AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Late Report: 1
(A-26)

Introduced by: RFS Governing Council

Prepared by: RFS Committee on Public Health and RFS Committee on Business and Economics

Subject: Price Equity and Restrictions of Price Negotiation

Referred to: Reference Committee

Background

Your RFS Committee on Public Health and Committee on Business Economics were asked by your RFS Governing Council to prepare a report in response to RFS Resolution 9, A-25, which read as follows:

Whereas, our American Medical Association (AMA) supports transparency in the price and cost of prescription drugs, health plans, and health services; and

Whereas, our AMA supports the transparency of rebate and discount information of pharmacy benefit managers; and

Whereas, our AMA supports actions that promote competition in the healthcare industry, and affirms antitrust relief is a top priority; and

Whereas, there is significant price variability for the same service offered by the same provider or facility dependent on the individual payer[1,2]; and

Whereas, there is significant price variability in the amount paid by the same payer for the same service dependent on the provider or facility[2]; and

Whereas, there is significant price variability in premiums and coverage offered by the same payer to different employers[2,3]; therefore, be it

RESOLVED, that our American Medical Association Resident and Fellow Section (AMA-RFS) study the implications of legally prohibiting price negotiations or discounts between a provider or facility and payer and requiring that all providers and facilities offer the same price for the same service to all payers; and be it further

RESOLVED, that our AMA-RFS study the implications of legally requiring health insurance payers to offer the same coverage plan to every employer and individual.

Key Issues:

This proposal is a theoretical exercise with massive variations in economic impact depending on the specific implementations, accompanying regulations, and relevant enforcement. As such, no specific economic modeling is possible, nor would it be within the RFS's ability to perform. Given that, it is only possible to discuss the theoretical issues brought up by this proposal.

Fundamentally, this is a variant of an all-payer system, focused on provider networks within insurance plans and the market of potential customers for healthcare plans.

Three key issues emerge:
1. Potential Goals of Policy
2. Potential Impact of Distortion of Market Forces
3. Legality and Political Viability of Restrictions

Section 1: Potential Goals of Policy

The highly fractured American Healthcare system is undeniably complex, expensive, and rife with market distortions that further drive up costs and encourage undesirable outcomes, such as consolidation in healthcare markets. Currently, there is enormous pressure on hospitals and physician groups to achieve greater scale to gain negotiating power and counteract the oversized market power of consolidated insurance providers. Organizations that achieve effective local monopolies in healthcare services can negotiate for far higher compensation rates and far lower effective costs than smaller organizations or independent providers. This differential in market power has allowed many large organizations to demand higher rates than potential competitors, making themselves the only viable provider for many services and further diminishing the potential for effective competition. At the same time, insurance providers have created a wide array of overly complex plans, with enormous variations in cost and availability, driven by the market power of large employers.

Legally prohibiting price negotiations or discounts between a provider or facility and payer and requiring that all providers and facilities offer the same price for the same service to all payers would aim to create a level playing field for all participants in the market, reduce consolidation pressures, and potentially increase simplicity in offerings and thus help reduce administration costs for both provider organizations and insurance companies.

Legally requiring health insurance payers to offer the same coverage plan to every employer and individual would theoretically create a level playing field for all potential insurance plan customers in the market. Larger employers are often able to negotiate access to superior plans and lower costs for their employees based on scale, and limiting this could create more equal access and standardized options, improving access to care.

Section 2: Potential Impact of Distortion of Market Forces

Currently, the variances in reimbursement rates and insurance prices are dictated by market forces of supply and demand. Consolidation has distorted both sides of this equation through vertical and horizontal integration of payers and healthcare provider organizations; however, the continued presence of these forces has kept competition and innovation active in many markets. Market forces continue to drive many companies to develop products and services to better serve their markets.

If implemented, these kinds of proposals would fundamentally shift healthcare away from a consumer service towards a more regulated public good. This could have many positive impacts by reducing waste and costs through reduction in profit motives for undesirable behaviors but would also reduce choice, the diversity of available options, and potentially require broader restructuring of the healthcare system into a full All-Payer or unified financing structure in order to deal with the externalities of one size fits all systems potentially divorced from purely economic drivers and instead driven by political will, demand for public services, and workforce needs.

Section 3: Legality and Political Viability of Restrictions

Implementing a ban on price negotiations would likely face significant legislative and judicial challenges, including limits on interference with existing payer/provider contracts under the

Contract Clause, issues with state-level rules affecting interstate insurance or provider markets under the Dormant Commerce Clause, or federal preemption under ERISA for employer-sponsored plans. Antitrust issues could also be raised in many markets, given the high level of consolidation, with further consolidation of plans due to making all plans standard and available universally at a fixed cost. These issues would likely be highlighted and thoroughly litigated during the political backlash from all major players in the current healthcare system who benefit from the status quo.

While business regulations can absolutely limit the types of insurance plans offered within a given healthcare market and regulate what is included in those plans, full-on restrictions on negotiations and business offerings outside anticompetitive collusion standards would likely be seen as radical and extreme in the United States. Restrictions on free enterprise, including freedom of association and speech, are often viewed unfavorably by the US electorate and judicial bodies. Limitations on insurance usually focus on minimum coverage standards, limiting variables that can be used to set pricing, such as requiring gender neutrality, truth-in-advertising rules, adequate network coverage, or maintaining adequate reserves to ensure claims are paid. Restricting the right to associate, speak, and form contracts would likely not be seen in the same light as these types of restrictions.

Insurance companies benefit from tailoring plans to appeal to a wide range of potential customers and extract maximum value from them, depending on their unique needs and ability to pay. Large companies can secure significant discounts due to their scale. Large provider groups and hospitals can demand higher reimbursement rates and more effectively dominate their markets. Each of these entrenched stakeholders is strongly financially incentivized to fight any efforts that could reduce their ability to use their size to maximize profits and minimize competition. These organizations all invest heavily in lobbyists and industry organizations and have deep pockets for significant political contributions. Politicians are very sensitive to both the heavy lobbying efforts and the recognition that these large organizations are often among the largest employers within their constituencies.

Patients not employed by large providers or seeking care in highly consolidated markets often face higher costs and more limited access to care; however, they lack significant direct market participation because employer-based health insurance models limit end-user influence on the system. Overall, consumer frustration with the healthcare system is extremely high, but it has repeatedly been demonstrated how difficult it is to transform that frustration into a political force powerful enough to overcome industry lobbying and political gridlock. At this time, such a broad restriction is likely not politically viable in most jurisdictions; however, because healthcare is primarily regulated at the state level, it may be possible in some more progressive states.

Conclusion

An All-Payer healthcare system (which this resolution ultimately asks us to explore as a variant) is a strong contender as a superior alternative to our broken healthcare system. Given the complexities of adopting an entirely new system with different incentives and structures, the AMA RFS is not the appropriate body to conduct a thorough study of the issue; this should instead be done by appropriately trained and resourced staff if further investigation is desired. Economic modeling would require a far more detailed proposal and specialized resources beyond the capabilities of the RFS committees.

Over the last few years, there has been extensive discussion in the House of Delegates about all-payer systems and attempts by the RFS to soften existing AMA opposition to other alternative healthcare models, including universal financing and single-payer systems. At the last House, in particular, there was significant discussion about developing a vision for the future of medicine. As such, your committees believe the existing RFS internal policy is sufficient and

that there would be little appetite to bring this to the House at this time. No further action on this item is recommended at this time.

Recommendation

Your RFS Governing Council recommends that this report be filed.

REFERENCES

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AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Late Report: 2
(A-26)

Introduced by: RFS Governing Council

Prepared by: RFS Committee on Business and Economics

Subject: Update on Financial Transparency of the Revenue Generated by Trainees at Health Systems

Referred to: Reference Committee

Background

At its 2023 Interim Meeting, the American Medical Association Resident and Fellow Section Assembly referred Resolution 8, "Financial Transparency of the Revenue Generated by Trainees at Health Systems," which asked that the American Medical Association "advocate for increased transparency of revenue generated for health systems by resident and fellow physicians" and "work with relevant stakeholders to require health systems to report revenue generated by care associated with resident and fellow physicians in the form of a publicly-accessible annual report."

The Resident and Fellow Section Committee on Business and Economics prepared a report pursuant to this referral, which was presented at the 2024 Meeting of the American Medical Association Resident and Fellow Section Assembly as Report C, "Financial Transparency of the Revenue Generated by Trainees at Health Systems." This report asked that the American Medical Association "ask the Accreditation Council for Graduate Medical Education (ACGME) to conduct a multi-institutional study including all specialties comparing trainee pay and workload to the healthcare provider pay and workload that would be needed if trainees were not present at that institution and that ACGME publicly publish the findings of this study." This report was likewise referred for further study and report back by the Resident and Fellow Section Assembly, with the Reference Committee report citing a desire for greater clarity regarding complicated relationships around the economics of hospitals and concern from AMA medical education staff that the ACGME would not be the appropriate body to administer such a study. AMA medical education staff also communicated the complexities if such a study were to be undertaken, iterating that "a financial analysis of revenue generated by trainees would have to take account of the training requirements for each specialty, the payor mix at each teaching institution for each setting residents provide clinical services, and the reimbursement rates for each payor for those services."

Over the course of its deliberations, the Resident and Fellow Section Committee on Business and Economics reviewed recent AMA policy-making in this realm, including Resolution 321 from the 2015 Annual Meeting of the House of Delegates, introduced by the Texas delegation, which asked that the American Medical Association "advocate that resident and fellow trainees should not be financially responsible for their training" and "evaluate and work to establish consensus regarding the appropriate value of resident and fellow services, and address this in upcoming reports regarding graduate medical education financing." The first resolve clause was adopted, while the second was referred for study. The Committee on Business and Economics also reviewed the resultant report, Council on Medical Education Report 4 presented at the 2016 Annual Meeting of the House of Delegates, which asked:

1. That American Medical Association (AMA) Policy H-305.988 be amended by addition and deletion to read as follows: … (10) supports AMA monitoring of trends that may lead to a reduction in ~~stipends paid~~ compensation and benefits provided to resident physicians.
2. That our AMA modify Policy H-310.922 by addition and deletion to read as follows: "~~Our AMA encourages that residents' level of training, cost of living, and other factors relevant to appropriate compensation be considered by graduate training programs when establishing salaries for residents.~~ Our AMA encourages teaching institutions to base residents' salaries on the resident's level of training as well as local economic factors, such as housing, transportation, and energy costs, that affect the purchasing power of wages, with appropriate adjustments for changes in cost of living."
3. That our AMA encourage teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare and transportation.
4. That our AMA collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
5. That our AMA monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
6. That our AMA continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents' compensation and lifetime earnings.

This Council on Medical Education report was adopted as amended above.

In its preliminary deliberations, the Committee on Business and Economics considered the current state of the literature on the issue, focusing on new developments published since the Annual 2015/Annual 2016 debates. The Committee also interrogated the intended goal of a study on the value of residents and the intended endpoints of such a study. The Committee further contemplated which organization might be the appropriate target for advocacy and/or development of the study, whether the AMA, one of the medical education bodies, or a federal agency. No further steps were deemed meaningful or actionable at that time.

At the A25 RFS Assembly, it was recommended that the RFS Committee on Business and Economics continue to review relevant data and welcome continued comments from the Resident and Fellow Section Assembly. Since that time, this topic has continued to spark strong emotions and interest among students and trainees, with the AMA-MSS welcoming Dr. Brian Carmody (well known for his YouTube channel, 'The Sheriff of Sodium') to share research-based estimates of the economic value generated by residents. The Committee did not identify any new research published about the economic value generated by residents since A25; however, the Committee noted two opinion pieces that were published:

A 2025 NEJM review by Walensky and McCann examined challenges to the physician workforce, discussing GME funding mechanisms and the bottleneck created by limited federally funded residency positions. The authors noted that while Medicare spent $16.2 billion on GME in 2020, teaching hospitals concentrated in the Northeast profit from training residents, and 15,000 new residency slots have been created in the past 20 years outside of federal funding—suggesting hospitals find economic value in resident training even without full federal support. The review also highlighted that the 2014 Institute of Medicine recommendations for GME reform (including pay-for-performance models) have seen little progress due to opposition from

hospital associations that benefit from current funding structures.

A 2025 JAMA Viewpoint by Frederick and colleagues offered their perspective on the financial pressures facing teaching hospitals amid rising resident unionization. The authors noted that more than one-third of US hospitals are operating at negative margins, with hospital revenue failing to keep pace with inflation and Medicare physician payment rates falling by approximately 30% since 2001 (adjusted for inflation). They raised concerns that as resident compensation costs rise through union negotiations, hospitals may find alternatives, such as advanced practice clinicians, more financially viable, potentially leading to program cuts. This paper was not convincing to the Committee, given the large difference in productivity and workforce development value created by residents compared to alternatives. The Committee retains the position that midlevel providers are important and respected members of the physician-led healthcare team, not acceptable replacements for physicians, whether in training or in practice. Resident unionization efforts have played a significant role in restoring some market power to residents in unionized programs, resulting in improved compensation and working conditions, with resulting improvements in competing programs as well, although that is beyond the scope of this report.

Neither of these papers provides any meaningful change in the previous conclusion that the economic value residents create clearly exceeds the current level of resident compensation, with resident compensation being largely distorted due to a lack of effective market forces. Further characterization of this value, however, is difficult to meaningfully assess in greater granularity due to a lack of available data, a lack of comparability across specialties, and heterogeneity in training program structures and healthcare market economics, both within and across healthcare systems. The Committee supports the intent of the original ask but does not believe existing data structures exist to implement such a report and that efforts to create such a standard that would allow for meaningful comparison universally across all programs are beyond the scope of the AMA, ACGME, or any identifiable agency or organization as it would require forcing a universal accounting standard far more stringent and prescriptive than GAAP or the existing tax code.

The Committee believes that, at this time, the most impactful action the AMA-RFS could take is to adopt an internal policy that promotes greater transparency of revenue generated for health systems by resident and fellow physicians, which could bolster efforts at local institutions.

Recommendation

Based on the report prepared by the AMA-RFS Committee on Business and Economics, your RFS Governing Council recommends that following resolved clause be adopted and the remainder of the report be filed:

1. RESOLVED, that our AMA-RFS supports increased transparency of revenue generated for health systems by resident and fellow physicians.

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2. Frederick PJ, Seshadri M, Zsiros E, McLean K. Reflections on Medical Trainee Unions and Health Care Systems. JAMA. *2025;333(12):1043-1044. doi:10.1001/jama.2025.14762.*

A-26 CBE Late Statement – Late Reports 1 & 2

Your Committee on Business and Economics apologizes for the delays in submission of these two very important reports referred by the Governing Council. Your Committee faced unexpected burdens. Rather than submit reports without proper attention and discussion, your Committee decided to continue the work beyond the deadline. The Committee on Business and Economics worked closely with our colleagues on the Committee for Public Health to ensure that the relevant report with overlap reflected the consensus of all members who were able to participate. Your Council on Business and Economics believes that additional time will not allow for further improvement in these reports or change the recommendation.

However, there is concern that anticipated turnover in CBE leadership will result in a loss of background knowledge regarding the writing of the findings and recommendations in these reports, prompting us to encourage adopting these reports as late items of business rather than deferring until Interim 2026. We also feel these topics are of timely interest to the section and warrant consideration and debate by the RFS, with the potential for the section to give feedback on the report to send back to the committee should the section so choose, with further guidance to the Committee on what else the section may want to see done on these important issues.

Procedural History:

A-26, Late Report 1

Resolution 9, A-25—Fair Pricing in Healthcare

- *RESOLVED, that our American Medical Association Resident and Fellow Section (AMA-RFS) study the implications of legally prohibiting price negotiations or discounts between a provider or facility and payer and requiring that all providers and facilities offer the same price for the same service to all payers; and be it further*
- *RESOLVED, that our AMA-RFS study the implications of legally requiring health insurance payers to offer the same coverage plan to every employer and individual.*

RFS Assembly Action: **adopted**; assigned to CPH & CBE
Did not receive @ I-25; carryover to A-26
Received as Late Report 1, A-26: (new title) "Price Equity and Restrictions of Price Negotiation"

A-26, Late Report 2

Resolution 8, I-23—Financial Transparency of the Revenue Generated by Trainees at Health Systems

- *RESOLVED, that our AMA advocate for increased transparency of revenue generated for health systems by resident and fellow physicians; and it be further*
- *RESOLVED, that our AMA work with relevant stakeholders to require study the feasibility and implications of requiring health systems to produce a publicly-accessible annual report of revenue generated by care associated with resident and fellow physicians. in the form of a publicly-accessible annual report.*
- RFS Assembly Action: **referred**; assigned to CBE who submitted a report for A-24

Report C, A-24—Financial Transparency of the Revenue Generated by Trainees at Health Systems

- *Recommendation: Based on the report prepared by the AMA-RFS Committee on Business and Economics, your RFS Governing Council recommends the following:*

    - *That our American Medical Association (AMA) ask the Accreditation Council for Graduate Medical Education (ACGME) to conduct a multi-institutional study including all specialties comparing trainee pay and workload to the healthcare provider pay and workload that would be needed if trainees were not present at that institution and that ACGME publicly publish the findings of this study.*

RFS Assembly Action: **referred**; re-assigned to CBE
No submission @ I-24; carryover to A-25
Report E, A-25—Financial Transparency of the Revenue Generated by Trainees at Health Systems

- *Recommendation: Based on the report prepared by the AMA-RFS Committee on Business and Economics, your RFS Governing Council recommends the following:*
    - *The RFS Committee on Business and Economics continue to review relevant data and welcomes continued comments from the Resident and Fellow Section Assembly; and*
    - *The Committee submits an actionable report to the Resident and Fellow Section Assembly at the 2025 RFS Interim Meeting.*

RFS Assembly Action: **adopted**; re-assigned to CBE
CBE requested extension @ I-25 to prepare report for A-26;
Received as A-26, Late Report 1—Update on Financial Transparency of the Revenue Generated by Trainees at Health Systems

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Late Resolution: 1
(A-26)

Introduced by: Ashley Glass, DO, MA, Aquilla Chase, MD, MS, Dayna Isaacs, MD, MPH, Daniel Resnick, DO, MBA, Sean de Leon, MD

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

Referred to: Reference Committee

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

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

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

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

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

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

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

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

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

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

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

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

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

RESOLVED, that our American Medical Association (AMA) work with appropriate stakeholders to promote patient safety by opposing AI prescription services that operate without direct physician oversight; and be it further

RESOLVED, that this resolution be immediately forwarded to the AMA House of Delegates at the 2026 Annual Meeting.

Fiscal Note: Modest

REFERENCES

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14. Utah Steps into Autonomous AI Medicine with Prescription Renewal Pilot. Stanford.edu. Published March 19, 2026. Accessed May 27, 2026. https://healthpolicy.fsi.stanford.edu/news/utah-steps-autonomous-ai-medicine-prescription-renewal-pilot-program

RELEVANT AMA POLICY

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

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

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

1. General Governance
    a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
    b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
    c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
    d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
    e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce [See also Augmented Intelligence in Health Care H-480.939 at (1)]
    f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
    g. Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications

and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.

h. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.

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

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

a. Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.

i. AI disclosure should align and meet ethical standards or norms.

ii. Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.

iii. When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.

iv. When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.

b. AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.

c. When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.

d. The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.

3. What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies

a. When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow

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

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

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

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

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

4. Generative Augmented Intelligence

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

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

b. Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
    i. Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
    ii. Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
    iii. Lack of regulatory or clinical oversight to ensure performance of the tool.
    iv. Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
    v. Data privacy.
    vi. Cybersecurity.
    vii. Physician liability associated with the use of generative AI tools.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on

a. clinical validation.
b. alignment with clinical decision-making that is familiar to physicians.
c. high-quality clinical evidence.

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

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

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

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

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

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

Use of Augmented Intelligence for Prior Authorization D-480.956

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

Safe and Efficient Prescribing H-120.921

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

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

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

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

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

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

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

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

Drug Abuse Related to Prescribing Practices H-95.990

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

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

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

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

Internet Prescribing H-120.956

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

Non-Physician Prescribing H-120.955

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

Late Resolution 1: Bringing Physicians' Voices to the Implementation of AI Prescribers

Author's Statement:

This resolution is being submitted after the first-draft deadline of April 6th, 2026, because the implementation of AI prescribers was not widely publicized until after that date. News articles did not publish information regarding Legion Health's AI prescription model until on or after April 6th. Although Doctronic's AI prescription model was public prior to this date, the legal matters are ongoing, as evidenced by the Utah Medical Board's April 20th, 2026, letter urging caution regarding Doctronic.

This resolution is timely given AI's rapid expansion and the AMA's recent launch of its Center for Digital Health and AI. It is urgent and important, as AI prescribers are currently being launched and utilized, directly impacting patient care and safety. This resolution is therefore submitted late to address this urgent and consequential development, ensuring that the AMA considers timely advocacy for AI prescribers.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Late Resolution: 2
(A-26)

Introduced by: Anthony Sean de Leon, MD, Sarah Costello, MD, Rosalynn Conic, MD, Rishab Chawla, MD, Aquilla Chase, MD, MS, Marina Alnaser MD

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

Referred to: Reference Committee

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

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

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

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

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

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

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

Whereas, our AMA includes many recently re-affirmed/reviewed policies (e.g., D-250.988, D-255.966, D-255.967, D-255.969, D-255.980, D-255.991, D-255.993, and H-255.988) that advocate for urgent resumption of visa processing to minimize disruption to residency programs and continuity of care; therefore be it

RESOLVED, that our American Medical Association (AMA) prevent disruption of patient care and graduate medical education by immediately encouraging federal agencies to establish a temporary non-enforcement policy for non-US citizen physicians and trainees with pending visa adjudication, including those who have matched this year; and be it further

RESOLVED, that our AMA develop a list of federal/national resources for residency and fellowship programs in helping residents and fellows with indeterminate visa statuses; and be it further

RESOLVED, that this resolution be immediately forwarded to the AMA House of Delegates at the 2026 Annual Meeting.

Fiscal Note: Modest

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9. Jordan M. Second Venezuelan doctor is released from immigration custody. *New York Times*. Published May 13, 2026. Accessed May 25, 2026. https://www.nytimes.com/2026/05/13/us/venezuelan-doctor-released-from-immigration-custody-texas.html?unlocked_article_code=1.lVA.Ks9f.dW8uP1fJvVXN&smid=url-share
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RELEVANT RFS POSITION STATEMENTS

220.001R Employment of Non-Certified International Medical Graduates
That our AMA-RFS:
(1) oppose efforts to employ graduates of international medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met State criteria for full licensure, and (2) support states that have difficulty recruiting doctors to underserved areas exploring the expanded use of incentive programs such as the National Health Service Corps or J1 or other visa waiver programs. (Resolution 2, A-03) (Reaffirmed Report D, I-13) (Reaffirm with editorial changes Report I, A-24)

220.002R Restoration of J-1 Visa Waivers for Underserved Communities
That our AMA-RFS support the restoration and maintenance of programs by federal agencies and state governments through which an adequate number of international medical may obtain J-1 visa waivers to provide medical services in underserved communities. (Resolution 10, A-02) (Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)

RELEVANT AMA POLICY:

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

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

Physician Visa Protection and Pathway to U.S. Permanent Residency D-255.967
1. Our American Medical Association advocates for a viable, expedited, and separate pathway for physicians to obtain permanent residence in the United States.
2. Our AMA advocates for the federal government to work to ensure physicians are exempt from unreasonable increases in H-1B visa fees.
3. Our AMA advocates for the creation of a dedicated visa pathway specifically for physicians. [Res. 213, I-25]

Urgent Advocacy to Restore J-1 Visa Processing for International Medical Graduate Physicians D-255.969
1. Our American Medical Association publicly advocates to resume the scheduling of new J-1 visa appointments affecting International Medical Graduates.
2. Our AMA will issue urgent advocacy communications to Congress, the Department of Homeland Security, the Department of State, and other relevant agencies, calling for the immediate resumption of J-1 visa processing for International Medical Graduates.
3. Our AME will collaborate with key parties, including program directors, Designated Institutional Officers, medical schools, and healthcare organizations to monitor the impact of visa appointment suspensions on patient care and physician workforce stability.
4. Our AMA will work proactively and transparently to reverse policies harmful to IMGs and mitigate future disruptions, emphasizing the essential contributions of International Medical Graduates to healthcare delivery in the United States. [Res. 237, A-25]

Employment of Non-Certified IMGs H-255.970
1. Our American Medical Association will oppose efforts to employ graduates of foreign medical schools who are neither certified by the ECFMG (a member of Intealth) nor have met state criteria for full licensure.
2. Our AMA encourages states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J-1 or other visa waiver programs. [Res. 309, A-03; Reaffirmed: CME Rep. 2, A-13; CME Rep. 01, A-23]

Addressing Work Requirements for J-1 Visa Waiver Physicians D-255.972
Our American Medical Association advocates for federal visa and visa waiver policies to include time for administrative tasks, professional development opportunities, and other professional responsibilities within the federally mandated work week requirements for direct patient care. [BOT Rep. 04, I-24]

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

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

Visa Complications for IMGs in GME D-255.991

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

J-1 Visa and Waivers D-255.993

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

Timely Issuance of Social Security Number D-310.960

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

AMA Principles on International Medical Graduates H-255.988

1. Our AMA supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:
    a. completion of medical school and residency training outside the U.S.;
    b. extensive U.S. medical practice; and
    c. evidence of good standing within the local medical community.
13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. Our AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. Our AMA membership outreach to IMGs to include

a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
d. expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.

17. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
24. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
25. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.
26. Our AMA will uphold its commitment to opposing discrimination against IMGs in all aspects of medical education and training. [BOT Rep. Z, A-86; Reaffirmed: Res. 312, I-93; Modified: CME Rep. 2, A-03; Reaffirmation I-11; Reaffirmation: CME Rep. 1, I-13; Modified: BOT Rep. 25, A-15; Modified: CME Rep. 01, A-16; Appended: Res. 304, A-17; Modified: CME Rep. 01, I-17; Reaffirmation: A-19; Modified: CME Rep. 2, A-21; Modified: CME Rep. 1, A-22; Modified: CCB/CLRPD Rep. 1, A-22; Reaffirmed: CME Rep. 03, A-23; Reaffirmed: Res. 312, A-25; Reaffirmed in lieu of the first resolve: Res. 234, A-25; Reaffirmed: Res. 241, A-25; Appended: Res. 304, I-25]

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

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

5. Our AMA supports federal and state efforts to remove immigration enforcement from workplaces and employment consideration, including the removal of E-Verify mandates. [Res. 004, A-25]

Mass Deportation as a Public Health Issue H-440.793

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

Late Resolution 2: Protecting Resident Physicians with Pending Immigration Status and Ensuring Safe Participation in Professional Activities

Author's Statement:

Two resident physicians were detained by immigration enforcement after April 6, 2026, the original submission deadline for RFS resolutions. Although both residents were eventually released from detention as of this month, ICE detainment of non-citizen residents and fellows with indeterminate visa status is a real situation that could happen again. Thus, we feel that this resolution is timely and important, especially with a new set of interns coming this July 1.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: A
(A-26)

Introduced by: Nikita Sood, MD, RFS Delegate, Sarah Mae Smith, MD, PhD, RFS Alternate Delegate

Subject: Sunset Mechanism (2015)

Referred to: Reference Committee

At the 1985 Interim Meeting, the American Medical Association-Resident and Fellow Section (AMA-RFS) Assembly adopted a report entitled, “Sunset of AMA-RFS Policy.” This report established a mechanism to systematically review AMA-RFS actions ten years after adoption and identify and rescind outmoded, irrelevant, duplicative, or inconsistent actions. These actions are and will continue to be cataloged in the AMA-RFS Position Compendium. As of A-19, the amended IOPs specify that an informational report be prepared for review at the Interim Meeting, with final recommendations to be considered for action at the Annual Meeting.

Due to a change in nomenclature standards in the updated IOPs, all resolutions archived in the RFS Position Compendium shall state “Our AMA-RFS” and hereafter be referred to as “internal position statements.” The appendix of this report contains a list of recommended actions regarding internal position statements last reviewed from the RFS 2015 fiscal year, as well as other relevant or associated outdated positions. Positions considered outmoded, irrelevant, duplicative, and inconsistent with more current positions will have specific recommendations. For each internal position statement under review, this sunset report recommends whether to: (1) rescind, (2) reaffirm, (3) reconcile with more recent actions, or (4) reaffirm with editorial changes, which constitutes a first-order motion. A brief justification for each recommendation will be provided. Due to the IOP change, all existing statements not up for review on the sunset calendar or that do not require reconciliation will be updated with editorial changes in the RFS Position Compendium but will not be reset on the sunset calendar and are not included in the appendix of this report.

Each item may be extracted from the report to be discussed by the RFS General Assembly, but only in the frame of adopting or not adopting the original recommendation, as additional amendments will not be allowed from the floor. Any action that retains or updates an item resets the sunset timeline. Defeated sunset recommendations extend the item for one year, to be reconsidered in the next fiscal year.

This information was presented to the Assembly at the November 2025 Interim Meeting as an informational report to allow ample time for delegates to consider these initial recommendations. Your Section Delegates present the Sunset Report in its final draft for consideration of the Assembly.

APPENDIX I

RECOMMENDED ACTIONS ON 2015 RFS POSITIONS

Position No.	Title	Current Text	Recommendation
10.001R	Accident Prevention: Concussions	That our AMA-RFS support state-based initiatives to require prevention for all contact sports in pediatric and young adult populations by: (1) encouraging the use of protective equipment in sports, (2) encouraging sports physicals to include a basic neurocognitive screening by qualified healthcare professionals for pediatric and young adults populations playing contact sports (3) urging policy on return to play protocol for athletes to achieve optimal recovery and reduce or avoid long term health outcomes (4) advocating for education on increasing concussion awareness among the public, coaches and the medical community. (Resolution 17, A-16)	Reaffirm
10.002R	Amending Child Restraints Laws	That our AMA-RFS support federal legislation that increases law enforcement standards for child safety seat use in the U.S. and support state and federal legislation that updates child car seat violations from a secondary to a primary law. (Resolution 4, A-07)	Reaffirm
10.004R	Impact of Speed Limits on Road Safety	That our AMA-RFS support the promotion of research and education regarding injury prevention and continue to assess the impact of increased vehicular speeds on overall road safety. (Substitute Resolution 28, A-95) [See also, AMA Policy H-15.990] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
10.006R	Promoting Protective Guards and Helmet Use in In-Line Skating	That our AMA-RFS support working with other organizations concerned with health and safety to ensure widespread distribution of information and educational materials about in-line skating including the use of protective wrist, elbow, and knee guards and	Reaffirm

		helmets. (Resolution 29, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	
10.007R	Chronic Traumatic Encephalopathy	That our AMA-RFS supports that appropriate agencies promote education for physicians and the public on the detection, treatment and prognosis of chronic traumatic encephalopathy (CTE); and That the AMA-RFS encourages interested agencies and organizations to advocate for further research into the causes of and treatments for chronic traumatic encephalopathy (CTE). (Resolution 7, A-16)	Reaffirm
20.001R	Global HIV/AIDS Prevention	That our AMA-RFS: (1) support continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives, or grantee pledges of opposition to prostitution, and (2), support comprehensive family-life education to foreign aid programs, promoting abstinence as the best method to prevent sexually-transmitted disease transmission while also discussing the role of condoms in disease prevention. (Late Resolution 5, A-08)	Reaffirm
20.002R	Support of a National HIV/AIDS Strategy	That our AMA-RFS support the concept of a national HIV/AIDS strategy and that our AMA-RFS support the following guiding principles: (a) Improve prevention, care, and treatment outcomes through reliance on evidence-based programming; (b) Set ambitious and credible prevention, care, and treatment targets and require annual reporting on progress toward goals; (c) Identify clear priorities for action across federal	Reaffirm

		agencies and assign responsibilities, timelines, and follow-through; (d) Include, as a primary focus, the prevention and treatment needs of African Americans and other communities of color, women of color, men who have sex with men (MSM) of all races and ethnicities, and other groups at elevated risk for HIV; (e) Address social, economic, and structural factors that increase vulnerability to HIV infection; (f) Promote a strengthened and more highly coordinated HIV prevention and treatment research effort; (g) Involve many sectors in developing the Strategy, including government, business, community, civil rights organizations, faith-based groups, researchers, and people living with HIV/AIDS; and (h) With the White House Office of National AIDS Policy, the Department of Health and Human Services Office of HIV/AIDS Policy, and other relevant bodies to develop, enact, and maintain a national HIV/AIDS strategy. (Resolution 4, A-09)	
20.003R	Review of AMA Policy on Physicians with HIV	That our AMA-RFS strongly support proposed changes in the Council on Ethical and Judicial Affairs (CEJA) Opinion 4-A-99, Physicians and Infectious Diseases and CEJA and Opinion 5-A-99, HIV-Infected Patients and Physicians, which change the terminology regarding the level of risk of physician-to-patient transmission of bloodborne infections appropriate for restricting a physician's medical practice from "identified risk" to "significant risk". (Substitute Resolution 3, A-99) (Reaffirmed Report C, I-09)	Rescind, these opinions have since been archived and are no longer active in the AMA Code of Medical Ethics
20.006R	Discrimination Against Persons with HIV/AIDS Seeking	That our AMA-RFS oppose discrimination against persons with HIV/AIDS seeking rehabilitative, residential and nursing care	Reaffirm

	Rehabilitative, Residential, and Nursing Care Placements	placements for the reason of HIV/AIDS positive status. (Resolution 7, A-15)	
30.001R	Alcohol and Youth	That our AMA-RFS support: (1) state medical societies working with the appropriate agencies to develop a state-funded educational campaign to counteract pressures on young people to use alcohol and (2) working with the appropriate medical societies and agencies to draft legislation minimizing alcohol promotions, advertising, and other marketing strategies by the alcohol industry focused on adolescents. (Substitute Resolution 9, A-01)	Reaffirm
30.002R	Advertising of Alcoholic Beverages	That our AMA-RFS oppose televised advertising of alcoholic beverages. (Substitute Resolution 38, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reaffirm
40.001R	Midwifery Scope of Practice and Licensure	That our AMA-RFS support: (1) the development of model legislation regarding appropriate physician and regulatory oversight of midwifery practice, under the jurisdiction of either state nursing or medical boards; (2) monitoring state legislation activities regarding the licensure and scope of practice of midwives; and (3) and that our AMA work with state medical societies and interested specialty societies to advocate in the interest of safeguarding maternal and neonatal health regarding the licensure and the scope of practice of midwives. (Resolution 5, A-08)	Reaffirm with editorial changes That our AMA-RFS support: (1) the development of model legislation regarding appropriate physician and regulatory oversight of midwifery practice, under the jurisdiction of either state nursing or medical boards; (2) monitoring state legislation activities regarding the licensure and scope of practice of midwives; and (3) ~~and that~~ our AMA in working with state medical societies and interested specialty societies to advocate in the interest of safeguarding maternal and neonatal health regarding the licensure and the scope of practice of midwives.
40.002R	Mid-Level Practitioner Tracking System	That our AMA-RFS support the tracking of mid-level practitioners for the purpose of identifying their role in underserved rural communities. (Resolution, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reaffirm

40.005R	Opposition of Non-Healthcare Providers from Seats on Medical Boards	That our AMA-RFS oppose non-physician healthcare providers from holding a seat on medical boards that provide oversight of physician undergraduate medical education, graduate medical education, certification or licensure, and advocate that a non-physician seat on these boards be held by non-medical public professionals. (Report F, I-13)	Reaffirm
50.001R	Pediatric Suspected Intentional Trauma	That our AMA-RFS: (1) support comprehensive reporting and investigation of all cases of reasonably suspected child abuse and neglect using an inclusive and interdisciplinary method in accordance with state and federal laws; and (2) support the creation of a national standardized pediatric intentional trauma curriculum for medical students and residents. (Resolution 3, A-07)	Reaffirm
50.003R	Harmful Practices in Child Athletics	That our AMA-RFS: (1) support working with all interested organizations to identify harmful practices in the sports training of children and adolescents; and (2) support the establishment of appropriate health standards for sports training of children and adolescents. (Substitute Resolution 28, I-95) [See also: AMA Policy H-60.966] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
50.004R	Opposition to Proposed Budget Cuts in WIC and Head Start	That our AMA-RFS oppose any reductions in funding for WIC and Head Start and other programs that significantly impact child and infant health and education. (Late Resolution 1, I-94) [See also: AMA Policy H-245.979] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reaffirm
50.005R	Protection of Pre-school Children from Passive Smoking	That our AMA-RFS oppose the use of tobacco products of any kind in day care centers or other establishments where pre-school	Rescind as federal law prohibits smoking in facilities providing federally funded children's services

		children attend for educational or child-care purposes. (Substitute Resolution 17, A-94) [See also: AMA Policy H-60.954] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	
50.006R	Childcare at AMA Meetings	That our AMA-RFS: (1) support the AMA offering organized childcare services at all AMA national meetings; and (2) Hospitality Committee and other relevant stakeholders publicize family friendly activity information within each meetings' respective host cities. (Report F, I-15)	Reaffirm
80.002R	Prescription Drug Shortages, A National Emergency	That our AMA-RFS acknowledge the critical issue of medicine shortages in the United States and support legislative efforts to address these issues. (Resolution 2, I-11)	Reaffirm
80.003R	Reviewing the Effectiveness of Current Drug Policies	That our AMA-RFS (1) support the review of the effectiveness of current drug policies pertaining to illegal drug use; (2) support the review of the current availability of and access to evidence-based treatments for drug abuse and dependence; (3) support the review of the effectiveness of current medical training for primary care physicians in evaluating and treating drug abuse; and (4) monitor the work on this issue by both national and international organizations, including, but not limited to the National Institute of Drug Abuse, United Nations, WHO, UNODC, and UNAIDS. (Resolution 2, I-10)	Reaffirm
80.015R	Online Access to Prescription Drug Formularies	That our AMA-RFS supports promoting the value of online access to prescription drug formulary plans from all insurance providers nationwide. (Resolution 11, I-15)	Rescind as federal rules require insurers to make formularies available online.
80.016R	Universal Prescriber Access	That our AMA-RFS supports legislation and regulatory action	Rescind as all states have PDMPs prescribers can access

	to Prescription Drug Monitoring Programs	that would authorize all prescribers of controlled substances, including residents, to have access to their state prescription drug monitoring program. (Resolution 3, A-16)	
80.018R	Universal Prescriber Access to Prescription Drug Monitoring Programs	that our AMA-RFS supports legislation and regulatory action that would authorize all prescribers of controlled substances, including residents, to have access to their state prescription drug monitoring program. (Resolution 3, A-16)	Reaffirm
90.001R	Emergency Preparedness	That our AMA-RFS: 1) commend the physicians and other volunteers who demonstrated the true spirit of medicine during the September 11, 2001 terrorist attacks, (2) support the AMA's development and maintenance of a physicians volunteer database, and (3) support the AMA's effort to educate physicians on natural and man-made disaster related topics. (Substitute Resolution 1, I-01)	Reaffirm
90.003R	Emergency Medical Skills Training in Medical Education	That our AMA-RFS support the proposition that a formal emergency medicine experience including didactic and clinical training in basic skills should be a part of undergraduate medical education. (Resolution 8, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reaffirm
90.005R	Physician Education in Flight Medicine	that our AMA-RFS supports requiring that airlines provide a list of available inflight medical supplies in accessible locations; and that our AMA-RFS supports facilitate the creation of a centralized and standardized system to report all medical emergencies requiring assistance from a medically-trained passenger or from ground-based communications; and that our AMA-RFS supports ensuring that a routine process exists to verify functionality of medical equipment and medicines used for in-flight	Reaffirm

		medical emergencies. (Resolution 9, I-15)	
100.001R	Code Status Requirements for Nursing Home Residents	That our AMA-RFS: (1) oppose any requirement that would allow a nursing home facility to require that a patient consent to a DNR order as a condition of admission unless that facility is limited to palliative care; 2) oppose any legislative or regulatory attempts that would allow a nursing home facility to require that a patient consent to a DNR order as a condition of admission unless that facility is limited to palliative care. (Substitute Resolution 8, I-97) (Reaffirmed Report C, I-07) [Also see AMA Policy H-140.945]	Reaffirm
100.003R	Filming Patients for News or Entertainment	That our AMA-RFS assert that efforts to disguise a patient (such as blurring the face, changing the voice, or any other technology) do not obviate the need to obtain consent as outlined in AMA Policy E-5.045 for publication of any material related to the treatment of a patient. (Resolution 1, A-15)	Reaffirm
100.004R	Ethical Physician Conduct in the Media	That our AMA-RFS support: (1) an AMA report on the professional ethical obligations for physicians in the media, including guidelines for the endorsement and dissemination of general medical information and advice via television, radio, internet, print media, or other forms of mass audio or video communication; (2) an AMA study of disciplinary pathways for physicians who violate ethical responsibilities through their position on a media platform; and (3) the release of a statement affirming the professional obligation of physicians in the media to provide quality medical advice supported by evidence-based principles and transparent to any conflicts of interest, while denouncing the dissemination of	Reconcile with more recent actions That our AMA-RFS recognizes the professional obligation of physicians in the media to provide quality medical advice supported by evidence-based principles and transparent to any conflicts of interest, while denouncing the dissemination of dubious or inappropriate medical information through the public media including television, radio, internet, and print media.

