policy H-285.939 as follows:

MANAGED CARE MEDICAL DIRECTOR LIABILITY

Our American Medical Association policy is that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine.

1. Our AMA seeks to include in federal and state patient protection legislation a provision subjecting medical directors of managed care organizations to state medical licensing requirements, state medical board review, and disciplinary actions.
2. That medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services, including prior authorizations.
3. That our AMA continue to undertake federal and state legislative and regulatory measures necessary to bring about this accountability.

710. PARITY IN ACCESS TO EVIDENCE-BASED OBESITY TREATMENT

Introduced by American Society for Metabolic and Bariatric Surgery, Society of American Gastrointestinal and Endoscopic Surgeons, Obesity Medical Association, American Academy of Sleep Medicine, American Association of Clinical Endocrinology, Medical Student Section and The Endocrine Society

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-440.784

RESOLVED, that our American Medical Association promote policies and recommend to all public and private health insurance plans to provide coverage parity for evidence-based obesity treatments, including chronic weight management medications, bariatric and metabolic surgery, intensive behavioral therapy, dietary counseling and medical nutrition therapy, equivalent to coverage provided for other chronic diseases such as type 2 diabetes and cardiovascular disease, without exclusionary carve-outs, annual or lifetime caps specific to obesity, or "fail first"/step therapy requirements not applied to comparable chronic conditions.

RESOLVED, that our AMA advocate for federal legislation to permanently repeal the Medicare Part D statutory exclusion of medications for anti-obesity indications.

RESOLVED, that our AMA oppose as discriminatory any insurance practice that terminates, reduces, or restricts coverage for evidence-based obesity treatment on insurer-defined weight loss targets, body mass index (BMI) thresholds, or other arbitrary metrics that are not aligned with individualized, evidence-based clinical decision-making as well as advocate for federal and state regulation prohibiting such practices.

RESOLVED, that our AMA oppose, in the absence of supporting clinical evidence, any mandatory supervised weight loss period as a prerequisite for bariatric or metabolic surgery coverage, and advocate for the elimination of such requirements at the federal and state level.

RESOLVED, that our AMA affirm that treatment decisions for patients with obesity — including the sequencing and selection of pharmacologic therapy, behavioral intervention, and bariatric or metabolic surgery — should be made through individualized, evidence-based, shared decision-making between the physician and patient, free from payer-imposed treatment hierarchies or mandatory sequencing requirements.

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711. OPPOSE DENIALS BASED ON ORIGIN OF REFERRAL
Introduced by Ohio

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: **ADOPTED**
See Policy H-320.933

RESOLVED, that our American Medical Association advocate against prior authorization denials based solely upon the referring physician or appropriately licensed clinician

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712. ADDRESSING THE COMMODITIZATION OF MEDICINE THROUGH RECOGNITION OF THE FULL SCOPE OF PHYSICIAN WORK AND CONTRIBUTIONS
Introduced by American Academy of Dermatology, American College of Mohs Surgery, Society for Investigative Dermatology

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: **ADOPTED**
See Policy H-405.944

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;

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;

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.

713. REDUCING PRIOR AUTHORIZATION DELAYS TO IMPROVE ACCESS TO NEUROMODULATION AND NON-OPIOID PAIN THERAPIES
Introduced by North American Neuromodulation Society

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: **ADOPTED**
See Policy H-320.932

RESOLVED, that our American Medical Association advocate for the reduction of prior authorization requirements for evidence-based neuromodulation therapies and other non-opioid pain treatments when clinically indicated.

RESOLVED, that our AMA work with public and private insurers to ensure that coverage policies for neuromodulation therapies and other non-opioid pain treatments are evidence-based, consistent across payers, and minimize administrative barriers to care.

RESOLVED, that our AMA support policies and legislation aimed at reducing administrative delays that negatively impact patient outcomes and access to non-opioid pain care.

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RESOLVED, that our AMA encourage further research on the impact of insurance-related delays on clinical outcomes, healthcare disparities, and cost-effectiveness in neuromodulation and pain management therapies.

RESOLVED, that our AMA advocate for appropriate reimbursement and equitable access to neuromodulation therapies and other evidence-based, non-opioid pain treatments regardless of insurance type or socioeconomic status.

714. PHYSICIAN CASE LOG PORTABILITY
Introduced by American Academy of Emergency Medicine

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: **ADOPTED**
See Policy H-315.956

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 case logs in a deidentified, electronically transferrable, nonproprietary format when requested to do so.

RESOLVED, that such policies establish a mandatory and enforceable timeline for production of case logs, that ensures timely access to these files but takes into consideration operational realities, verification processes, and patient privacy safeguards.

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.

715. OPPOSE THE LEGAL POSITION THAT VIRTUAL CREDIT CARDS ARE A LEGAL METHOD OF PAYMENT UNDER HIPAA
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: **ADOPTED**
See Policy H-190.953

RESOLVED, that our American Medical Association will advocate that a vendor or clearinghouse that offers a multi-payer platform may not create separate payer-specific enrollment mechanisms into standard adopted HIPAA transactions;

RESOLVED, that our AMA will advocate that a health plan may not use a vendor for electronic transactions that unnecessarily create duplicate administrative work for physician practices by creating a separate mechanism of enrollment in the same standard transaction for different health plans.

716. EQUAL OPPORTUNITY FOR PAYMENT FOR "ON CALL" DUTY
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: **REFERRED**

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.

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717. ADVOCACY FOR A FAILURE-PROOF NATIONAL CENTRALIZED ELECTRONIC TRANSACTION CLEARINGHOUSE
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: REFERRED WITH REPORT BACK AT A-27

RESOLVED, that our American Medical Association advocate for implementation of the standard national health plan identifier (HPID) that all transactions must be communicated directly with the health plan.

RESOLVED, that our AMA advocates for the implementation of a national centralized electronic healthcare transaction clearinghouse that would allow physician practices, other providers, health plans, clearinghouses, health IT vendors, state and federal regulators, digital health products, and consumer apps to maintain only one standard direct connection through which all electronic transactions can flow seamlessly, securely, and at low cost to any other participant guided by a transaction ID and a standard identifier such as a health plan identifier (HPID) and/or national provider identifier (NPI).

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