		dubious or inappropriate medical information through the public media including television, radio, internet, and print media. (Resolution 21, A-15)	
100.007R	Physician and Health Institution Publicity and Responsibility	That our AMA-RFS encourages physicians when engaged in public discourse related to health and medical science to disclose whether stated positions are based on rigorously tested evidence, standard of care, or personal opinion. (Resolution 12, I-14)	Reaffirm
120.001R	U.S. Farm Subsidies	That our AMA-RFS support reform and updates to the US Farm Bill including redirecting subsidies in the US Farm Bill that perpetuate calorie-dense, nutrition-poor products toward programs that reduce obesity. (Resolution 1, I-11)	Reaffirm
120.002R	Healthy Food Options for Shift Workers	That our AMA-RFS support encouraging companies who have shift workers to explore making healthier food options available to workers during the evening and nighttime hours. (Report H, A-09)	Reaffirm
120.003R	Support of Calorie Labeling in Restaurants	That our AMA-RFS support working with state medical associations, state restaurant associations, state departments of health, and other interested parties to promote the display of nutritional information on restaurant menus and menu boards for all food and beverage items. (Resolution 4, I-08)	Reaffirm
120.006R	Banning the Artificial Use of Trans Fats in the United States	That our AMA-RFS support a total ban on using artificial trans fats in food products. (Resolution 14, A-15)	Reaffirm
130.001R	Opting Out of Health Information Exchanges	That our AMA include in its current ongoing study of health information exchanges, concern for potential risks to patient privacy and safeguards against compromise of patient information. (Resolution 3, I-11)	Rescind, this study has been conducted and included these concerns
130.002R	Marriage Equality to Reduce Health	That our AMA-RFS support ending the exclusion of same-sex couples	Reconcile with recent actions as same-sex couples are no longer

	Care Disparities	from civil marriage in order to reduce health care inequities affecting those gay and lesbian individuals and couples, their families and their children. (Resolution 5, A-10)	excluded from civil marriage That our AMA-RFS support recognition of civil marriage of same-sex couples and its role in reducing health care inequities for LGBTQ+ couples and their families.
130.003R	Medical Confidentiality of Sexual Orientation in the Military	That our AMA-RFS oppose the use of sexual orientation, same sex marriage or domestic partnerships obtained in patient-physician, or other patient-health care provider communications from being the basis for dismissal from the US Military in order to not impede the patient-physician relationship and to improve the provision of good medical care to all of our service personnel. (Resolution 1, I-09)	Reaffirm
130.004R	Access to Equivalent Benefits for Children and Other Dependents of Military Personnel with Same Sex Marriages	That our AMA-RFS support US military personnel in legal same sex marriages having the ability to acknowledge these relationships and receiving equal death benefits and other benefits (including health care coverage) to the dependent children and spouses of legal same sex marriages as provided to married US military personnel. (Resolution 2, I-09)	Reaffirm
130.005R	Removing Barriers to Care for Transgender Patients	That our AMA (1) support public and private health insurance coverage for treatment of gender identity and (2) oppose categorical exclusions of coverage for treatment of gender identity disorder when prescribed by a physician. (Resolution 1, I-07)	Reaffirm with editorial changes That our AMA-RFS supports our AMA in (1) supporting public and private health insurance coverage for treatment of gender identity and (2) oppose~~e~~ing categorical exclusions of coverage for treatment of gender identity disorder when prescribed by a physician.
130.006R	Cost-Effectiveness of Medicaid Eligibility Criteria for People with Chronic Illness	That our AMA examine the appropriateness and cost-effectiveness of "the spend down option" to meet Medicaid eligibility criteria in the broader context of Medicaid reform with a report back at I-02. (Substitute Resolution 6, A-01)	Rescind
130.008R	Early and Periodic	That our AMA-RFS support	Reaffirm

	Screening, Diagnosis, and Treatment	guaranteed Medicaid coverage of basic preventative services and treatment of diseases found on screening for children and adolescents including those covered by the Early and Periodic Screening, Diagnosis, and Treatment component.	
130.010R	Rural Healthcare Initiative	That our AMA-RFS support financial incentives, such as federal tax incentives, to both rural health care providers and rural health care institutions serving patient populations that fall outside a 60-mile radius of urban areas with a population of 50,000 or greater. (Substitute Resolution 16, A-95) [See also: AMA Policy H-465.994, H-465.997] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
130.020R	Management of Perioperative Pain	That our AMA-RFS encourages hospitals to adopt practices for the management of perioperative pain that include services dedicated to acute pain management and the use of multimodal analgesia strategies aimed at minimizing opioid administration without compromising adequate pain control during the perioperative period. (Resolution 10, A-16)	Reaffirm
140.001R	Health Care Reform Plan	That our AMA-RFS (1) continue to advocate for health system reform which makes health insurance coverage accessible for all U.S. citizens; (2) support requiring all children to have health insurance as a strategic priority; (3) advocate for sufficient federal subsidy or tax credit amounts so that all U.S. citizens can afford to purchase health insurance; (4) support the requirement for private insurers that children up to age 26 could continue family coverage through their parents' plan; (5) support working with the federal government to ensure that if federal	Reaffirm

		programs are to be expanded, that proper checks and balances are in place to ensure that reimbursements reflect the actual cost of care and that patient access is not limited; and (6) support that under the National Health Insurance Exchange (or any similar proposed program) that participating insurers provide high quality, transparent services, and that their reimbursements reflect the actual cost of care. (Report H, I-08)	
140.002R	Assessing the Health Care Proposals of the U.S. Presidential Candidates	That our AMA-RFS: (1) request that the AMA collect and disseminate details of the health care proposals of every declared candidate for U.S. President; and (2) that this resolution be forwarded to our AMA House of Delegates every four years prior to every Presidential election. (Resolution 14, A-07)	Reaffirm
140.003R	Health Care as a Right for All People	That our AMA-RFS assert that all people deserve access to quality, affordable, basic and preventative healthcare. (Substitute Resolution 11, A-07)	Reaffirm
140.004R	AMA-Health Care Delivery Task Force	That our AMA-RFS: support the creation of a multi-organizational task force of relevant stakeholders to develop consensus recommendations on a health care system or health care delivery principles that best serve the needs of the American public using the goals and principles of the Health Access America as a starting point. (Substitute Resolution 28, A-97) (Reaffirmed Report C, I-07)	
140.005R	The Fundamental Importance of Universal Access	That our AMA-RFS: (1) strongly assert that the fundamental goal of any change in the American health care system should be to move toward increased access to quality health care for every American citizen; and (2) support access to high quality health care for all	Reaffirm

		Americans as a clear guiding principle in evaluating and responding to proposals to change the American health care system. (Substitute Resolution 33, I-95) [See also: AMA Policy H-165.918, H-165.969] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	
140.006R	Advocating for Patients and Health Care Reform	That our AMA-RFS support the principle that AMA negotiations with Congress on health system reform continue assigning priority to patient advocacy. (Substitute Resolution 29, I-95) [See also: AMA Policy H-320.954] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
140.105R	Oppose Funding Reductions on Health Centers Receiving Title X and/or Medicaid Funding	That our AMA-RFS supports access to preventative and reproductive health services for all patients and legislation and restrictions that diminish funding and/or access to such services; and That our AMA-RFS opposes restrictions for funding of all providers and clinics who provide preventive and reproductive health services, when those providers and clinics otherwise meet the usual standards for eligibility. (Resolution 3, I-15)	Reaffirm with editorial change That our AMA-RFS supports access to preventative and reproductive health services for all patients ~~and legislation and restrictions that diminish funding and/or access to such services~~; and That our AMA-RFS opposes restrictions for funding of all providers and clinics who provide preventive and reproductive health services, when those providers and clinics otherwise meet the usual standards for eligibility.
150.004R	Evidence-Based Sexual Education Enforcement in School	that our AMA-RFS encourages all interested parties to develop best-practice, evidence-based guidelines for developmentally appropriate sexual education curricula that are medically, factually, and technically accurate. (Resolution 10, I-15)	Reaffirm with editorial changes That our AMA-RFS ~~encourages all interested parties to develop~~ supports the development of best-practice, evidence-based guidelines for developmentally appropriate sexual education curricula that are medically, factually, and technically accurate.
160.001R	Screening for Pre-Existing Conditions	That our AMA-RFS support health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, with community or modified community rating, in addition to guaranteed renewability.	Reaffirm

		(Resolution 3, A-09)	
160.002R	Mitigating Abusive Pre-Certification/Pre-Authorization Practices	That our AMA-RFS oppose abusive practices by health insurance entities in pre-certification and pre-authorization of services and medications. (Resolution 15, A-16)	Reaffirm
160.003R	Individual Responsibility to Participate in Insurance Coverage	That our AMA-RFS support: (1) policies that include personal responsibility to participate in private insurance risk pooling arrangements including financial disincentives (penalties) on persons who choose to forgo coverage until they are sick, (2) that an individual responsibility requirement is necessary to preserve an effective private insurance risk-pool, and (3) support working with stakeholders to explore all options, consistent with the goal of assuring that all Americans have access to health insurance coverage without regard to health status, especially in the event that individual responsibility requirements are overturned by court decisions. (Resolution 3, A-11)	Reaffirm
160.004R	Use of Confidential Medical Information by Employers	That: (1) the RFS reaffirm its support for AMA Policy H-190.996, Employers' Violation of Patient Privacy with Group Medical Insurance Claim Forms and (2) the RFS Governing Council report back to the Assembly at I-99 on the AMA's advocacy efforts to safeguard patient confidentiality in employer self-insured plans. (Substitute Resolution 13, A-99) (Reaffirmed Report C, I-09)	Rescind, H-190.996 no longer exists and RFS GC report has been completed
160.005R	Arbitration Agreements	That our AMA-RFS support legislation that would require third party payors to disclose any arbitration agreements to prospective clients prior to, or at the time of enrollment. (Substitute Resolution 26, A-97) (Reaffirmed Report C, I-07)	Reaffirm
160.006R	Discrimination	That our AMA-RFS support that	Reaffirm

	Against Victims of Domestic Violence	health insurance benefits cover conditions arising from injuries associated with domestic violence and prohibit insurance discrimination against victims of domestic violence and abuse. (Substitute Resolution 10, I-94) [See also: AMA Resolution 402, A-95] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	
160.008R	Health Insurance Carriers Cancelling Coverage for Thousands of Patients	That our AMA-RFS support: (1) allowing individual subscribers to health insurance plans that were not in compliance with the Affordable Care Act (ACA), and who therefore experienced cancellations of their health insurance, be able to renew their recently-cancelled insurance contracts for one year; (2) working with other interested stakeholders to delay penalties for non-insurance under the ACA for one year and extend the deadline to enroll for insurance under the ACA for one year, only for those who experienced cancellations of their individual health insurance due to noncompliance with the ACA; and (3) working with other interested stakeholders to help implement fixes to the ACA that will help individual subscribers to health insurance plans that were not in compliance with the ACA and who therefore experienced cancellations of their health insurance. (Emergency Resolution 1, I-13)	Rescind, specifically relevant to initial implementation of ACA which has since passed
160.011R	Administrative Resources for Housestaff	That our AMA-RFS encourages residency programs to offer administrative resources to housestaff for practice-based support including but not limited to pre-certification and pre-authorization of medications and services; and that our AMA-RFS encourages residency programs to offer administrative resources to	Reaffirm

		housestaff for practice-based support including but not limited to pre-certification and pre-authorization of medications and services. (Resolution 15, A-16)	
170.001R	Funding for Preventive Medicine Residencies	That our AMA-RFS support working with the American College of Preventive Medicine, other preventive medicine specialty societies, and other allied partners, to formally support legislative efforts to fund Preventive Medicine Training Programs. (Late Resolution 1, A-05) (Reaffirmed Report E, A-16)	Reaffirm
170.003R	National Committee to Evaluate Medical School Closings	That our AMA-RFS support working with appropriate agencies to develop recommendations regarding the number of graduates of U.S. medical schools consistent with appropriate workforce needs. (Substitute Resolution 9, I-97) (Reaffirmed Report C, I-07)	Reaffirm
170.004R	Resident Training Slots	That our AMA-RFS oppose limitations on the number of residency positions, where such limitations would jeopardize the quality of patient care. (Substitute Resolution 35, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reaffirm
170.005R	Physicians as National and Regional Health Board Members	That our AMA-RFS oppose components of any health care proposal which excludes practicing physicians as members of national or regional regulatory boards. (Substitute Resolution 20, A-94) [AMA Sub. Res. 127, A-94 was adopted in lieu of Resolution 127 and Resolution 149. See also: AMA Policy H-165.960] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reaffirm
180.002R	Hospital Emergency Codes on ID Badges	That our AMA-RFS support the implementation of mandatory cards containing hospital emergency paging codes be included with the identification badge. (Resolution 2,	Reaffirm

		A-11)	
180.003R	Non-Medical Indications for Hospitalization	That our AMA-RFS: (1) oppose arbitrary time requirements of inpatient services in determination of eligibility for inpatient, outpatient or extended recovery, rehabilitative, or other post-hospital extended care services; (2) oppose public and/or private insurance statutes, policies, and regulations that require hospitalization longer than medically necessary for determination of benefit eligibility, including eligibility for skilled nursing facility care and other post-hospital extended care services; and (3) support changes in regulations that would include all continuous time spent in the hospital, including time spent in the emergency department, observational status or inpatient status, count requirement, should they exist. (Late Resolution 2, I-15)	Reaffirm
220.003R	Licensing of International Medical Graduates	That our AMA-RFS, in order to maintain competency of physicians and uphold the quality of medical care, oppose proposals that would establish differential licensing guidelines for international medical graduates, even during periods of unusual migration. (Report I, A-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
230.001R	Clinical Implications and Policy Considerations of Cannabis Use: Medicinal Cannabis	That our AMA-RFS support: (1) state and federal based legalization of cannabis for medicinal use; regulation of medicinal cannabis in states that have legalized its use; and (2) funding and other efforts to continue research into the efficacy and side effects of medicinal cannabis use. (Report G, A-16)	Reaffirm with editorial change combining with (230.002R and 230.003) as follows That our AMA-RFS support: (1) state and federal based legalization of cannabis for medicinal use; regulation of medicinal cannabis in states that have legalized its use; ~~and~~ (2) funding and other efforts to continue research into the efficacy and side effects of medicinal cannabis use; (~~1~~3) the decriminalization of recreational cannabis; (~~2~~4) taxation and

			regulation of recreational cannabis in states that have legalized the sale and use of recreational cannabis; ~~and~~ (~~3~~5) funding, including the allocation of a portion of cannabis sales tax revenue, toward cannabis abuse education programs, harm reduction strategies, and continued research into public health consequences of recreational cannabis use; (6) public health-based strategies, rather than incarceration, in handling of individuals possessing cannabis for personal use in states where it is not currently legal.
230.002R	Clinical Implications and Policy Considerations of Cannabis Use: Recreational Cannabis	That our AMA-RFS support: (1) the decriminalization of recreational cannabis; (2) taxation and regulation of recreational cannabis in states that have legalized the sale and use of recreational cannabis; and (3) funding, including the allocation of a portion of cannabis sales tax revenue, toward cannabis abuse education programs, harm reduction strategies, and continued research into public health consequences of recreational cannabis use. (Report G, A-16)	Reaffirm with editorial changes as above
230.003R	Clinical Implications and Policy Considerations of Cannabis Use: Medicinal and Recreational Cannabis Use	That our AMA-RFS support public health-based strategies, rather than incarceration, in handling of individuals possessing cannabis for personal use in states where it is not currently legal. (Report G, A-16)	Reaffirm with editorial changes as above
230.004R	Advocacy Regarding FICA Taxation for Housestaff	That our AMA-RFS support the AMA studying the consequences of classifying housestaff as either employees or students for the purpose of FICA tax payment and take appropriate action (such as filing an amicus brief in Mayo) on this issue. (Emergency Resolution 1, A-10)	Rescind, this pertained to *Mayo Foundation for Medical Education and Research v. United States*, a 2010 Supreme Court case which has since passed.
230.005R	Eliminating Questions Regarding Marital	That our AMA-RFS (1) oppose questioning residency or fellowship applicants regarding marital status,	Reaffirm

	Status, Childbearing and Dependent Children During the Residency and Fellowship Application Process	dependents, plans for marriage or children, sexual orientation, and religion and (2) support the AMA working with the ACGME, NRMP and other interested parties to eliminate questioning about marital and dependent status, S future plans for marriage or children, sexual orientation, and religion during the residency and fellowship application process. (Resolution 6, I-08)	
230.006R	Defensive Medicine	That our AMA-RFS: (1) affirm that defensive medicine exists in many forms that have variable and difficult to quantify economic consequences for patients, physicians, third-party payers, insurance providers and other parties involved in the delivery of health care; (2) affirm that defensive medicine in its many forms may result in adverse health effects on patients through exposure to unnecessary risk from tests and procedures as well as limited access to health care resources; and (3) supports the AMA continue to work with other interested parties through legislative and public awareness activities to advocate for medical liability reform which would minimize the practice of defensive medicine. (Report F, A- 08)	Reaffirm
230.007R	Inclusion of Residents in Medical Liability Reform	That our AMA-RFS: (1) support the inclusion of all physicians, including unlicensed residents, in state and federal medical liability caps, (2) support the inclusion of unlicensed residents in all pending and future federal medical liability reform legislation, and (3) support state medical societies advocating for the inclusion of unlicensed residents in all current, pending, and future state medical liability reform legislation. (Report H, I-05)	Reaffirm

		(Reaffirmed Report E, A-16)	
230.015R	Conservation, Recycling, and Environmental Stewardship	That our AMA-RFS encourages all health systems to facilitate effective and robust recycling programs with a recommended goal of a 25% rate when feasible; and that our AMA-RFS encourages all undergraduate and graduate medical education programs to facilitate effective and robust recycling programs when feasible; and That our AMA-RFS encourages health systems, medical schools, and graduate medical education offices to evaluate their overall environmental impact, create goals for improvement, and create a plan and a timeline to meet those goals; and That our AMA-RFS supports resources and incentives that aid and encourage hospital employees and physicians who partake in environmentally conscientious activities (benefits for carpooling or taking the bus, showers at work for biking/jogging to work, etc.) (Resolution 6, I-15)	Reaffirm
240.001R	Telemedicine and Medical Licensure	That our AMA study how guidelines regulating medical licenses are affected by telemedicine and medical technological innovations that allow for physicians to practice outside their states of licensure. (Resolution 4, I-07)	Reaffirm with editorial changes to read as follows: “That our AMA-RFS <u>support the</u> study of how guidelines regulating medical licenses are affected by telemedicine and medical technological innovations that allow for physicians to practice outside their states of licensure.”
240.005R	Resident Fees	That our AMA-RFS: (1) support reducing licensure fees and Drug Enforcement Agency certification fees for resident physicians; and (2) oppose any "provider fees" which would increase the financial burden on resident physicians. (Substitute Resolution 37, A-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
240.006R	Feedback from Licensing and Board	That our AMA-RFS support: (1) the Federation of State Medical Boards and the National Board of Medical	Reaffirm

	Examinations	Examiners providing examinees more detailed and specific performance feedback than currently provided, to allow examinees to identify areas of deficit and to facilitate educational improvement, and (2) all specialty boards providing examinees more detailed and specific performance feedback than currently provided to allow examinees to identify areas of deficit and to facilitate educational improvement. (Substitute Resolution 2, I-00) (Reaffirmed Report C, I-10)	
240.007R	Reporting Unqualified Residents	That the AMA-RFS support the recommendations in CME Report 8 (A-99), Alternatives to the Federation of State Medical Boards Recommendations on Licensure. (Report I, I-99) (Reaffirmed Report C, I-09)	Reaffirm
240.008R	National Licensure for Physicians	That our AMA-RFS support the study of the feasibility and implications of national licensure for physicians. (Substitute Resolution 8, I-99) (Reaffirmed Report C, I-09)	Reaffirm
240.009R	RFS Response to FSMB Recommendations on Licensure	That our AMA-RFS: (1) advocate that successful completion of one year of post-graduate training in an accredited residency program, as certified by the resident's program director, is sufficient to obtain an unrestricted medical license; (2) oppose state medical board oversight of medical students; and (3) in conjunction with the AMA, provide state and local medical societies with supporting materials, including model state legislation, that promotes AMA policy concerning training requirements for unrestricted medical licensure. (Substitute Resolution 6, A-99) (Reaffirmed Report C, I-09)	Reaffirm
240.011R	Resident Physician Licenses	That our AMA-RFS support: (1) the option of limited educational licenses in all states; and (2)	Reaffirm

		reduced licensure fees for resident physicians when a full license is required by a state. (Substitute Resolution 35, I-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	
250.001R	CMS, Medicaid, and Health Insurance Corporation Ranking Systems	That our AMA-RFS support current AMA efforts to evaluate and distribute information about individual health insurers, as exemplified by BOT Report 11 (A-08). (Resolution 10, A-08)	Reaffirm
250.002R	Carve-outs and Discrimination in Managed Mental Health Care	That our AMA-RFS support payors eliminating mental health and chemical dependency carve-outs so that benefits for mental health and chemical dependency are managed and administered like other health care services. (Resolution 5, I-00) (Reaffirmed Report C, I-10)	Reaffirm
250.004R	Protection of Residency Education	That our AMA-RFS oppose the role of external financial influence on residency education. (Substitute Resolution 3, A-95) (Reaffirmed Report C, I-05)	Reaffirm
250.005R	Preserving Residency Training and Board Certification	That our AMA-RFS support: (1) policy to remove board certification as a requirement for enrollment in managed care contracts and to pursue with the insurance industry alternatives to board certification for quality non-boarded physicians; (2) study of alternatives to board certification; and (3) continuation of the requirement of both residency training and a passing score on a board exam in the appropriate specialty for board certification. (Substitute Resolution 4, I-95) [See also: AMA Policy H-275.944] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
260.001R	Eliminating Legacy Admissions	That our AMA-RFS oppose the use of legacy status in medical school application forms. (Resolution 4, A-16)	Reaffirm
260.003R	NRMP All-In Policy	That our AMA-RFS does not	Reaffirm with editorial changes as

		support the current “All-In” policy for the Main Residency Match to the extent that it eliminates flexibility within the match process. Also asked that the AMA work with the NRMP, and other external bodies (1) to revise match policy, including the secondary match or scramble process to create more standardized rules for all candidates and (2) to develop mechanisms that limit inequities within the residency application process and allow both flexibility and standard rules for applicants. (Report F, A-11)	follows: That our AMA-RFS does not support the current “All-In” policy for the Main Residency Match to the extent that it eliminates flexibility within the match process. ~~Also asked that the AMA work with the NRMP, and other external bodies~~ That our AMA-RFS support the AMA working with the NRMP, and other external bodies (1) to revise match policy, including the secondary match or scramble process to create more standardized rules for all candidates and (2) to develop mechanisms that limit inequities within the residency application process and allow both flexibility and standard rules for applicants.
260.004R	Value of Autopsy	That our AMA-RFS supports: (1) that the autopsy continues to be a valuable tool for quality assurance, medical education, determination of cause of death, and accurate reporting of vital statistics, and (2) supports working with the Liaison Committee on Medical Education to encourage all medical schools to include greater exposure to autopsy education as part of the medical school curriculum including methods of communication with families, education on autopsy technique, and facilitating opportunities to witness a postmortem autopsy. (Resolution 5, A-11)	Reaffirm
260.005R	Deficiency in Education Related to Autopsy	That our AMA-RFS support studying: (1) areas of deficiency in education relating to autopsy in medical school and residency, in order to identify key interventions in medical education that will have the largest impact in increasing autopsy rates, including, but not limited to, mandating participation in an autopsy during medical school and multiple educational sessions about	Reaffirm

		autopsies for residents, and (2) potential legislative barriers to autopsy and potential efforts to improve autopsy rates. (Resolution 6, A-11)	
260.006R	Competency-Based Learning Portfolios	That our AMA-RFS support the AMA working with the ACGME and other appropriate bodies to define the usefulness of learning portfolios and their role in medical education. (Report E, I-10)	Reaffirm
260.007R	Support of Access and Flexibility to Breast Feeding During Required National Medical Exams	That our AMA-RFS support: (1) the provision of additional time during all standardized medical certification and licensing examinations to allow for pumping or nursing a baby per American Academy of Pediatrics recommendations, (2) testing facilities providing a secured, private, and sanitary location separate from lavatory facilities; and (3) that testing locations with these facilities be designated and clearly identifiable at the time of exam registration. (Resolution 2, A-10)	Reaffirm
260.014R	Medical Student Training in Airway Management	That our AMA-RFS support training in techniques and decision making in airway management of the unconscious patient for all medical students as part of their undergraduate medical education. (Substitute Resolution 1, I-97) (Reaffirmed Report C, I-07)	Reaffirm
260.015R	Establishing Essential Requirements for Medical Education in Substance Abuse	That our AMA-RFS support: (1) that alcohol and other drug abuse education needs to be an integral part of medical education; and (2) the development of programs to train medical students in the identification, treatment and prevention of alcohol use disorder and other chemical dependencies. (Substitute Resolution 31, A-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reaffirm
270.001R	Promoting Patient	That our AMA-RFS support: (1)	Reaffirm

	Access to Established Physicians	direct patient access to physicians of their choice, regardless of whether the physician is a generalist or specialist; and (2) asking medical specialty organizations to develop guidelines for care provided according to specialty and to document the impact of the guidelines on the quality and cost-effectiveness of direct access to care. (Substitute Resolution 3, A-94) [See also: AMA Policy H-230.999, H-385.992, H-405.985] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	
280.001R	Principles of GME Funding Reform	That our AMA-RFS support: (1) that federal funding for Graduate Medical Education (GME) should be based on the actual cost of training residents and fellows (including but not limited to salary, benefits, and institutional support for training and education) and include yearly adjustments for geographic and inflation-based cost-of-living; (2) that the allocation of GME funds within an institution should be transparent and accountable to all stakeholders; (3) that funding for GME should strive to meet the health needs of the public including but not limited to the size of the training program, geographic distribution, and specialty mix; (4) that federal funding for GME from the Centers for Medicare/Medicaid Services or any federal successors should be disbursed through a single transparent funding stream while maintaining opportunities for a multi-payor system; and (5) additional federal funding for the GME that provides flexibility for innovation in training and education above and beyond current levels of funding. (Resolution 20, A-15)	Reaffirm
280.002R	Making GME	That our AMA-RFS support: (1) that	Reaffirm with editorial changes

	Financing and Reform a Priority for AMA	funding for and distribution of positions for graduate medical education (GME) are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (2) expanding medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and (3) making increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda. (Resolution 6, I-11)	"That our AMA-RFS: (1) recognize that funding for and distribution of positions for graduate medical education (GME) are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (2) support expanding medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and (3) support making increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda."
280.003R	Protecting Graduate Medical Education: Revisiting the All-Payer System	That our AMA-RFS support working together with other stakeholders to actively lobby the current Congress for legislation requiring all payers to contribute towards graduate medical education, while simultaneously continuing to lobby to protect Medicare and Medicaid Graduate Medical Education payments. (Resolution 7, A-07)	Reaffirm
280.004R	Securing Medicare GME Funding for Research and Outside Rotations	That our AMA-RFS: (1) support studying current funding mechanisms for residency training programs and potential funding limitations; (2) encourage research and extramural educational opportunities; and (3) oppose work regulations and funding guidelines which may limit research and extramural educational opportunities during residency training. (Resolution 12, A-07)	Reaffirm
280.005R	Comparable Financial Support for Residents	That our AMA-RFS support a comparable level of financial support of housestaff positions by level of training within institutions. (Report I, I-95) [See also: AMA Policy H-310.988] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
280.007R	Compensation for	That the AMA oppose the use of	Reaffirm

	Teaching Physicians	Medicare rules regarding reimbursement of teaching physicians for unsupervised services, by private payors and Medicaid unless the payor contributes to graduate medical education on a scale commensurate to Medicare's contribution to graduate medical education. (Report H, A-97)	
280.012R	Reimbursement and Residency Training	That our AMA-RFS support: (1) that residents should be allowed to fully participate in the care of all patients, regardless of reimbursement mechanisms; (2) appropriate reimbursement for services that are provided by residents under the degree of supervision appropriate for the level of training and the educational setting; and (3) that programs must continue to provide appropriate supervision of trainees. (Report E, A-95) [See also: AMA Policy H-310.979, H-310.981] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
280.013R	Compensation for Teaching Staff Physicians	That our AMA-RFS: (1) support appropriate compensation for physician time spent teaching residents, fellows, and students; and (2) oppose any and all sanctions against physicians who see fewer patients and/or perform fewer procedures as a direct consequence of teaching obligations. (Substitute Resolution 30, A-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
280.014R	Reinstatement of Full Medicare Payment for Second Residencies in Primary Care or Shortage Specialties	That our AMA-RFS support full Medicare Direct Graduate Medical Education reimbursement to training hospitals for residents who have the minimum years of training for first board eligibility and who are seeking to enter a postgraduate training program in a primary care or shortage specialty. (Resolution	Reaffirm

		37, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	
280.017R	Funding of Education and Research Under Prospective Payment Plans	That our AMA-RFS endorse: (1) the concept that research, development and education are intrinsic components of the "product" medical care and as such, their costs should fairly be assumed by private and public medical insurance programs, health care plans and industry; and (2) asking relevant groups to strive toward a better balance between immediate medical cost containment and long-term concern for medical excellence and progress. (Substitute Resolution 19, A-84) (Reaffirmed Report C, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reaffirm
280.018R	Specialty-Specific Allocation of GME Funding	That our AMA-RFS supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty. (Late Resolution 2, A-16)	
281.001R	Supporting Legislation to Create Student Loan Savings Accounts	That our AMA-RFS support federal legislation creating student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans. (Resolution 5, I-15)	Reaffirm
281.002R	Loan Repayment for Physicians in Designated Shortage Areas	That our AMA-RFS support: (1) the distribution of information regarding various opportunities surrounding loan repayment through mechanisms including but not limited to: a designated state contact, web resources, and informative meetings, so that residents can make an informed decision regarding employment; (2) tax benefits for physicians who practice in either state-designated or federally-designated shortage areas; and (3) initiatives that facilitate recruitment of physicians to designated shortage areas. (Resolution 8, A-09)	Reaffirm

281.003R	Expansion of Economic Hardship Loan Deferment	That our AMA-RFS support language advocating for expansion of eligibility for economic hardship deferment for residents and fellows to the greatest degree possible in advocacy activities. (Resolution 2, A-08)	Reaffirm
281.004R	Alternate Mechanisms for Addressing Medical Debt	That our AMA-RFS support alternate mechanisms that better address the financial needs of post-graduate trainees with educational debt. (Late Resolution 1, I-07)	Reaffirm
281.010R	Maintaining Financial Solvency During Residency Training	That our AMA-RFS: (1) encourage resident physicians to work with hospitals and universities to examine the issue of student loan indebtedness and possible solutions including increased compensation packages; and (2) continue to work with the AMA to encourage resident physicians to inform legislators of the impact of financing graduate medical education on career choice, specialty choice, and practice location. (Report N, I-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10)	Reaffirm
281.011R	Student Loan Deferment	That the AMA-RFS support: developing a grassroots campaign to educate federal legislators on the expanding burden of medical education debt in an effort to promote the need for extending deferment of student loans for post-graduate training; (2) the AMA lobbying the federal government for legislation that will achieve deferment of medical school loans for the entire residency and fellowship period. (Substitute Resolution 14, A-99; Reaffirmed, Report C, I-09)	Reaffirm
281.014R	Deferral and Deduction of Student Loans	That our AMA-RFS support full deferral of medical student loans through the entire duration of training. (Substitute Resolution 15, A-95) [See also: AMA Policy H-	Reaffirm

		305.972] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	
281.015R	Administrative Assistance with Medical Education Loans	That our AMA-RFS support all residency training programs providing financial advice and administrative assistance in managing trainee indebtedness. (Resolution 12, A-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
281.017R	Student Loan Deferment by Purchasing Institution	That our AMA-RFS support legislation addressing the fact that institutions selling loans do not always forward the original "request for deferment of payment" document to the loan purchasing institution. (Substitute Resolution 14, A-94) [HOD Resolution 210, I-94 was adopted as action, not policy] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reaffirm
281.020R	Student Loans	That our AMA-RFS support preserving student loan programs for undergraduate medical education. (Resolution 15, A-85) (Reaffirmed Report C, I-95) [See also: AMA Policies H-305.955, H-305.957, H-305.962 and H-305.973] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
281.026R	Recognizing the Actual Costs of Student Loans	That our AMA-RFS supports the consideration of the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates; and That that our AMA-RFS advocates for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high borrowers paying higher interest rates and fees in addition to having a higher overall loan burden; and That our AMA-RFS supports the collection of	Retaom

		data and reporting about student indebtedness that includes total loan costs at time of graduation; and That our AMA-RFS supports including amend D-305.984 to include Grad-PLUS loans in addition to Stafford loans when advocating for reductions in fixed interest rates. (Resolution 7, I-15)	
290.001R	Protecting Residents against Avoidable Financial Constraint Related to Reimbursed Work-Related Expenses	That our AMA-RFS support pay equity among trainees within the healthcare team and believes that salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence allowed by an individual's training program. (Report F, I-13)	Reaffirm
290.002R	Protection of the Titles "Doctor," "Resident" and "Residency"	That our AMA-RFS: (1) recognize that the terms "medical student," "resident," "residency," "fellow," "fellowship," "doctor," and "attending," when used in the healthcare setting, all connote completing structured, rigorous, medical education undertaken by physicians, thus these terms should be reserved to describe physician role; (2) supports that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; and (3) supports state legislation that would penalize misrepresentation of one's role in the physician-led healthcare team, up to and including to make it a felony to misrepresent oneself as a physician (MD/DO); and (4) supports state legislation that calls for statutory restrictions for nonphysician post-graduate diagnostic and clinical training; and that our AMA-RFS support Nurse Practitioners and Physician	Reaffirm

		Assistants pursuing postgraduate clinical training prior to working within a subspecialty field; and that our AMA-RFS support work with relevant stakeholders to assure that funds to support the expansion of postgraduate clinical training for non-physicians do not divert funding from physician GME; and that our AMA-RFS support efforts to partner with the ACGME to create standards requiring Program Directors and Designated Institutional Officials to notify the ACGME of proposed training programs for physicians or non-physicians that may impact the educational experience of trainees in currently approved residencies and fellowships. (Report F, I-13)	
291.001R	Improving Physician Well-Being by Exploring Partnerships with Companies that Promote Health and Fitness	That our AMA-RFS support entering into arrangements with companies which promote health and fitness that are willing to provide discounts to AMA-RFS members. (Resolution 4, A-15)	Reaffirm
291.003R	Information for Resident Grievances	That our AMA-RFS should include on its RFS website a link to general information and resources addressing resident grievances. (Resolution 8, I-15)	Reaffirm
291.004R	Protecting Rights of Breast/Chestfeeding Residents and Fellows	That our AMA-RFS support: (1) working with key stakeholders, including the ACGME, to mandate language in housestaff manuals or similar policy references of all training programs on the protected time and locations for milk expression and storage of breast milk; and (2) working with key stakeholders, including the ACGME and AAMC, to include language related to the learning and work environments for breast/chestfeeding persons in regular program reviews. (Resolution 12, A-16) (Report G, A-	Reaffirm

		24)	
291.005R	Evaluation of Factors During Residency and Fellowship that Impact Routine Health Maintenance	That our AMA-RFS support improved access and reduced barriers to seeking preventive and routine physical and mental health care for trainees in graduate medical education programs. (Resolution 5, A-15)	Reaffirm
291.007R	Preserving the Opportunity to Moonlight	That our AMA-RFS support working with appropriate stakeholders including the ACGME, the AOA, and GME programs to discourage denying resident and fellow physicians the opportunity for internal and external moonlighting that complies with current training standards. (Resolution 4, I-11)	Reaffirm
291.008R	Resident and Fellow Duty Hours and Quality of Training	That our AMA-RFS support the Accreditation Council for Graduate Medical Education (ACGME) to not adopting the IOM report's call for protected sleep periods and for reducing the number of hours that residents can work without time for sleep to 16, until research shows improved patient care and safety; That our AMA encourage the ACGME to allow appropriate flexibility for different disciplines and different training levels within the current ACGME maximum duty hours standards; That our AMA work with other key stakeholders to continue to develop strategies for implementing optimal work schedules to improve resident education and patient safety in healthcare. (Emergency Resolution 2, A-10)	Reaffirm with editorial changes That our AMA-RFS support: (1) the Accreditation Council for Graduate Medical Education (ACGME) ~~to~~ in not adopting the IOM report's call for protected sleep periods and for reducing the number of hours that residents can work without time for sleep to 16, until research shows improved patient care and safety; ~~That~~ (2) our AMA in encourage~~e~~ing the ACGME to allow appropriate flexibility for different disciplines and different training levels within the current ACGME maximum duty hours standards; and (3) ~~That~~ our AMA in work<u>ing</u> with other key stakeholders to continue to develop strategies for implementing optimal work schedules to improve resident education and patient safety in healthcare.
291.011R	Provision of Child Care by Residency and Fellowship Training Programs	That our AMA-RFS: (1) begin collecting more comprehensive data on the provision of child care services or stipends for child care by residency and fellowship programs using the Freida database and (2) evaluate the progress made in the provision of child care and different models	Reaffirm

		being utilized by training programs. (Resolution 4, A-08)	
291.013R	Monitoring of At-Home Call Implementation by Residency Programs	That our AMA-RFS: (1) oppose the use of at-home call if being used to circumvent the intent of current ACGME duty hour restrictions; (2) support working with the ACGME and other interested organizations to collect additional information on how residency programs nationwide are using at-home call rotations; (3) support working with the ACGME and other interested organizations to study the impact of at-home call on resident well-being, sleep patterns, and patient safety, commenting on issues such as, but not limited to, total hours worked, number of pages and phone calls received, and hours of continuous sleep; and (4) support working with the ACGME and other interested organizations to study and develop best practices for implementing at-home call in residency and fellowship programs. (Resolution 3, I-07)	Reaffirm
291.014R	Resident and Fellow Leave Policy	That our AMA reaffirm existing AMA and AMA-RFS policies on resident and fellow leave. [AMA and AMA-RFS policies reaffirmed in lieu of Res. 5, I-06; See AMA Policies H-420.966, H-420.961, H-420.987, H-420.967, and AMA-RFS Policies 310.581R, 310.590R, 310.594R, 310.599R, 310.799R] (Report E, A-07)	Rescind, these AMA policies have been sunset or changed in some way that they are no longer available on AMA Policy Finder
291.023R	Intern and Resident Work Standards	That our AMA-RFS support: (1) various ACGME-RRC standards as a template for reasonable resident work conditions; (2) the development of effective sanctions for violation of ACGME resident work standards; and (3) publishing the list of programs with work hour violations in print and in electronic form. (Substitute Resolution 1, I-00) (Reaffirmed Report C, I-10)	Reaffirm

291.027R	Extended Leave Policy for Residents	That our AMA-RFS support the ACGME and employers providing extended leave of up to one year for resident physicians with extraordinary and long term personal or family medical tragedies without the loss of previously accepted residency training positions. (Substitute Resolution 11, A-97) (Reaffirmed Report C, I-07)	Reaffirm
291.030R	Resident Work Hours	Recommended that our AMA-RFS Governing Council continue to monitor resident working conditions, including working hours, and report back to the Assembly as appropriate. (Report G, I-95) [See also: AMA Policy H-310.957, H-310.979, H-310.981] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
291.032R	Residency Working Hours	That our AMA-RFS support alternatives to the traditional night call system in undergraduate and graduate medical education training to ensure quality patient care and sustain good health for physicians in training. (Substitute Resolution 34, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reaffirm
291.033R	Recognition and Definition of Resident Abuse	That our AMA-RFS: (1) recognize resident abuse as a valid issue and apply the definition established for medical student abuse to residents; and (2) support further research on medical student and resident abuse. (Substitute Resolution 17, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reaffirm
291.040R	No Trainee Left Behind	That our AMA-RFS update language in its Digest of Actions to ensure that position statements are reflected to include fellows in the positions already in the Digest for resident protections, benefits, salary, when appropriate; and that our AMA-RFS support our AMA in amending the Residents and	Rescind

		Fellows' Bill of Rights H-310.912 by addition to read as follows: 5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services, and will encourage institutions to provide parity in salary and benefits between residents and fellows at a level that is at minimum commensurate with their postgraduate year.	
291.043R	Mental Health Services for Medical Staff	That our AMA-RFS encourages health systems, hospitals, and medical schools to offer physicians and medical students access to confidential and comprehensive mental health services not affiliated with their place of employment. (Resolution 17, A-15)	Reaffirm
291.044R	Resident and Fellow Physician Health and Wellness	1. That our AMA-RFS supports educational initiatives to raise awareness about burnout, including but not limited to depression and suicide prevalence, among resident and fellow physicians. 2. That our AMA-RFS supports training for residency and fellowship programs on recognizing, screening, and intervening in cases of resident and fellow physician burnout. 3. That our AMA-RFS supports residency and fellowship programs in developing resident and fellow physician wellness initiatives. 4. That our AMA-RFS supports the promotion of a culture of resident physician wellness within physician training programs. 5. That our AMA-RFS supports the promotion of confidential and accessible mental health services for resident and fellow physicians. 6. That our	Reaffirm

		AMA-RFS encourages further research on the causal factors of resident and fellow physician burnout and its sequelae, including but not limited to its effect on quality of healthcare delivery and patient health outcomes. (Report C, A-15)	
292.002R	Protection of Peer Review Evaluations During Litigation	That our AMA-RFS oppose the utilization of resident and fellow performance evaluations for any purpose other than providing educational feedback. And that our AMA-RFS specifically opposes utilization of any evaluations of resident and fellow performance during a litigation process. (Resolution 5, A-09)	Reaffirm
292.003R	Appropriate Use of 360-Degree Resident Evaluations	That our AMA-RFS support working with the Accreditation Council on Graduate Medical Education to: (1) study mechanisms used by residency programs to evaluate resident performance in the ACGME six general competencies, including 360-degree evaluation tools, and (2) develop standards for the use of 360-degree evaluations, including a determination of their validity in resident assessment, and methods to ensure that the content of individual evaluations remains confidential and legally protected. (Resolution 4, I-09)	Reaffirm
292.005R	Increasing Resident and Fellow Awareness of Local Representation	That our AMA-RFS support the ACGME requiring institutions to annually disseminate to all residents and fellows the current full-text institutional due process rules for residents and fellows and the current names and contact information of residents serving on hospital committees and the responsibilities of their respective committees. (Substitute Resolution 5, A-00) (Reaffirmed Report C, I-10)	Reaffirm
292.006R	Due Process for Housestaff in All	That our AMA-RFS support proposed modifications to the	Reaffirm

	Loss-of Employment Situations	ACGME Institutional Requirements that would expand the provision of a grievance process to situations including non-renewal of contract and other actions that would threaten the career of a resident physician. (Substitute Resolution 2, A-00) (Reaffirmed Report C, I-10)	
292.008R	Confidential Resident Complaint Procedure	That our AMA-RFS support mandatory RRC use of annual anonymous resident surveys prior to site visits, and that the AMA-RFS continue to pursue mechanisms for resident input into the program review process. (Report J, A-95) [See also: AMA Policy H-310.995] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
293.001R	Physician Scientist Benefit Equity	That our AMA-RFS support the concept that all resident and fellow physicians who function in a role as physician scientists are provided with benefits packages comparable to those provided to their peers in clinical residencies or fellowships. (Resolution 1, A-07)	Reaffirm
293.004R	Housestaff Organizations	That our AMA (1) continue to support the development of independent housestaff associations as one option for resident and fellow physicians who wish to organize and advocate to improve or affect the quality of patient care; (2) be prepared to implement a national labor organization specifically for all eligible resident and fellow physicians at such time as the National Labor Relations Board determines that resident and fellow physicians are authorized to organize a bargaining unit under the National Labor Relations Act; and (3) continue to vigorously support antitrust relief that would permit collective bargaining between groups of self-employed physicians and health	Reconcile with more recent actions as the NLRB has determined that trainee physicians are authorized to organize a bargaining until under the National Labor Relations Act That our AMA-RFS support our AMA in (1) continu~~e~~ing to support the development of independent housestaff associations as one option for resident and fellow physicians who wish to organize and advocate to improve or affect the quality of patient care~~; (2) be prepared to implement a national labor organization specifically for all eligible resident and fellow physicians at such time as the National Labor Relations Board determines that resident and fellow physicians are authorized to organize a bargaining unit under the~~

		plans/insurers/hospitals, and be prepared to implement a national labor organization for these physicians should antitrust relief occur. (Report F, A-99) (Reaffirmed Report C, I-09)	~~National Labor Relations Act;~~ and (3) continue to vigorously support antitrust relief that would permit collective bargaining between groups of self-employed physicians and health plans/insurers/hospitals, and be prepared to implement a national labor organization for these physicians should antitrust relief occur.
293.006R	Collective Negotiations by Residents	That our AMA ask its representatives to the ACGME to continue their diligence in supporting inclusion of the following AMA proposed amended language into Section 1,B,3,e(1) of ACGME's Institutional Requirements: Section 1,B,3,e(1) Provision of an organization system for communication and resolution of resident concerns on all issues pertaining to resident educational programs, patient care and resident well being. Institutions must allow resident physicians the ability to form a resident organization and use it or other forums to facilitate regular assessment of resident concerns; (2) that the AMA approve a nationwide program offering supporting materials and telephone and on-site assistance to groups of residents seeking to form independent housestaff organizations advocating no actions resulting in withholding care; and (3) that the AMA study the potential affects on future resident demand for housestaff associations or unionizations should the NLRB rule that all residents are subject to legal protections under the NLRA and make recommendations as to ways in which the AMA can appropriately address those demands. (Report F, A-98)	Reaffirm with editorial changes That our AMA-RFS (1) support our AMA in asking its representatives to the ACGME to continue their diligence in supporting inclusion of the following AMA proposed amended language into Section 1,B,3,e(1) of ACGME's Institutional Requirements: Section 1,B,3,e(1) Provision of an organization system for communication and resolution of resident concerns on all issues pertaining to resident educational programs, patient care and resident well being. Institutions must allow resident physicians the ability to form a resident organization and use it or other forums to facilitate regular assessment of resident concerns; and (2) support our ~~that the~~ AMA in approving~~e~~ a nationwide program offering supporting materials and telephone and on-site assistance to groups of residents seeking to form independent housestaff organizations advocating no actions resulting in withholding care~~; and (3) that the AMA study the potential affects on future resident demand for housestaff associations or unionizations should the NLRB rule that all residents are subject to legal protections under the NLRA and make recommendations as to ways in which the AMA can appropriately address those demands.~~ (Report F,

			A-98)
293.008R	Exposure to Residency Contracts for First Year Residents Prior to Match Day	That our AMA-RFS support the Accreditation Council on Graduate Medical Education (ACGME) requiring programs to provide representative first year contracts to medical students interviewing for positions within their program prior to the submission of rank list. (Substitute Resolution 15, A-97) (Reaffirmed Report C, I-07)	Reaffirm
293.009R	Rules for Resident Negotiations	That our AMA-RFS support the development of appropriate guidelines for addressing and negotiating contract and employment disputes which affect trainees as a group. (Resolution 18, A-97) (Reaffirmed Report C, I-07)	Reaffirm
293.010R	Impact of Healthcare Merging on Residents' Welfare:	That our AMA-RFS: (1) strongly oppose any compromise of residents' contractual rights or benefits, which would be affected by the merging of institutions; (2) support the right of resident representatives to be present at all negotiations involving residents' contractual rights or benefits; and (3) support documentation and publication of any infractions upon contractual rights of residents as a result of the mergers. (Substitute Resolution 27, A-95) [See also: AMA Policy H-310.999] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
294.001R	Telemedicine in Graduate Medical Education	That our AMA-RFS: (1) support educating resident and fellow physicians on the use of tele-health technology in their future practices; and (2) studying the barriers to optimizing the use of tele-health technology for the purposes of tele-education and specifically tele-precepting in Graduate Medical Education and the solutions to overcoming these barriers. (Resolution 16, A-15)	Reaffirm
294.002R	Primary Care and	That our AMA-RFS support: (1) the	Reaffirm with editorial changes

	Mental Health Training in Residency	incorporation of integrated mental health and primary care services into existing psychiatry and primary care training programs' clinical settings; That our AMA encourage primary care and psychiatry residency training programs to create and expand opportunities for residents to obtain clinical experience working in an integrated mental health and primary care model, such as the collaborative care model; That our AMA advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings. (Resolution 13, A-16)	That our AMA-RFS support: (1) the incorporation of integrated mental health and primary care services into existing psychiatry and primary care training programs' clinical settings; (2) ~~That~~ our AMA in encouraging~~e~~ primary care and psychiatry residency training programs to create and expand opportunities for residents to obtain clinical experience working in an integrated mental health and primary care model, such as the collaborative care model; (3) ~~That~~ our AMA in advocating~~e~~ for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.
294.003R	Improving Access to Care and Health Outcomes	That our AMA-RFS support training opportunities for students and residents to learn cultural humility for community health workers. (Resolution 16, A-16)	Reaffirm
294.004R	Report on the Deficiency in Medical Education Relating to Autopsy	That our AMA-RFS support: 1) working with all relevant organizations to advocate for participation in an autopsy during medical school or residency training and to overcome legislative and other barriers to improving autopsy rates; and 2) working with all relevant parties to develop a standard a model curriculum or teaching module on discussion of autopsy, obtaining consent, and autopsy results as part of a patient care specialty. (Report G, I-11)	Reaffirm
294.005R	ACGME Allotted Time off for Health Care Advocacy and Policy Activities	That our AMA-RFS urge the ACGME to acknowledge that "activities in organized medicine" facilitate competency in professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice; That our AMA encourage all residency	Reaffirm with editorial changes That our AMA-RFS (1) urge the ACGME to acknowledge that "activities in organized medicine" facilitate competency in professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice; (2) support

		and fellowship programs to support their residents and fellows in their involvement in and pursuit of leadership in organized medicine; That our AMA encourage the ACGME to adopt policy that every resident and fellow be allotted additional of time per year, beyond of scheduled vacation time, to be used for activities of organized medicine, including but not limited to, health care advocacy and health policy; That our AMA study the other barriers and possible options to overcome these barriers to resident and fellow involvement in of organized medicine, including but not limited to, health care advocacy and health policy. (Resolution 6, A-10)	~~That~~ our AMA in encouragin~~e~~ all residency and fellowship programs to support their residents and fellows in their involvement in and pursuit of leadership in organized medicine; (3) support ~~That~~ our AMA in encouragin~~e~~ the ACGME to adopt policy that every resident and fellow be allotted additional of time per year, beyond of scheduled vacation time, to be used for activities of organized medicine, including but not limited to, health care advocacy and health policy; and (4) ~~That~~ our AMA in studying the other barriers and possible options to overcome these barriers to resident and fellow involvement in of organized medicine, including but not limited to, health care advocacy and health policy.
294.006R	Knowledge of Medical Costs Among Residents and Fellows in Training	That our AMA-RFS support the integration of cost-effectiveness education into medical training, including how to analyze and apply cost-effectiveness data to medical decision-making; That our AMA work with the ACGME and other appropriate bodies to incorporate cost-effectiveness education into medical training, including how to analyze and apply cost-effectiveness data to medical decision-making in residency and fellowship training programs. (Report G, A-10)	Reaffirm with editorial changes That our AMA-RFS support (1) the integration of cost-effectiveness education into medical training, including how to analyze and apply cost-effectiveness data to medical decision-making; and (2) ~~That~~ our AMA in working with the ACGME and other appropriate bodies to incorporate cost-effectiveness education into medical training, including how to analyze and apply cost-effectiveness data to medical decision-making in residency and fellowship training programs.
294.007R	Evaluation of Increasing Residency Review Committee (RRC) Requirements	That our AMA study residency/fellowship documentation requirements for program accreditation and their impact on program directors and residents with recommendations for improvement. (Substitute Resolution 9, A-07)	Reconcile with more recent actions That our AMA-RFS support our AMA working with the Accreditation Council for Graduate Medical Education and American Osteopathic Association to monitor and study residency/fellowship documentation requirements for program accreditation and the impact of these documentation requirements on program directors

			and residents with recommendations for improvement.
294.012R	Education and Regulation of Electrologists	That our AMA-RFS support the appropriate agencies to establishing regulatory and practice guidelines for electrologic procedures including education in the prevention of disease transmission during hair removal procedures. (Substitute Resolution 1, A-97) (Reaffirmed Report C, I-07)	Reaffirm with editorial changes: That our AMA-RFS support the appropriate agencies ~~to~~in establishing regulatory and practice guidelines for electrologic procedures including education in the prevention of disease transmission during hair removal procedures.
294.013R	ACLS Training for Residents	That our AMA-RFS support the ACGME to requiring programs to provide (finance, arrange, and record) current certification in specialty-congruent advanced life support before allowing residents to participate in patient care rotations. (Report J, A-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm with editorial changes: That our AMA-RFS support the ACGME ~~to~~in requiring programs to provide (finance, arrange, and record) current certification in specialty-congruent advanced life support before allowing residents to participate in patient care rotations.
294.014R	Americans with Disabilities Act and Resident Training Files	That our AMA-RFS support working with appropriate entities to ensure that all residency program directors and department chairs are advised of the Americans with Disabilities Act (ADA) and its legal ramifications pursuant to disclosure of training files. (Resolution 7, A-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
294.016R	Support for Women's Health	That our AMA-RFS support efforts to promote the multidisciplinary incorporation of women's health education, research and training across all medical specialties and in medical school, residency training, and continuing medical education. (Substitute Resolution 11, I-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
294.028R	Education in Business and Economics	1. That our AMA-RFS supports work by collaborate with appropriate organizations and committees to develop business and economics educational materials to be incorporated into	Reaffirm with editorial changes: 1. That our AMA-RFS supports ~~work by~~ collaborate~~e~~ing with appropriate organizations and committees to develop business and economics educational materials to be

		graduate and undergraduate medical education. These materials could include, but are not limited to: 1) a model curriculum; 2) a competency evaluation mechanism; and 3) a strategy for elucidating the effect of such education on important outcomes including: physician readiness to practice, patient outcomes, and health care service utilization and physician satisfaction; 2. That our AMA-RFS supports offer education in business and economics for to residents and fellows in the form of online modules, live seminars or other already planned AMA and AMA-RFS strategies for dissemination of educational materials; 3. That our AMA-RFS encourages medical schools and residency and fellowship programs to make educational resources on personal finance and healthcare economics available to all of their trainees. (Report A, A-15)	incorporated into graduate and undergraduate medical education. These materials could include, but are not limited to: 1) a model curriculum; 2) a competency evaluation mechanism; and 3) a strategy for elucidating the effect of such education on important outcomes including: physician readiness to practice, patient outcomes, and health care service utilization and physician satisfaction; 2. That our AMA-RFS supports offering education in business and economics ~~for~~ to residents and fellows in the form of online modules, live seminars or other already planned AMA and AMA-RFS strategies for dissemination of educational materials; 3. That our AMA-RFS encourages medical schools and residency and fellowship programs to make educational resources on personal finance and healthcare economics available to all of their trainees.
294.029R	Education in Medication-Assisted Treatment of Opioid Use Disorders	That our AMA-RFS encourages the expansion of residency and fellowship training opportunities to provide clinical experience in the medication-assisted treatment of opioid use disorders, under the supervision of an appropriately trained physician; and that our AMA-RFS supports additional funding to overcome the financial barriers that exist for trainees seeking clinical experience in the medication-assisted treatment of opioid use disorders. (Resolution 11, A-16)	Reaffirm
295.001R	Transparency in Consumer Communications	That our AMA-RFS support: 1) an Federal Trade Commission (FTC) investigation of whether advertising which refers to certain "board certifications" is false and misleading under the FTCA and FTC regulations when it refers to	Reaffirm

		boards that are so-called "knock-off boards," (i.e. those which have weak certification standards and give the false appearance of certification by a competent certifying body); and 2) language from section 4(a) of the current AMA Truth in Advertising Campaign model bill being added to current legislation on health care transparency. (Resolution 9, I-11)	
295.003R	Publishing Evaluations of Residency Programs	That our AMA-RFS: (1) support asking the ACGME to publish the accreditation letter sent to each program reviewed by an RRC that includes the length of approved accreditation and the programs strengths and weaknesses, and response prepared by the program to the accreditation letter; (2) ensure that accreditation actions are presented in an accessible and understandable format on AMA FREIDA; and (3) support the AMA request to the ACGME to require anonymous surveys of residents. (Report G, A-00) (Reaffirmed Report C, I-10)	Reaffirm
295.004R	Minimum Resident Benefits	That our AMA-RFS continue to monitor the revision of the "General Requirements" of the Essentials of Accredited Residencies in Graduate Medical Education for significant changes in benefits language, and act on them as appropriate within current AMA-RFS actions and AMA policies. (Report I, I-89) (Reaffirmed Report C, I-99) (Reaffirmed Report C, I-09)	Reaffirm
295.006R	Enforcement of ACGME Requirements	That our AMA study and report back on methods the ACGME could use, in addition to probation and withdrawal of accreditation, to enforce its Institutional Requirements and RRC Program Requirements. (Substitute Resolution 11, A-99) (Reaffirmed Report C, I-09)	Reaffirm

300.001R	Inclusion of Sexual Orientation and Gender Identity Information in Electronic Health Records	That our AMA-RFS advocate for inclusion of sexual orientation and gender identity in electronic health records (EHRs). (Resolution 2, A-16)	Reaffirm
330.003R	Effective Communication with HCFA	That our AMA-RFS Governing Council meet with the Health Care Financing Administration (HCFA) to discuss the Medicare guidelines governing reimbursement for resident supervision during residency training with a report back the AMA-RFS Assembly. (Substitute Resolution 6, I-97) (Reaffirmed Report C, I-07)	Rescind - HCFA has since been renamed CMS and Sections are not permitted to meet with external bodies without permission by the AMA/Board of Trustees
340.001R	Universal Color Scheme for Respiratory Inhalers	That our AMA-RFS support: (1) working with leading respiratory inhaler manufacturing companies and health agencies such as the Federal Drug Administration (FDA) and the American Pharmacists Association (APhA) to develop consensus of a universal color scheme for short-acting beta-2 agonist respiratory inhalers that are used as “rescue inhalers” in the United States; (2) working with leading respiratory inhaler manufacturing companies to ensure a universal color scheme for respiratory inhalers would allow for the least disruption possible to current inhaler colors, taking into account distribution of each brand and impact on current users if color were to change; and (3) working with leading respiratory inhaler manufacturing companies to ensure that any universal color scheme for respiratory inhalers be designed for adherence and sustainability, including governance for future companies entering the respiratory inhaler market, and reserving colors for possible new drug classes in the future. (Resolution 14, A-16)	Reaffirm
340.002R	Cumulative Radiation Exposure	That our AMA-RFS support: (1)	Reaffirm

		current FDA policy including safe use of medical imaging devices, informed clinical decision making, and increasing patient awareness; (2) working with all relevant parties to advocate for inclusion of an individual registry containing the patient's historical (test and procedure-based) cumulative radiation dose, as well as research the fiscal impact such a registry would incur; (3) the continued development and use of standardized electronic medical record (EMR) systems that will help physicians track the number of imaging procedures a patient is receiving and that will help physicians discuss the potential dangers of high level of radiation exposure with patients; and (4) initiatives to increase awareness of ionizing radiation exposure from medical imaging and practices that lower radiation exposure from medical imaging, such as the "Image Wisely" "Image Gently" Campaigns. (Resolution 10 and Report E, A-11)	
340.003R	Patient Prescriptions	That our AMA-RFS support improving prescription labeling for visually or otherwise impaired patients and increasing awareness of available resources. (Late Resolution 1, A-08)	Reaffirm
340.004R	Improving Transfer of Care Communication	That our AMA-RFS investigate models of effective, efficient transfer of care communication, taking into consideration the use of electronic medical records. (Resolution 10, A-07)	Rescind
360.001R	Removing Barriers to Organ Donation	That our AMA-RFS support the AMA working with legislators to remove financial barriers to living organ donation to pass laws which include: (1) provisions for expenses involved in the donation incurred by the organ donor, (2) providing	Reaffirm

		access to health care coverage for any medical expense or disability related to the donation, (3) prohibiting employment discrimination on the basis of living donor status, and (4) prohibiting the use of living donor status as the sole basis for denying health and life insurance coverage. (Resolution 4, A-11)	
370.001R	Reimbursement for Phone Consultations	That our AMA-RFS support working with relevant parties to create a method of billing and reimbursement for phone consultations. (Report F, I-11)	Reaffirm
380.001R	Protecting the Privacy of Physician Information Held by the ACGME	That our AMA-RFS support: (1) requesting that the Accreditation Council for Graduate Medical Education (ACGME) and any other organization with a similar case and procedure log for resident physicians develop and implement a system to remove or sufficiently protect identifying data from individual physicians' data logs; (2) requesting that the ACGME and any other organization with a similar case and procedure log for resident physicians adopt a policy not to disseminate any data specific to individual physicians without the written consent of the physician; and (3) requesting that the ACGME and any other organization with a similar case and procedure log for resident physicians permanently expunge its database of specific identifying physician information upon completion or cessation of training. (Late Resolution 1, I-03) [HOD Resolution 301, A-04] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reaffirm
380.002R	Independent Practice of Medicine	That our AMA-RFS support: (1) working at the local, state, and federal levels of government, through both legislation and regulation, to prevent the	Reconcile with more recent actions by combining with 380.004R to read as follows: That our AMA-RFS: (1) oppose the independent practice of mid-level

		independent practice of medicine by mid-level health care providers, as medicine should only be practiced by a fully licensed physician qualified by reason of education, training, and experience in such practice; and (2) working toward regulation and legislation that create reimbursement models do not reimburse mid-level providers at the same rates as physicians. (Resolution 8, A-11)	providers in the interest of patient safety and provider competency, (2) support working at the local, state, and federal levels of government, through both legislation and regulation, to prevent the independent practice of medicine by mid-level health care providers, as medicine should only be practiced by a fully licensed physician qualified by reason of education, training, and experience in such practice; and (3) support working toward regulation and legislation that create reimbursement models do not reimburse mid-level providers at the same rates as physicians
380.003R	Proper Identification of Health Care Providers	That our AMA-RFS support state medical boards and state medical societies in adopting advisory opinions and advancing legislation requiring all healthcare providers to clearly identify their credentials to patients. (Resolution 9, A-11)	Reaffirm
380.004R	Scope of Practice of Mid-Level Providers	That our AMA-RFS oppose the independent practice of mid-level providers in the interest of patient safety and provider competency. (Resolution 3, A-10)	Reconcile more recent actions by combining with 380.002R as above
380.005R	Radiation Oncology is not an Ancillary Service	That our AMA 1) affirm that radiation therapy is not ancillary to any service; 2) that any designation of radiation therapy as an ancillary service is inaccurate; and 3) oppose any legal or other designation of Radiation therapy as an "in-office ancillary service." (Resolution 5, I-08)	Reaffirm with editorial changes That our AMA-RFS support the AMA in 1) affirming that radiation therapy is not ancillary to any service; 2) affirming that any designation of radiation therapy as an ancillary service is inaccurate; and 3) opposinge any legal or other designation of Radiation therapy as an "in-office ancillary service."
380.007R	AMA Policy on Physician Provider Information	That our AMA investigate: (1) the publication of physician information on internet websites; and (2) potential solutions to erroneous physician information contained on Internet websites. (Substitute Resolution 13, A-07)	Reaffirm with editorial changes That our AMA-RFS support the AMA investigatinge: (1) the publication of physician information on internet websites; and (2) potential solutions to erroneous physician information contained on Internet websites.
380.010R	Loan Payback in Shortage Areas	That our AMA utilize U.S. Senate Bill 288, House of Representatives Bill 324, and other legislative	Reconcile with more recent action as these bills corresponded to a specific legislative session and were

		resources to achieve federal income tax exemption for state and federal loan repayment programs designed to improve physician supply in underserved areas. (Substitute Resolution 8, A-99) (Reaffirmed Report C, I-09)	not necessarily passed That our AMA-RFS support the AMA in utilizing legislative resources to achieve federal income tax exemptions for state and federal loan repayment programs designed to improve physician supply in underserved areas.
380.014R	"No Compete" Clauses in Residency and Fellowship Contracts	That our AMA-RFS strongly oppose contractual restrictions on the future practice of residents by institutions sponsoring residency training. (Substitute Resolution 5, A-97) (Reaffirmed Report C, I-07)	Reaffirm
380.017R	"No Compete" Contracts	That our AMA-RFS support: (1) studying the development of model state legislation to effect changes in contract law that will preclude "no compete" clauses; and (2) making a formal statement against "no compete" contracts which border on antitrust activity. (Resolution 5, I-95) [See also: AMA Policy H-165.945] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
380.018R	Encouraging Academic Career and Adequate Research Funding	That our AMA-RFS support residents and young physicians of all disciplines considering careers in academic medicine. (Substitute Resolution 35, A-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reaffirm
390.001R	Teenage Pregnancy Prevention	That our AMA-RFS support the AMA: (1) providing testimony to Congress; and (2) actively supporting funding that provides reproductive preventative screenings and family planning services which are an essential part of women's health services and vital for unintended pregnancy prevention. (Resolution 7, A-11)	Reaffirm
390.002R	Home Deliveries	That our AMA-RFS support the recent American College of Obstetricians and Gynecologists (ACOG) statement that "the safest setting for labor, delivery, and the immediate post-partum period is in	Reaffirm

		the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the American Academy of Pediatrics (AAP) and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers." (Resolution 6, A-08)	
390.003R	Appropriate Conditions for Breastfeeding by Residents and Fellows	That our AMA-RFS encourage all medical schools and Graduate Medical Education programs to support all residents and medical students who provide breast milk for their infants, by providing appropriate time and facilities to express and store breast milk during the working day. (Late Resolution 3, A-05) (Reaffirmed Report E, A-16)	Reaffirm
400.001R	Criminalization of Providing Healthcare to Undocumented Residents	That our AMA: (1) reaffirm AMA Policy H-440.876; (2) work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of healthcare to undocumented residents; and (3) oppose proof of citizenship as a condition of providing healthcare. (Resolution 6, A-07)	Reaffirm
400.002R	Opposition of Central Data Collections of Physicians (in Particular Residents) Named in Malpractice Suits	That our AMA implement AMA Policy H-355.983 which opposes the reporting to the National Practitioner Data Bank of residents named in any malpractice suits which occurred during the required activities of residency training. (Substitute Resolution 13, A-97) (Reaffirmed Report C, I-07)	Reaffirm with editorial changes That our AMA-RFS support the AMA in ~~implement AMA Policy H-355.983 which opposes~~ opposing the reporting to the National Practitioner Data Bank of residents named in any malpractice suits which occurred during the required activities of residency training.
400.002R	Primary Care Physician Liability Under Managed Care Contracts	That our AMA-RFS support strategies to minimize liability exposure of primary care physicians who are restricted in	Reaffirm

		their treatment and referral decisions by the managed care plan in which they are participating. (Substitute Resolution 12, A-96) (Reaffirmed Report C, I-06)	
400.003R	Informing Residents about the National Practitioner Data Bank	That our AMA-RFS support the dissemination of information regarding the National Practitioner Data Bank. (Substitute Resolution 17, I-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10)	Reaffirm
410.001R	Addressing Decreased Access to Mammography	That our AMA-RFS support accessibility to screening mammography and oppose the inappropriate application use of the U.S. Preventative Services Task Force (USPSTF) mammography recommendations to limit access to reimbursement for screening with mammography when a patient and physician believe this to be a beneficial test for the patient. (Resolution 4, A-10)	Reaffirm
410.002R	Direct to Consumer Advertising	That our AMA-RFS oppose Direct to Consumer Advertising of prescription drugs and implantable medical devices. (Report I, A-09) (Reaffirmed in lieu of adopting Resolution 8, A-16)	Reaffirm
410.003R	Payment for Vaccines by Medicare	That our AMA lobby for Medicare to pay for both the cost of the vaccine and the cost of administration by physicians of all vaccines covered under Medicare Part D. (Late Resolution 2, A-08)	Rescind, per the Inflation Reduction Act of 2022, Medicare must cover all vaccines recommended by ACIP and covered by Part D at no cost to Medicare beneficiaries
410.004R	Safe Disposal of Unused Pharmaceuticals	That our AMA-RFS support: (1) requesting that the Environmental Protection Agency conduct studies to better understand the public health and environmental impact of discarded pharmaceuticals on the nation’s drinking water; and (2) developing programmatic guidelines for the disposal of unused pharmaceuticals that optimally protect public health, patient confidentiality, and environmental resources.	Reaffirm

		(Resolution 1, I-05) [See also: AMA Policy H-135.993] (Reaffirmed Report E, A-16)	
410.005R	Covering the Uninsured as AMA's Top Priority	That the AMA-RFS support health system reform that achieves reasonable health insurance for all Americans which emphasizes prevention, quality and safety in such a way that addresses the broken medical liability system and the flaws in Medicare and Medicaid and improves the physician practice environment. (Report I, I-05) [See also: AMA Policy H-165.847] (Reaffirmed Report E, A-16)	Reaffirm
410.006R	Obesity Epidemic	That the AMA-RFS: (1) recognize obesity as a health problem of epidemic proportions; and (2) recognize that education regarding identification and prevention of obesity is appropriate. (Resolution 5, A-04) (Reaffirmed Report D, I-14)	Reaffirm
410.012R	Use of Bittering Agents as a Deterrent Against Ingestion of Potentially Toxic Household Products	That our AMA-RFS support any AMA efforts to encourage the use of bittering agents in household and other products which represent potential toxic hazards when ingested. (Substitute Resolution 19, I-89) (Reaffirmed Report C, I-99) (Reaffirmed Report C, I-09)	Reconcile with more recent action by combining with 410.022R: That our AMA-RFS support any AMA efforts to encourage and any legislation or regulations mandating the use of bittering agents in household and other products which represent potential toxic hazards when ingested in order to reduce accidental poisonings.
410.013R	Low Literacy as a Barrier to Healthcare	That: (1) our AMA-RFS support the recommendations outlined in the Council on Scientific Affairs Report 1 (A-98); and (2) our AMA develop and implement initiatives to raise awareness among residents and fellows of limited patient literacy. (Substitute Resolution 4, A-99) (Reaffirmed Report C, I-09)	Reaffirm with editorial changes That our AMA-RFS support our AMA in: (1) recognizing that limited patient literacy is a barrier to effective medical diagnosis and treatment ~~our AMA-RFS support the recommendations outlined in the Council on Scientific Affairs Report 1 (A-98)~~; (2) encouraging the development of undergraduate, graduate, and continuing medical education programs that train physicians to communicate with

			patients who have limited literacy skills, (3) encouraging all third party payers to compensate physicians for formal patient education programs directs at individuals with limited literacy skills, (4) encouraging the allocation of federal and private funds for research on health literacy; and (~~2~~5) our AMA develop and implement initiatives to raise awareness among residents and fellows of limited patient literacy.
410.017R	Public Health Care Benefits	That our AMA-RFS support maintenance of funding for public health care benefits for all immigrants. (Substitute Resolution 2, I-97) (Reaffirmed Report C, I-07) [See also: AMA Policy H-440.903]	Reaffirm
410.018R	Danger of Car Phones	That our AMA support further study into the dangers of the use of car phones and their impact on road traffic safety. (Substitute Resolution 20, A-97) (Reaffirmed Report C, I-07)	Reaffirm with editorial changes That our AMA-RFS support the AMA in supporting further study into the dangers of the use of car phones and their impact on road traffic safety.
410.019R	Latex Alternatives	That our AMA-RFS strongly encourage health care facilities to provide non-latex alternatives alongside their latex counterparts in all areas of patient care. (Substitute Resolution 3, A-97) (Reaffirmed Report C, I-07)	Reaffirm
410.021R	Latex Allergy Warning	That our AMA-RFS support labeling on medical products specifying “contains latex,” when applicable. (Substitute Resolution 6, A-96) (Reaffirmed Report C, I-06)	Reaffirm
410.022R	Bittering Agents to Reduce Accidental Poisonings	That our AMA-RFS support any legislation or regulations mandating the use of bittering agents in household products to reduce accidental poisonings. (Resolution 8, A-95) [See also: AMA Policy H-10.976] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reconcile with more recent action by combining with 410.012R as above
410.026R	Safe and Equitable Access to Voting	That our AMA-RFS support measures to facilitate safe and equitable access to voting as a	Reaffirm

		harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to: (a)extending polling hours; (b) increasing the number of polling locations; (c) extending early voting periods; (d) mail-in ballot postage that is free or prepaid by the government; (e) adequate resourcing of the United States Postal Service and election operational procedures; (f) improve access to drop off locations for mail-in or early ballots; and that our AMA-RFS oppose requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail. (Resolution 4, I-13)	
410.029R	Medical Vaccination Exemptions	That our AMA-RFS support: (1) the removal of all state-based, non-medical exemptions to vaccination in accordance with each state's list of required vaccinations; and (2) legislative efforts that would establish national vaccination requirements for minors. (Resolution 18, A-15)	Reaffirm
420.005R	Alternative vs. Adjunctive Medical Treatments	That our AMA-RFS support the scientific investigation of alternative medicine techniques. (Substitute Resolution 10, I-95) [See also: AMA Policy H-185.996] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
420.006R	Comprehensive Access to Safety Data from Clinical Trials	That our AMA-RFS support: (1) the FDA investigating and developing means by which academic investigators can access original source safety data from industry-sponsored trials upon request; and (2) support the adoption of universal policy by medical journals requiring principal investigators to have independent access to all study data from industry-sponsored	Reaffirm

		trials.	
420.008R	Principles of Human Subjects Research Shall Apply to Online Research Projects	That our AMA-RFS: (1) considers social media sites' Terms of Service as an insufficient proxy for informed consent prior to being enrolled in an experiment; and (2) supports online social networks providing users with specific informed consent outlining the aims, risks, and possible benefits of an experiment prior to study enrollment. (Resolution 1, I-14)	Reaffirm
440.001R	Privacy Personal Use and Funding of Mobile Devices	That our AMA-RFS ask that our AMA: (1) encourage further research in integrating mobile devices in clinical care, particularly to address challenges of reducing work burden while maintain clinical autonomy for residents and fellows; (2) collaborate with the ACGME to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure a more uniformed regulation of mobile devices in medical education and clinical training; and (3) encourage medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines in using personal devices in clinical environment. (Report F, A-16)	Reaffirm with editorial changes That our AMA-RFS ask that our AMA: (1) encourage further research in integrating mobile devices in clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows; (2) collaborate with the ACGME to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure a more uniformed regulation of mobile devices in medical education and clinical training; and (3) encourage medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines in using personal devices in clinical environment
440.002R	Interoperability of Medical Devices	That our AMA adopt the following statement on the Interoperability of Medical Devices: "The AMA believes that intercommunication and interoperability of electronic medical devices could lead to important advances in patient safety and patient care, and that the standards and protocols to allow such seamless intercommunication should be developed fully with these advances in mind. The AMA also recognizes that, as in all technological advances,	Reaffirm with editorial changes That our AMA-RFS support the AMA in adopting the following statement on the Interoperability of Medical Devices: "The AMA believes that intercommunication and interoperability of electronic medical devices could lead to important advances in patient safety and patient care, and that the standards and protocols to allow such seamless intercommunication should be developed fully with these advances in mind. The AMA also

		interoperability poses safety and medico legal challenges as well. The development of standards and production of interoperable equipment protocols should strike the proper balance to achieve maximum patient safety, efficiency, and outcome benefit." (Resolution 1, I-08)	recognizes that, as in all technological advances, interoperability poses safety and medico legal challenges as well. The development of standards and production of interoperable equipment protocols should strike the proper balance to achieve maximum patient safety, efficiency, and outcome benefit."
440.003R	Genetic Screening	That our AMA-RFS: (1) support legislative action providing for the confidentiality of information obtained from genetic tests, such that it cannot be used: a) in making decisions concerning employment, b) by insurance companies in making decisions about eligibility for health insurance, and c) by insurance companies in making decisions about eligibility for group life and disability insurance; and (2) support all genetic diagnostic services being held to carefully considered and practicable standards; such that, at a minimum, proposed genetic screening plans should demonstrate: a) well-defined and attainable goals, b) provisions for patient education and counseling, c) informed consent, d) an accurate and reliable test, e) a mechanism for quality control, f) acceptable costs, g) assurance of equal access, and h) adequate follow-up services. (Substitute Resolution 19, A- 94) [AMA Res. 503, I-94 was referred] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reaffirm
460.001R	Tobacco Regulation	That our AMA-RFS support the regulation of tobacco as a drug by the FDA. (Substitute Resolution 21, I-95 (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
470.001R	Restrictions on Adolescent Tobacco Sale	That our AMA-RFS oppose the sale of tobacco and nicotine products to minors. (Substitute Resolution 23,	Reaffirm

		A-97) (Reaffirmed Report C, I-07)	
470.003R	Duty-Free Allowances for Tobacco Products	That our AMA-RFS support the repeal of duty-free allowance for importing tobacco products into the United States. (Resolution 6, A-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reaffirm
470.004R	Smoking in Health Care Facilities	That our AMA-RFS oppose the use of all tobacco products everywhere on the premises of hospitals, physicians' offices and other health care facilities. (Resolution 7, A-85) (Reaffirmed Report C, A-95) [See also: AMA Policies H-505.991 and H-490.982.(4)] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
480.001R	Opposition to Violent and Sexually Explicit Television Programming	That our AMA-RFS support: (1) the AMA's continuing efforts to work with state and federal agencies as well as private organizations to mitigate the development of violent and sexually explicit programming; and (2) the AMA's continuing efforts to educate the public about the epidemiological risks of violent and sexually explicit television programming. (Substitute Resolution 15, I-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
500.001R	AMA Physician Profile	(1) That our AMA ensure that the AMA Physician Profile and AMA Masterfile include the complete name of the training program (i.e. “Program Name” as listed on the Accreditation Council for Graduate Medical Education (ACGME) website); (2) That our AMA ensure that the AMA Physician Profile and AMA Masterfile stop deleting from Physician Profiles and the Masterfile the name of the medical school or training program that is already listed and verified in the Physician Profile as it corresponds to the name of the institution at the time of the physician’s graduation,	Reaffirm with editorial changes and combine with 500.002R That our AMA-RFS support the AMA in: (1) ~~That our AMA ensur~~inge that the AMA Physician Profile and AMA Masterfile include the complete name of the training program (i.e. “Program Name” as listed on the Accreditation Council for Graduate Medical Education (ACGME) website); (2) ~~That our AMA~~ ensuringe that the AMA Physician Profile and AMA Masterfile stop deleting from Physician Profiles and the Masterfile the name of the medical school or training program

		and (3) That if the AMA Physician Profile and AMA Masterfile include the new updated name of a medical school or training program, this information be included in addition to but not in place of the name of the medical school or training program at the time of the physician's graduation. (Late Resolution 3, A-08)	that is already listed and verified in the Physician Profile as it corresponds to the name of the institution at the time of the physician's graduation, ~~and~~ (3) ensuring that if the AMA Physician Profile and AMA Masterfile include the new updated name of a medical school or training program, this information be included in addition to but not in place of the name of the medical school or training program at the time of the physician's graduation, and (4) ensuring that for trainees who transfer programs that the AMA Physician Profile lists "Completed Training: Program reports specialty training at this institution as Completed" for the program(s) from which a resident has graduate.
500.002R	AMA Physician Profile for Residents Transferring Programs	That our AMA Physician Profile standard primary source verification confirming residency graduation states on the profile: "Completed Training: Program reports specialty training at this institution as Completed" for the program(s) from which a resident has graduated. (Late Resolution 4, A-08)	Reaffirm by combining with 500.001R as above
500.005R	Minimizing Unnecessary Mail	That our AMA: (1) offer to members on applications and renewals for membership the ability to refuse any AMA periodicals they do not wish to receive as member benefits; (2) offer to members on applications and renewals for membership the ability to exclude their names from mailing lists that the AMA may provide to outside vendors or publishers; and (3) encourage state, county, and medical specialty societies to establish similar mechanisms and policies. (Substitute Resolution 31, A-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10)	Reaffirm with editorial changes That our AMA-RFS support our AMA in: (1) offering to members on applications and renewals for membership the ability to refuse any AMA periodicals they do not wish to receive as member benefits; (2) offering to members on applications and renewals for membership the ability to exclude their names from mailing lists that the AMA may provide to outside vendors or publishers; and (3) encouraging~~e~~ state, county, and medical specialty societies to establish similar mechanisms and policies.
500.006R	Waste Reduction	That our AMA-RFS support the	Reaffirm

	and Fiscal Responsibility	AMA reducing wastage whenever possible through reduction or elimination of the distribution of expendable supplies, such as notebook binders and stationery, to members of the Board, Councils, and Committees. (Resolution 46, A-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10) [See also: AMA Policy H-530.984]	
510.001R	Resident Representation on the American Medical Political Action Committee Board of Trustees	That our AMA-RFS support the appointment of a resident member to the AMPAC Board of Directors. (Substitute Resolution 28, A-96) (Reaffirmed Report C, I-06)	Rescind
510.002R	Campaign Expenditures for Resident Physician Candidates for AMA Offices	That the AMA-RFS support the following guidelines be followed by AMA-RFS-endorsed candidates: (1) Printed material should be factually accurate, tastefully reproduced and may include a limited number of mailings to the AMA House; (2) Candidates are encouraged to keep campaign paraphernalia to a minimum; (3) "Give away" items are discouraged; (4) Financial support for candidates to make telephone calls to AMA House members is acceptable; and (5) Lavish parties given exclusively for a candidate are discouraged. (Substitute Resolution 5, I-84) (Reaffirmed Report C, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reaffirm
520.001R	Residents in the AMA House of Delegates	That: (1) our AMA-RFS Governing Council include in the AMA-RFS Assembly handbook a semiannual report detailing information on AMA-RFS members sitting in the AMA House of Delegates including, but not limited to, name and state or specialty society representation; and (2) invite all resident members of the AMA House of Delegates to the AMA-RFS Assembly and caucuses. (Resolution 26, A-90)	Reaffirm

		(Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10)	
540.001R	Election Day Voting Time	That our AMA-RFS: (1) encourage state medical societies to inform residents and students of local voter laws to include education on absentee balloting; and (2) encourage medical schools and residency training programs to define mechanisms specific to their institution to allow residents and students the opportunity to vote in local and national elections. (Substitute Resolution A-95) [See also: AMA Policy H-565.991] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
540.002R	Creating Legislative Visitation Programs	That our AMA-RFS: (1) encourage state medical associations and specialty societies to create programs that will enable resident physicians to participate directly in the legislative process at the state level; and (2) encourage state medical associations and specialty societies choosing to create legislative visitation programs to consider the Florida Medical Association's Legislative Visitation Program as a possible model in designing their own such programs. (Resolution 1, A-95) [See also: AMA Policy H-565.992] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm
550.002R	Expanding Underrepresented Voices of Racial and Ethnic Minority Groups in the AMA-RFS	That the AMA-RFS: 1) create bylaws to specifically and systematically outline how a physician organizations of racial and ethnic minority groups may gain representation in the RFS national assembly; 2) research the major underrepresented physician organizations of racial and ethnic minority groups with a focus on the level of involvement of resident and fellow members in each organization, on the percentage of	Reaffirm

		AMA members in each organization, and on the level to which each minority physician organization desires to be involved with the AMA-RFS; 3) leadership work with the Specialty and Service Society (SSS) to determine the needed steps that physician organizations of racial and ethnic minority groups would have to take to become seated members of the AMA-HOD. (Report F, I-08)	
550.004R	AMA-RFS Leadership Handbook	That: (1) our AMA-RFS staff and Governing Council design a Leadership Handbook outlining the structure and function of the RFS, leadership positions, and state society contacts; (2) that our AMA-RFS encourage state, county, and specialty societies to develop similar materials; and (3) that our AMA-RFS make the Leadership Handbook available at the Annual and Interim Meetings and upon request. (Substitute Resolution 3, I-97) (Reaffirmed Report C, I-07)	Reaffirm
550.005R	Centralized Resource for Listing Residency and Fellowship Vacancies	That our AMA-RFS work to create and maintain a centralized resource that lists available residency and fellowship vacancies for its membership. (Substitute Resolution 25, A-97) (Reaffirmed Report C, I-07)	Reaffirm
550.006R	AMA Support for Section Web Pages	That our AMA-RFS: (1) maintain the AMA-RFS Home Page, managed by AMA staff in conjunction with an RFS Computer Advisory Committee designee; and (2) procure and maintain space on the AMA server. (Substitute Resolution 13, I-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reaffirm with editorial changes That our AMA-RFS~~: (1)~~ retain and ~~maintain the AMA-RFS Home Page, managed by AMA staff in conjunction with an RFS Computer Advisory Committee designee; and (2) procure and maintain~~ a dedicated space on the AMA website and the AMA server.
560.001R	Standing Committees	That our AMA-RFS Governing Council shall annually appoint standing committees including, but not limited to, long range planning, public health, medical education,	Rescind

		legislative awareness, membership and the poster symposium, composed of members of the Section to serve annual terms to further the mission of the Section; The Governing Council shall make an open solicitation of applications from the members of the section and shall select from among those who have applied; Should there be insufficient applications in order to adequately staff these committees, the Governing Council shall be empowered to make direct solicitations and appointments to the committees. (Report E, A-08)	
560.005R	Peer-Nominated Representation on Institutional Councils and Committees	That our AMA-RFS: (1) encourage the ACGME to require that resident representatives on institutional GME Committees be peer-selected and (2) study ways to ensure that the resident representatives on institutional GME Committees play a meaningful role at their institutions. (Substitute Resolution 9, I-99) (Reaffirmed Report C, I-09)	Reaffirm
580.002R	AMA-RFS Strategic Plan	The following strategic plan for AMA- RFS was adopted for 2010-2011: In the realm of Membership: 1. The RFS should work with the MSS, membership staff, YPS, and County and State medical societies, to develop longitudinal membership drive initiatives that encompass all aspects of physician training from medical school graduation to completion of residency and fellowship training; 2. The AMA-RFS should ensure that there is an RFS-GC member and staff member who is in regular contact with the AMA membership staff and who will serve in an advisory role to the membership department in regards to the creation and implementation of RFS membership initiatives;	Rescind

		3. The AMA-RFS should work with the AMA membership staff to research and develop new membership incentives tailored to prospective RFS members In the realm of Advocacy: 4. The RFS will work with staff and local medical societies to secure additional funding and resources to increase resident activism at the National Advocacy Conference and Lobby Day; 5. The RFS continue to schedule RFS national lobby day concurrently with State and Specialty societies, while at the same time maintaining a direct interaction with the MSS during MSS lobby day; In the realm of Communication: 6. The AMA-RFS should publicize the RFS Facebook page, and utilize the Facebook page to create discussion and interaction among members; 7. The GC should appoint a member to serve as a moderator over the AMA-RFS website, Facebook page, and e-mail publications, who will be responsible to post information to the sites as well as moderate and/or create discussion topics; 8. The RFS Voice should be continued as a print mailing to RFS members, and the RFS should augment print mailings with an on-line newsletter over national and regional list-servs; 9. The RFS should work with the AMA to gather new and current members' e-mail addresses and maintain a members' e-mail database; In the realm of the RFS Regions: 10. The RFS should conduct a thorough examination of the role of the regions within the RFS	

		including the function of the Regional Council, improved communication within the regions, and expansion of regional leadership; 11. The RFS should set the goal of planning with region leadership one to two local-regional events in centers of high concentration of physicians in training; In General the Committee recommends that: 12. The RFS GC report back to the RFS from time to time regarding the progress of each of these recommendations, with a first mandated report back at A-11; 13. The RFS mandate that a strategic plan should be developed for the section at least every 3 years. (Report F, A-10)	
580.004R	Demographics	That our RFS: (1) determine mechanisms to strengthen ties with Specialty Societies and improve logistical support for members involved through their Specialty Societies (i.e. Region 8); (2) determine a system to apportion Specialty Society delegate and alternate delegate positions in the RFS assembly that accounts for the number of RFS members represented by Specialty Societies and ensures broad Specialty Society participation; (3) examine the ability of the Region structure to meet the stated goals of disseminating RFS information to local members, increasing RFS membership, and increasing involvement of RFS members at the regional and local level; and (4) that the RFS Governing Council report back to the RFS Assembly regarding the progress of the above recommendations by A-09. (Report G, A-08)	Reconcile with more recent actions as our RFS no longer has regions That our RFS: (1) determine mechanisms to strengthen ties with Specialty Societies and improve logistical support for members involved through their Specialty Societies ~~(i.e. Region 8);~~ and (2) determine a system to apportion Specialty Society delegate and alternate delegate positions in the RFS assembly that accounts for the number of RFS members represented by Specialty Societies and ensures broad Specialty Society participation~~; (3) examine the ability of the Region structure to meet the stated goals of disseminating RFS information to local members, increasing RFS membership, and increasing involvement of RFS members at the regional and local level; and (4) that the RFS Governing Council report back to the RFS Assembly regarding the progress of the above~~

			~~recommendations by A-09.~~
580.008R	Election Bylaws	That our AMA-RFS Governing Council design and implement an educational program for the Assembly to clarify the vote counting method for rank order balloting. (Substitute Resolution 1, I-99) (Reaffirmed Report C, I-09)	Rescind
580.009R	AMA-RFS External Resolutions	That our AMA-RFS include in the AMA-RFS delegate package and in the AMA-RFS Handbook information explaining the options for each resolution and the process for determining how resolutions are forwarded to either the AMA-RFS assembly and/or the AMA-HOD. (Substitute Resolution 5, I-97) (Reaffirmed Report C, I-07)	Reaffirm
580.010R	Background Information on Resident and Fellow Section Resolutions	That our AMA-RFS require the authors of resolutions to provide pertinent references and relevant existing AMA policy on the issue. (Substitute Resolution 9, A-97) (Reaffirmed Report C, I-07)	Reaffirm
580.011R	Meeting Notices	That our AMA-RFS will include a schedule of annual and interim meeting dates, locations, and hotels in the AMA-RFS Handbook, proceedings, and other appropriate publications. (Substitute Resolution 9, A-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reaffirm
580.015R	RFS Reference Committee Reports	That: (1) AMA-RFS members not on the reference committee not be admitted to its executive session unless invited; and (2) members of a reference committee write and/or review its report prior to the presentation of its findings to the AMA-RFS Assembly. (Resolution 7, A-80) (Reaffirmed Report C, I-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10)	Reaffirm
590.001R	Update on the 50 State Membership Initiative	That our AMA-RFS Membership Committee work with AMA-RFS Staff to continuously update state and specialty society RFS information as outlined in the Late	Reaffirm

		Report 1 (A-09). 1. Membership Committee work with AMA-RFS Staff to obtain the necessary information in order to utilize the flow chart model (see Supplement 1) for state RFS leadership contact information and also utilize this model in order to appoint RFS leadership where necessary and possible. 2. Membership Committee provide updated informational reports of the Fifty State Resident and Fellow Membership Initiative at I-10 and A-11. 3. Governing Council and the Membership Committee work with each state and specialty society RFS to increase membership and encourage increased participation and activity of its membership both at the state and national level. 4. Governing Council and the Membership Committee encourage and assist with the formation of RFS in those states that do not have a formally organized RFS but have an active and interested group of physicians in training as recommended in Late Report 1 (A-09). (Report I, A-10)	
590.002R	Enhancement of Membership Retention During Educational Transitions	That our AMA develop systems to allow state medical associations access to medical student match data and membership information for the purpose of membership retention and outreach without breaching existing contractual obligations; That our AMA study means to improve communication between state medical associations and our AMA for purposes of membership, recruitment, and retention, particularly during times of transition between medical school, residency, and fellowship. (Resolution 7, A-10)	Reaffirm with editorial changes That our AMA-RFS support our AMA in: (1) developing systems to allow state medical associations access to medical student match data and membership information for the purpose of membership retention and outreach without breaching existing contractual obligations; ~~That our AMA~~ (2) studying means to improve communication between state medical associations and our AMA for purposes of membership, recruitment, and retention, particularly during times of transition between medical school, residency,

			and fellowship.
590.003R	Enhancing Involvement of New Meeting Attendees	That our RFS-CLRP develop specific criteria for the use of At-Large positions; That the RFS pilot the use of At-Large positions and a program to incorporate new attendees and non-voting members into existing positions, within the purview of our AMA-RFS IOPs as well as state and specialty society procedures, prior to the commencement of the meeting at I-10; That the RFS-CLRP report the results of the pilot at A-11 and the Assembly vote to determine if the pilot becomes permanent. (Report H, A-10)	Rescind
590.004R	Developing a Mentoring Program for New AMA-RFS Attendees	That our AMA-RFS work to create a mentoring program to welcome new attendees to the section's meetings including, but not limited to, linking mentors and mentees of the same region to sit near each other during RFS business, apprising the mentee of evening social activities, and contacting the mentee before the subsequent meeting. (Report L, I-09)	Reaffirm
590.005R	Expanding AMA Participation by Underrepresented in Medicine Award Winners	That our AMA-RFS increase recruitment and retention of future award winners (including minority scholar award winners) by developing a strategic plan for leadership development and that our AMA-RFS report back on this issue at A-09. (Resolution 8, A-08)	Rescind
590.009R	Facilitating a Smoother Transition Through the Medical Student Section (MSS), Resident and Fellow Section (RFS), and Young Physician Section (YPS)	That our AMA-RFS work with the MSS and the Young Physician Section (YPS) to implement methods to facilitate the transition between the sections. (Substitute Resolution 8, A-97) (Reaffirmed Report C, I-07)	Reaffirm

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: B
(A-26)

Introduced by: RFS Governing Council

Prepared by: RFS Ad Hoc Committee on Policy Compendium (CPC)

Subject: Implementation of Report E (A-24): Inclusion of All Passed Resolutions in the RFS Digest of Actions: Ten Year Lookback

Referred to: Reference Committee

BACKGROUND

At the 2023 Annual Meeting, the AMA-RFS Assembly adopted amended Resolution 12, "Inclusion of All Passed Resolutions in the RFS Digest of Actions." The impetus for this resolution was the lack of a specified process for including or removing resolutions written with an external ask (that is, resolutions adopted by the AMA-RFS Assembly to be sent by the AMA-RFS Delegation to the House of Delegates) in the RFS Digest of Actions. Under the current system, policies sent to the House by the RFS were sometimes subsequently removed from the policy digest, leaving the RFS without a position on an issue upon which it had voted as an Assembly to take a position.

As adopted, I-23's Resolution 12 called on the RFS to perform a ten-year lookback review of all external policies adopted by the Section and subsequently never added to the Digest when the resolution was sent to the House to reconcile it with our internal policy digest. This resolution clarified that in the future, all resolutions written as external resolutions would also become internal policy of the RFS and should be added to our RFS Digest of Actions. The spirit of the resolution was to expand the internal digest to more accurately reflect the intent of the RFS as voted upon in the RFS Assembly and to provide improved voting directives in the House of Delegates. This would, in theory, decrease the need for caucus votes on items at the House of Delegates meeting since there would be an expanded compendium of positions which the AMA-RFS adopted to draw upon. This change in processes would also maintain the original wording of language adopted by the RFS even if the language changes at the House of Delegates after RFS submission.

The Committee on Legislation and Advocacy systematically reviewed the Summary of Actions and Delegate Reports of every meeting from Annual 2013 to Annual 2023, reconciling each internal and external policy with the existing RFS Digest of Actions (Report E). For simplicity, the Committee only included items which were (1) adopted or (2) adopted as amended. Items that were (1) referred, (2) called for a study (i.e., "The AMA-RFS study…), (3) not adopted, (4) informational, or (5) written as a Sunset Report were not included. The Ad Hoc Committee on Policy Compendium was established by the 2025-2026 RFS Governing Council to accomplish the following goals as set forth by the original report:

1. That our AMA-RFS will retain all policies that are adopted by the RFS Assembly, whether external or internal, in the RFS Digest of Actions, until they are removed by active rescission or sunset or altered by amendment.
2. That our AMA-RFS will modify our current Digest of Actions to add previously passed policy as per the "Recommendations" Column in Appendix A.

Over the course of the past year, your Committee on Policy Compendium has worked closely with RFS staff to ensure that the recommendations generated from the systematic review have been integrated into the current version of the Policy Compendium, which is updated as of Interim 2025. The subsequent resolveds from Report E will be accomplished by the Governing Council in a separate report:

3. That our AMA-RFS Governing Council will reconcile those policies by which more attention is needed to determine appropriate placement per the “Recommendations” Column in Appendix A of this report.
4. That our AMA-RFS Governing Council will produce a report which details how the added and reconciled policies were combined with the current Digest of Actions.

DISCUSSION

Moving forward, all internal and external policies adopted by the AMA-RFS Assembly will be added to the Digest of Actions (now Position Compendium). As a note, the text that was adopted by the RFS Assembly will be placed in the Compendium for external resolutions. However, it should be noted that when a resolution is sent to the House of Delegates, it may be amended by the House so that the final form of the resolution present in AMA PolicyFinder may differ from that adopted by the AMA-RFS.

This information is presented to the Assembly at this Annual 2026 Meeting as a report. If a delegate disagrees with the recommendation, that delegate may extract individual Recommendations for individual policies without extracting the entire report. A reproduction of the original review by the Committee on Legislation and Advocacy is found in Appendix A.

REFERENCES

1. RFS Committee on Legislation and Advocacy (COLA). Report E: Inclusion of All Passed Resolutions in the RFS Digest of Actions: Ten-Year Lookback. Policy report, A-24.

ACKNOWLEDGEMENTS

We thank Chelsea Prouty, Rosa Karbowiak, and the current RFS Governing Council for their continued dedication to RFS policy coordination.

APPENDIX A - RECOMMENDED ACTIONS ON PREVIOUSLY ADOPTED POLICIES

Resolution	Text	Recommendation
Annual 2013		
Late Resolution 1 - Addressing the Physician Workforce Shortage by Increasing GME Funding	RESOLVED, that our AMA-RFS~~,~~ work with the AMA and in ~~with~~ consultation with ~~of~~ interested stakeholders~~,~~ to develop a comprehensive framework for a sustainable GME financing plan that addresses the physician workforce shortage and could be implemented at both the state and federal levels, and be it further RESOLVED, that our AMA-RFS work with the AMA to support pilot projects supported through state and federal funding in medically under-served areas that foster resident training programs, offer loan repayment, and support independent practice development as a means to address the physician workforce shortage.	No action; already in Digest.
Resolution 2 – Simulation: An Educational Tool for Training and Skill Maintenance	RESOLVED, that our AMA-RFS encourage medical schools and teaching hospitals to incorporate simulation as an educational tool and develop ways in which it could become a method of evaluating medical student/physician performance.	No action; already in Digest.
Resolution 3 – Transparency on Maternity and Paternity Leave Policies for Trainees	RESOLVED, that our AMA encourages all medical education and training programs ~~facilities~~ to make maternity, ~~and~~ paternity, and adoption ~~and family and medical~~ leave policies transparent and readily available to any applicant in a manner which unequivocally states if and how leave may be taken for these events without incurring extension of training. ~~removes fear of prejudice for having requested that information. Graduate medical training programs should create an anonymous means of obtaining that information, whether it be available in writing or online, to all applicants for a training program; and be it further~~ ~~RESOLVED, that this resolution be immediately forwarded for consideration during the 2013 Annual meeting of the AMA House of Delegates.~~ Amended by change in title to read: TRANSPARENCY ON MATERNITY, PATERNITY, AND ADOPTION LEAVE POLICIES FOR TRAINEES	No action; already in Digest.
Resolution 4 – Graduate Medical Education Funding and Quality of Resident Education	RESOLVED, that our AMA explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the ACGME.	No action; already in Digest.
Emergency Resolution 1 - Policy-making meetings for MSS and RFS	RESOLVED, that our AMA-RFS support one policy making meeting per year for the AMA-HOD.	No action; already in Digest.

Late Report H – AMA-RFS 2013-2016 Working Plan	V. RECOMMENDATIONS In the Realm of **National Meetings** 1. The RFS Governing Council should work with the AMA to encourage RFS participation ~~in a second business meeting to occur after the annual~~ between meetings and that; a. The RFS should continue to work to ensure that the MSS/RFS research poster symposia continues to be held at a national meeting; b. The RFS Governing Council will continue to work with staff to increase resident and fellow attendance at leadership training events, including the National Advocacy Conference and AMA leadership retreats 2. The RFS Governing Council should continue to improve the process of election procedures to ensure adequacy, transparency and integrity of the results; 3. The RFS Governing Council should continue to work to improve content at national meetings that will be relevant to members and that will engage them in the core areas of AMA involvement, Advocacy, Public Health, Community Service, Legislative Policy, Leadership Development and Membership; In the realm of **Advocacy** that; 4. The RFS should continue to make preserving and improving GME funding and addressing future physician workforce issues a key priority of our advocacy actions; 5. The RFS Governing Council should continue to annually identify key issues and mobilize the grassroots network to involve our section in advocating for RFS friendly positions on said issues and continue to educate the general assembly on these issues; 6. That the RFS should continue to work with other resident and fellow based organizations to ensure that the RFS serve as the national spokesperson for all resident and fellow centered issues including student debt, graduate medical education, medical licensure, and resident work hours. In the realm of **Membership and Outreach**; 7. The RFS and RFS Governing Council should investigate mechanisms to increase retention of members as they transition from one section to another including; a. Members transitioning from MSS to RFS; b. Members transitioning from the RFS to the YPS; c. Members transitioning out of IPM programs; 8. The RFS should continue to work with the MSS and the YPS to improve mentoring strategies and increase mentoring opportunities such as combined	No action; generated a report.

networking events, mentoring panels, combined working groups and specific events targeted by specialty, year or location;

9. The RFS should continue to examine and improve the role of the regions within the RFS, which should include:
    a. Current contact information for region leadership and their contact information available online for access by members;
    b. The current level of activity in each region and ways to increase involvement;
    c. The roles and responsibilities of the region leadership;
    d. Novel ways to improve communication, foster leadership and increase membership;
    e. Collaboration with MSS and YPS Sections, including joint region meetings and community service events;
10. The RFS Governing Council should work to establish local membership liaisons that will work directly with GME programs to reach out to residency programs and recruit members;
11. The RFS should continue to work with AMA membership staff to assist with planning local membership recruitment programs and coordinate the involvement of local RFS leaders in said programs;
12. RFS leaders should continue to encourage Section participants to introduce the Introduction of the Practice of Medicine program to their relevant academic and medical center faculty.

In the realm of **Communication:**

13. The RFS and RFS Governing Council should work to establish online social media portals to encourage involvement in RFS activities and increase RFS awareness;
14. The RFS Governing Council should investigate methods to ensure there is effective communication with the region leadership on a regular basis;
15. The -RFS Governing Council should establish a mechanism to provide Governing Council updates and direct communication to our membership and work with AMA staff to ensure that these updates be disseminated to all RFS members;
16. The RFS Governing Council should actively work to increase utilization of the RFS list-serve and make it available to new members;

Lastly, in general the Committee recommends that:

17. The RFS recommend that a Working Plan be developed by the Committee on Long Range Planning for the RFS Governing Council and approved by the assembly at least every 3 years.

Report G – Comprehensive Access to Safety Data from Clinical Trials	RESOLVED, That our AMA urge the Federal Drug Administration to investigate and develop means by which academic investigators can access original source safety data from industry-sponsored trials upon request; and be it further RESOLVED, That our AMA support the adoption of universal policy by medical journals requiring principal investigators to have independent access to all study data from industry-sponsored trials.	No action; generated a report.
Interim 2013		
Emergency Resolution 1: AMA-HOD Resolution 819 (I-13) on "Health Insurance Carriers Canceling Coverage for Hundreds of Thousands of Patient Across the Country"	~~RESOLVED, that our AMA-RFS encourage our American Medical Association to work with the President, legislators, and the Centers for Medicare and Medicaid Services, so that *individual subscribers to health insurance plans that were not in compliance with Affordable Care Act standards, and who therefore experienced cancellations of their health insurance*, be able to renew or otherwise extend their existing insurance contracts until such time that affordable and comparable replacements are available through the Exchanges or within the private market. (Directive to Take Action)~~ RESOLVED, that our AMA-RFS support President Obama's plan to allow individual subscribers to health insurance plans that were not in compliance with the Affordable Care Act (ACA), and who therefore experienced cancellations of their health insurance, be able to renew their recently-cancelled insurance contracts for one year; and be it further RESOLVED, that our AMA-RFS work with other interested stakeholders to delay penalties for non-insurance under the Affordable Care Act (ACA) for one year and extend the deadline to enroll for insurance under the ACA for one year, only for those who experienced cancellations of their individual health insurance due to noncompliance with the ACA; and be it further RESOLVED, that our AMA-RFS work with other interested stakeholders to help implement fixes to the Affordable Care Act that will help individual subscribers to health insurance plans that were not in compliance with the Affordable Care Act (ACA), and who therefore experienced cancellations of their health insurance	Added to Policy Compendium.
Late Resolution 3: Exemption of Fellows from Requirements of Physician Payment Sunshine Act	Resolved, that our AMA advocate in conjunction with appropriate stakeholders, that the CMS use our AMA definition of Resident when formulating rules and regulations. ~~Resolved, that our AMA work in conjunction with all appropriate state and specialty societies to conduct a study to determine the impact of the Physician Payment Sunshine Act on Fellows, as defined by CMS, and be it further~~ ~~Resolved, that our AMA develop recommendations regarding further action to clarify the status of Fellows and prevent inappropriate or unanticipated reporting under the requirements of the Physician Payment Sunshine Act, with a report back at A-14, and be it further~~	No action; already in Digest.

	Resolved, that this resolution be immediately forwarded for consideration during the 2013 Interim Meeting of the AMA House of Delegates.	
Resolution 1: Providing Residency Applicants a Timely Response to Residency Application Outcome	~~RESOLVED, that our AMA encourage the AAMC and ACGME to propose a standardized timeframe for residency programs to provide a timely response of rejection to residency applicants.~~ RESOLVED, that HOD policy H-310.998 Residency Interview Schedules be amended by addition and deletion as below: The AMA encourages ~~accredited~~ residency and fellowship programs to incorporate in their ~~residency~~ interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. The AMA encourages the ACGME and other accrediting bodies to require ~~residency~~ programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. The AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of their application materials and timely notification of when an applicant is no longer under consideration for an interview. ~~about their interview status and provide a time frame of notification dates in the application materials.~~ (Res. 93, I-79; Reaffirmed: CLRPD Rep. B, I-89; Appended: Res. 302 and Res. 313, I-97; Reaffirmed: CME Rep. 2, A-07)	No action; already in Digest.
Late Report F: Protecting Residents Against Avoidable Financial Constraint Related to Reimbursed Work-Related Expenses	Resolved, that our AMA promote training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds. Resolved, that our AMA encourage a system of expedited repayment for purchases of $200 or less, for example through payment directly from their programs (in contrast to following traditional workflow for reimbursement). Resolved, that our AMA encourage training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where *Planned expenses* should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment is strongly recommended in advance but at a minimum, reimbursement should be completed at 2 weeks and not to exceed 1 month after submission of relevant reimbursement documents; and *Unplanned expenses* which includes money spent collectively above the planned amount by trainees is strongly recommended to be reimbursed by 1 month after submission of relevant reimbursement documents, with a period not to exceed 6 weeks.	No action; already in Digest.

	Resolved, that this report and its recommendations as adopted by our Assembly be transmitted to GME programs nationwide.	
Report E: Amending the ACGME Residency Due Process Requirements	That our ~~American Medical Association~~ AMA-RFS advocate for the amendment of the ACGME's Institutional Requirements to specifically require that institutional grievance policies governing the dismissal or non-renewal of a resident or fellow include the following principles, in writing:	No action; already in Digest.
Resolution 1—Resident and Fellow Work-Life Balance	RESOLVED, That our AMA advocate for resident and fellow trainees to be regularly given separately allotted protected time dedicated for mental health, rather than the current practice of sharing "personal days" with illness, other health-related appointments, family emergencies, and interviews; so that trainees can participate in elective stigma-free mental health and substance use disorder services, in order to maximize work-life balance; and be it further RESOLVED, That our AMA support governing bodies, including ACGME, in developing and expanding on formal policy and standards aimed at protecting resident and fellow trainees' well-being, including professionally, physically, psychologically, and socially, during the course of their training.	No action; generated a report.
Resolution 2 Denouncing Racial Essentialism in Medicine	RESOLVED, That out AMA-RFS recognizes that race is a social construct rather than an inherent biological or genetic trait, and their false conflation can lead to inadequate examination of true underlying risk factors; and be further RESOLVED, That our AMA-RFS recognizes that structural racism exists in the American healthcare system and that it is a systemic and public health crisis; and be it further RESOLVED, That our AMA-RFS acknowledge that there may be inherent biologic and genetic traits, distinct from race, linked to certain diseases and that these should be studied and appropriately factored into risk algorithms, screening, and treatment; and be it further RESOLVED, That out AMA-RFS encourages appropriate stakeholders to eliminate racial essentialism from clinical algorithms in an evidence-based fashion; and be it further RESOLVED, That our AMA-RFS encourages appropriate stakeholders to eliminate racial essentialism in medical education curricula and board examinations.	No action; already in Digest.
Resolution 3—Availability of Personal Protective Equipment (PPE)	RESOLVED, That our American Medical Association advocate that it is the responsibility of healthcare facilities to provide sufficient personal protective equipment (PPE) for all employees and staff in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need (Directive to Take Action); and be it further RESOLVED, That our AMA support minimum evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions (New HOD Policy); and be it further	No action; already in Digest.

	RESOLVED, That our AMA advocate that physicians and healthcare professionals must be permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided PPE without penalty (Directive to Take Action); and be it further RESOLVED, That our AMA affirm that the medical staff of each health care institution should be meaningfully involved in disaster planning, strategy and tactical management of ongoing crises (New HOD Policy); and be it further RESOLVED, That our AMA work with The Joint Commission, the American Nurses Credentialing Center, the Center for Medicare and Medicaid Services, and other regulatory and certifying bodies to ensure that credentialing processes for healthcare facilities include consideration of adequacy of PPE stores on hand as well as processes for rapid acquisition of additional PPE in the event of a pandemic (Directive to Take Action); and be it further RESOLVED, That our AMA study a physician's ethical duty to serve in a pandemic including but not limited to the following considerations: 1. The availability and adequacy of institution-supplied PPE and whether inadequate PPE modifies a physician's duty to act; 2. Whether a physician's duty to act is modified by the personal health of the physician and/or those with whom the physician has regular extended contact; 3. Whether a physician's duty to their personal and population safety allows them to speak with local and national media about the safety of their work environment as it relates to the risk it places on themselves, their immediate family and regular social contacts, and the public at large; 4. How medical students, residents, and fellows are affected in the setting of a pandemic in terms of their ethical obligation to care for patients, ramifications to their education, and the protections necessary given their vulnerable status; and 5. The ethical obligation of healthcare institutions and the federal government to protect the physical and emotional wellbeing of physicians and other healthcare workers during and after a pandemic. (Directive to Take Action)	

Resolution 4—Support for Safe and Equitable Access to Voting	RESOLVED, That our AMA support measures to facilitate safe and equitable access to voting ~~reduce crowding at polling locations~~ as a harm-reduction strategy ~~and facilitate equitable access to voting as a means~~ to safeguard public health and mitigate unnecessary risk ~~to immunocompromised groups, including:~~ of infectious disease transmission~~;~~ by measures including but not limited to: (a) extending polling hours; (b) increasing the number of polling locations; (c) extending early voting periods; (d) mail-in ballot postage that is free or prepaid by the government; (e) adequate resourcing of the United States Postal Service and election operational procedures; (f) improve access to drop off locations for mail-in or early ballots; and be it further ~~(g) stipulating that ballots postmarked by Election Day must be counted; and be it further~~ RESOLVED, That our AMA oppose requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail; and be it further RESOLVED, That this resolution be immediately forwarded to the November 2020 House of Delegates Special Meeting.	Added to Policy Compendium.
Report F—Physician Autonomy Resolution 6—Non-Physician Post-Graduate Medical Training	RESOLVED, That our AMA support pay equity among trainees within the healthcare team and believes that salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence allowed by an individual's training program; and be it further RESOLVED, That our AMA amend policy H-275.925 "Protection of the Titles "Doctor," "Resident" and "Residency" by addition and deletion to read as follows: Our AMA: (1) recognize that the terms "medical student," "resident," "residency," "fellow," "fellowship," "doctor," and "attending," when used in the healthcare setting, all connote completing structured, rigorous, medical education undertaken by physicians, thus these terms should be reserved to describe physician role; ~~(1)~~ (2) ~~will~~ advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; and ~~(2)~~ (3) support~~s~~ state legislation that would penalize misrepresentation of one's role in the physician-led healthcare team, up to and including to make it a felony to misrepresent oneself as a physician (MD/DO)~~.~~; and (4) support state legislation that calls for statutory restrictions for non-physician post-graduate diagnostic and clinical training	R1, R5, R6, R7, R8: Added to Policy Compendium. R2, R3, R7: No action; would not affect internal policy. R4: No action; asking for report.

	programs using the terms “medical student,” “resident,” “residency,” “fellow,” “fellowship,” “doctor,” or “attending” in a healthcare setting.; and be it further RESOLVED, That our AMA amend policy H-160.949, “Practicing Medicine by Non-Physicians” by addition to read as follows: …(7) support Nurse Practitioners and Physician Assistants pursuing postgraduate clinical training prior to working within a subspecialty field.; and be it further RESOLVED, That our AMA study curriculum and accreditation requirements for graduate and postgraduate clinical training programs for non-physicians and report back at A-22 and biennially thereafter, on these standards, their accreditation bodies, their supervising boards, and the impact of non-physician graduate clinical education on physician graduate medical education; and be it further RESOLVED, That our AMA work with relevant stakeholders to assure that funds to support the expansion of post-graduate clinical training for non-physicians do not divert funding from physician GME; and be it further RESOLVED, That our AMA partner with the ACGME to create standards requiring Program Directors and Designated Institutional Officials to notify the ACGME of proposed training programs for physicians or non-physicians that may impact the educational experience of trainees in currently approved residencies and fellowships; and be it further RESOLVED, That policy H-310.912 “Resident and Fellow Bill of Rights” be amended by addition and deletion to read as follows: …B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice. With regard to supervision, residents and fellows ~~should expect supervision by physicians and non-physicians~~ must be ultimately supervised by physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. ~~It is neither feasible nor desirable to develop universally applicable and precise requirement for supervision of residents.~~ In instances where education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution, or ACGME as appropriate.; and be it further	

	RESOLVED, That our AMA will distribute and promote the *Residents and Fellows' Bill of Rights* online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles; and be it further RESOLVED, That our AMA oppose non-physician healthcare providers from holding a seat on medical boards that provide oversight of physician undergraduate medical education, graduate medical education, certification or licensure, and advocate that a non-physician seat on these boards be held by non-medical public professionals. RESOLVED, That this resolution be immediately forwarded for consideration at the November 2020 Special Meeting of the House of Delegates.	
Annual 2014		
Late Resolution 1: Protecting the Right of a Residency Trained Physician to Practice Medicine Within His/Her Scope of Practice and Maintain Board Certification While Doing So	Derived from Digest of Actions rather than Annual Digest of Actions: RESOLVED, that our AMA-RFS oppose the establishment of scope of practice limitations through use of board certifications by the American Board of Medical Specialties and its member organizations.	No action; already in Digest.
Resolution 2: Facilitating Resident Transfers In and Out of Residency Programs	RESOLVED, That our AMA-RFS study the issue of resident transfers between programs to better identify the scope of this issue.	No action; generated a report.
Resolution 3: Environmental Toxins and Reproductive Health	RESOLVED, that our AMA-RFS support rigorous scientific investigation into the causes and prevention of birth defects; and be it further RESOLVED, that our AMA-RFS support rigorous scientific investigation into the linkages between environmental hazards and adverse reproductive and developmental health outcomes; and be it further RESOLVED, that our AMA-RFS support policies to identify and reduce exposure to environmental toxic agents; and be it further RESOLVED, that our AMA-RFS support policies to address the consequences of exposure to environmental toxic agents, including the reporting of identified environmental hazards to appropriate agencies; and be it further RESOLVED, that our AMA-RFS encourage physicians to learn about toxic environmental agents common in their community and educate patients on how to avoid toxic environmental agents; and be it further RESOLVED, that our AMA-RFS support policies and practices that support a healthy food system. ~~; and be it further~~	No action; already in Digest.

	~~RESOLVED, that our AMA reaffirm its policy H-150.947, to encourage pregnant and breastfeeding women, as well as women in the preconception period, to eat carefully washed fruits and vegetables and to avoid fish containing high levels of methyl mercury (such as shark, swordfish, king mackerel, and tilefish).~~	
Resolution 4: AMA Participation in Medical Student Debt	RESOLVED, that our ~~American Medical Association explore the feasibility~~ AMA-RFS support the exploration of the development of an affinity program in which student, resident and fellow members of the AMA could consolidate existing educational loans or obtain new educational loans from one or multiple national banks or other financial intermediaries. ~~Membership in the AMA would be required during the life of the loan (typically 10 years or more following medical school), and such activitie4s or program would neither result in the AMA becoming subject to regulation as a financial institution nor impair the AMA's ability to continue to be treated as a not-for-profit entity; and be it further~~ ~~RESOLVED, that our AMA HOD receive a progress report on these discussions by the 2014 Interim Meeting (Directive to Take Action); and be it further~~ ~~RESOLVED, that this resolution be immediately forwarded to the AMA at A-14.~~	No action; already in Digest.
Resolution 5: Insurance Coverage for Fertility Preservation in Patients Receiving Cytotoxic or Immunomodulatory Agents	Derived from Digest of Actions rather than Annual Digest of Actions: RESOLVED, That our AMA-RFS support: (1) payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or by necessary cytotoxic and/or immunomodulatory therapies as determined by a licensed physician; and (2) lobbying for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary cytotoxic and/or immunomodulatory therapies as determined by a licensed physician.	No action; already in Digest.
Resolution 8: Overemphasis on P-Values in Medical Literature	RESOLVED, that our AMA-RFS and AMA discourage the use of generalized qualitative statements of significance, such as through the use of p-values, without the reporting of effect-size, such as through the use of confidence intervals; and be it further RESOLVED, that our AMA-RFS and AMA encourage the formation of a clear distinction between statistical significance and clinical significance in the planning and reporting stages of scientific research; and be it further RESOLVED, that our AMA-RFS encourage, through formal communication to major medical journals and publications, efforts to improve scientific integrity in medical literature by: ● discouraging the reporting of hypothesis testing with generalized phrases such as "significant" or "p-value < 0.05";	No action; already in Digest.

	• promoting the reporting of effect size and measures of spread or variability, such as confidence intervals and standard deviations; • requiring that authors clearly distinguish between accepted levels of statistical significance and clinical significance; and • making efforts to anticipate and avoid language that may mislead as to the importance or impact of a statistical outcome when communicating the results of medical studies to the general public; and be it further RESOLVED, that our AMA-RFS support efforts to incorporate ongoing education on statistical interpretation and reporting in undergraduate, graduate, and continuing medical education with an emphasis on interpreting the distinction between clinical and statistical significance.	
Resolution 11: Development and Promotion of Use of Single National Prescription Drug Monitoring Program (PDMP)	RESOLVED, that our AMA encourage the creation of one national prescription drug monitoring program (PDMP) database of controlled substances for physicians to detect and monitor prescription drug abuse; and be it further RESOLVED, that our AMA oppose ~~*Ensuring Patient Access and Effective Drug Enforcement Act of 2014* (H.R. 4069) and any similar~~ requirements that ~~require~~ physicians must ~~to~~ consult such programs before prescribing medications; and be it further ~~RESOLVED, that our AMA support the creation of a national PDMP database which allows for an online log of patient controlled prescriptions filled and with proactive mechanisms that alert physicians to suspicious prescribing behavior under their name and patient receiving similar controlled substances from multiple prescribers; and be it further~~ RESOLVED, that this resolution be immediately forwarded to the HOD at A-14. ~~The AMA-RFS consider sending to AMA HOD at A-14 given the urgency of H.R. 4069.~~	No action; already in Digest.
Resolution 14: Improving Familiarity and Utilization of Mobile Medical Technology	RESOLVED, that our AMA-RFS support the development of educational programming ~~develop programming to educate residents and fellows~~ on how to use ~~these~~ mobile medical applications for clinical decision- making support, for communication with patients, and how to advise patients to best use mobile technology for health benefit; and be it further RESOLVED, that our AMA-RFS encourage our AMA to work with other interested stakeholders such as the innovators of existing mobile applications and other medical societies to develop or improve existing mobile applications to deliver accurate medical information based on current medical guidelines. ~~; and be it further~~ RESOLVED, that our AMA-RFS encourage our AMA to educate physicians on discerning between evidence-based mobile applications and mobile applications that are not medically accurate. ~~,and develop a list of "quality mobile applications" that are evidence based and user friendly for~~	No action; already in Digest.

	~~provider use and for providers to recommend to their patients; and be it further~~ ~~RESOLVED, that this resolution be forwarded to the AMA HOD for consideration at A-14.~~	
Resolution 15: Regulation of Electronic Nicotine Delivery Systems (ENDS)	RESOLVED, that our AMA-RFS support taxing, labelling and regulating electronic nicotine delivery systems (ENDS) as tobacco products and drug delivery devices; and be it further RESOLVED, that our AMA-RFS support legislation that restricts the minimum age, locations of permissible use, advertising, promotion, and sponsorship of ENDS to that of tobacco products; and be it further RESOLVED that our AMA-RFS support transparency and disclosure concerning the design, content and emissions of ENDS; and be it further RESOLVED, that our AMA-RFS recommend secure, child proof, tamper proof packaging and design of ENDS; and be it further RESOLVED, that our AMA-RFS support enhanced labelling that warns of the potential consequences of ENDS use~~,~~ ~~restriction of ENDS marketing as tobacco cessation tools,~~ restriction of ENDS marketing as tobacco cessation tools until clear evidence based research arises suggesting the contrary, as well as restriction of the use of characterizing flavors in ENDS; and be it further RESOLVED, that our AMA-RFS encourage basic, clinical, and epidemiological research concerning ENDS. ~~; and be it further~~ ~~RESOLVED, that our AMA-RFS forward this resolution to the AMA HOD at A-14.~~	No action; already in Digest.
Report E: Delegate Counts for Assembly Meetings	No text in Summary of Actions and no text in Digest.	Recommend reconciliation.
Interim 2014		
Resolution 1: Principles of Human Subjects Research Shall Apply to Online Research Projects	RESOLVED, That our AMA shall declare social media sites' Terms of Service as an insufficient proxy for informed consent prior to being enrolled in an experiment; and be it further RESOLVED, That our AMA recommend that ~~any member of an~~ online social networks ~~be~~ ~~given~~ provide users with specific informed consent outlining the aims, risks and possible benefits of an experimental ~~research~~ study prior to ~~their~~ study enrollment. ~~; and be it further~~ ~~RESOLVED, That this resolution be immediately forward to the AMA-HOD at I-14.~~	No action; already in Digest.
Resolution 2: Allowing the AMA-RFS Delegation to Act as a Representative Body	No text in Summary of Actions however generated report in subsequent meeting.	No action; generated a report.

Resolution 5: AMA Response to Epidemics and Pandemics	RESOLVED, That our AMA provide regular updates in a timely manner on any disease classified by the World Health Organization as urgent epidemics or pandemics potentially affecting the US population; and be it further RESOLVED, That our AMA work with the CDC and international health organizations to provide organizational assistance to curb epidemics, including calling on American physicians to provide needed resources such as human capital and patient care related supplies; and be it further RESOLVED, That our AMA encourage relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics; and be it further RESOLVED, That this resolution be immediately forwarded to the HOD at I-14.	No action; already in Digest.
Resolution 6: Encouraging Protocols to Assist with the Management of Obese Patients	~~RESOLVED, That our AMA encourage providers to address the logistical requirements of caring for obese patients safely, efficiently and effectively and develop obesity protocols to address issues including but not limited to equipment, imaging machines, and transportation devices; and be it further~~ RESOLVED, That our AMA encourage ~~providers to train~~ healthcare providers ~~professionals and protect them from~~ to learn about techniques and devices to prevent potential injury and to provide safe and efficient care ~~in caring~~ for obese patients.	No action; already in Digest.
Resolution 7: Mitigation of Physician Performance Metrics on Trainee Autonomy and Education	RESOLVED, that our AMA ~~study the~~ assess ways to mitigate the negative effects of physician performance metrics on trainee autonomy and clinical experience during ~~reporting programs on the quality of~~ residency and fellowship training.~~;~~ ~~and be it further~~ ~~RESOLVED, that our AMA advocate that Sunshine Act disclosures related to clinical training for residents and fellows be exempt from reporting.~~	No action; already in Digest.
Resolution 9: Addressing Immigrant Health Disparities	RESOLVED, That our AMA urge federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children ~~populations~~ regardless of legal status, based on medical evidence and disease epidemiology; and be it further RESOLVED, That our AMA, ~~as a professional society, commit to standing against scaremongering, profiling and other stigmatizing and discriminatory practices, intentional or unintentional,~~ advocate against and publically correct medically inaccurate accusations that contribute to anxiety, fear, and marginalization of specific populations ~~based on inaccurate accusations that they pose a threat to public health working with state chapters, educating members, taking public positions and providing professional guidance against scaremongering~~; and be it further RESOLVED, That our AMA advocate for policies to make available and effectively deploy resources needed to narrow health disparities borne by immigrants, refugees or asylees.	No action; already in Digest.

Resolution 10: Sustainable Community Based Falls Prevention Programs to Optimize Functional Outcomes in Elderly Populations	RESOLVED, That our AMA to work with ~~the~~ ~~CDC, Department of Public Health, and~~ relevant ~~agencies~~ organizations to ~~support~~ encourage research into community-based falls prevention programs. ~~to strengthen their overall efficacy and sustainability and~~ ~~to optimize functional outcomes for the~~ ~~elderly.~~	No action; already in Digest.
Resolution 12: Physician and Health Institution Publicity and Responsibility	RESOLVED, That our AMA encourage physicians when engaged in public discourse related to health and medical science to disclose whether stated positions are based on rigorously tested evidence, standard of care, or personal opinion.	Added to Policy Compendium.
Annual 2015		
Resolution 1: Filming Patients for News or Entertainment	RESOLVED, That our AMA-RFS ~~adopt policy which states~~ assert that ~~study whether when filming in the health care setting~~, efforts to disguise a patient (such as blurring the face, changing the voice, or any other technique) do not ~~may~~ obviate the need to obtain consent as outlined in AMA Policy E-5.045 for publication of any material related to the treatment of a patient.	No action; already in Digest.
Resolution 2: Smoke Free Residential Housing	RESOLVED, That our AMA-RFS shall encourage health care institutions that provide employee housing to make such housing smoke free to the extent allowed by applicable local laws.	No action; already in Digest.
Resolution 4: Improving Physician Well-Being by Exploring Partnerships with Companies that Promote Health and Fitness	RESOLVED, That our AMA-RFS ~~Board of Trustees ask AMA management to~~ evaluate entering into arrangements with companies which promote health and fitness that are willing to provide discounts to AMA-RFS members.	No action; already in Digest.
Resolution 5: Evaluation of Factors During Residency and Fellowship that Impact Routine Health Maintenance	RESOLVED, that our AMA study ways to improve access and reduce barriers to seeking ~~mechanisms, such as through existing accreditation and survey processes, to track whether residency programs are adequately providing for their trainees' ability to access necessary~~ preventive and routine physical and mental health care for trainees in graduate medical education programs.	No action; already in Digest.
Resolution 6: Evaluation of Resident and Fellow Compensation Levels	RESOLVED, That our AMA develop recommendations for appropriate ~~adjustments~~ protections and increases to resident and fellow compensation and benefits with input from residents, fellows, and other involved parties including residency and fellowship programs.~~; and be it further~~ ~~RESOLVED, That our AMA assess the impact on the compensation and benefits of residents and fellows from future or current implementation of the Institute of Medicine's report on the Governance and Financing of Graduate Medical Education.~~	No action; already in Digest.
Resolution 7: Discrimination Against Persons with	RESOLVED, that our AMA-RFS oppose discrimination against persons with HIV/AIDS seeking rehabilitative, residential, and nursing care placements for the reason of	No action; already in Digest.

HIV/AIDS Seeking Rehabilitative, Residential, and Nursing Care Placements	HIV/AIDSpositive status.~~; and be it further RESOLVED, that our AMA oppose discrimination against persons with HIV/AIDS seeking rehabilitative, residential, and nursing care placements for the reason of HIV/AIDS-positive status; and be if further~~ ~~RESOLVED, that our AMA encourage practices and policies, consistent with existing federal, state, and local law and regulations, that protect and affirm the rights of persons with HIV/AIDS seeking rehabilitative, residential, and nursing care placements.~~	
Resolution 8: Definition of Resident and Fellow	RESOLVED, that the AMA Council on Constitution and Bylaws develop amendments to the existing bylaws to accomplish the following: For purposes of membership in the AMA-RFS, the term Resident shall be applied to any physician who meets at least one of the following criteria: 1) Members who are enrolled in a residency approved by the ACGME or the AOA 2) Members who are active duty military or public health service residents required to provide service after their internship as general medical officers (including dive medical officers or flight surgeons) before their return to complete a residency program and are within the first five years of service after internship 3) Members serving, as their primary occupation, in a structured educational, vocational, or research program of at least one year to broaden competency in a specialized field prior to completion of their residency For purposes of membership in the AMA-RFS, the term Fellow shall be applied to any physician who has graduated from residency, and meets at least one of the following criteria: 1) Members serving in fellowships approved by the ACGME or AOA 2) Members serving, as their primary occupation, in a structured clinical, educational, vocational, or research training program of at least one year six months to broaden competency in a specialized field, ~~provided it is prior to their working as an independent attending physician;~~ and be it further; and For purposes of membership in the AMA-RFS, any physician meeting the definition of Resident or Fellow shall be eligible for discounted membership dues to the AMA and membership within the AMA Resident and Fellow Section.	Recommend reconciliation; likely to have generated "530.002R. Definition of a Resident" but does not actually establish RFS policy to reference.
Resolution 10: Childcare and Family Entertainment at AMA Meetings	RESOLVED, that our AMA-RFS study and report back, by I-15, on the feasibility of working with ~~our AMA Alliance and other~~ interested organizations to provide: ~~1) Structured activities for travelling family members of members of our House of Delegates, including:~~ ~~a) the number of spouses/significant others/family~~	No action; already in Digest.

	~~members who travel to the Annual and Interim meetings of the House of Delegates and its member sections and the number of spouses/significant others/family members who would travel to the House of Delegates meetings if structured activities were available~~ ~~2)~~ 1) Onsite, low cost, age-appropriate ~~activities and~~ childcare ~~for~~ during AMA meetings, ~~children of our House of Delegates and its member sections,~~ including but not limited to: ~~a)~~ the appropriate hours to providing such childcare, ~~b)~~ the cost associated with such childcare, ~~c)~~ the number of members of our House of Delegates and its member sections who bring their children to the meeting as well as the number of members of our House of Delegates and its member sections who would bring their children to the meeting were such childcare available	
Resolution 11: Increasing Awareness of Nootropic Use	Marked as Adopted as Amended however no text and marked as "NA" regarding HOD Action, but has similarly titled policy in HOD Compendium H-95.935.	Recommend reconciliation; likely Added to Policy Compendium.
Resolution 12: Physician and Health Institution Publicity and Responsibility	RESOLVED, That our AMA encourage physicians when engaged in public discourse related to health and medical science to disclose whether stated positions are based on rigorously tested evidence, standard of care, or personal opinion.	Recommend reconciliation; likely duplicative of Resolution 12 at I-14 .
Resolution 14: Banning the Artificial Use of Trans Fats in the United States	RESOLVED, that our AMA-RFS support a total ban on using artificial trans fats ~~partially hydrogenated oil~~ in food products.	No action; already in Digest.
Resolution 15: Balloting Procedures	RESOLVED, that our AMA-RFS study alternate procedures for balloting including but not limited to: (1) coordinating with the MSS, OMSS, and any other AMA entities to use pre-existing AMA balloting equipment before HOD sessions; (2) develop or have outside vendors develop a unique computer program to handle AMA-RFS elections; (3) use an existing Internet or nonInternet based ballot counting computer program; and implement such measures found to be most appropriate by Interim 2015.	No action; generated a report.
Resolution 16: Telemedicine in Graduate Medical Education	RESOLVED, that our AMA advocate for educating resident and fellow physicians during their training on the use of tele-health technology in their future practices, and be it further; RESOLVED, that our AMA study the barriers to optimizing the use of tele-health technology for the purposes of tele-education and specifically tele-precepting in Graduate Medical Education and the solutions to overcoming these barriers, and be it further; RESOLVED, that this resolution be forwarded to the House of	No action; already in Digest.

	Delegates at A-15.	
Resolution 17: Mental Health Services for Medical Staff	RESOLVED, that our AMA encourage health systems, hospitals, and medical schools to offer physicians and medical students access to confidential and comprehensive mental health services not affiliated with their place of employment.	Added to Policy Compendium.
Resolution 18:NonMedical Vaccination Exemptions	RESOLVED, That our AMA-RFS advocate for the removal of all state-based, non-medical exemptions to vaccination in accordance with each state's list of required vaccinations; and be it further RESOLVED, That our AMA-RFS support legislative efforts that would establish national vaccination requirements for minors.	No action; already in Digest.
Resolution 20: Principles of GME Funding Reform	~~RESOLVED, That our AMA supports the following principles for Graduate Medical Education Funding Reform:~~ ~~(1) Funding for Graduate Medical Education should be based on the actual costs to train and educate a resident/fellow including yearly adjustments for geographic and inflationbased cost-of-living;~~ RESOLVED, That our AMA supports that federal funding for Graduate Medical Education should be based on the actual costs to train and educate a resident/fellow (including but not limited to salary and benefits and institutional support for training and education) including yearly adjustments for geographic and inflation-based cost-of-living; and be it further RESOLVED, That our AMA supports~~(2)~~ that the allocation of Graduate Medical Education funds within an institution should be transparent and accountable to all stakeholders; and be it further RESOLVED, That our AMA support that ~~(3)~~ federal funding for Graduate Medical Education should strive to meet the health needs of the public including but not limited to size of the training program, geographic distribution, and specialty mix; and be it further ~~(4) Federal funding for Graduate Medical Education from the Centers for Medicare/Medicaid Services or a federal successor should be disbursed through a single transparent funding stream.~~ ~~RESOLVED, That our AMA Support that federal funding for graduate Medical Education should strive to meet the health needs of the public including but not limited to the size of the training program, geographic distribution, and specialty mix; and be it further~~	No action; already in Digest.

	RESOLVED, That our AMA support that federal funding for Graduate Medical Education from the Centers for Medicare/Medicaid Services or a any federal successors should be disbursed through a single transparent funding stream while maintaining opportunities for a multi-payor system; and be it further ~~that provides flexibility for innovation in training and education in addition to current levels of funding; and be it further~~ RESOLVED, That our AMA support additional federal funding for Graduate Medical Education that provides flexibility for innovation in training and education above and beyond current levels of funding; and be it further	
Resolution 21: Ethical Physician Conduct in the Media	RESOLVED, That our AMA report on the professional ethical obligations for physicians in the media, including guidelines for the endorsement and dissemination of general medical information and advice via television, radio, internet, print media, or other forms of mass audio or video communication; and be it further RESOLVED, That our AMA study disciplinary pathways for physicians who violate ethical responsibilities through their position on a media platform; and be it further RESOLVED, That our AMA release a statement affirming the professional obligation of physicians in the media to provide quality medical advice supported by evidence-based principles and transparent to any conflicts of interest, while denouncing the dissemination of dubious or inappropriate medical information through the public media including television, radio, internet, and print media~~.~~; and be it further RESOLVED, that this resolution be immediately forwarded to our AMA House of Delegates at A15.	No action; already in Digest.
Report A: Education in Business and Economics	The American Medical Association Resident and Fellow Section Governing Council recommends the following be adopted and the remainder of this report be filed: 1. That our AMA collaborate with appropriate organizations and committees to develop business and economics educational materials to be incorporated into graduate and undergraduate medical education. These materials could include, but are not limited to: 1) a model curriculum; 2) a competency evaluation mechanism; and 3) a strategy for elucidating the effect of such education on important outcomes including: physician readiness to practice, patient outcomes, and health care service utilization and physician satisfaction. 2. That our AMA offer education in business and economics to residents and fellows in the form of online modules, live seminars or other already planned AMA strategies for dissemination of educational materials. 3. That our AMA encourage medical schools and residency programs to make educational resources on personal finance and healthcare economics available to all of their trainees.	Added to Policy Compendium.

Report B: AMA-RFS Caucus Structure and Function	Recommendations 1. That our AMA-RFS amend its Internal Operating Procedures to reflect the following structure and rules of the Residents and Fellows Caucus of the AMA House of Delegates: A. RFS Caucus Structure 1. The RFS sectional and alternate delegates, together with the RFS Delegate and Alternate, form the RFS Caucus. 2. The RFS Delegate and RFS Alternate Delegate should be considered the chair and vice chair of the caucus respectively and their responsibilities in those positions include, but are not limited to: a. Overseeing debate, discussion, and voting that occurs within the caucus, or designating a member of the caucus to fulfill this role if they are unable to perform it themselves. b. Assigning sectional and alternate delegates to reference committees c. Speaking on behalf of the RFS in reference committee hearings and the HOD, or delegating the responsibility to speak on behalf of the RFS to other members of the section. d. Developing general RFS strategy for passing or defeating resolutions e. Coordinating and negotiating with the leadership of other groups within the HOD. 3. Other resident and fellow delegates to the AMA HOD, including residents or fellows appointed to their state or specialty delegations, are not considered members of the caucus. They are encouraged to take part in RFS Caucus meetings and participate in discussions. If willing, they may still be assigned to speak on behalf of the RFS by the RFS Delegate. B. Determining RFS Caucus Positions on AMA HOD Resolutions 1. For all RFS Caucus activities requiring a vote, all members of the caucus shall be given one vote. 2. A quorum of at least 50% of voting members must participate for a vote to be valid. 3. In the AMA HOD, the RFS Caucus must take positions on resolutions that are consistent with the existing policy of the RFS as defined in the RFS Digest of Actions whenever possible. 4. In areas where relevant RFS policy exists, but the interpretation is uncertain, a majority vote of a quorum of delegates will determine the caucus's interpretation.	No action; change in IOP.

	5. When a resolution is before the AMA HOD for which RFS policy does not exist, any member of the RFS Caucus may move that the RFS take a position on the resolution. Such a movement requires a second by another caucus member and a 2/3rds majority vote to pass. 6. Positions set using the procedures described in section B.5 are valid for the duration of that meeting only, and do not apply to future interim or annual meetings. C. Reporting of Caucus Actions 1. The RFS Delegate and Alternate shall be responsible for authoring a report of actions taken, which shall be presented to the RFS Assembly at the next national meeting. This report will list the resolved clauses of all AMA HOD resolutions for which the RFS took a position, and will specifically identify those resolutions for which the RFS Caucus took a position that was not grounded in existing internal policy. It will also detail the action taken, motivation for taking such action, and suggestions for new AMA-RFS policy on the issue in question.	
Report C: Resident and Fellow Physician Health and Wellness	Recommendations The American Medical Association Resident and Fellow Section Public Health Committee recommends the following be adopted and the remainder of this report be filed: 1. The AMA support educational initiatives to raise awareness about burnout, including but not limited to depression and suicide prevalence, among resident and fellow physicians. 2. The AMA collaborate with the ACGME, COCA, and other interested parties to promote training for residency and fellowship programs on recognizing, screening, and intervening in cases of resident and fellow physician burnout. 3. The AMA collaborate with the ACGME, COCA, and other interested parties to assist residency and fellowship programs in developing resident and fellow physician wellness initiatives. 4. The AMA promote a culture of resident physician wellness within physician training programs. 5. The AMA promote confidential and accessible mental health services for resident and fellow physicians. 6. The AMA encourage further research on the causal factors of resident and fellow physician burnout and its sequelae, including but not limited to its effect on quality of healthcare delivery and patient health outcomes.	Added to Policy Compendium.
Report D: Sunset Mechanism	Resolved clauses of report not listed in Summary of Actions.	Recommend reconciliation; likely generated bylaws report and may not require any action.
Interim 2015		

Late Resolution 1: Clarification of Medical Necessity for Treatment of Gender Dysphoria	RESOLVED, that our AMA recognize that treatment for gender dysphoria should be determined by shared decision making between patient and physician, consistent with generally-accepted standards of medical and surgical practice; and be it further RESOLVED, that our AMA ~~advocate for access to and reimbursement for medically necessary and appropriate treatment for individuals with gender dysphoria.~~ amend H-185.950 as follows: **H-185.950 Removing Financial Barriers to Care for Transgender Patients** Our AMA supports public and private health insurance coverage for treatment of gender ~~identity disorder~~ dysphoria as recommended by the patient's physician.	No action; already in Digest.
Late Resolution 2: NonMedical Indications for Hospitalization	RESOLVED, that our AMA oppose arbitrary time requirements of inpatient services in determination of eligibility for inpatient, outpatient or extended recovery, rehabilitative, or other post-hospital extended care services; and be it further RESOLVED, that our AMA oppose public and/or private insurance statutes, policies, and regulations that require hospitalization longer than medically necessary ~~for determination of benefit eligibility, including eligibility in order to be eligible~~ necessary for determination of benefit eligibility, including eligibility for skilled nursing facility care and other post-hospital extended care services; and be it further RESOLVED, that our AMA-RFS support changes in regulations that would include all continuous time spent in the hospital, including time spent in the emergency department, observational status or inpatient status, count toward any minimum length of stay requirement, should they exist	No action; already in Digest.
Late Resolution 3: Abuse of Free-Market Pharmaceuticals	RESOLVED, that our AMA-RFS advocate for pharmaceutical pricing that ~~the appropriate regulatory bodies of the federal government exercise its "march-in-rights" authority under the Bayh-Dole Act to assure the availability of pharmaceuticals at~~ is fair and reasonable ~~prices~~ to consumers, and be it further ~~RESOLVED, that our AMA-RFS reaffirms its policy of advocating that Medicare be granted the right to negotiate of drug prices with pharmaceutical companies.~~ RESOLVED, that our AMA-RFS advocate that the Centers for Medicare and Medicaid Services be granted the right to negotiate drug prices with pharmaceutical companies.	No action; already in Digest.
Resolution 2: Privacy Personal Use and Funding of Mobile Devices	RESOLVED, that our AMA-RFS support that physicians should not be required to use personal funding to purchase mobile devises (tablets, laptops, cell phones, PDAs, etc.) or their data plans for work-related purposes; and be it further	No action; generated a report.

	RESOLVED, that our AMA-RFS support that all physicians should retain their right to keep their personal information private and separate from the workplace, such as their home address and personal telephone number; and be it further RESOLVED, that our AMA-RFS support that if a person elects to use their own device, employers should provide full disclosure prior to use regarding their ability to monitor and access personal information; and be it further RESOLVED, that our American Medical Association work with the Accreditation Council of Graduate Medical Education and other interested parties to develop and support policies that protect physicians' privacy relating to the use of personal technology in the workplace while minimizing financial burden.	
Resolution 3: Opposing Funding Reductions on Health Centers Receiving Title X and/or Medicaid Funding	RESOLVED, that our AMA support ~~men's and~~ ~~women's~~ access to preventative and reproductive health services for all patients and oppose ~~non-evidence-based~~ legislation and restrictions that diminish funding and/or access to such services; and be it further RESOLVED, that our AMA oppose ~~non-evidence-based~~ restrictions for funding of all providers and clinics who provide preventive and reproductive health services, when those providers and clinics otherwise meet the usual standards for eligibility; and be it further RESOLVED, that this resolution be immediately forwarded to the AMA House of Delegates at Interim 2015.	Added to Policy Compendium.
Resolution 5: Supporting Legislation to Create Student Loan Savings Accounts	RESOLVED, that our AMA advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.	No action; already in Digest.
Resolution 6: Conservation, Recycling, and Environmental Stewardship	RESOLVED, that our AMA encourages all health systems to facilitate effective and robust recycling programs with a recommended goal of a 25% rate when feasible; and be it further RESOLVED, that our AMA encourages all undergraduate and graduate medical education programs to facilitate effective and robust recycling programs when feasible; and be it further RESOLVED, that our AMA encourages health systems, medical schools, and graduate medical education offices to evaluate their overall environmental impact, create goals for improvement, and create a plan and a timeline to meet those goals; and be it further RESOLVED, that our AMA supports resources and incentives that aid and encourage hospital employees and physicians who partake in environmentally conscientious activities (benefits for carpooling or taking the bus, showers at work for	Added to Policy Compendium.

	biking/jogging to work, etc.).	
Resolution 7: Recognizing the Actual Costs of Student Loans	RESOLVED, that our AMA ~~recognize the total cost of student loans includes not only interest rates, but also loan origination fees as well as appreciate the value of some loans in terms of other benefits such as tax deductibility and loan forgiveness; and be it further~~ consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates; and be it further RESOLVED, that our AMA amend D-305.984 to include Grad-PLUS loans ~~and reflect the actual total cost of loans such that we not only advocate for loan rates, but also other costs of loans~~, as follows: ~~; and be it further~~ **D-305.984 Reduction in Student Loan** **Interest Rates** 1. Our American Medical Association will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%. 2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the GradPLUS loan program. RESOLVED, that our AMA advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of highborrowers paying higher interest rates and fees in addition to having a higher overall loan burden; and be it further RESOLVED, that our AMA ask the AAMC to collect data and report student indebtedness that includes total loan costs at time of graduation.	R1, R3, R4: Added to Policy Compendium; note that amendment appears to have been passed. R2: Added to Policy Compendium as internal policy.
Resolution 8: Information for Resident Grievances ~~Hotline and Website~~	RESOLVED, that our AMA-RFS should include on ~~add to~~ its RFS website a link to general information and resources addressing resident grievances. ~~to assist and help direct residents with grievances to the appropriate venue. Said webpage would contain basic guidelines for filing a report, references to the resident bill of rights, and links to outside sources such as the NRMP, ACGME, etc. in order to guide a resident to resources to pursue to find a resolution for workforce issues and grievances; and be it further~~ ~~RESOLVED, that our AMA-RFS should request that the ACGME consider establishing an anonymous way for residents to submit grievances without fear or retaliation, either by a web submission form without identifying~~	No action; already in Digest.

	~~information via their website or a confidential grievance phone line as a resource.~~	
Resolution 9: ~~Physician Education in~~ In-Flight ~~Medicine~~ Medical Emergencies	~~RESOLVED, that our AMA-RFS encourage all resident training programs to promote familiarization of available inflight medical supplies, common IFMEs, and legal protections when responding to IFMEs.~~ ~~RESOLVED, that our AMA-RFS study physician familiarity with IFMEs and in-flight medical supplies.~~ RESOLVED, that our AMA work with the FAA and other appropriate organizations to require airlines provide a list of available inflight medical supplies in accessible locations. RESOLVED, that our AMA work with the FAA and other appropriate organizations to facilitate the creation of a centralized and standardized system to report all medical emergencies requiring assistance from a medically-trained passenger or from ground-based communications. RESOLVED, that our AMA work with the FAA and other appropriate organizations to ensure that a routine process exists to verify functionality of medical equipment and medicines used for in-flight medical emergencies.	Added to Policy Compendium.
Resolution 10: Evidence-Based Sexual Education Enforcement in School	~~RESOLVED, that our AMA advocate strongly for the promotion of evidence-based comprehensive sexuality education programs including but not limited to the following actions: 1) Encourage the Department of Health and Human Services to mandate evidence-based sexual education for all recipients of federally-derived sexual education programs funding; and 2) Encourage all States and US Territories to require primary and secondary school sexual education that is medically, factually and technically accurate.~~ RESOLVED, that our AMA encourage all interested parties to develop best-practice, evidence-based guidelines for developmentally appropriate sexual education curricula that are medically, factually, and technically accurate.	Added to Policy Compendium.
Resolution 11: Online Access to Prescription Drug Formularies	RESOLVED, that our AMA promote the value of online access to prescription drug formulary plans from all insurance providers nationwide; and be it further RESOLVED, that our AMA support state medical societies in advocating for state legislation of online access to prescription drug formularies for all insurance plans in the state health exchanges.	Added to Policy Compendium.
Report F: Childcare at the AMA Meetings	~~1. That our American Medical Association (AMA) not directly provide options for on site childcare at this time.~~ 1.~~2.~~ That our AMA ~~RFS ask the AMA~~ and/or relevant ~~subcommittee(s) to prepare~~ a brief survey directed towards ~~meeting~~ attendees addressing the desire and need ~~for future onsite childcare and report back~~ on these results by ~~A-17.~~ survey recent attendees of the AMA section meetings	No action; already in Digest.

	as well as the HOD on whether or not they have brought their children to AMA meetings and on the desire and need for onsite childcare and report back on these results at I-16. (Directive to Take Action) 2.~~3.~~ That ~~until such time as said survey is completed,~~ our AMA RFS Hospitality Committee and other relevant organizations ~~be asked to~~ publicize family friendly activity information within each meeting's respective host cities. (Directive to Take Action)	
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Late Resolution 2: Specialty-Specific Allocation of GME Funding	RESOLVED, that our AMA support specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty; and be it further RESOLVED, that this resolution be immediately forwarded to the HOD at A-16.	Added to Policy Compendium.
Resolution 1: Expansion of Public Service Loan Forgiveness	RESOLVED, that our AMA study mechanisms to allow residents and fellows working in for-profit institutions to be eligible for Public Service Loan Forgiveness, and be it further RESOLVED, that this resolution be forwarded immediately to A-16 HOD meeting.	No action; request for report.
Resolution 2: Inclusion of Sexual Orientation and Gender Identity (SOGI) Data Collection in Information in Electronic Health Records (EHRs)	RESOLVED, that our AMA advocate federal ~~agencies to include~~ for inclusion of sexual orientation and gender identity ~~(SOGI) data~~ collection in electronic health records (EHRs). ~~RESOLVED, that our AMA supports efforts to optimize sexual orientation and gender identity (SOGI) information data collection within standardized nomenclature systems.~~ ~~RESOLVED, that our AMA advocate for SOGI data collection in federal surveys and studies where appropriate.~~	Added to Policy Compendium.
Resolution 3: Universal Prescriber Access to Prescription Drug Monitoring Programs	RESOLVED, that our AMA support legislation and regulatory action that would authorize all prescribers of controlled substances, including residents, to have access to their state prescription drug monitoring program.	Added to Policy Compendium.
Resolution 4: Eliminating Legacy Admissions	RESOLVED, that our AMA-RFS oppose the use of legacy status in medical school applications forms. ~~RESOLVED, that our AMA oppose the use of legacy status in the residency application process.~~	No action; already in Digest.
Resolution 6: Expanding GME Concurrently with UME	RESOLVED, that our AMA study the effect of medical school expansion that occurs without corresponding graduate medical education expansion, and be it further RESOLVED, that this resolution be immediately forwarded.	No action; request for report.

Resolution 7: Chronic Trauma Encephalopathy (CTE)	RESOLVED, that our AMA amend H-470.954 to include a part (C)that appropriate agencies "promote education for physicians and the public on the detection, treatment and prognosis of chronic traumatic encephalopathy (CTE)." RESOLVED, that the AMA work with interested agencies and organizations to advocate for further research into the causes of and treatments for chronic traumatic encephalopathy (CTE).	Added to Policy Compendium.
Resolution 9: Firearm Background Checks	RESOLVED, that our AMA ~~amend H-145.996 as follows:~~ ~~**H-145.996 Handgun Availability**~~ ~~The~~ AMA-RFS (1) advocates a waiting period and background check for all ~~handgun~~ firearm purchasers; (2) encourages state and federal legislation that enforces a waiting period for all transactions, and background check for all purchasers, ~~and a license for all sellers~~ during firearm transactions ~~handgun purchasers~~; and (3) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.	No action; already in Digest.
Resolution 10: Reducing Perioperative ~~Narcotic~~ Opioid Consumption	RESOLVED, that our AMA encourage hospitals to adopt practices for the management of perioperative pain that include services dedicated to acute pain management and the use of multimodal analgesia strategies aimed at ~~decreasing appropriate narcotic~~ minimizing opioid administration without compromising adequate pain control during the perioperative period. ~~RESOLVED, that our AMA encourage relevant stakeholders to introduce perioperative pain management billing codes and insurance reimbursement strategies.~~	Added to Policy Compendium.
Resolution 11: Expanding the Treatment of Opiate Dependence Using Medication-Assisted Treatment By Physicians in Residency Training Programs	RESOLVED, that our AMA encourage the expansion of residency and fellowship training opportunities to provide clinical experience in the medication-assisted treatment of opioid use disorders, under the supervision of an ~~addiction medicine~~ appropriately trained physician. RESOLVED, that our AMA support additional funding to overcome the financial barriers, ~~such as buprenorphine training and waivers, supervision by experienced addiction medicine physicians, and clinical infrastructure~~ that exist for trainees seeking clinical experience in the medication-assisted treatment of opioid use disorders.	Added to Policy Compendium.
Resolution 12: Protecting Rights of Breastfeeding Residents and Fellows	RESOLVED, that our AMA work with appropriate bodies, such as the ACGME, to mandate language in housestaff manuals or similar policy references of all training programs on the protected time and locations for milk expression and storage of breast milk; and be it further	Added to Policy Compendium.

	RESOLVED, that our AMA work with appropriate bodies, such as the ACGME and AAMC, to include language related to the learning and work environments for breast feeding mothers in regular program reviews.	
Resolution 13: Primary Care and Mental Health Training in Residency	~~RESOLVED, that our AMA advocate for enhanced funding for residency training programs which emphasize the integration of mental health and primary care.~~ RESOLVED, that our AMA advocate for the ~~inclusion~~ incorporation of integrated mental health and primary care services into existing psychiatry and primary care training programs' clinical settings. RESOLVED, that our AMA encourage primary care and psychiatry residency training programs to create and expand opportunities for residents to obtain clinical experience working in an integrated mental health and primary care model, such as the collaborative care model. RESOLVED, that our AMA advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.	Added to Policy Compendium.
Resolution 14: Universal Color Scheme for Respiratory Inhalers	RESOLVED, that our AMA work with leading respiratory inhaler manufacturing companies and health agencies such as the Federal Drug Administration (FDA) and the American Pharmacists Association (APhA) to develop consensus of a universal color scheme for short-acting beta-2 agonist respiratory inhalers that are used as "rescue inhalers" in the United States. RESOLVED, that our AMA work with leading respiratory inhaler manufacturing companies to ensure the universal color scheme for respiratory inhalers would allow for the least disruption possible to current inhaler colors, taking into account distribution of each brand and impact on current users if color were to change. RESOLVED, that our AMA work with leading respiratory inhaler manufacturing companies to ensure that universal color scheme for respiratory inhalers be designed for adherence and sustainability, including governance for future companies entering the respiratory inhaler market, and reserving colors for possible new drug classes in the future.	No action; already in Digest.
Resolution 15: Mitigating Abusive Pre-Certification/Pre-	RESOLVED, that our AMA-RFS oppose abusive practices by health insurance entities in pre-certification and pre-authorization of services and medications.	R1: No action; already in Digest. R2: Added to

Authorization Practices	RESOLVED, that our AMA encourage residency programs to offer administrative resources to housestaff for practice-based support including but not limited to pre-certification and pre-authorization of medications and services. RESOLVED, that this resolution be immediately forwarded to AMA-HOD at A-16.	Policy Compendium.
Resolution 16: Improving Access to Care Health Outcomes	~~RESOLVED, that our AMA encourages states to incorporate community health workers (CHW) in health care systems.~~ RESOLVED, that our AMA support training opportunities for students and residents to learn cultural competency from community health workers ~~(CHW)~~. ~~RESOLVED, that our AMA support legislation for reimbursement of community health workers (CHW).~~	Added to Policy Compendium.
Resolution 17: Accident Prevention: Concussions	RESOLVED, that our AMA-RFS ~~encourages states~~ support state-based initiatives to require prevention for all contact sports in pediatric and young adult populations by (1) ~~mandating~~ encouraging the use of protective equipment in sports, (2) ~~requiring~~ encouraging sports physicals to include a basic neurocognitive screening ~~evaluation~~ by qualified healthcare professionals ~~physicians~~ for pediatric and young adults populations ~~ages 8 to 21~~ playing contact sports (3) urging policy on return to play protocol for athletes to achieve optimal recovery and reduce or avoid long term health outcomes (4) advocating for education on increasing concussion awareness among the public, coaches and the medical community.	No action; already in Digest.
Report F: Privacy Personal Use and Funding of Mobile Devices	Recommends that the AMA-RFS Governing Council recommends the following be adopted and the remainder of this report be filed: 1. That our AMA encourage further research in integrating mobile devices in clinical care, particularly to address challenges of reducing work burden while maintain clinical autonomy for residents and fellows; 2. That our AMA collaborate with the ACGME to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure a more uniformed regulation of mobile devices in medical education and clinical training. 3. That our AMA encourage medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines in using personal devices in clinical environment.	No action; already in Digest.
Report G: ~~Marijuana and the Cannabinoid~~	Medicinal Cannabis: 1. That the RFS support state and federal based legalization of ~~marijuana/cannabinoids~~ cannabis for ~~both~~ medicinal ~~and~~	No action; internal policy was adopted and amendments

~~Conundrum~~: Clinical Implications and Policy Considerations of Cannabis Use	~~recreational~~ use ~~so they may be regulated and taxed similar to tobacco products.~~ 2. That the RFS support regulation of medicinal cannabis in states that have legalized its use. 3. That the RFS support funding and other efforts to continue research into the efficacy and side effects ~~public health consequences~~ of both medicinal ~~and recreational marijuana/cannabinoid~~ cannabis use. Recreational Cannabis: 4. The RFS supports the decriminalization of recreational cannabis. 5. That the RFS supports taxation and regulation of recreational cannabis in states that have legalized the sale and use of recreational cannabis. ~~encourage states who have legalized and currently tax marijuana/cannabinoids to allocate a portion of tax revenue towards marijuana/cannabinoid education and harm reduction public health strategies.~~ 6. That the RFS supports funding, including the allocation of a portion of cannabis sales tax revenue, toward cannabis abuse education programs, harm reduction strategies, and continued research into public health consequences of recreational cannabis use. Medicinal and Recreational Cannabis Use: 7. That the RFS support public health based strategies, rather than incarceration, in handling of individuals possessing cannabis for personal use in states where it is not currently legal. ~~That the RFS support restrictions on marijuana/cannabinoids the sale of recreational cannabis sale for both medicinal and recreational use to non-minors. and those otherwise deemed old enough to consume alcohol.~~ ~~That Policy H-170.992 "Alcohol and Drug Abuse Education", Policy H-95.936 "Cannabis Warnings for Pregnant and Breastfeeding Women", and Policy H-95.938 "Immunity From Federal Prosecution for Physicians Recommending Cannabis" be reaffirmed by the RFS.~~ Policy Amendments: 8. That our ~~the RFS ask the~~ AMA ~~to~~ amend policy **H-95.998** by addition and deletion to read as follows: Our AMA believes that (1) cannabis is a dangerous drug and as such is a public health concern; ~~(2) sale of cannabis should~~ ~~not be legalized; (3)~~ (2) public health based strategies, rather than incarceration, should be utilized in the handling of individuals possessing cannabis for personal use; and ~~(4)~~ (3) additional research should be encouraged. 9. That our ~~the RFS ask the~~ AMA ~~to~~ amend policy **D-95.976** by deletion to read as follows:	would not affect internal policy.

	Our AMA will educate the media and legislators as to the health effects of cannabis use as elucidated in CSAPH Report 2, I-13, A Contemporary View of National Drug Control Policy, and CSAPH Report 3, I-09, Use of Cannabis for Medicinal Purposes, and as additional scientific evidence becomes available. 2. Our AMA urges legislatures to delay initiating full legalization of any cannabis product until further research. is completed on the public health, medical, economic and social consequences of use of cannabis and, instead, support the expansion of such research. 3. Our AMA will also increase its efforts to educate the press, legislators and the public regarding its policy position that stresses a "public health", as contrasted with a "criminal," approach to cannabis. 4. Our AMA shall encourage model legislation that would require placing the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: ~~"Marijuana has a high potential for abuse. It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States."~~	
	Interim 2016	
Late Resolution 3: The DEA Order to Reduce Opioid Production	RESOLVED, That our AMA encourage relevant stakeholders to research the overall effects of opioid production cuts; and RESOLVED, That our AMA encourage the DEA to postpone any opioid production cuts until the potential effects of production quotas are better elucidated; and, RESOLVED, That our AMA encourage the DEA to be more transparent when developing medication production guidelines; and	Added to Policy Compendium.
Resolution 1: Tobacco Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by Smoking	RESOLVED, That our AMA advocate for tobacco harm reduction approaches to be added to existing tobacco treatment and control efforts; and be it further RESOLVED, That our AMA educate physicians and patients on the myriad health effects of different nicotine products and emphasize the critical role of smoke and combustion in causing disease; and be it further RESOLVED, That our AMA encourage physicians to adopt patient-specific, individualized approaches to smoking cessation, particularly for patients with disease secondary to smoking and for patients who have otherwise failed traditional methods for smoking cessation; and be it further RESOLVED, That our AMA continue its focus on research to	Added to Policy Compendium.

	identify and expand options that may assist patient to transition away from smoking, including nicotine replacement therapies and noncombustible nicotine products (including e-cigarettes); and be it further RESOLVED, That the AMA reaffirm its position on strong enforcement of FDA and other agency regulations for the prevention of use of all electronic nicotine delivery systems (ENDS) and tobacco products by anyone under the legal minimum purchase age. This shall include marketing to children, direct use or purchasing by children and indirect diversion to children. Further, the AMA shall reaffirm physician education of patients to limit these products for children in any and all capacity.	
Resolution 2: Legislative Pain Care Restrictions	RESOLVE, that our AMA-RFS oppose legislative or other policies that harm patients by restricting their ~~arbitrarily restrict a patient's~~ ability to receive effective, patient-specific, evidence-based, comprehensive pain care.	No action; already in Digest.
Resolution 3: Eliminating Financial Barriers for Evidence-Based HIV Pre-Exposure Prophylaxis	RESOLVE, That our AMA amend policy H-20.895 by addition to read as follows: **Pre-Exposure Prophylaxis for HIV H-20.895** 1. Our AMA will educate physicians and the public about the effective use of pre- exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines. 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances (Res. 106, A-16) 3. Our AMA advocate that individuals not be denied various financial products, including disability insurance, on the basis of HIV pre-exposure prophylaxis (PrEP) use.	Added to Policy Compendium.
Resolution 4: Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons	RESOLVED, That our AMA will support the implementation of routine screening for HCV in prisons; and be it further RESOLVED, That our AMA will advocate for the initiation of treatment for HCV in all incarcerated patients with the disease and seeking treatment; and be it further RESOLVED, That our AMA will support negotiation for affordable pricing for therapies to treat and cure Hepatitis C virus ~~Direct Acting Antiviral Medication therapies~~ between among correctional facility health care providers, correctional facility health care payors, and drug companies to maximize access to these disease-altering medications.	Added to Policy Compendium.
Resolution 6: Funding for Emergent Communicable Disease Public Health Crises ~~Zika Control and Research~~	~~RESOLVED, That our RFS support AMA efforts in urging Congress to enact legislation that provides increased and sufficient funding for research, prevention, control, and treatment of illnesses associated with the Zika virus commensurate with the public health emergency that the virus poses without diverting resources from other essential health initiatives.~~	No action; already in Digest.

	RESOLVED, That our RFS support AMA efforts in urging Congress to expeditiously act to ensure sufficient funding for research, prevention, control, and treatment of newly identified communicable diseases that pose a public health emergency without diverting resources from other essential health initiatives.	
Resolution 7: Fair Access to Evidence-Based Family Planning Methods	~~RESOLVE, That our AMA-RFS support all family planning methods including medical or surgical termination of pregnancy which are supported by evidence of improvements in health outcomes in patients of reproductive age.~~ RESOLVE, That our AMA-RFS recognize that choices regarding family planning and medical or surgical termination of pregnancy are personal and autonomous and are to be made by a patient in concert with their health care provider ~~as they see fit.~~ RESOLVE, That our AMA-RFS support changes to public and private payment mechanisms that would make evidence-based family planning methods and medical or surgical termination of pregnancy accessible to all patients, regardless of socioeconomic background. ~~RESOLVE, That our AMA-RFS support sufficient compensation by public and private payors for the acquisition of family planning supplies and the delivery of services by clinicians.~~ ~~RESOLVE, That our AMA-RFS recognize that family planning is a personal and autonomous decision to be made by a patient with consultation of the clinician and partner, as desired.~~	No action; already in Digest.
Resolution 8: Mental Health Disclosures on Physician Licensing Applications	RESOLVED, That our AMA encourage state medical boards to consider physical and mental conditions similarly. RESOLVED, That our AMA encourage state medical boards to recognize that the presence of a mental health condition does not equate with an impaired ability to practice medicine. RESOLVE, that our AMA amend policy Licensure Confidentiality H-275.970 by addition and deletion to read as follows: **Licensure Confidentiality H-275.970** The AMA (1) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (2) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (3) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (4) encourages state medical societies and specialty societies to	R1, R2, R4: Added to Policy Compendium. R3: Added to Policy Compendium as internal policy.

	join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (5) encourages state licensing boards to require disclosure of physical or mental health history by physician health programs or providers only if they believe the illness of the physician they are treating is likely to impair the physician's practice of medicine or presents a public health danger. ~~that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine.~~ (CME Rep. B, A-88 Reaffirmed: BOT Rep. 1, I-933 CME Rep. 10 - I 94 Reaffirmed: CME Rep. 2, A-04 Reaffirmed: CME Rep. 2, A-14) RESOLVED, That our AMA encourage state medical societies to advocate that state medical boards not ~~change policies which reserve the right to issue~~ sanction~~s to~~ physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.	
Resolution 9: Interpretation of Governing Council Responsibilities Regarding Actions of the RFS Sectional Delegate Caucus	~~RESOLVED, That our RFS Governing Council present actual language adopted by ad hoc actions of the AMA-RFS Caucus in a Consent Calendar format, subject to extraction and amendment by individual item.~~ ~~RESOLVED, That our AMA-RFS Caucus, acting as a Standing Committee of the RFS, introduce a single report for each meeting of the AMA House of Delegates that discusses, separately, each ad hoc action of the RFS Caucus which includes formal and actionable policy recommendations subject to debate and vote.~~ RESOLVED, That our AMA-RFS Governing Council Report on *ad hoc* actions of the AMA-RFS Caucus identify the names and endorsing groups of all attending members of the Caucus	No action; generated a report.
Resolution 10: Improving Drug Affordability	RESOLVED, That our AMA supports drug price transparency legislation that requires pharmaceutical manufacturers to disclose, in a timely fashion, the basis for the prices of all of prescription drugs, including but not limited to (1) research and development costs paid by both the manufacturer and any other entity; (2) manufacturing costs; (3) advertising and marketing costs; (4) total revenues and direct and indirect sales; (5) unit price; (6) financial assistance provided for each drug including any discounts, rebates and/or prescription drug assistance; (7) any offshoring of either jobs or profits; (8) any reverse payment settlements; (9) payments to third parties—such as wholesalers, group purchasing organizations (GPOs), managed care organizations (MCOs), and pharmacy benefit management companies (PBMs); and be it further RESOLVED, That our AMA support legislation that requires pharmaceutical manufacturers to provide public notice before increasing the wholesale price of any brand or specialty drug by 10% or more each year or per course of treatment; and be it further RESOLVED, That our AMA support legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical	Added to Policy Compendium.

	manufacturers and increase access to affordable drugs for patients. RESOLVED, That our AMA support the expedited review of generic drug applications and prioritize review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.	
Resolution 11: Reimbursement Neutrality in the Merit Based Incentive Payment System (MIPS) of MACRA	RESOLVED, That our AMA-RFS limit support of initiatives included in the Merit-Based Incentive Payment System (MIPS) to those which are projected to be neutral with respect to geography and specialty; and be it further RESOLVED, That our AMA-RFS advocate for transparency among public and private payors in the creation and utilization of formulas intended to rank physicians for the purposes of reimbursement of public comparison.	No action; already in Digest.
Report E: Resident Engagement In and Awareness of Value-Based Care and Reimbursement Strategies	The American Medical Association Resident and Fellow Section Committee on Quality Improvement and Patient Safety recommends the following be adopted and the remainder of this report be filed: 1. That our AMA-RFS support efforts to gather data on resident awareness of reimbursement models and the transition to quality-based and value-based reimbursement models. 2. That our AMA-RFS develop education materials for current residents and medical students that familiarize them with the concepts and theory of value-based reimbursement and the current and proposed value-based reimbursement strategies offered by major insurers. 3. That our AMA-RFS develop education materials designed to help physicians understand the role of quality metrics in designing a practice or in their contractual service to an employer 4. That our AMA work with governing bodies in medical education to encourage integration of value-based care training into graduate medical education programs 5. That our AMA advocate that the positive and negative impacts of value-based care and reimbursement on resident education to be studied, longitudinally followed, and reported nationally.	R1-R3: Recommend reconciliation; it is unclear why the originally supported internal policy was not added and if had been subsequently removed for some specific reason. R4, R5: Added to Policy Compendium.
	Annual 2017	
Late Resolution 1: Protection of Access and Coverage of Women's Preventative and Maternity Care	RESOLVE, that our AMA-RFS support ~~the continued efforts and~~ legislation and regulations that ensure~~s~~ women have comprehensive coverage and access to preventative care, contraception ~~contraceptives~~, and maternity care with no cost sharing.	No action; already in Digest.
Late Resolution 2: Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine	RESOLVED, That our RFS support conducting studies on the participation of academic and teaching physicians, residents, fellows, and medical students, and community-based faculty members of medical schools and graduate medical education programs in organized medicine on medical school campuses and in teaching hospitals; and be it further	No action; already in Digest.

	RESOLVED, That our RFS support identifying successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine at the training sites.	
Resolution 1: Improving FDA Expedited Approval Pathways	RESOLVED, That our AMA work with FDA and other interested stakeholders to design and implement via legislative action (including ensuring appropriate FDA staffing) a process by which drugs which obtain FDA approval via the Fast Track, Accelerated Approval, or Breakthrough Therapy pathways be granted FDA approval on a temporary basis not to exceed 5 years, ~~until permanent approval can be granted by the FDA based on a formal review of post-marketing surveillance data, and be it further pending further evidence of safety and efficacy that is at the level set for the standard drug approval process.~~ pending further evidence of safety and efficacy that is at the level set for the standard drug approval process. RESOLVED, That our AMA work with the FDA and other interested stakeholders to define "specialty drugs" and the process for designating "specialty drugs" for expedited approval pathways. ~~in improving the process by which drugs are selected for the expedited pathway to improve the prevalence of these drugs that are classified as "specialty drugs."~~	Added to Policy Compendium.
Resolution 2: Amendment to RFS Policy 410.030R	RESOLVED, That our AMA-RFS amend RFS policy 410.030R by addition to read as follows: **410.030R Emergent Communicable Disease Public Health Crises:** That our RFS support AMA efforts in urging Congress to expeditiously act to ensure sufficient funding for research, prevention, diagnosis, control, and treatment of newly identified communicable diseases that pose a public health emergency without diverting resources from other essential health initiatives. (Resolution 6, I-16)	No action; already in Digest.
Resolution 3: Harmful Effects of Screen time ~~and Blue Light Exposure with~~ Children	RESOLVED, That our AMA encourage ~~all~~ primary and secondary schools to incorporate into health class curriculum the topic of balancing screen time with physical activity and sleep; and be it further ~~RESOLVED, That the AMA encourage research into the utility of blue light filtering glasses and a blue light filter option on devices such as smart phones and tablets; and be it further~~ RESOLVED, That our AMA encourage primary care physicians to assess all pediatric patients and educate all parents about amount of screen time, physical activity and sleep habits.	Added to Policy Compendium.
Resolution 4: Education on, Screen, and Reporting of Elder Abuse and Neglect	RESOLVED, That our AMA-RFS promote elder abuse screening during patient encounters when deemed appropriate by the provider. ~~RESOLVED, That our AMA promote research to ascertain if the use of educational programs and interventions improves~~	No action; already in Digest.

	~~attitude and knowledge of all caregivers and ultimately leads to the reduction of elder abuse incidents.~~	
Resolution 5: RFS Sunset Mechanism	RESOLVED, That our AMA-RFS Governing Council present actionable sunset recommendations to RFS policy via a yearly report at our Annual Meeting; and be it further RESOLVED, That each adopted resolve or recommendation clause within an RFS policy shall be considered individually with regard to the sunsetting process; and be it further RESOLVED, That our AMA-RFS annually review ten-year-old RFS policies and recommend whether to (a) reaffirm the policy, (b) rescind the policy, (c) reconcile the policy with more recent and like policy, or (d) make editorial changes which maintain the original intent of the policy; and be it further RESOLVED, That each RFS sunset recommendation regarding RFS policy may be extracted from the Consent Calendar and handled individually by our Assembly, but may only be adopted or not adopted; and be it further RESOLVED, That an action of the RFS Assembly that retains or updates an existing RFS policy shall reset the sunset "clock," making the reaffirmed RFS policy viable for ten additional years; and be it further RESOLVED, That defeated RFS sunset recommendations be reaffirmed for one year, to be readdressed via RFS Governing Council report or resolution from the RFS Assembly at or prior to the next RFS Annual Meeting; and be it further RESOLVED, That nothing in this policy shall prohibit a report or resolution to sunset an RFS policy earlier than its ten-year horizon if it is no longer relevant, has been superseded by a more current RFS policy, or has been accomplished; and be it further RESOLVED, That **580.013R Sunset of AMA-RFS Policy** be rescinded.	No action; speaks to IOP.
Resolution 6: RFS Caucus Vote Mechanism	RESOLVED, That ~~prior to I-17,~~ following the conclusion of each House of Delegates meeting, not to exceed 30 days, our ~~Governing Council~~ RFS Delegate and Alternate Delegate will ~~develop a mechanism to~~ provide a brief summary of any ~~educate the RFS Assembly at large on the~~ *ad hoc* policy actions of the RFS Caucus as to allow related resolutions to be written within existing deadlines.	No action; speaks to IOP.
Resolution 8: Financial Protections for Doctors in Training	RESOLVED, That our AMA ~~support~~ study the impact of encouraging training programs to offer ~~retirement plans for all residents and fellows, which includes~~ retirement plan matching and the unique nature of vesting as applied to residents in order to further secure the financial stability of physicians in training ~~and increase financial literacy during training~~; and be it further	R2: Added to Policy Compendium.

	RESOLVED, That our AMA ~~support~~ encourage ~~that all~~ training programs to provide financial education ~~advising~~ to residents and fellows.	
Resolution 10: Implicit Bias, Diversity and Inclusion in Medical Education and Residency Training	That our AMA will: (1) Actively support the development and implementation of training in implicit bias, diversity and inclusion as a component of medical education ~~in all medical schools and residency programs~~; (2) Identify and publicize effective strategies for educating residents in all specialties about disparities in their fields according to race and ethnicity, with particular regard to access to care and health outcomes; and (3) Support research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes ~~according to race and ethnicity~~.	Added to Policy Compendium.
Report E: RFS Election Reform	1. AMA-RFS IOP VII.D.2-5 shall be amended by insertion and deletion to read: 2) Method of Endorsement. ~~Where there is o~~ Only one resident or fellow member of the AMA ~~candidate, endorsement~~ may be endorsed by the Resident and Fellow Section (RFS) Assembly to serve as the Resident and Fellow Trustee. ~~by affirmation. When there are multiple candidates, a motion to endorse more than one candidate shall be in order. Endorsements shall be by ballot. Votes shall be cast by approval balloting, such that any candidate whom the delegate deems worthy of endorsement should be marked affirmatively by that delegate. There shall be no ranking, and it should be made clear that marking a second candidate in no way jeopardizes the chances of a first candidate to be endorsed.~~ 3) The AMA-RFS Assembly may endorse a resident or fellow member at the Interim Meeting to be a candidate for a *single election ~~term~~*. The Assembly may choose not to endorse any candidate for the position of Trustee. ~~4)~~3. ~~Processing.~~ Endorsements shall be by private ballot. No ballots will be cast after the expiration of the voting period. On the official ballot, votes may be cast for one candidate or for no candidates. ~~The ballot boxes will be collected by members of the Rules Committee. The Rules Committee and the boxes will be sequestered in a private location. At this time the Chair of the Rules Committee will open the ballot box and the Rules Committee will then count the ballots and tabulate the results. Counting shall proceed by counting the number of affirmative votes for each candidate. Every candidate who receives an affirmative vote from greater than 50% of those who cast legal ballots shall be endorsed.~~ ~~5)~~ The candidate must receive an affirmative vote from greater than 50% of those who cast legal ballots from the AMA-RFS Assembly to be endorsed by the AMA-RFS.	No action; speaks to IOP.

	6)As per RFS Internal Operating Procedures V.F.5.b, there shall be a run-off ballot between the two highest vote recipients in the event that no single candidate receives a majority of legal votes cast for a given office. 7)4. Validating. Upon completion of the tabulation, the Chair of the Rules Committee will validate the election results by determining that each ballot is official, that the number of ballots cast is equal to or less than the number distributed and will then certify the results in writing. He or she will then immediately forward these results to the Assembly's presiding officer. The candidate who receives a majority of legal votes cast shall receive complete AMA-RFS endorsement. Upon receipt of the RFS Rules Committee's election results and verification, the presiding officer will announce the results to the Assembly. 8)5. Late Endorsement. At the time of the RFS Annual Meeting, if no candidate has been endorsed, Aa candidate may ask for endorsement by the Assembly at the aAnnual mMeeting of the Assembly. This is subject to the same rules described above and additionally requires a 2/3 vote of the Assembly for endorsement. In the case of an individual seeking late endorsement, any individual who has already been endorsed for the position shall be allotted equal time before the Assembly and shall have his or her materials reprinted in the Assembly handbook upon request. 2. AMA-RFS IOP VIII.D.2-4 shall be amended by insertion and deletion to read: 2) Method of Endorsement: Where there is only one candidate for a given council, endorsement may be by affirmation. When there are multiple candidates, a motion to endorse more than one candidate shall be in order. Endorsements shall be by ballot. There shall be a separate ballot for each Council. Votes shall be cast by approval balloting, such that any candidate whom the delegate deems worthy of endorsement should be marked affirmatively by that delegate. There shall be no ranking, and it should be made clear that marking a second candidate in no way jeopardizes the chances of a first candidate to be endorsed. Only one resident or fellow member of AMA may be endorsed by the Resident and Fellow Section (RFS) Assembly to serve as a non-appointed Council member. 3) The AMA-RFS Assembly may endorse a resident or fellow member at the Interim Meeting to be a candidate for a *single election* ~~*term*~~. The Assembly may choose not to endorse any candidate for the position of non-appointed Council member. 4) 3. Processing. Endorsements shall be by private ballot. No ballots will be cast after the expiration of the voting	

period. On the official ballot, votes may be cast for one candidate or for no candidates. ~~The ballot boxes will be collected by members of the Rules Committee. The Rules Committee and the boxes will be sequestered in a private location. At this time the Chair of the Rules Committee will open the ballot box and the Rules Committee will then count the ballots and tabulate the results. Counting shall proceed by counting the number of affirmative votes for each candidate.~~

5) ~~Every~~ The candidate ~~who~~ must receive~~s~~ an affirmative vote from greater than 50% of those who cast legal ballots from the AMA-RFS Assembly to ~~shall~~ be endorsed by the AMA-RFS.

6) As per RFS Internal Operating Procedures V.F.5.b, there shall be a run-off ballot between the 2 highest vote recipients in the event that no one candidate receives a majority of legal votes cast for a given office.

7) The candidate who receives a majority of legal votes cast shall receive complete AMA-RFS endorsement. Upon receipt of the Rules Committee's election results and verification, the prescribing officer will announce the results to the Assembly.

8) ~~4. Late Endorsement.~~ At the time of the RFS Annual Meeting, if no candidate has been endorsed, a ~~A~~ candidate may ask for endorsement by the AMA-RFS Assembly at the ~~a~~ Annual ~~m~~ Meeting ~~of the Assembly.~~ This is subject to the same rules described above and additionally requires a 2/3 vote of the Assembly for endorsement. ~~In the case of an individual seeking late endorsement, any individual who has already been endorsed for the position shall be allotted equal time before the Assembly and shall have his or her materials reprinted in the Assembly handbook upon request.~~

1. AMA-RFS IOP VII AND VIII shall be amended by insertion to read:

G. Expiration of Endorsement. Any endorsement of a resident or fellow member, whether endorsed by a specialty society, state society or the RFS Assembly, shall only be valid for two consecutive AMA-RFS Assembly and AMA House of Delegates meetings, which includes the meeting during which the initial endorsement was obtained. If a resident or fellow member is seeking re-endorsement following expiration of previous endorsement, the member would be required to obtain new endorsement for the desired position.

1. AMA-RFS IOP V.C.1 shall be amended by insertion to read:

~~1)~~All members of the RFS, including fourth year medical students who have matched into a residency program, are eligible for election to the Governing Council, provided that they do not hold other AMA-RFS ~~Leadership~~

	~~Positions~~ Governing Council Positions, Board of Trustees and RFS seats on HOD Councils with terms that would overlap with the desired Governing Council position, with the exception of RFS Chair-Elect. ~~These AMA-RFS Leadership positions include: RFS Governing Council positions and RFS positions on HOD Councils.~~	
Report F: Residency Transfers	1) That the AMA-RFS continue to actively promote the resident and fellow vacancy page. 2) That the AMA-RFS ~~consider organizing~~ organize the information, including links to specialty society websites, on the resident and fellow vacancy page in a user-friendly format. 3) That the AMA-RFS initiate conversation to integrate the resident and fellow vacancies into FRIEDA, a resource well known to residents and fellows, to make the information more widely distributed and easily accessible. 4) That the AMA-RFS include information about procedures and logistics of transferring residency and fellowship programs or specialties.	No action; already in Digest.
Report G: Fellowship Start Date	That the AMA survey physicians who have undergone ~~this~~ revised fellowship start dates to further evaluate the benefits and drawbacks from this transition.	No action; generated a report.
Report H: Health Fitness Partnership	We strongly urge the AMA: 1)To promote health and wellness among its members. 2)To further investigate and explore partnerships to promote health and wellness among its members, including a partnership that provides some financial benefit to AMA members.	Added to Policy Compendium.
	Interim 2017	
Emergency Resolution 1: Support of Protesting Resident Physicians in Poland	RESOLVED, That the AMA-RFS support the application of its ideals regarding the health of patients and the rights of physicians in training to all situations where inadequate health care systems and/or injustice exist regardless of national affiliation.~~; and be it further~~ ~~RESOLVED, That our AMA-RFS ask the AMA to issue a statement on the issue of the Polish junior physician protests encouraging a good faith dialogue between junior physicians and members of the Polish government to achieve the mutually beneficial goals of adequate healthcare spending, a sufficient healthcare workforce and improved working conditions and pay for physicians in training; and be it further (Directive to Action)~~ ~~RESOLVED, That this resolution be immediately forwarded to the House of Delegates for consideration at the 2017 Interim Meeting (Directive to Action)~~	No action; already in Digest.
Late Resolution 1: Network Adequacy	RESOLVED, That our AMA-RFS recognize network adequacy as a central element of access to care; and be it further RESOLVED, That our AMA-RFS recognize that network adequacy must include emergency and psychiatric care; and be it further RESOLVED, That our AMA-RFS work with interested	No action; already in Digest.

	sections ~~and organizations~~ to ensure that out-of-network policies do not limit access to care by creating undue financial and administrative burdens for patients and physicians.	
Resolution 1: Regulating Tattoo and Permanent Makeup Inks	RESOLVED, That our AMA encourage the Food and Drug Administration (FDA) to adopt regulatory standards for tattoo and permanent makeup inks that include at minimum the disclosures expected for injectable drugs and cosmetics and mandate that this information be available to both the body licensed to perform the tattoo and to the person receiving the tattoo; and be it further RESOLVED, That our AMA study the safety of any chemical in tattoo and permanent makeup inks. ~~encourage the FDA to ban from tattoo and permanent makeup inks any chemical for which significant concern exists with regard to their carcinogenic, mutagenic, reprotoxic, and sensitizing properties~~.	No action; already in Digest.
Resolution 2: Prevention of Physician and Medical Student Suicide	RESOLVED, That our AMA request ~~recommend~~ that the Liaison Committee on Medical Education and Accreditation Council of Graduate Medical Education ~~investigate conditions and circumstances at~~ collect data on ~~any~~ medical ~~school~~ student, resident and fellow ~~residency program that has experienced a~~ suicides to identify patterns that could predict such events.	No action; already in Digest.
Resolution 5: The Intracranial Hemorrhage Anticoagulation Reversal (ICHAR) Initiative	~~RESOLVED, That the AMA-RFS support initiatives and legislation in the US Congress to promote the use of anticoagulation reversal medications up-to-date with the most current nationally recognized, evidence-based stroke guidelines for patients with intracranial hemorrhage.~~ ~~RESOLVED, That the AMA-RFS support initiatives and legislation in the US Congress adding requirements for stroke centers and high-stroke volume hospitals to carry and use anticoagulation reversal agents or risk penalties determined by the appropriate supervising bodies.~~ RESOLVED, That that the AMA support ~~studying ways~~ initiatives to improve and reduce the barriers to the use of anticoagulation reversal agents in emergency settings to reduce the occurrence, disability, and death associated with hemorrhagic stroke and other life-threatening clinical indications.	No action; already in Digest.
Resolution 6: Setting Boundaries for Extending Residents' Training Beyond Traditional Residency Completion Dates	*Reaffirmed existing policy.*	No action; already in Digest.
Resolution 7: Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows	~~RESOLVED, That our AMA strongly support the preservation of the incorporation of the clinical practice of pathology and laboratory medicine into integrated undergraduate and specialty tailored graduate medical education.~~ RESOLVED, That our AMA study current standards within medical education regarding pathology and laboratory medicine to identify potential gaps in training ~~in collaboration~~	No action; already in Digest.

	~~with other entities invested in medical education, provide educational resources, including guidelines for competencies in pathology and laboratory medicine for medical student, resident and fellow members~~.	
Resolution 8: Evaluation of Changes to Residency and Fellowship Application and Matching Processes	~~RESOLVED, That our AMA and AMA-RFS support proposed changes to residency and fellowship application requirements only when those changes have been evaluated by working groups which have students and residents as representatives, there is data which demonstrates that the proposed application components contribute to an accurate representation of the candidate, there is data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of implicit bias that affects medical students and residents from underrepresented minority backgrounds, and the costs to medical students and residents are mitigated.~~ ~~RESOLVED, That it asks that our AMA and AMA-RFS oppose the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application process until such time as the above conditions are met.~~ ~~RESOLVED, That it also asks that our AMA and AMA-RFS continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements.~~ <u>RESOLVED, That our AMA and AMA-RFS</u> 1. <u>Support proposed changes to residency and fellowship application requirements only when</u> a. <u>Those changes have been evaluated by working groups which have students and residents as representatives</u> b. <u>There ~~is~~ are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate</u> c. <u>There ~~is~~ are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of implicit bias that affects medical students and residents from underrepresented minority backgrounds</u> d. <u>The costs to medical students and residents are mitigated</u> 2. <u>Oppose the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application process until such time as the above conditions are met</u> 3. <u>Continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application</u>	No action; already in Digest.

	process in an effort to accomplish these requirements; and be it further ~~RESOLVED, That our AMA~~ ~~1. Support proposed changes to residency and fellowship application requirements only when~~ ~~a. Those changes have been evaluated by working groups which have students and residents as representatives~~ ~~b. There are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate~~ ~~c. There are data available to demonstrate that the new application requirements do not increase, the impact of implicit bias that affects medical students and residents from underrepresented minority backgrounds~~ ~~d. The costs to medical students and residents are mitigated~~ ~~Oppose the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application process until such time as the above conditions are met~~ ~~Continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements~~	
Resolution 11: Residency Match Systems and Timelines	RESOLVED, That our AMA~~-RFS support the AMA to~~ work with all invested stakeholders, specialties and application systems in the residency match excluding the military match to support and ensure parity with the match timeline and the ability to couples match by moving towards a unified and standardized process. RESOLVED, That our AMA~~-RFS request the AMA to~~ work with all invested stakeholders to design a provisional match system whereby medical students matching into preliminary (PGY-1) and, separately, advanced (PGY-2) residency programs match through a staggered system so that the PGY-2 match is timed with the match for all categorical PGY-1 positions and the match for preliminary PGY-1 programs is subsequently delayed to allow for a reduction in application and travel costs with the SOAP to follow the staggered match. RESOLVED, That our AMA~~-RFS request the AMA to~~ support and encourage all match application systems to provide robust match data to their applicants. RESOLVED, That our AMA-RFS support working with all invested stakeholders, specialties and application systems in the residency match excluding the military match to support and ensure parity with the match timeline and the ability to couples match by moving towards a unified and standardized process.	No action; already in Digest.

	RESOLVED, That our AMA-RFS support working with all invested stakeholders to design a provisional match system whereby medical students matching into preliminary (PGY-1) and, separately, advanced (PGY-2) residency programs match through a staggered system so that the PGY-2 match is timed with the match for all categorical PGY-1 positions and the match for preliminary PGY-1 programs is subsequently delayed to allow for a reduction in application and travel costs with the SOAP to follow the staggered match. RESOLVED, That our AMA-RFS support and encourage all match application systems to provide robust match data to their applicants.	
Resolution 12: Improving Utility of Clinical Documentation	RESOLVED, That our AMA-RFS advocate that the appropriate ~~regulatory~~ institutions determine level of care and reimbursement based more on complexity of medical diagnoses and medical decision making rather than quantity of components in medical documentation.	No action; already in Digest.
Resolution 14: Support for the Income-Driven Repayment Plans	RESOLVED, That our AMA ~~collaborate with interested third party organizations to~~ advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student loan burden.	No action; already in Digest.
Resolution 15: Support for the Development and Distribution of HIPAA-compliant Communication Technologies	RESOLVED, That our AMA ~~advocate for~~ promote the development and use of HIPAA-compliant technologies for text messaging, electronic mail and video conferencing. ~~RESOLVED, That our AMA develop a database of existing HIPAA-compliant technologies to be made accessible to the medical community.~~	No action; already in Digest.
Report E: AMA-RFS Sunset Mechanism Procedure	RESOLVED, That our AMA-RFS Governing Council present actionable sunset recommendations to RFS policy via a yearly report at our Annual Meeting; and be it further RESOLVED, That each adopted resolve or recommendation clause within an RFS policy shall be considered individually with regard to the sunsetting process; and be it further RESOLVED, That our AMA-RFS annually review ten-year-old RFS policies and recommend whether to (a) reaffirm the policy, (b) rescind the policy, (c) reconcile the policy with more recent and like policy, or (d) make editorial changes which maintain the original intent of the policy; and be it further RESOLVED, That each RFS sunset recommendation regarding RFS policy may be extracted from the Consent Calendar and handled individually by our Assembly, but may only be adopted or not adopted; and be it further RESOLVED, That an action of the RFS Assembly that retains or updates an existing RFS policy shall reset the sunset "clock," making the reaffirmed RFS policy viable for ten additional years; and be it further RESOLVED, That defeated RFS sunset recommendations be	No action; speaks to IOP.

	reaffirmed for one year, to be readdressed via RFS Governing Council report or resolution from the RFS Assembly at or prior to the next RFS Annual Meeting; and be it further RESOLVED, That nothing in this policy shall prohibit a report or resolution to sunset an RFS policy earlier than its ten-year horizon if it is no longer relevant, has been superseded by a more current RFS policy, or has been accomplished; and be it further RESOLVED, That **580.013R Sunset of AMA-RFS Policy** be rescinded.	
	Annual 2018	
Emergency Resolution: Separation of Children from their Parents at Border	RESOLVED, That our AMA oppose the practice of separating migrating children from their caregivers in the absence of immediate physical or emotional threats to the child's well-being; and be it further (New HOD Policy) RESOLVED, That our AMA urge the federal government to withdraw its policy of requiring separation of migrating children from their caregivers, and instead, give priority to supporting families and protecting the health and well-being of the children within those families; and be it further (Directive to Take Action)	No action; already in Digest.
Resolution 1 - Naming Convention for AMA-RFS Policy Resolution 17 - Internal Operating Procedures Revision	RESOLVED, That our AMA-RFS will form an ad hoc committee ~~(Committee)~~ broadly representing the membership of the Assembly for the purpose of reviewing and revising the AMA-RFS IOPs with a progress report at I-18. ~~; and be it further~~ ~~RESOLVED, That our AMA-RFS will receive from the Governing Council at I-18 a comprehensive draft report from the Committee reviewing the IOPs and detailing proposed revisions thereto; and be it further~~ ~~RESOLVED, That the Governing Council will make the draft report available electronically to the membership of the AMA-RFS Assembly at least 42 days prior to I-18; and be it further~~ ~~RESOLVED, That our AMA-RFS will dedicate time during the I-18 business meeting for comment on the draft report and the proposed revisions to the IOPs; and be it further~~ ~~RESOLVED, That our AMA-RFS will receive from the Governing Council at A-19 a final report from the Committee detailing final proposed revisions to the IOPs based on comment obtained at I-18; and be it further~~ ~~RESOLVED, That the Governing Council will make the final report available electronically to the membership of the AMA-RFS Assembly at least 2 months prior to A-19; and be it further~~	Recommend reconciliation; if completed no action needed however no report in Summary of Actions I-18.

	~~RESOLVED, That our AMA-RFS Speaker call for a vote either to approve or to refer the final report of the Governing Council in the normal course of business at A-19, unless such order of business be modified by the will of the Assembly; and be it further~~ ~~RESOLVED, That our AMA-RFS Speaker may call for a vote to approve or refer individual bylaws or groups of bylaws using the discretion afforded by the Rules of Parliamentary Procedure to reflect the will of the RFS Assembly and to maintain internal consistency in the approved bylaws; and be it further~~ ~~RESOLVED, That the Governing Council will return with a revised report from the Committee addressing all referred items at each subsequent meeting during which a vote will be taken to either approve or refer the report as a whole or in part; and be it further~~ ~~RESOLVED, That our AMA-RFS follow normal operating procedure by submitting revised IOPs to the AMA for approval only after the RFS Assembly has approved a complete set of IOP revisions through this process; and be it further~~ ~~RESOLVED, That our AMA-RFS reconvene the Committee every 10 years to modify, as needed, our IOPs except as otherwise provided in future revisions of the IOPs.~~	
Resolution 2 - Comprehensive Breast Cancer Treatment	RESOLVED, That our AMA-RFS: (1) believes that reconstruction of the breast for rehabilitation of the post-treatment cancer patient with in situ or invasive breast neoplasm should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided (New RFS Policy); and be it further RESOLVED, That our AMA-RFS acknowledge that access to breast reconstruction is a pivotal part of the breast cancer care pathway (New RFS Policy); and be it further RESOLVED, That our AMA-RFS advocate that reconstructive techniques for partial mastectomy be covered to the same degree as reconstruction following complete mastectomy (New RFS Policy); and be it further	R1-R3: already in Digest R4: Added to Policy Compendium as internal policy.

	RESOLVED, That our AMA amend Policy H-55.973 by addition and deletion as follows: Our AMA: (1) believes that reconstruction of the breast for rehabilitation of the ~~postmastectomy~~ post-treatment ~~cancer~~ patient with in situ or invasive breast neoplasm should be considered reconstructive surgery rather han aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided. (Amend HOD Policy)	
Resolution 3 - Mandating Critical Congenital Heart Defect Screening in Newborns	RESOLVED, That our AMA support~~s mandated~~ screening for critical congenital heart defects ~~by pulse oximetry~~ for newborns following delivery prior to hospital discharge. (New HOD Policy)	No action; already in Digest.
Resolution 4 - Fertility Preservation in Pediatric and Reproductive Aged Cancer Patients	RESOLVED, That our AMA encourage full disclosure to cancer patients on risks to fertility when gonadotoxicity due to cancer treatment is ~~unavoidable~~ a possibility (New RFS Policy); and be it further RESOLVED, That our AMA support ~~enhanced training of pediatric oncology fellows and reproductive endocrinology fellows in providing thorough counseling to oncology patients~~ education for providers who counsel patients ~~who~~ that may benefit from fertility preservation. (New RFS Policy)	No action; already in Digest.
Resolution 5- Removal of the Food and Drug Administration Risk Evaluation and Mitigation Strategy for Mifepristone Use in Early Pregnancy Failure	RESOLVED, That our AMA-RFS ~~encourage the FDA to remove~~ support the removal of the FDA Risk Evaluation and Mitigation Strategy for mifepristone in early pregnancy failure (Directive to Take Action); and be it further RESOLVED, That our AMA-RFS support ~~increase~~ education and training of practitioners who diagnose and are allowed to treat early pregnancy failure with mifepristone ~~rather than an inferior regimen~~. (New RFS Policy)	No action; already in Digest.
Resolution 6-Access to Care Restriction on IMG Moonlighting	RESOLVED, That our AMA ~~RFS~~ advocate for changes to federal legislation allowing physicians with a J-1 visa in fellowship training programs the ability to moonlight ~~bill Medicare and Medicaid~~ (Directive to Take Action)~~; and be it further~~ ~~RESOLVED, That this resolution be forwarded to the AMA House of Delegates at I-18. (Directive to Take Action)~~	No action; already in Digest.
Resolution 8- Medical Technology and Artificial Intelligence: Regulation and	RESOLVED, That our American Medical Association (AMA) work with the Food and Drug Administration (FDA) to ensure that warnings are issued when artificial intelligence and technological innovations, regarding human health, are used	No action; generated a report.

Oversight Requirements by the Food and Drug Administration	for purposes outside their intended FDA approved medical use by individuals that are not licensed medical professionals (Directive to Take Action); and be it further RESOLVED, That our AMA work with the FDA to restrict use of artificial intelligence and technological innovations in medicine and human health to be in consult with physicians and physician-led health care teams comprised of licensed medical professionals after verification of clinical applicability, safety, and accuracy. (Directive to Take Action)	
Resolution 9- Ownership and Sale of Medical Data	RESOLVED, That our ~~American Medical Association (AMA)~~ AMA-RFS support our AMA's development of model legislation concerning ownership of medical records (Directive to Take Action)	No action; already in Digest.
Resolution 10- Coordinating Correctional and Community Healthcare	RESOLVED, That our AMA support linkage of those incarcerated to community clinics upon release in order to accelerate ~~linkage~~ access to primary care and improve health outcomes among this vulnerable patient population, as well as adequate funding (Directive to Take Action); and be it further RESOLVED, That our AMA support the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community. (Directive to Take Action)	No action; already in Digest.
Resolution 11- A Study to Evaluate Barriers to Medical ~~School Matriculation~~ Education for ~~Students~~ Trainees with Disabilities	~~RESOLVED, That our AMA and AMA-RFS partner with relevant stakeholders to increase outreach efforts directed at students with disabilities to support a culture of inclusion (Directive to Take Action); and be it further~~ RESOLVED, That our AMA ~~and AMA-RFS~~ work with relevant stakeholders to study available data on medical trainees with disabilities and consider revision of technical standards for medical ~~school admission~~ education programs. (Directive to Take Action)	No action; already in Digest.
Resolution 12- Support for Deferred Action Childhood Arrivals (DACA) Medical Students and Physicians	RESOLVED, That our AMA-RFS ~~re~~affirm support for the Deferred Action for Childhood Arrivals (DACA) for current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients (Directive to Take Action); and be it further RESOLVED, That the AMA-RFS continues supporting any legislation to protect DACA recipients. (Directive to Take Action)	No action; already in Digest.
Resolution 13- Scholarly Activity by Resident and Fellow Physicians	RESOLVED, That our AMA-RFS defines resident and fellow scholarly activity as any rigorous, skill-building experience approved by their program director that involves the discovery, integration, application, or teaching of knowledge, including but not limited to peer-reviewed publications, national leadership positions within health policy organizations,local quality improvement projects, curriculum development, or any activity which would satisfy faculty requirements for scholarly activity ~~resident or fellow experience that involves the discovery, integration, application, or teaching of knowledge .(New RFS Policy);~~ and	No action; already in Digest.

	be it further RESOLVED, That our AMA work with partner organizations to ensure that residents and fellows are able to fulfill scholarly activity requirements with any rigorous, skill-building experience approved by their program director that involves the discovery, integration, application, or teaching of knowledge, including but not limited to ~~for residents,fellows, and faculty are not restricted to only~~ peer-reviewed publications, national leadership positions within health policy organizations, local quality improvement projects, curriculum development, or any activity which would satisfy faculty requirements for scholarly activity ~~and resident and fellow scholarly activity requirements can be fulfilled by the breadth of experiences permitted within faculty requirements.~~(Directive to Take Action)	
Resolution 14-Investigation into Residents, Fellows, and Physician Unions	~~RESOLVED, That our AMA-RFS ask our AMA to support a change to internal policies and its stance on unions; and be it further~~ RESOLVED, That the AMA~~-RFS support and ask our AMA to support~~ study the feasibility of a national house-staff union to represent all interns, residents and fellows~~.; and be it further~~ ~~RESOLVED, That our AMA investigate, with internal resources, the possibility, feasibility, and advisability of the AMA in organizing and running a physician union that prohibits actions that affect patient care while collectively representing all physicians as a true union and present a report on its findings no later than the AMA Annual Meeting 2019; and be it further~~ ~~RESOLVED, That our AMA-RFS forward this resolution to the AMA House of Delegates at the 2018 Interim Meeting.~~	No action; already in Digest.
Resolution 16-Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of “Dense Breasts” on Mammogram	RESOLVED, That our AMA support insurance coverage for supplemental screening recommended for patients with “dense breast” tissue following a conversation between the patient and their physician (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for insurance coverage for and adequate access to supplemental screening recommended for patients with “dense breast” tissue following a conversation between the patient and their physician. (Directive to Take Action)	No action; already in Digest.
	Interim 2018	
Late Resolution 1: Extending Pregnancy Medicaid To One Year Postpartum	RESOLVED, That our AMA petition CMS to extend pregnancy Medicaid to a minimum of one year postpartum.	No action; already in Digest.
Late Resolution 2: Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients	RESOLVED, That our AMA work with relevant stakeholders in developing sustainable plans for the appropriate discharge of chronically-homeless patients from hospitals; and be it further RESOLVED, That our AMA reaffirm H-270.962 and H-130.940; and be it further	No action; already in Digest.

	RESOLVED, That this resolution be immediately forwarded to the House of Delegates for consideration.	
Late Resolution 3: Affirming the Medical Spectrum of Gender	RESOLVED, That our AMA-RFS support initiatives that educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and be it further RESOLVED, That our AMA-RFS affirm that an individual's genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth.	No action; already in Digest.
Resolution 1: Support for Medicare Disability Coverage of Contraception for Non Contraceptive Use	RESOLVED, That our AMA ~~RFS encourage~~ work with Center for Medicare and Medicaid Services and other stakeholders ~~CMS prescription benefit plans~~ to include coverage for all FDA-approved contraception, ~~including the levonorgestrel intrauterine device,~~ for non-contraceptive use for patients covered by Medicare ~~in patients covered by Medicare disability insurance.~~	No action; already in Digest.
Resolution 2: Support for Medicare Disability Coverage of Contraception for Women of Reproductive Age	RESOLVED, That our AMA-RFS encourage CMS to provide coverage for all FDA-approved contraception for reproductive aged women covered by Medicare disability insurance.	Added to Policy Compendium.
Resolution 3: Increasing Rural Rotations During Residency	RESOLVED, That our AMA work with state and specialty societies, medical schools, teaching hospitals, ACGME, CMS and other interested stakeholders to encourage and incentive qualified rural physicians to serve as preceptors, volunteer faculty, etc. for rural rotations in residency; and be it further RESOLVED, That our AMA work with ACGME, ABMS, FSMB, CMS and other interested stakeholders to lessen or remove regulations or requirements on residency training and physician practice that preclude formal educational experiences and rotations for residents in rural areas; and be it further resolved RESOLVED, That our AMA work with interested stakeholders to identify strategies to increase residency training opportunities with a report back to the HOD and formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.	No action; already in Digest.
Resolution 4: Promoting Nutrition Education Among Healthcare Providers	AMA Policy H-465.988 be reaffirmed in lieu of Resolution 3.	Added to Policy Compendium as internal policy.
Resolution 5: DACA in GME	AMA Policies D-255.991 and D-350.986 be reaffirmed in lieu of Resolution 5.	No action; would not affect internal policy.
Resolution 6: Contraception for Incarcerated Women	~~RESOLVED, That our AMA supports access to contraceptive options for advocates for state and local health departments to work with correctional facilities to provide contraception to incarcerated women prior to release.; and be it further~~	No action; already in Digest.

	RESOLVED, That our AMA supports incarcerated persons' access to evidence-based contraception counseling, access to all contraceptive methods and autonomy over contraceptive decision making prior to release. ~~RESOLVED, That our AMA encourage partnerships between healthcare providers and correctional care communities, including state and local health departments, correctional facilities and community healthcare centers, so that access to contraception among women recently released from correctional facilities may be increased; and be it further~~ ~~RESOLVED, That our AMA recognize that access to contraception is a serious healthcare concern among incarcerated women; and be it further~~ ~~RESOLVED, That our AMA petition the National Commission on Correctional Healthcare to recognize that access to contraception is a serious healthcare concern among incarcerated women.~~	
Resolution 7: Decreasing Financial Burdens on Residents and Fellows	RESOLVED, That our AMA partner with the ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing subsidized access to day care facilities and other basic necessities such as on call meal allowances for residents taking in-house call, and free parking on site, and further be it RESOLVED, That this resolution be forwarded to AMA-HOD at A-19.	No action; referred for study.
Resolution 8: Strategies to Reduce Burnout in Medical Trainees	AMA-RFS policy 291.015R be reaffirmed in lieu of Resolution 8.	No action; already in Digest.
Resolution 9: Medical Aid in Dying	RESOLVED, That our AMA-RFS support changes to AMA policy to support laws that allow for Medical Aid in Dying; and be it further RESOLVED, That our AMA-RFS support changes to AMA policy to move the AMA towards public support of Medical Aid in Dying; and be it further RESOLVED, That our AMA-RFS support changes to AMA policy which codify that it is within the AMA's Code of Medical Ethics for physicians to involve Medical Aid in Dying in their practice when allowed by law and agreed to by the patient and provider; and be it further RESOLVED, That our AMA-RFS work with appropriate external organizations to ensure that resident and fellow training includes training in Medical Aid in Dying as allowed by law and at the discretion of the trainee, and support policy changes within the AMA which seek to do the same; and be it further RESOLVED, That our AMA-RFS support the AMA in ending its practice of using the term "physician assisted suicide" and instead replace it with the term "Medical Aid in Dying."	No action; referred for report.

Resolution 10: Improving Patient Care Through Patient Self Awareness of Personal Health Information	RESOLVED, That our AMA-RFS ask our AMA to evaluate methods to garner patient responsibility to provide Protected Health Information (PHI) to their healthcare providers, and be it further RESOLVED, That our AMA-RFS ask our AMA to study the impact such methods may have on health outcomes.	No action; not adopted
Resolution 11: Delegation of Informed Consent	RESOLVED, That our AMA in cooperation with other relevant stakeholders advocate that a qualified physician be able to delegate his or her duty to obtain informed consent to another provider that has knowledge of the patient, the patient's condition, and the procedures to be performed on the patient. RESOLVED, That our AMA study the implications of the Shinal v. Toms ruling and its potential effects on the informed consent process.	No action; already in Digest.
	Annual 2019	
Emergency Resolution 1 – Interference with Practice of Medicine by the Nuclear Regulatory Commission	~~RESOLVED, That our AMA advocate for a follow-up review by the Institute of Medicine of the Nuclear Regulatory Commission's medical use program, specifically evaluating effects of the Nuclear Regulatory Commission's regulatory policy in the last 25 years on the current state of nuclear medicine in the U.S. and patients' access to care. (Directive to Action)~~ Our AMA will express its opposition to the imminent proposed changes to the Section 10 CFR Part 35.390(b) by the Nuclear Regulatory Commission (NRC) which would weaken the requirements for Authorized Users of Radiopharmaceuticals (AUs), including shortening the training and experience requirements, the use of alternative pathways for AUs, and expanding the use of non-physicians, with AMA advocacy for such opposition during the open comment period ending July 3, 2019.	Added to Policy Compendium.
Late Resolution 1 - AMA HOD Election Reform	RESOLVED, That the AMA-RFS support that the AMA create a speaker-appointed task force to re-examine election rules and logistics including regarding social media, emails, mailers, receptions and parties, ability of candidates from smaller delegations to compete, balloting electronically, and timing within the meeting, and to report back recommendations regarding election processes and procedures to accommodate improvements to allow delegates to focus their efforts and time on policy-making;~~ and be it further~~ ~~RESOLVED, That AMA-RFS support that the AMA's speaker-appointed task force consideration should include addressing (favorably or unfavorably) the following ideas:~~ ~~a) SElections being held on the Sunday morning of the annual and interim meetings of the House of Delegates. b) SCoordination of a large format interview session on Saturday by the~~ ~~Speakers to allow interview of candidates by all interested delegations simultaneously. c) SSeparating the logistical election~~ ~~process based on the office (e.g. larger interview session for~~	No action; already in Digest.

	~~council candidates, more granular process for other offices) d) SAn easily accessible system allowing voting members to either opt in or opt out of receiving AMA approved forms of election materials from candidates with respect to email and physical mail. e) SElectronic balloting potentially using delegates' personal devices as an option for initial elections and runoffs in~~ ~~None; internal position statement 520.002R~~ ~~This document does not represent official policy of the American Medical Association (AMA). Refer to AMA PolicyFinder for official policy of the Association.~~ ~~3~~ ~~order to facilitate timely results and minimal interruptions to the business. f) SSeeking process and logistics suggestions and feedback from HOD caucus leaders, non-HOD physicians (potentially more objective and less influenced by current politics in the HOD), and other constituent groups with a stake in the election process.g) SAddress the propriety and/or recommended limits of the practice of delegates being directed on how to vote by other than their sponsoring society (e.g. vote trading, block voting,~~ ~~etc.); and be it further~~ ~~RESOLVED, That the AMA-RFS support that the task force report back to the HOD at the A-20 meeting.~~	
Resolution 1 - Improving Medical Clearance Policies for Cognitive Impairment ~~Improving Medical Clearance Policies for Traumatic Brain Injury Patients~~	~~RESOLVED, That our AMA-RFS advocate for amending current federal and state laws to clearly include symptomatic TBI patients as prohibited from obtaining or retaining a license to carry a firearm until they are medical cleared; and be it further~~ ~~RESOLVED, That our AMA-RFS create policy, advocate for, and support any state legislation that expands medical clearance requirements and firearm purchasing restrictions to all individuals that have medical conditions likely to cause substantial impairment in judgment, mood, perception, impulse control, intellectual ability, possibly leading to harm of self or other, and who will require continuous medical treatment for any of these issues, or has been diagnosed by a licensed physician or declared by a court to be incompetent to manage~~ ~~his or her affairs; and be it further~~ ~~RESOLVED, That our AMA-RFS advocate for legislation focused on physician reporting of all patients with prohibitive conditions, including symptomatic TBI patients, to appropriate state oversight agencies relating to driving and/or gun use; and be it further~~ ~~RESOLVED, That our AMA-RFS advocate for physician-led committees in each state to give recommendations to the state regarding further driving and/or gun use by individuals who are~~	No action; already in Digest.

	~~cognitively impaired and/or a danger to themselves or others.~~ RESOLVED, That our AMA advocate for federal and state legislation that aides and eases the burden to report individuals with severe and/or concerning cognitive impairments with functional problems to appropriate boards and other authorities responsible for the public health, safety of the state relating to driving gun use; and be it further (referred) RESOLVED, That our AMA-RFS support advocacy for physician-led committees (i.e. medical advisory boards) in each state to give recommendations to the state regarding further driving and/or gun use by individuals who are cognitively impaired and possibly a danger to themselves or others, as stated in federal law 18 U.S.C. § 922(g)(4). (adopted)	
Resolution 2 - Decreasing the Use of Oximetry Monitors for The Prevention of Sudden Infant Death Syndrome ~~Decreasing Use of Non-FDA Regulated Oximetry Monitors in Infants~~	RESOLVED, That our AMA-RFS oppose the sale and use of ~~publish a policy statement condemning the use of commercial, non-FDA regulated~~ oximetry monitors to prevent sudden infant death syndrome. RESOLVED, That this resolution be forwarded to the House of Delegates at I-19.	No action; already in Digest.
Resolution 4- Supporting the Reclassification of Complex Rehabilitation Technology to Improve Access to Individuals with Substantially Disabling and Chronic Conditions	RESOLVED, That our AMA-RFS support reclassifying complex rehabilitation technology equipment into its own distinct payment category under the Centers for Medicare & Medicaid Services to improve access to individuals with substantially disabling and chronic conditions.	No action; already in Digest.

	RESOLVED, That our AMA-RFS support national and state efforts for allowing emancipated mature minors to give their own informed consent for vaccinations; and be it further RESOLVED, That Policy H-440.970, "Nonmedical Exemptions from Immunizations" be amended by deletion ~~addition~~ to read as follows: Our American Medical Association believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large. Therefore, our AMA (1) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (2) supports legislation eliminating nonmedical exemptions from immunization; (3) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (4) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (5) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (6) recommends that states have in place: (a) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (b) policies that permit immunization exemptions for medical reasons only.; ~~SUand~~ ~~(7) encourages states to allow mature minors to consent for CDC-recommended vaccinations if~~ ~~deemed by the physician as in their best interest;~~ ~~and be it further SRESOLVED, That this resolution be immediately~~ ~~forwarded to the House of Delegates at A-19.~~	R1: No action; already in Digest. R2: Added to Policy Compendium as internal policy.
Resolution 10—Residency and Fellowship Program Director, Assistant/Associate Program Director, and Core Faculty Protected Time and Salary Reimbursement	RESOLVED, That our AMA-RFS support amending the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors ~~Sof a given residency or fellowshipS Sand work with the ACGME and other relevant stakeholders to accomplish this goalS~~; and be it further RESOLVED, That our AMA work with the ACGME and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific	Added to Policy Compendium.

	ACGME program requirements enabling specialtiesU to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors; and be it further RESOLVED, That this resolution be immediately forwarded to the AMA HOD at SIS-SA-19.	
Resolution 12—Facilitating Physicians in Training Seeking Mental Health Care Through Physician Health Programs	RESOLVED, That our AMA amend the AMA Model Bill: Physician Health Programs Act, adding the definition of a "physicians in training" as a physician in an ACGME-accredited training program to Section 6. "Definitions"; and be it further RESOLVED, That our AMA amend the AMA Model Bill: Physician Health Programs Act, adding the following subsection within the section "Application to a PHP for voluntary assistance": "a physician in training who voluntarily requests participation in a PHP for a substance use disorder, mental health condition or other medical disease shall have his or her training program directly and actively involved in all stages of PHP assessment, treatment planning, enrollment, and monitoring"; and be it further RESOLVED, That this resolution be immediately forwarded to the AMA HOD at A-19.	Recommend reconciliation; multiple proposed changes to this model legislation and unclear if should be included in Digest.
Report B—Internal Operating Procedures Renewal	[revised RFS IOPs submitted to Council on Constitution & Bylaws post-meeting]	No action; IOPs renewal.
Report C—Contraceptive Access	1. Our AMA-RFS support the continued use of public funding for affordable and accessible family planning services that are ~~financially and physically accessible~~ free of undue burden, in an effort to reduce the rates of unplanned pregnancies. 2. Our AMA-RFS support over-the-counter access to ~~oral~~ contraceptives ~~pills~~. 3. Our AMA-RFS support policies and any work the AMA does with other interested organizations to increase access to and awareness of over-the-counter emergency contraception (H75.985, D75,997). 4. Our AMA-RFS support affordable Long- Acting Reversible Contraception access for all patients, including those in the immediate postpartum period. 5. Our AMA-RFS support training and financial assistance for providers to offer Long- Acting Reversible Contraception.	No action; already in Digest.
Report D—Medical Aid in Dying	1. That our AMA-RFS support the AMA ending its practice of using the term "physician-assisted suicide" and instead replace it with "medical aid in dying"; 2. That our AMA-RFS support protections for physicians and patients who participate in medical aid-in-dying in states where it is legal; and	No action; already in Digest.

	3. That our AMA-RFS adopt a position of neutrality toward physician aid in dying.	
Report F—Decreasing Financial Burdens on Residents and Fellows	1. That our AMA include expanded information on employee benefits in the AMA FRIEDA database, such as, but not limited to: subsidized access to day care facilities, on call meal allowances for residents taking in-house call, and free parking on site.	Added to Policy Compendium.
Report G—Healthcare Coverage and Access Proposals 2019	~~1. SCoverage: SIdeal health plans should strive to achieve universal healthcare coverage. Therefore, the AMA-RFS supports proposals that increase access to healthcare coverage across all ages and income levels, do not discriminate or limit coverage based on pre-existing conditions, and encompass comprehensive coverage of routine healthcare needs of patients including women's health and reproductive services.~~ ~~2. SAffordability: SThe issue of affordability is critical in healthcare~~ ~~proposals. Healthcare plans should be affordable to people across the United States, and affordability should not hinder patients' access to care. Therefore, the AMA-RFS supports proposals that cap premiums and limit cost sharing to a reasonable level.~~ ~~3. SAccess: SPatients should be able to access providers that are best able to serve their medical needs. Therefore, the AMA-RFS supports proposals that include adequate networks of providers and physician-led healthcare teams.~~ 1. AMA-RFS supports proposals that increase access to healthcare coverage across all ages and income levels, do not discriminate or limit coverage based on pre-existing conditions, and encompass comprehensive coverage of routine healthcare needs of patients including women's health and reproductive services. 2. AMA-RFS supports proposals that cap premiums and limit cost sharing to a reasonable level. 3. AMA-RFS supports proposals that include adequate networks of providers and physician-led healthcare teams.	No action; already in Digest.
Report J—Drug Costs and Shortages	1. Our AMA-RFS support that the AMA advocate for legislative and regulatory mechanisms to ensure more affordable generic biosimilar access without placing undue burdens on drug innovation. 2. Our AMA-RFS support the repeal of the 1987 Safe Harbor exemption to the Anti-Kickback Statute for Group Purchasing Organizations (GPOs) and PBMs (Pharmacy Benefit Managers).	No action; already in Digest.
	Interim 2019	
Late Resolution 1 – Safe Supervision of Complex Radiation Oncology Therapeutic Procedures	RESOLVED, That our AMA advocate that radiation therapy services should be exempted from the Hospital Outpatient Prospective Payment System (HOPPS) rule requiring only general supervision of hospital therapeutic services; and be it further	Added to Policy Compendium.

	RESOLVED, That our AMA advocate that direct supervision of radiation therapy services by a physician trained in radiation oncology should be required by the Centers for Medicare and Medicaid Services; and be it further RESOLVED, that this resolution be immediately forwarded to the AMA House of Delegates at I-19.	
Resolution 1 – Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure	RESOLVED, That our AMA study and provide recommendations on how the process of assisting orphaned ~~trainees~~ residents and fellows could be improved in the case of training hospital or training program closure, including: 1. The current processes by which a displaced resident or fellow may seek and secure an alternative training position; and 2. How CMS and other additional or supplemental GME funding is re-distributed, including but not limited to: a. The direct or indirect classification of ~~trainees~~ residents and fellows as financial assets and the implications thereof; and b. Transfer of ~~full versus partial funding for~~ training positions between institutions and the subsequent impact on ~~trainee~~ resident and fellow funding lines in the event of closure; and ~~be it further~~ c. Transfer of full versus partial funding for new training positions; and ~~be it further~~ d. e. Transfer of funding for orphaned ~~trainees~~ residents and fellows who switch specialties; and be it further RESOLVED, That our AMA work with the Centers on Medicare and Medicaid Services (CMS) to establish regulations which protect ~~trainees~~ residents and fellows impacted by program or hospital closure which may include recommendations for: 1. Notice by the training hospital ~~of filing~~ intending to file for bankruptcy within 30 days, to all residents and fellows ~~trainees~~ primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows ~~trainees~~ to find and obtain alternative training positions which minimize undue financial and professional consequences, including but not limited to the maintenance of specialty choice, length of training, initial expected time of graduation, location~~,~~ and reallocation of funding~~.~~, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed; 2. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution~~.~~;	R1: No action; recommended report. R2-4: Added to Policy Compendium.

	3. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and ~~be it further~~ 4. Protections against the discrimination of orphaned residents and fellows consistent with H-295.969; and be it further RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, the Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which ~~trainees in~~ orphaned ~~residencies~~ residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program; and be it further RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, the Centers for Medicare and Medicaid Services, and other relevant stakeholders to: ~~develop a mechanism by which orphaned residents and fellows can obtain new training positions.~~ 1. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions; and 2. Create a centralized, regulated process for orphaned residents and fellows to obtain new training positions; and be it further RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at I-19.	
Resolution 4 – Breast-Implant-Associated Anaplastic Large Cell Lymphoma **Implant-Associated Anaplastic Large Cell Lymphoma**	RESOLVED, That our AMA support appropriate coverage of cancer diagnosis, treating surgery and other ~~adjuvant~~ systemic treatment options for ~~breast~~ implant-associated anaplastic large cell lymphoma.	Added to Policy Compendium.
Resolution 5- Resident and Fellow Access to Fertility Preservation	RESOLVED, That our AMA support education for residents and fellows regarding the natural course of female fertility in relation to the timing of medical education, and the option of fertility preservation and infertility treatment; and be it further RESOLVED, That our AMA ~~encourage~~ advocate inclusion of insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and	Added to Policy Compendium.

	fellows offered through graduate medical education programs; and be it further RESOLVED, That our AMA support the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including the need to attend medical visits to complete the oocyte preservation process and to administer medications in a time-sensitive fashion.	
Resolution 6-Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training	RESOLVED, That our AMA support current efforts by ~~petition~~ the ACGME ~~and the~~, American Board of Medical Specialties (ABMS), and other relevant stakeholders to develop and implement minimum requirements for parental leave during residency and fellowship training and urge these bodies to adopt minimum requirements in accordance with policy H 405.960; and be it further RESOLVED, That our AMA petition ACGME to recommend strategies to prevent undue burden on trainees related to parental leave. RESOLVED, That our AMA petition the ACGME ~~and the~~, ABMS, and other relevant stakeholders to develop specialty specific pathways for residents and fellows ~~trainees~~ in good standing, who take maximum allowable parental leave, to complete their ~~residency or fellowship~~ training within the original time frame.	Added to Policy Compendium.
Resolution 7—Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients	RESOLVED, That our AMA oppose performing ~~educational~~ physical exams on patients under anesthesia or on unconscious patients that offer the patient no personal benefit and are performed solely for teaching purposes without prior ~~explicit~~ informed consent to do so; and be it further ~~RESOLVED, That our AMA encourage institutions to review alignment of their current practices with published guidelines, recommendations, and policies with respect to informing patients about educational physical exams performed under anesthesia or when unconscious and obtaining explicit informed consent to do so; and be it further~~ RESOLVED, That our AMA encourage institutions to align current practices with published guidelines, recommendations, and policies to ensure patients are educated on pelvic, genitourinary, and rectal exams that occur under anesthesia; and be it further RESOLVED, That our AMA strongly oppose issuing blanket bans on student participation in educational physical exams; and be it further RESOLVED, That our AMA reaffirm policy H-320.951.	R1, R3, R4: Added to Policy Compendium. R2: No action; not adopted. R5: Added to Policy Compendium as internal policy.

Resolution 8—Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance	RESOLVED, That our AMA ~~-RFS~~ recognizes the importance of providing avenues for affordable health insurance coverage and health care access to patients who do not have employer-sponsored health insurance, or for whom employer-sponsored health insurance does not meet their needs; and be it further RESOLVED, That our AMA ~~-RFS~~ recognizes that a significant and increasing proportion of patients are unable to meet their health insurance or health care access needs through employer-sponsored health insurance, and that these patients must be considered in the course of ongoing efforts to reform the healthcare system in pursuit of universal health insurance coverage and health care access.	Added to Policy Compendium.
Resolution 9—E-Cigarette and Vaping Associated Illness	RESOLVED, That our AMA advocate for diagnostic coding systems including the ICD codes to have a mechanism to release emergency codes for emergent diseases; and be it further RESOLVED, That our AMA advocate for creation and release of ~~the addition of~~ ICD~~-10-CM~~ codes to include appropriate diagnosis codes for both the use of and toxicity related to e-cigarettes and vaping, including pulmonary toxicity; and be it further ~~RESOLVED, That our AMA supports banning flavored e-cigarettes products; and be it further~~ RESOLVED, That this resolution be immediately forwarded to the House of Delegates at I-19.	Added to Policy Compendium.
Resolution 10—Removing Sex Designation from the Public Portion of the Birth Certificate	RESOLVED, That our AMA-RFS advocate for the removal of “sex” as a designation on the public portion of the birth certificate, and that it be visible for medical and statistical use only.	No action; already in Digest.
Resolution 11—Studying Physician Supervision of Allied Health Professionals Outside Their Fields of Graduate Medical Education	RESOLVED, That our AMA conduct ~~support~~ a systematic study to collect and analyze publicly available physician supervision data from all sources to determine how many allied health professionals are being supervised by physicians in fields which are not a core part of those physicians’ completed residencies and fellowships.	No action; request for report.
Report A—Matched Medical Students	*Recommendation 1:* Your AMA-RFS Governing Council recommends the following changes to the “American Medical Association Resident and Fellow Section Internal Operating Procedures” by addition as follows: **V. Elections** B. **Eligibility.** All members of the RFS are eligible for elected positions and endorsements. Medical students with AMA membership who have secured a residency position, signed a contract, and will be starting residency within 45 days of	No action; forwarded to CCB for IOP change in Dec 2019.

	election may also be considered eligible for RFS elected positions. RFS members may not hold concurrent positions on the RFS Governing Council, Board of Trustees, or Councils with the exception of RFS Chair-Elect. All candidates must formally disclose to voters prior to the election any portion of their term during which they will not meet membership requirements. *Recommendation 2:* Your AMA-RFS Governing Council recommends the following changes to the "American Medical Association Resident and Fellow Section Internal Operating Procedures" by addition as follows: **IX. Business Meeting** **A. Other Representatives to the Business Meeting.** 1. At-Large Representatives. Active RFS members of the AMA may be eligible to serve as at-large representatives to the Business Meeting. a. Apportionment. The number of representatives shall be 10% of the average number of registered RFS delegates and alternate delegates from the previous year. b. Criteria for the At-Large Delegate positions include the following: 1. A candidate must be an AMA-RFS member or a medical student with AMA membership who has secured a residency position, signed a contract, and will be starting the aforementioned residency program within 45 days of the AMA Annual Meeting, and is not simultaneously credentialed in the Medical Student Section Assembly. 2. A candidate must submit an application to the RFS Governing Council for consideration. In the event that all available At-Large positions are not filled by application to the Governing Council, these positions may be filled at the meeting (Annual or Interim) on a first-come, first served basis. *Recommendation 3:* Your AMA-RFS Governing Council recommends the following changes to the "American Medical Association Resident and Fellow Section Internal Operating Procedures" by addition as follows: **IX. Business Meeting**	

	F. Participation. 3. All medical students with AMA membership who have secured a residency position, signed a contract, and will be starting the aforementioned residency program within 45 days of the AMA Annual Meeting, and are not RFS At-Large Delegates may be granted "Official Observer" status in the RFS Assembly. *Recommendation 4:* Your AMA-RFS Governing Council recommends the following changes to the "American Medical Association Resident and Fellow Section Internal Operating Procedures" by addition as follows: **E. Credentialing.** The names of the duly selected voting RFS Business Meeting Delegates and Alternate Delegates from each state and specialty society should be received, in writing, by the Director of Resident and Fellow Services of the AMA at least 45 days prior to the start of the Business Meeting. Prior to the start of business on each day of the Business Meeting, credentialing will take place, where each voting member must officially identify themself to the Credentials Committee as having been duly selected to represent their state society, specialty society, or branch of the armed services. Those being credentialed must be (i) members of the RFS or (ii) medical students with AMA membership who have secured a residency position, signed a contract, and will be starting residency within 45 days of the Business Meeting and have secured an endorsement from a representative organization. 1. Registered RFS members or medical students with AMA membership who have secured a residency position, signed a contract, and will be starting residency within 45 days whose clinical responsibilities and travel arrangements require them to arrive during a day's business but after the close of credentialing may, at least four weeks prior to the Business Meeting, petition the Governing Council to be allowed to credential late for the meeting. The decision to allow an RFS member to credential late will be made by majority vote of the Speaker, Vice Speaker, Delegate, Alternate Delegate, and Chair of the Rules Committee with such vote being communicated to the RFS member and the Credentialing Committee, in writing, at least two weeks prior to the start of the meeting. 2. Previously registered RFS members who miss credentialing due to unforeseeable travel delays may, on a case-by-case basis, be allowed to credential late for that day's business. This would	

	be determined by a majority vote of the Speaker, Vice Speaker, and Chair of the Rules Committee, and communicated to the RFS member and the remainder of the Credentialing Committee. 3. Only credentialed RFS ~~members~~ delegates present in the Business Meeting room may vote on items of business being considered.	
Report B—AMA Resident/Fellow Councilor Term Limits	*Recommendation 1:* That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows: **6.5 Council on Ethical and Judicial Affairs.** **6.5.7 Term.** **6.5.7.2** Except as provided in Bylaw 6.11, the resident/fellow physician member of the Council shall be elected for a term of 2~~3~~ years provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant. **6.5.8 Tenure.** Members of the Council may serve only one term, except that the resident/fellow physician member shall be eligible to serve for 3 terms and the medical student member shall be eligible to serve for 2 terms. A member elected to serve an unexpired term shall not be regarded as having served a term unless such member has served at least half of the term. **6.5.9 Vacancies.** **6.5.9.2 Resident/Fellow Physician Member.** If the resident/fellow physician member of the Council ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates at the next Annual Meeting, on nomination by the President, for a 2~~3~~-year term. *Recommendation 2:* That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows: **6.6 Council on Long Range Planning and Development.** **6.6.3 Term.** **6.6.3.2 Resident/Fellow Physician Member.** The resident/fellow physician member of the Council shall be appointed for a term of 2~~3~~ years beginning at the conclusion of the Annual Meeting provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for	No action; forwarded to CCB for Bylaws change in Dec. 2019 BOT.

	which appointed except as provided in Bylaw 6.11, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant. **6.6.5 Vacancies.** **6.6.5.2 Resident/Fellow Physician Member.** If the resident/fellow physician member of the Council ceases to complete the term for which appointed, the remainder of the term shall be deemed to have expired. The successor shall be appointed by the Speaker of the House of Delegates for a 2~~3~~-year term. *Recommendation 3:* That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows: **6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.** **6.9.1 Term.** **6.9.1.2 Resident/Fellow Physician Member.** The resident/fellow physician member of these Councils shall be elected for a term of 2~~3~~ years. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant. **6.9.3 Vacancies.** **6.9.3.2 Resident/Fellow Physician Member.** If the resident/fellow physician member of these Councils ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates for a 2~~3~~-year term.	
	Annual 2020	
	Meeting was canceled given COVID-19 outbreak.	
	Interim 2020	
Report A—AMA-RFS Sunset Mechanism (2011)	Text not provided in Summary of Actions.	No action; would not affect internal policy.
Report B—AMA-RFS Sunset Mechanism (2008-2010)	Text not provided in Summary of Actions.	No action; would not affect internal policy.

Report C—Sectional Delegate Allotment	RFS Internal Operating Procedures (IOPs) VII. Sectional Delegates and Alternate Delegates to the House of Delegates E. Limitations 1. There shall be a limit of ~~one~~ two Sectional Delegates and ~~one~~ two Sectional Alternate Delegates per state or specialty society in the AMA House of Delegates.	No action; change in IOP
Report D—Decreasing Financial Burdens on Residents and Fellows	RESOLVED, That our AMA work with relevant stakeholders to ensure that medical trainees have access to on-site and subsidized childcare (Directive to Take Action); and be it further RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to advocate for additional ways to defray costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties (Directive to Take Action); and be it further RESOLVED, That our AMA work with relevant stakeholders to define "access to food" for medical trainees to include overnight access to fresh food and healthy meal options within all training hospitals (Directive to Take Action); and be it further RESOLVED, That the Residents and Fellows' Bill of Rights be prominently published online on the AMA website and be disseminated to residency and fellowship programs (Directive to Take Action); and be it further RESOLVED, That the AMA Policy H-310.912, "Residents and Fellows' Bill of Rights," be amended by addition and deletion to read as follows: 5. Our AMA partner with ACGME and other relevant stakeholders to encourage~~s~~ training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services ~~teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation~~. (Modify Current HOD Policy).	R1-R4: Added to Policy Compendium. R5: Added to Policy Compendium as internal policy.
Report E—Traumatic Brain Injury and Access to Firearms	1) That our AMA reaffirm policy H-145.972 "Firearms and High-Risk Individuals." 2) That our AMA amend policy H-145.975 "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care" by addition and deletion to read as follows:	Added to Policy Compendium as internal policy.

	2. Our AMA supports initiatives designed to enhance access to the comprehensive assessment and treatment of mental health and substance use disorders in patients with ~~cognitive health care, with greater focus on the diagnosis and management of~~ traumatic brain injury~~y~~ies. ~~mental illness and concurrent substance use disorders,~~. ~~and~~ 3. Our AMA work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to evaluate the risk of potential violent behavior in patients with traumatic brain injury~~y~~ies. ~~and mental health assessment for potential violent behavior.~~ ~~3.~~ 4. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.	
Report G—Facilitating Physicians in Training Seeking Mental Health Care Through Physician Health Programs	1) That our AMA-RFS Governing Council propose amendments (as indicated above) to the AMA Advocacy Resource Center regarding the AMA Model Bill: Physician Health Programs Act, to include changing the definition of "physicians in training" in Section 6. "Definitions" to be: (1) medical students in medical schools accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA), (2) residents in training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), or (3) fellows in ACGME or non-ACGME accredited training programs. 2) That our AMA-RFS Governing Council propose amendments (as indicated above) to the AMA Advocacy Resource Center regarding the AMA Model Bill: Physician Health Programs Act, to include changing the following subsection within the section "Application to a PHP for voluntary assistance" to read: "a physician in training who voluntarily requests participation in a PHP for a substance use disorder, mental health condition or other medical disease shall, only if they desire, have their medical school or training program involved any stage of PHP assessment, treatment planning, enrollment, and monitoring." 3) That the AMA-RFS Governing Council report back the outcome of these actions to the AMA-RFS assembly at A-21. **Subsequent language in A-21**	Recommend reconciliation; multiple proposed changes to this model legislation and unclear if should be included in Digest.

	. That our AMA work with the ACGME~~, AOA,~~ and other relevant stakeholders to ensure physician health programs (PHPs) are promoted by training programs and transparent information is disseminated by programs to their trainees about PHP reporting requirements, benefits of participation, and limitations of such programs; and be it further ~~5~~ 2. That our AMA recognize PHPs ~~physician health programs~~ as one of many resources available to support physician trainee mental health.	
Report H—Pharmaceutical Advertising in Electronic Health Record Systems	1) That our AMA-RFS oppose medical education institutions and teaching hospitals accepting pharmaceutical and device advertising in EHRs.	No action; already in Digest.
	Annual 2021	
Resolution 1—Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use	RESOLVED, That our AMA oppose mandatory use of gonad shields in medical imaging considering the risks far outweigh the benefits; and be it further RESOLVED, That our AMA advocate that the FDA amend the code of federal regulations to oppose the routine use of gonad shields in medical imaging; and be it further RESOLVED, That our AMA, in conjunction with state medical societies, support model state and national legislation to oppose or repeal mandatory use of gonad shields in medical imaging.	Added to Policy Compendium.
Resolution 2—Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent	RESOLVED, That our AMA add "Middle Eastern/North African (MENA)" as a separate racial category on all AMA demographics forms; and be it further ~~RESOLVED, That our AMA advocate for the use of "Middle Eastern/North African (MENA)" as a separate demographic identifier in all medical records; and be it further~~ ~~RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of "Middle Eastern/North African (MENA)" as a demographic identifying category in the U.S. Census and for all federally-funded research using racial/ethnic categories.~~ RESOLVED, That our AMA advocate for the use of "Middle Eastern/North African (MENA)" as a separate race category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education.	Added to Policy Compendium.
Resolution 4—Opposition to Mid-level Provider Bias Against Physicians and Physician-Led Care	THE IMPACT OF MIDLEVEL PROVIDERS ON MEDICAL EDUCATION RESOLVED, That our AMA study, using surveys among other tools that protect identities, how commonly bias against physician-led healthcare is experienced within undergraduate medical education and graduate medical education,	Added to Policy Compendium.

Resolution 5—Non-Physician Continued Education, Specialty and Subspecialty Training	interprofessional learning and team building work and publish these findings in peer-reviewed journals ~~methods to regulate and ensure non-physician post-graduate education is rigorous and adequate to maintain the ability to practice within the intended field of practice with physician oversight~~; and be it further RESOLVED, That our AMA work with the LCME and ACGME to ensure all physician undergraduate and graduate training programs recognize and teach physicians that they are the leaders of the healthcare team and are adequately equipped to diagnose and treat patients independently only because of the intensive, regulated and standardized education they receive; and be it further RESOLVED, That our AMA study the harms and benefits of establishing mandatory postgraduate clinical training for Nurse Practitioners and Physician Assistants prior to working within a specialty or subspecialty field; and be it further RESOLVED, That our AMA study the harms and benefits of establishing national requirements for structured and regulated continued education for Nurse Practitioners and Physician Assistants in order to maintain licensure to practice.	
Resolution 6—Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers	RESOLVED, That our AMA reaffirm policies H-160.947 and H-160.950 ~~advocate that midlevel providers practicing independently without physician supervision be required to obtain informed consent from patients acknowledging and understanding that they are not being treated by a physician~~; and be it further RESOLVED, That our AMA work with relevant regulatory agencies to ensure physicians are notified in writing when their license is being used to “supervise” midlevel providers; and be it further ~~RESOLVED, That our AMA advocate for the appropriate supervision of midlevel providers by physicians as opposed to “collaboration,” which falsely equates non-physician training to that of physicians; and be it further~~ RESOLVED, That our AMA oppose mandatory physician supervision of midlevel providers as a condition for physician employment and in physician employment contracts, especially when physicians are not provided adequate resources and time for this responsibility; and be it further RESOLVED, That our AMA advocate for the right of physicians to deny “supervision” to any midlevel provider whom they deem a danger to patient safety and the ability to report unsafe care provided by mid-levels to the appropriate regulatory board with whistleblower protections for physician employment.	R1: Added to Policy Compendium as internal policy. R2, R4, R5: Added to Policy Compendium.

Resolution 7—Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care	~~RESOLVED, That our AMA acknowledge that the corporate practice of medicine has led to diminished quality of patient care, erosion of the physician-patient relationship, erosion of physician-driven care, physician burnout, and created a conflict of interest between profit and training the next generation of physicians needed for our nations physician shortage; and be it further~~ RESOLVED, That our AMA study the impact that individual physician scope of practice advocacy has had on physician employment and contract terminations ~~work with relevant stakeholders to support and provide legal resources to physicians who are terminated from employment for speaking out about scope of practice issues~~; and be it further RESOLVED, That our AMA study the views of patients on physician and non-physician care to identify best practices in educating the general population on the value of physician-led care ~~lead a national campaign to educate patients on the value of physician-led care and about the Dunning-Kruger effect in order to combat the false campaigns by midlevel providers/non-physicians~~; and be it further RESOLVED, That our AMA study the utility of ~~work with relevant stakeholders to create~~ a physician-reported database to track and report institutions that replace physicians with midlevel providers ~~and develop a platform~~ in order to aid patients in seeking physician-led medical care as opposed to care by midlevel providers practicing without physician supervision.	No action; generated a report.
Resolution 9—The Impact of Private Equity on Medical Training	RESOLVED, That our AMA work with relevant stakeholders including specialty societies and the ACGME to study the level of financial involvement and influence ~~on medical practice and education of~~ private equity firms have in graduate medical education training programs and report back at I-21 with concurrent publication of their findings in a peer-reviewed journal; and be it further RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at the June 2021 Special Meeting of the HOD.	Added to Policy Compendium.
Resolution 10—Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc. Equitable for IMGs	RESOLVED, That our AMA work with ~~the ACGME, NBME, ECFMG, FSMB, and other~~ all relevant stakeholders to reduce application, exam, licensing fees and related financial burdens for IMGs to ensure cost equity with US MD and DO trainees. RESOLVED, that our AMA amend current policy H-255.966 "Abolish Discrimination in Licensure of IMGs" by addition to read as follows: "2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements, and associated costs, for all physicians, whether U.S. medical school graduates or international medical graduates."	R1: Added to Policy Compendium. R2: Added to Policy Compendium as internal policy.

Resolution 11—Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education	RESOLVED, That our American Medical Association advocate to the Liaison Committee on Medical Education and other relevant stakeholders for the incorporation of Osteopathic Manual Therapy into the education curriculum of allopathic schools in the United States; and be it further RESOLVED, That our AMA advocate to the Accreditation Council for Graduate Medical Education and other relevant stakeholders for the incorporation of Osteopathic Manual Therapy into the education curriculum of all primary care residency training programs in the United States; and be it further RESOLVED, That our AMA continue to support equal treatment of osteopathic students, trainees and physicians in the residency application cycle and workplace through continued education on the training of Osteopathic physicians.	No action; generated a report.
Resolution 12—Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cancer	RESOLVED, That our AMA amend current policy H-440.872 "HPV Vaccine and Cervical Cancer Prevention Worldwide" by addition and deletion to read as follows: 1. Our AMA (a) urges physicians to educate themselves and their patients about <u>all</u> HPV<u>-mediated</u> ~~and associated~~ diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs. 2. Our AMA will intensify efforts to improve awareness and understanding about <u>all</u> HPV<u>-mediated</u> ~~and associated~~ diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public. 3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination. 4. <u>Our AMA supports efforts (a) to enhance awareness in the general public regarding the association between HPV infection and oropharyngeal squamous cell carcinoma, and (b)</u>	Added to Policy Compendium as internal policy.

	to further develop oropharyngeal squamous cell carcinoma screening tools. RESOLVED, That our AMA amend current policy H-440.872 "HPV Vaccine and Cervical Cancer Prevention Worldwide" by title change to "HPV Vaccine and ~~Cervical~~ HPV-mediated Cancer Prevention Worldwide"; and be it further RESOLVED, That our AMA reaffirm policies D-170.995 "Human Papillomavirus (HPV) Inclusion in our School Education Curricula" and D-440.955 "Insurance Coverage for HPV Vaccine."	
Resolution 13—COVID-19 Vaccination Rollout to Emergency Departments and Urgent Cares	RESOLVED, That our AMA acknowledge that our nation's COVID-19 vaccine rollout is not yet optimized, and we have a duty to vaccinate as many people in an effective manner; and be it further RESOLVED, That our AMA work with other relevant organizations and stakeholders to lobby the current Administration for the distribution of COVID-19 vaccinations to our nation's emergency departments and urgent ~~cares~~ care facilities; and be it further RESOLVED, That our AMA advocate for additional funding to be directed towards increasing COVID-19 vaccine ambassador programs in emergency departments and urgent care facilities; and be it further RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at the June 2021 Special Meeting of the HOD.	Added to Policy Compendium.
Resolution 14—Expanding the AMA's Study on the Economic Impact of COVID-19	RESOLVED, That our AMA work with relevant organizations and stakeholders to study the economic impact and long-term recovery of the COVID-19 pandemic on healthcare institutions in order to identify and better understand which groups of physicians, patients and organizations may have been disproportionately affected by the financial burdens of the COVID-19 pandemic; and be it further RESOLVED, that our AMA work with relevant organizations and stakeholders to study the overall economic impact of office closures, cancellations of elective surgeries and interruptions in patient care, as well as the economic impact of utilizing telemedicine for an increasing percentage of patient care.	Needs addition to Policy Compendium.
Resolution 15—Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis	~~RESOLVED, that our AMA advocate at all levels of government for equitable policies to transition rapidly away from the use of coal, oil and natural gas to clean, safe, and renewable energy and energy efficiency; and be it further~~ RESOLVED, that our AMA reaffirm policy H-135.949 "Support of Clean Air and Reduction in Power Plant Emissions"; and be it further RESOLVED, that our AMA establish a climate crisis campaign that will distribute evidence-based information on the relationship between climate change and human health,	R2: Added to Policy Compendium as internal policy. R3: Added to Policy Compendium.

	determine high-yield advocacy and leadership opportunities for physicians, and centralize our AMA's efforts towards environmental justice and an equitable transition to a net-zero carbon ~~create an appropriate climate health crisis-focused longitudinal body or center for the purpose of determining the highest-yield advocacy leadership opportunities for our AMA in this public health crisis and for coordinating, strengthening and centralizing efforts toward advocating for an equitable and inclusive transition to a climate-neutral~~ society by 2050.	
Resolution 16— Accountable Organizations to Resident and Fellow Trainees	RESOLVED, That our AMA work with relevant stakeholders to: (1) determine which organizations or governmental entities are best suited for being permanently responsible for resident and fellow interests without conflicts of interests; (2) determine how organizations can be held accountable for fulfilling their duties to protect the rights and wellbeing of resident and fellow trainees as detailed in the Residents and Fellows' Bill of Rights; (3) determine methods of advocating for residents and fellows that are timely and effective without jeopardizing trainees' current and future employability; (4) study and report back by A-22 on how such an organization may be created, in the event that no organizations or entities are identified that meet the above criteria; and (5) determine transparent methods to communicate available residency positions to displaced residents.	Added to Policy Compendium.
	Interim 2021	
Report A— AMA- RFS Sunset Mechanism (2011)	The Sunset Mechanism 2011 RFS Positions contains a list of recommended actions regarding internal position statements last reviewed from the RFS 2011 fiscal year, as well as other relevant or associated outdated positions. Positions considered outmoded, irrelevant, duplicative, and inconsistent with more current positions will have specific recommendations. For each internal position statement under review, this sunset report recommends to: (1) rescind, (2) reaffirm, (3) reconcile with more recent actions, or (4) reaffirm with editorial changes, which constitutes a first order motion.	No action; will not affect internal policy.
Resolution 1— Bereavement Leave for Medical Students and Physicians	RESOLVED, That our AMA supports ~~adopts as policy the following guidelines for, and encourages the implementation of,~~ 'Bereavement Leave for Medical Students and Physicians': 1) Our AMA urges medical schools, residency and fellowship training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of bereavement leave policies as part of the physician's standard benefit agreement. 2) Recommended components of bereavement leave policies for medical students and physicians include: ~~a) policy and duration of leave for the death of close family members, extended family members, close friends, and associates;~~ ~~b) definitions of those qualifying as close family members and extended family members;~~	No action; already in Digest

	~~c)~~ a) whether cases requiring extensive travel qualify for additional days of leave and, if so, how many days; ~~d)~~ b) policy and duration of leave for an event impacting pregnancy or fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy arrangement, or an event that impacts pregnancy or fertility; ~~e)~~ c) whether leave is paid or unpaid; ~~f)~~ d) whether obligations and time must be made up; and ~~g)~~ e) whether make-up time will be paid. 3) Our AMA encourages medical schools, residency and fellowship programs, specialty boards, specialty societies, and medical group practices to incorporate into their bereavement leave policies a three-day minimum leave ~~allowance for the death of close family members and events of reproductive loss~~, with the understanding that no physician or medical student should be required to take minimum leave. 4) Medical students and physicians who are unable to work beyond the defined bereavement leave period because of physical or psychological stress, medical complications of pregnancy loss, or another related reason should refer to their institution's sick leave policy, family and medical leave policy, and other benefits on the same basis as other physicians who are temporarily unable to work for other reasons. 5) Our AMA ~~endorses~~ supports the concept of equal bereavement leave for pregnancy loss and other such events impacting fertility in a physician or their partner as a benefit for medical students and physicians regardless of gender or gender identity. 6) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs. 7) These guidelines ~~policies~~ as above should be freely available online and in writing to all applicants to medical school, residency, or fellowship.	
Resolution 2— Solicitation of the AMA Brand	RESOLVED, that our AMA ~~create a task force to~~ study ~~and report back on~~ the use of AMA branded solicitation material mailed to physicians, the impact it has on the perception of our AMA by current and potential physician members, and the merits of continuing to use these materials in future communications; and be it further RESOLVED, that our AMA study our membership on the preferred method to receive third party solicitation material (mail, phone, email, social media) and provide a method to opt-out of certain methods if not desired.	No action; already in Digest
Resolution 3— Transparency of Resolution Fiscal Notes	TRANSPARENCY OF RESOLUTION AND REPORT FISCAL NOTES RESOLVED, That our AMA amend current policy G-600.061 by addition and deletion to read as follows:	No action; already in Digest

	"(d) A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of ~~the~~ any proposed ~~policy, program,~~ study or directive to take action shall be generated and published by AMA staff in consultation with the sponsor. prior to its acceptance as business of the AMA House of Delegates. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in the AMA House of Delegates Handbook to justify each fiscal note~~. When the resolution or report is estimated to have a resource implication of $50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers~~ (such as travel, consulting fees, meeting costs, or mailing). No resolution or report that proposes ~~policies, programs,~~ studies or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy."	
Resolution 4— Shortage of Bedside Nurses, Nurse Practitioner "Diploma Mills" and the Effects on Patient Safety and Quality Care	RESOLVED, That our AMA create a national campaign aimed at educating the population and state legislatures about the shortage of bedside nurses resulting from the push to create more nurse practitioners by "diploma mills"; and be it further RESOLVED, That our AMA oppose the expansion of nurse practitioner educational programs at the cost of exacerbating a shortage of bedside nurses and diverting resources from physician education; and be it further RESOLVED, That our AMA work with relevant stakeholders to push for standardized in-person clinical training in current nurse practitioner programs to curtail the poor training practices of nurse practitioner "diploma mills."	Recommend reconciliation; referred for Annual 2022, however not in Annual 2022 Summary of Actions (and not in AMA policy).
Resolution 5— Preserving Physician Leadership in Patient Care	RESOLVED, That our AMA work with relevant stakeholders to ~~conduct~~ commission an independent study comparing medical care provided by physician-led health care teams versus care provided by unsupervised non- physician ~~mid-level~~ providers, reporting on ~~practicing independently with regard to~~ quality of health outcomes, cost and cost effectiveness, and access to necessary medical care, and publish the findings in a peer-reviewed medical journal ~~such as JAMA~~; and be it further RESOLVED, That our AMA oppose physicians being referred to as "providers" in all healthcare settings; and be it further RESOLVED, That our AMA supports that National Physicians Week and National Doctors' Day be reserved solely for recognizing physicians.	No action; already in Digest

Resolution 6—Amend AMA Policy H-215.981 Corporate Practice of Medicine	RESOLVED, That our AMA amend policy H-215.981 Corporate Practice of Medicine by addition: 4. Our AMA acknowledges that the corporate practice of medicine has led to ~~diminished quality of patient care~~, erosion of the physician-patient relationship, erosion of physician-driven care, ~~physician burnout~~, and created a conflict of interest between profit and training the next generation of physicians ~~needed for our nation's physician shortage.~~	No action; already in Digest
Resolution 7—Comparing Student debt Earnings, Work Hours, and Career Satisfaction Metrics in Physicians	RESOLVED, That our AMA, ~~in order to better inform our advocacy efforts to preserve and improve physician-led care~~, study student debt, earnings, work hours, and job satisfaction metrics, including but not limited to burnout and work/life balance for MD and DO physicians as compared to other health professionals, such as physician assistants and nurse practitioners, and publish these findings in a peer reviewed journal, such as JAMA.	No action; generated a report
Resolution 8—Medicare Coverage of Dental, Vision, and Hearing Services	RESOLVED, That our AMA support new Medicare funding that is independent of the physician fee schedule for coverage of: (1) preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures; and (2) routine eye examinations and visual aids, including eyeglasses; and be it further RESOLVED, That our AMA amend Hearing Aid Coverage H-185.929 by addition as follows: 1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids. 2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear. 3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services. 4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team, aural rehabilitative services, and hearing aids as part of Medicare's Benefit. 5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly. 6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.	No action: already in Digest

	7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. RESOLVED, That this resolution be immediately forwarded to our AMA House of Delegates at the November 2021 Special Meeting.	
Resolution 9—Sunset of the Interim Meeting Focus Requirement and the Resolutions Committee	DISSOLUTION OF THE RESOLUTION COMMITTEE RESOLVED, That our American Medical Association remove the Interim Meeting focus requirement by amending the AMA Bylaws B-2.12.1.1 “Business of Interim Meeting,” as follows by deletion: ~~2.12.1.1 Business of Interim Meeting. The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring action prior to the following Annual Meeting may also be considered at an Interim Meeting. In addition, any other business may be considered at an Interim Meeting by majority vote of delegates present and voting.;~~ and be it further RESOLVED, That our AMA dissolve the Resolution Committee by amending the AMA Bylaws B-2.13.3, “Resolution Committee,” as follows by deletion: ~~Resolution Committee. B-2.13.3 The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.~~ ~~2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.~~ ~~2.13.3.2 Size. The committee shall consist of a maximum of 31 members.~~ ~~2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.~~ ~~2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.~~ ~~2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.~~ ~~2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in~~	Added to Policy Compendium as internal policy.

	~~the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.~~ ~~2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker.~~ RESOLVED, That this resolution be immediately forwarded to our AMA House of Delegates at the November 2021 Special Meeting.	
Resolution 10—Recognition of National Anti-Lynching Legislation as Public Health Initiative	RESOLVED, That our AMA supports national legislation that recognizes lynching and mob violence towards an individual or group of individuals as a hate crimes; and be it further RESOLVED, That our AMA work with relevant stakeholders to support medical students, trainees, and physicians receiving education on the inter-generational health outcomes related to lynching and its impact on the health of vulnerable populations; and be it further RESOLVED, That current AMA policy H-65.965, "Support of Human Rights and Freedom" be amended by addition: Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, phenotypic appearance, religion, ~~political affiliation~~, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.~~:~~ ~~(5) support legislation to end lynching and mob violence against individuals and groups in the United States.~~ RESOLVED, That our AMA reaffirm policy H- 65.952 "Racism as a Public Health Threat."	No action; already in Digest
Resolution 11—Improvement in Care and Resource Allocation for Homeless Persons in the Global Pandemic	IMPROVEMENT OF CARE AND RESOURCE ALLOCATION FOR HOMELESS PERSONS IN THE GLOBAL PANDEMIC RESOLVED, That our AMA support training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; and be it further	No action; already in Digest

	RESOLVED, That our AMA support the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and be it further RESOLVED, that our AMA reaffirm existing policies H-160.903, "Eradicating Homelessness," and H-345.975, "Maintaining Mental Health Services by States"; and be it further RESOLVED, that our AMA reaffirm existing Policy H-160.978, "The Mentally Ill Homeless", with a title change "Housing Insecure Individuals with Mental Illness."	
Resolution 12—Affirmatively Protecting the Safety and Dignity of Physicians and Medical Students as Workers	RESOLVED, That our AMA review ~~affirmatively monitor and solicit media and member~~ reports of unsafe working conditions and unfair retaliation for public expression of safety concerns on the part of physicians and trainees and consider methods ~~to investigate and intervene~~ to provide logistical and legal support to such aggrieved parties; and be it further RESOLVED, That our AMA develop and distribute specific guidelines on how physicians and trainees may make public comments on working conditions and legal options to promote workplace safety (e.g. filing formal OSHA complaints), as well as other workplace protection issues as appropriate; and be it further RESOLVED, That AMA policy H-440.810 be amended by addition to read as follows: 1. Our AMA affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises. 2. Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions. 3. Our AMA will AMA advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff, as well as trainees and contractors working in such facilities, in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need. 4. Our AMA supports physicians and health care professionals and other workers in health care facilities in being permitted to use their professional judgment and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty. 5. Our AMA supports a physician's right to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions	No action; already in Digest

	necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster; resident physicians and medical students must have the right to participate in public commentary addressing the adequacy of resources for their own safety in such conditions. 6. Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies. 7. Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel.; and be it further ~~RESOLVED, That our AMA advocate for legislation requiring hospitals that employ or contract with physicians at all stages of training provide due process protections to such individuals; and be it further~~ RESOLVED, That our AMA support legislation and other policies protecting physicians and medical students from violence and unsafe working conditions; and be it further RESOLVED, That this resolution be immediately forwarded to our AMA House of Delegates at the November 2021 Special Meeting.	
	Annual 2022	
Emergency Resolution 1— Opposition and Stance on a Permanent Reference Committee	RESOLVED, that our AMA-RFS strongly opposes the use of a Resolution Committee or similar “representative” body to filter out resolutions from the business of the HOD without the opportunity for universal extraction, and be it further RESOLVED, if a Resolution Committee is to inevitably be established, that our AMA-RFS will advocate for the following composition and rules: 1. Members representing the RFS and MSS shall be appointed by their respective Governing Councils for a one-year term 2. The composition of the Resolution Committee will be representative of AMA membership. 3. Resolution Committee members will be term limited and cannot serve for more than four years in total. 4. The Resolution Committee shall meet at least once to discuss all resolutions prior to voting. Resolutions submitted later by those societies or sections that meet after the resolution deadline (i.e. resolutions normally included in the Tote) will be discussed by the Resolution Committee and voted on prior to the publication of the Resolution Committee report. 5. Members will rank each resolution by priority on a single 0-	No action; already in Digest.

	to-5-point scale. The median score will be used to rank resolutions. A threshold for inclusion can be recommended, but extraction from the report will be possible for all resolutions. 6. Extraction of a resolution from the Resolution Committee report shall only be prevented by a two-thirds vote of the House of Delegates. 7. The deliberations of the Resolution Committee will be free of input or influence from the AMA Board of Trustees, Presidents, Speakers, or Councilors. <u>If a resolution committee is not established by Annual 2023, this Resolved shall be removed from the AMA-RFS policy digest.</u>	
Late Resolution 1—Preserving Access to Reproductive Health Services	RESOLVED, that our AMA: (1) Recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) Opposes limitations on access to evidence- based reproductive health services, including fertility treatments, contraception, and abortion; (3) Will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion; (4) Supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) Opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) Opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) Will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or (8) Will review the AMA policy compendium and recommend policies which should be amended or rescinded to reflect these core values, with report back at I-22; and be it further RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at A-22.	No action; already in Digest.
Resolution 1—Legalization of Fentanyl Test Strips Resolution 4—In Support of Drug	ILLICIT DRUG USE HARM REDUCTION STRATEGIES RESOLVED, That our AMA amend current policy D-95.987, “Prevention of Drug-Related Overdose,” by addition to read as follows:	No action; already in Digest.

Checking Services	4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of "drug paraphernalia" designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies. 5. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.	
Resolution 2—Assessing the Humanitarian Impact of Sanctions	RESOLVED, That our AMA recognizes that economic sanctions can negatively impact health and exacerbate humanitarian crises; and be it further RESOLVED, That our AMA supports ~~legislative and regulatory~~ efforts to study the ~~humanitarian~~ humanitarian ~~health~~ impact of economic sanctions imposed by the United States.	No action; already in Digest.
Resolution 3—Comprehensive Solutions for Medical School Graduates Who are Unmatched or Did Not Complete Training	COMPREHENSIVE SOLUTIONS FOR MEDICAL SCHOOL GRADUATES WHO ARE UNMATCHED OR DID NOT COMPLETE TRAINING RESOLVED, That our AMA work with US Centers for Medicare and Medicaid Services and other relevant stakeholders to create a commission to estimate future physician workforce needs and suggest re-allocation of available residency funding and available first-year positions accordingly; and be it further ~~RESOLVED, That our AMA RFS study the possibility of a pathway to ACGME certification of training, ABMS board certification, and ultimately independent practice in primary care for unmatched graduates of US MD and DO schools who take roles as "Assistant Physicians" or similar positions as established by several states.~~ RESOLVED, That our AMA work with relevant stakeholders to study the possibility of alternative pathways to ACGME certification of training, ABMS board certification, and medical practice for unmatched medical school graduates.	No action; already in Digest.
Resolution 5—The Criminalization of Medical Errors	THE CRIMINALIZATION OF HEALTH CARE DECISION MAKING AND PRACTICE RESOLVED, That policy H-160.946, "The Criminalization of Health Care Decision Making" be amended by addition and deletion with a change in title to read as follows: The Criminalization of Health Care Decision Making and Practice H-160.946 That our ~~The~~ AMA: (1) opposes the attempted criminalization of health care decision-making, practice, malpractice, and	No action; already in Digest.

	medical errors, including medication errors related to electronic medical record or other system errors, ~~especially as represented by the current trend toward criminalization of malpractice~~; it interferes with appropriate decision making and is a disservice to the American public; ~~and~~ (2) actively update and promote ~~will develop~~ model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making and practice, including cases involving allegations of medical malpractice and medical errors~~,~~; and (3) implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making, practice, malpractice, and medical errors. RESOLVED, that our AMA study the increasing criminalization of health care decision-making, practice, malpractice, and medical errors with report back on our advocacy to oppose this trend. RESOLVED, That our AMA study the ramifications of trying all health care decision-making, practice, malpractice, and medical error cases in health courts instead of criminal courts. RESOLVED, That our AMA reaffirm policies H-120.921, H-160.954, H-375.984, H-375.997, and H-435.950; and be it further RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at A-22.	
Resolution 6—Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time	RESOLVED, That our AMA supports the elimination of seasonal time changes; and be it further RESOLVED, That our AMA supports the adoption of year-round standard time; and be it further RESOLVED, That this resolution be ~~immediately~~ forwarded to our House of Delegates at the 2022 AMA ~~Annual~~ Interim Meeting.	No action; already in Digest.
Resolution 7—Analysis of Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and Other Relevant Associations or Organizations	RESOLVED, That our AMA advocate for significant modification or the repeal of Section 207 of the Pension Funding Equity Act of 2004 such that evidence of anti-competitive actions against the NRMP be admissible in federal court; and be it further RESOLVED, That our AMA work with relevant stakeholders to study alternative strategies for resident matching that ensure comparable efficiency and adequate market appreciation for medical residents.	No action; generated a report.
	Interim 2022	

Resolution 1—Prohibition of Death Penalty for Persons with Serious Mental Illness	RESOLVED, That our AMA-RFS support that defendants charged with capital crimes should not be sentenced to death or executed if, at the time of the offense, they had a mental disorder or disability that significantly impaired their capacity to appreciate the nature, consequences or wrongfulness of their conduct, to exercise rational judgment in relation to their conduct, or to conform their conduct to the requirements of the law.	No action; already in Digest.
Resolution 2—Increasing Female Representation in Oncology Clinical Trials	RESOLVED, That our AMA amend H-460.911, Increasing Minority Participation in Clinical Research, by addition and deletion to read as follows: Increasing Minority and Underrepresented Group Participation in Clinical Research H-460.911 1. Our AMA advocates that: a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations. b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and c. Resources be provided to community level agencies that work with those minorities and underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans. 2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities and underrepresented groups in clinical trials: a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs; b. Increased outreach to ~~female~~ all physicians to encourage recruitment of ~~minority and female~~ patients from underrepresented groups in clinical trials; c. Continued ~~minority physician~~ education for all physicians and physicians-in-training on clinical trials, subject recruitment, subject safety, and possible expense reimbursements, and that this education encompass discussion of barriers that currently constrain appropriate recruitment of underrepresented groups	No action; already in Digest.

	and methods for increasing trial accessibility for patients; d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and e. Fiscal support for minority and underrepresented group recruitment efforts and increasing trial accessibility through optimized patient-centered locations for accessing trials, the ready availability of transportation to and from trial locations, child care services, and ~~transportation, child care,~~ reimbursements, ~~and location.~~	
Resolution 4— Supporting the Use of Renewable Energy in Healthcare	RESOLVED, That our AMA-RFS advocate for ~~disseminate a public statement highlighting~~ the importance of healthcare systems' timely transition to renewable energy, including wind, solar, geothermal technology, biomass, and hydropower energy; and be it further RESOLVED, That our AMA-RFS support implementations of policies and incentives that promote the healthcare sector's transition to renewable energy.	No action; already in Digest.
Resolution 5— Medical School Management of Unmatched Medical Students	RESOLVED, That our AMA convene a task force of appropriate AMA councils, medical education organizations, licensing and credentialing boards, government bodies, impacted communities, and other relevant stakeholders to: 1. Study institutional and systemic factors associated with the unmatched medical graduate status, including, but not limited to: a) The GME bottleneck on training positions, including the balance of entry-level and categorical/advanced positions; b) New medical schools and the expansion of medical school class sizes; c) Race, geography, income, wealth, primary language, gender, religion, ability, and other structural factors; d) Student loan debt; e) Predatory business practices by medical schools, loan agencies, private equity, and other groups that prioritize profit over student success rates; f) The context, history, and impact of past reports on the state of undergraduate medical education, including the Flexner Report; g) The format and variations of institutional and medical organization guidance on best practices to successful matching; 2. Develop best practices for medical schools and medical organizations to support unmatched medical graduates, including, but not limited to: a) Tools to identify and remediate students at high risk for not matching into GME programs; b) Adequate data on student success rates (e.g., by specialty), and factors associated with success in matching; c) Medical school responsibilities to unmatched medical	No action; already in Digest.

	students and graduates; d) Outcomes-based tuition relief or reimbursement for unmatched students, wherein, unmatched students are returned some component of their tuition to ease the financial burden of being unable to practice clinical medicine; e) Transparent, equity-based solutions to address and ameliorate any inequities identified in the match process; f) Alternative, cost-neutral, graduate-level degrees with earlier graduation for students at high risk for not matching ~~(e.g., Master of Medical Sciences);~~ g) Career opportunities for unmatched U.S. seniors and US-~~IMGs, including, but not limited to, a streamlined portal for non-clinical positions, opportunities to transfer accrued educational credits to alternative advanced clinical degrees (e.g., NP or PA programs), and short-term clinical remediation programs with pathways to residency positions;~~ and 3. Require transparency from stakeholders, including medical schools, about any actions taken based on the report of this task force, particularly with regard to the remediation of medical students.	
Resolution 6— Support for GME Training in Reproductive Services	RESOLVED, That RFS internal position statement 294.017R, "~~Academic Freedom~~," be amended by addition and deletion to read as follows: Academic Freedom Access to Medication and Procedural Abortion Training That our AMA-RFS: (1) support the opportunity for residents to learn medication and procedural~~es for~~ abortion ~~termination of pregnancy~~; ~~and~~ (2) oppose efforts by other persons, governments, or organizations to interfere with or restrict the availability of training in medication and procedural~~es~~ for abortion ~~termination of pregnancy~~.; and (3) in the event that medication and procedural abortion are limited or otherwise unavailable at a home institution, supports cost subsidization for trainees traveling out-of-state and/or to another program to have hands-on training in medication and procedural abortion.; and be it further RESOLVED, That AMA policy H-295.923, "Medical Training and Termination of Pregnancy," be amended by addition and deletion to read as follows: Medical Training and Termination of Pregnancy 1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy. 2. Our AMA ~~supports~~ will advocate for the availability of	No action; already in Digest.

	abortion education and hands-on exposure to medication and procedural abortion ~~procedures for termination of pregnancy, including medication abortions~~, for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training. 3. In the event that medication and procedural abortion are limited or illegal in a home institution, our AMA supports pathways, including cost subsidization, to ensure trainees traveling to another program have hands-on training in medication and procedural abortion, and will advocate for legal protections for both trainees who cross state lines to receive education on reproductive health services, including medication and procedural abortion, as well as the institutions facilitating these opportunities. ~~3~~4. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the relevant Residency Review Committees ~~Review Committee for Obstetrics and Gynecology~~ and the American College of Obstetricians and Gynecologists' recommendations.; and be it further RESOLVED, That our AMA reaffirm policies H-100.948 "Supporting Access to Mifepristone (Mifeprex)" and H-425.969 "Support for Access to Preventive and Reproductive Health Services"; and be it further RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the November 2022 Interim Meeting.	
Report A— Analysis of Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and other Relevant Associations or Organizations	1. That the following resolved clauses be adopted in lieu of the original resolution: a) RESOLVED, That our AMA-RFS support efforts which seek to weaken the antitrust exemption for graduate medical education programs and the MATCH as stated in Section 207 of the Pension Funding Equity Act of 2004. ~~such that evidence of anti-competitive actions against the NRMP be admissible in federal court~~; and be it further b) RESOLVED, That our AMA study ~~with relevant stakeholders~~ alternatives to the current residency and fellowship MATCH process which would be less restrictive on free market competition for applicants. ~~to study alternative strategies for resident matching that ensure comparable efficiency and adequate market appreciation~~	No action; already in Digest.
	Annual 2023	
Late Resolution 1— Stand Your Ground Laws	RESOLVED, That our AMA's Gun Violence Task Force address and consider study the public health implications of "Stand Your Ground" laws and castle doctrine; and be it further RESOLVED, That this resolution be immediately	No action; already in Digest.

	forwarded to the House of Delegates at the 2023 Annual Meeting.	
Resolution 1—Confidentiality of Sexual Orientation and Gender Identity Data	RESOLVED, That AMA policy H-65.959, "Opposing Mandated Reporting of People Who Question Their Gender Identity" be amended by addition and deletion to read as follows: Our AMA opposes mandated reporting or disclosure of patient information related to sexual orientation, of individuals who question or express interest in exploring their gender identity, gender dysphoria, intersex identity, and any information related to gender transition for all individuals, including minors. RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the 2023 Annual Meeting.	No action; already in Digest.
Resolution 3—Amend Policy D-275.948, "Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training"	RESOLVED, That our AMA amend policy D275.948 by addition to read as follows: 1.) Our AMA acknowledges that a conflict of interest exists when non-physician health care professionals hold positions on physician regulatory bodies or physician boards when these individuals represent a field that either possesses or seeks to possess the ability to practice without physician supervision; and 2). Our AMA will work with and advocate to key regulatory bodies involved with physician education, accreditation, certification, licensing, and credentialing to: (1) increase transparency of the process by encouraging them to openly disclose how their board is composed and Imm. Fwd to HOD @ A-23; became Res. 323; Adopted as amended. (see below) This document does not represent official policy of the American Medical Association (AMA). Refer to AMA PolicyFinder for official policy of the Association. 4 members are selected; and (2) review and amend their conflict of interest and other policies related to non-physician health care professionals holding formal leadership positions (e.g., board, committee) when that nonphysician professional represents a field that either possesses or seeks to possess the ability to practice without physician supervision; and 3.) Our AMA opposes any non-physician having a voting position on a regulatory body or physician board responsible for physician education, accreditation, certification, licensing, or credentialing; and be it further RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the 2023 Annual Meeting.	No action; already in Digest.
Resolution 5—Elimination of NonCompete Clauses in Employment Contracts Resolution 10— Support of Banning Non-Compete Contracts for Physicians	ELIMINATION OF NON-COMPETE CLAUSES IN EMPLOYMENT CONTRACTS RESOLVED, That our AMA support the elimination of restrictive not-to-compete clauses within contracts for all physicians in clinical practice, regardless of the for-profit or non-for profit status of the employer; and be it further RESOLVED, That our AMA strongly advocate for policies that enable all physicians, including residents and fellows currently in training, to have greater professional mobility and the ability to serve multiple hospitals, thereby increasing specialist coverage in communities and improving overall patient care; and be it further RESOLVED, That our AMA ask the Council on Ethical and Judicial Affairs to evaluate amending the AMA Code of Medical Ethics in order to oppose non-compete clauses; and	No action; already in Digest.

	be it further RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the 2023 Annual Meeting.	
Resolution 6— Redressing the Harms of Misusing Race in Medicine	RESOLVED, That our AMA recognize the exacerbation of health and economic inequities due to race-based algorithms as a manifestation of racism within the medical field; and be it further RESOLVED, That our AMA revise the AMA Guides to the Evaluation of Permanent Impairment, in accordance with existing AMA policy on race as a social construct and national standards of care, to modify recommendations that perpetuate racial essentialism or racebased medicine; and be it further RESOLVED, That our AMA support and promote racism-conscious, reparative, community-engaged interventions at the health system, organized medical society, payor, local, state, and federal levels which seek to identify, evaluate, and address the health, economic, and other consequences of structural racism in medicine.; and be it further RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the 2023 Annual Meeting.	No action; already in Digest.
Resolution 7— Decriminalizing and Destigmatizing Perinatal Substance Use Treatment	RESOLVED, That our AMA will advocate that prenatal and peripartum toxicology tests should not be obtained without the informed consent of the birthing parent, if they have capacity to provide consent; and be it further RESOLVED, That our AMA-RFS support will advocate that state and federal child protection laws should be amended so that reporting of pregnant people with substance use disorders are only reported to welfare agencies when protective concerns are identified by the clinical team, rather than through mandated or categorical referral of all pregnant people with a positive toxicology test or verbal substance use screen. RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the 2023 Annual Meeting.	No action; already in Digest.
Resolution 8— Adopting a Neutral Stance on Medical Aid and Dying	RESOLVED, That our AMA adopt study the impact of adopt a neutral stance on medical aid in dying and respect respect the autonomy and right of self-determination of patients and physicians in this matter; and be it further RESOLVED, That our AMA-RFS support the research to better understand the study the benefits and risks of medical aid in dying, and to how such aid might affect improve the quality of end-of-life care.	No action; already in Digest.
Resolution 9—Traffic Related Death as a Public Health Crisis	RESOLVED, That our AMA recognize traffic related death as a preventable public health crisis that disproportionately harms marginalized populations; and be it further RESOLVED, That Our AMA recognize walking and cycling as healthy behaviors and walking and cycling safety as fundamental rights, especially for marginalized populations; and be it further RESOLVED, That Our AMA support evidencebased strategies to achieve zero traffic fatalities by 2050; and be it further RESOLVED, That Our AMA recognize that vehicle speed and weight are modifiable risk factors for traffic-related deaths.	No action; generated a report.
Resolution 11— Editorial Changes to Outdated	RESOLVED, That our AMA-RFS review our RFS position statements to editorially update outdated and stigmatizing	No action;

and Stigmatizing Language in the RFS Digest of Actions	language as guided by “Advancing Health Equity: A guide to language, narrative, and concepts” on a regular basis, with the language reflected in the Sunset Report; and be it further RESOLVED, That our AMA-RFS will use clinically accurate, non-stigmatizing terminology in all future resolutions, reports, and educational materials and discourage the use of stigmatizing terms	generated a report.
Resolution 12— Inclusion of All Passed Resolutions in the RFS Digest of Actions	RESOLVED, That our AMA-RFS retain all resolutions passed in RFS assembly in our RFS Digest of Actions, including those that pass at the AMA House of Delegates; and be it further RESOLVED, That our AMA-RFS review study past versions of our RFS Digest of Actions with a lookback period of up to 10 years to restore RFS policy that passed at the AMA House of Delegates and was subsequently removed.	No action; generated a report.
Resolution 13— Updating Language Regarding Families and Pregnant Persons	RESOLVED, That our AMA-RFS review and update the language used in our RFS Digest of Actions, and other resources and communications, to ensure that the language used to describe families and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures; and be it further RESOLVED, That our AMA review and update the language used in AMA policy, and other resources and communications, to ensure that the language used to describe families and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures.	No action; generated a report.
Report B— On the Creation of an RFS JEDI Committee	Based on the report and recommendations prepared by the AMA-RFS JEDI Ad-Hoc Committee, your AMA-RFS Governing Council recommends that the following be adopted and the remainder of the report be filed: 1. That our AMA-RFS formally found a Justice, Equity, Diversity, and Inclusion (JEDI) Standing Committee. 2. That the description of the AMA-RFS JEDI Standing Committee be as follows: Justice, Equity, Diversity, and Inclusion (JEDI) Standing Committee: This committee is dedicated to strengthening our Resident-Fellow Section through the promotion of justice, equity, diversity, and inclusion. Committee efforts are aligned with the strategic plan of the AMA Center for Health Equity. The committee aims to build justice and equity into our policy, advocacy, and business, and to ensure that the full diversity of resident and fellow membership is represented, welcome, and supported as members and in leadership. Committee members also work with the Governing Council and other stakeholders to create educational programing and policy. 3. That the responsibilities of the AMA-RFS JEDI Standing Committee be as follows: (a) Review of RFS resolutions and programming/webinar proposals for their impact on JEDI-related topics and collaboration to strengthen RFS policy for JEDI-related	No action; already in Digest.

	causes; (b) Regular creation and curation of JEDI-related content and programming for the RFS; (c) Act as liaisons with other JEDI-related groups within the AMA; (d) As-needed advocacy within our RFS and the AMA for greater support and implementation of JEDI within our organization and within healthcare	

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AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: C
(A-26)

Introduced by: RFS Governing Council

Introduced by: RFS Committee on Medical Education (CME)

Subject: Residency Slots and Shortages

Referred to: Reference Committee

INTRODUCTION

At the Annual 2025 (A-25) RFS Assembly, RHS Resolution 3, "Distribution of Residency Slots Commensurate with Shortages," asked the AMA-RFS to support new residency slots to be considered for specialties based on expected shortages.

The resolution, with the following resolve clause, was referred for study:

RESOLVED that our AMA-RFS support preferential distribution of new residency slots to general internal medicine, family medicine, preventive medicine, pediatrics, obstetrics and gynecology, and psychiatry, commensurate with their relative need and expected shortages.

The RFS Reference Committee recommended that the resolution be adopted as amended with the following rationale:

> "Your Reference Committee recommends that Resolution 3 be adopted as amended. Your Committee heard mixed testimony on this resolution, with arguments in support and concerns raised about the mechanism employed by this resolution to solve a problem all members agreed exists. The RFS Section Delegates noted there is currently a duplicate resolution being considered in the HOD at the 2025 Annual Meeting, and as written this resolution would remain an internal RFS position statement and allow our Section to show support for that resolution in the House. Your Reference Committee agrees with the amendment proffered to address concerns raised by an individual about how preventative medicine residencies are funded. Therefore, your Reference Committee recommends Resolution 3 be adopted as Amended."

During the RFS assembly, the item was extracted given concerns over preferential distribution of residency slots and alignment with existing AMA policy. The Assembly did not agree with the RFS Reference Committee recommendation and referred to the resolution for a report. \
This report is written in direct response to these calls for preferential distribution of new residency slots based on expected shortages in specialties with the following questions for consideration:

- How would "preferential distribution" of residency slots be operationalized within existing federal Graduate Medical Education (GME) funding frameworks?
- Could prioritizing residency slots for certain specialties unintentionally create rigidity or neglect regional workforce needs and shortages in other specialties?
- How does the proposed approach align with existing AMA policy, which has historically emphasized flexibility in residency slot distribution rather than strict specialty-based allocation?

During the RFS assembly, the item was extracted and the Assembly ultimately voted to be referred to the Governing Council. Your Governing Council assigned this report to the Committee on Medical Education.
In the following whereas clauses and subsequent discussion, we provide an overview of how residency slots are determined, consideration of how this can affect other specialties.

BACKGROUND

Determination and Funding of Residency Positions in the United States

The number of residency training positions in the United States is largely determined by GME funding, most of which comes from Medicare[1]. The Balanced Budget Act of 1997 capped the number of residency positions which each hospital can receive Medicare funding for, limiting large-scale expansion of training positions[2]. Teaching hospitals may create additional residency positions beyond their Medicare caps, but these must be supported through institutional funding, state programs, or other federal funding streams, which can limit program growth. Periodic legislation has authorized modest increases in funded residency positions, but these expansions have been incremental and competitive, often requiring programs to demonstrate workforce need and ability to provide quality training. Many pieces of legislation have also required that these funded positions be allocated towards certain specialties and geographic locations. For example, the Resident Physician Shortage Reduction Act of 2025 would add about 14,000 residency spots between 2026-2032, with the focus being on supporting rural residency programs[3]. As funding is tied to training programs rather than national workforce planning, the distribution of residency slots across specialties does not always correspond to projected physician workforce shortages.

Drivers of Current Workforce Inequities

Federal workforce projections estimate an overall shortage of approximately 139,940 physicians by 2036, with general internal medicine (GIM), family medicine, preventive medicine, pediatrics, obstetrics and gynecology(OBGYN), and psychiatry compromising approximately 83% of the projected shortage[7]. Workforce projections may underestimate shortages, as they assume increased reliance on physician assistants and nurse practitioners to meet healthcare demands[8]. National demographic changes are also increasing and diversifying the demand for care. The U.S. population over age 64 has grown rapidly in the last decade, reaching nearly 60 million people, representing an almost 40% increase in ten years[9]. Despite these trends, residency slot distribution reflects institutional priorities and historical program structures, rather than national workforce projections.

Specialties Experiencing Disproportionate Workforce Shortages

While many specialties are facing workforce shortages, there is significant concern regarding projected shortages in GIM, family medicine, preventive medicine, pediatrics, obstetrics and gynecology, and psychiatry. Awareness of the various residency funding mechanisms plays an essential role in understanding workforce shortages and providing a framework for continued discussion on a federal and state level for supporting new mechanisms for residency slots.

GIM residency positions are predominantly funded through Medicare GME payments, including both indirect and direct GME, with additional support from Medicaid and the Veterans Health Administration[1,12–14]. In comparison to family medicine, GIM training is primarily hospital-based. Therefore, substantial indirect medical education revenue is generated, making it financially advantageous for hospitals to grow and maintain these programs. Given this, internal medicine residency spots have expanded more rapidly, even above those Medicare funded positions. It is important to note that the increases in the number of spots doesn't necessarily reflect an increase in the internal medicine workforce, as a majority of trainees choose to pursue fellowship for further training.

Family medicine residency positions are funded primarily through Medicare GME, and are supplemented by Medicaid, Teaching Health Center GME (THCGME), and institutional support[10,11]. Medicare is the largest funding source for these residency spots, however, given the hospital-based structure and cap on residency positions, there is a limited expansion in outpatient-oriented specialties. To address these gaps, several programs, such as THCGME have been developed to provide support in training physicians for underserved communities. However, these programs also remain dependent on periodic federal reauthorization. Given these factors and constraints, the growth of family medicine residency spots has been slow and methodical despite projected and current workforce shortages.

Preventive medicine is a smaller primary care specialty that is often not included in workforce projections, but plays an important role in both clinical care and strengthening the public health workforce[19]. Preventive medicine residency positions are funded through a complex combination of limited Medicare GME funding, federal grants, which include Health Resources and Services Administration (HRSA) and CDC funding, and employer-based or institutional funding[20]. Preventive medicine is largely community and population based, as opposed to a traditional hospital-centered training model. HRSA provides funding for new programs to be opened given the training environments offered by various hospital-based programs. For many programs, the only source of funding is HRSA grants and funding[21]. Given the funding structure varies so drastically from the above-mentioned programs, the misalignment creates disparities in the workforce needs compared to the number of training spots.

Pediatrics residency training is funded through a variety of funding mechanisms, including a combination of Medicare GME payments, Medicaid, and the Children's Hospitals Graduate Medical Education (CHGME) program[15]. Since pediatrics care is largely not Medicare-based, they receive less funding compared to adult-serving programs. Therefore, Medicaid and CHGME funding are more important for pediatrics residency programs[16]. CHGME programs often rely on federal support, and Medicaid often relies on more state and federal support. Given these complexities, and that pediatrics funding is less stable, the expansion of pediatrics residency spots is an ongoing challenge, despite the documented workforce needs.

OBGYN residency positions are funded through a combination of sources. Medicare GME payments, Medicaid, and hospital-based funding all contribute to OBGYN residency allocations. Medicare contributes more often to gynecologic training, while obstetric care is more predominantly financed through Medicaid[12,17]. Given this, OBGYN residency programs are particularly sensitive to state-level funding. OBGYN relies on a combination of several different payment models, but since they do not have direct alternate sources of funding like pediatrics and family medicine, this contributes to a constrained growth of OBGYN residency spots, despite a significant workforce shortage.

Psychiatry residency positions are funded through Medicare GME payments, with some Medicaid support, the Veterans Health Administration funding, and some THCGME programs[12,18]. Psychiatry has been specifically prioritized in recent GME expansions, with a significant proportion of new Medicare-funded residency positions to be allocated to psychiatry residency spots. Psychiatry residency programs face similar difficulties to family medicine, in that their training also has a significant portion of an outpatient-based learning curriculum, and therefore, this makes expanding further more difficult.

Overall, evidence from multiple health systems has demonstrated that strong primary care infrastructure is associated with improved health outcomes, reduced hospitalizations, and emergency department utilization[22]. This simple fact highlights the continued importance of detecting and implementing stable funding structures for these specialties, among others.

Potential Implications of Redistributing Residency Positions

Policymakers have proposed allocating a greater proportion of new residency positions to specialties with the largest workforce shortages. For example, the bipartisan Senate Finance Committee Medicare GME Working Group proposed allocating 25% of new Medicare GME slots to primary care, and 15% to psychiatry[23]. Some stakeholders support targeted distribution of new residency positions to address workforce shortages more directly. For example, Section 5503 of the Affordable Care Act reallocated residency subsidies to high-need areas. Resident recruitment was also funneled into primary care specialties in high-need areas[24]. The Senate Finance Committee Medicare GME working group has also explored this possibility, based on workforce shortages more directly. However, this group has also recognized the concerns of rigidity in determining residency spot allocations[25]. Other stakeholders have also raised concerns that allocating residency positions by specialty alone could create unintended shortages in other fields or limit flexibility in workforce planning. For example, in rural areas, it may be more difficult to operate a robust healthcare organization without the workforce of primary care, surgery, anesthesia, OBGYN, among others. The Niskanen Center, a nonpartisan think tank, acknowledges the hard work that has been done to advance the number of residency positions, however, also notes the importance of flexibility when allocating these spots, noting that data-driven allocations can provide the opportunity for more balanced spots across specialties and geographic needs[26].

Current AMA policy itself reflects this concern by calling for residency expansion in a "balanced fashion based on expected specialty needs throughout our nation," and by supporting state efforts to address changing physician workforce needs and to train physicians in undersupplied specialties and subspecialties in their states/regions.

Evidence also exists that current geographic prioritization can be somewhat rigid. The Government Accountability Office (GAO) recently reported that some stakeholders believed that CMS's reliance on the highest Health Professional Shortage Area (HPSA) scores may have disadvantaged certain hospitals, including some rural hospitals where less than 50% of resident training time occurred inside a qualifying HPSA[27]. In other words, some programs may have been missed in receiving new residency spots because some of their training time was not in identified shortage areas.

Current GME and Policy Efforts Addressing Workforce Shortages

National policy discussions continue to focus on expanding GME funding to address projected physician shortages. The AMA has historically supported efforts to increase residency training capacity while emphasizing the importance of maintaining flexibility in how new residency slots are distributed across specialties. Additional workforce initiatives include programs such as the National Health Service Corps, which provides scholarship and loan repayment incentives for physicians training in shortage specialties and practicing in underserved areas[28].

DISCUSSION

Current data demonstrate that the current physician workforce is not meeting the current needs of the U.S. population, particularly within primary care specialties. This gap is only expected to worsen, despite the ongoing AMA efforts to expand the number of residency slots which were capped in 1997. While these shortages must be addressed, there are varying perspectives regarding the optimal approaches to allocating these new residency slots. The current proposed mechanism of preferentially distributing residency slots based on specialty raises important operational, policy, and systems-level considerations that warrant careful examination.

First, operationalizing "preferential distribution" under the current funding framework would be challenging. Funding is currently tied to individual programs, and institutions, rather than having a national- level strategy for funding allocation. Furthermore, GME financing varies widely depending on the specialty with GIM relying on Medicare, obstetrics and gynecology on

Medicaid and preventive medicine on federal grants and institutional funding. Thus, having a specialty-specific allocation framework may inadvertently limit some specialties.
Second, there is significant variation in workforce needs based on geographic region, health system and patient population. Having a nationalized policy prioritizing specific specialties would likely fail to account for regional shortages and evolving needs in rural and underserved communities. Historically, attempts at redistribution of residency slots towards more rural medicine and primary medical specialties, demonstrated minimal effects for rural medicine. While there was an increase in primary care physicians; however, this was outpaced by subspecialty training. Furthermore, even with expansion of residency slots within family medicine, medical students are not incentivized to choose this route, as demonstrated by a drop in fill rate from 85% to 83.6% in the 2026 Match Cycle[29].

Third, current AMA policy supports increasing the number of residency positions while advocating for a balanced and needs-based distribution that reflects both national workforce projections and regional variation. This language emphasizes flexibility and responsiveness, rather than prescriptive allocation by specialty shortages. The proffered language conflicts with current policy, and while the intent to address key specialty shortages is consistent with AMA priorities, this approach would provide a directive. Specifically, asking for preferential distribution may be interpreted as specialties being more “deserving” than others and could force policymakers to attach conditions to increased residency slot funding. In addition, pre-specifying specialties for residency slot allocation could overcorrect current shortages and limit responsiveness to future needs.

Finally, specialty shortages are not solely a consequence of the number of residency positions but are driven by variations in funding, institutional incentives, practice patterns, and trainee career choices. Thus, to address workforce shortages, a multifaceted approach needs to be applied, including payment reform, support for community-based training models, and incentives for practice in underserved areas.

CURRENT AMA POLICY & EFFORTS

The AMA is intimately involved in efforts involving increasing residency spots, and the funding associated with GME. Our AMA has a strong history of policy regarding residency training and funding extending all the way back to the 1980’s. In the present day, the AMA has been intimately involved in the Resident Physician Shortage Reduction Act, which aims to add 14,000 new residency positions over the next 7 years. Our AMA Council on Legislation and Council on Medical Education also released a report in 2025 which focuses on improving graduate medical education, and ensuring training opportunities[30]. In 2025, the AMA also advocated for the Specialty Physicians Advancing Rural Care Act, which authorizes a loan repayment program to encourage specialty medicine physicians to serve in rural communities experiencing a shortage of these vital physicians[31]. Among these, the AMA has also advocated for grants for training opportunities for medical students in rural health clinics, federally qualified health centers and health care facilities located in medically underserved communities. All of these initiatives have been crucial to supporting current AMA policies, as detailed below. The AMA has also showed their commitment through the Reimagining Residency Initiative, which provides a $15 million grant to support GME improvement through innovations which align residency training with the needs of their ever-evolving healthcare community needs[32].
All of these initiatives have shown the AMA’s commitment to furthering residency training opportunities for new physicians, and to continuously supporting our communities in their healthcare needs.

CONCLUSION

It is apparent that significant disparities and conversations on the best way to allocate new residency spots continue to exist. Rural healthcare workforce shortages are only worsening, and

the gap continues to widen. At the core of these issues is funding. Funding widely varies across specialties and programs. Residency spot allocation was capped 28 years ago, and we are experiencing the consequences today. Over the last several years, the AMA, and Congress have worked to correct this imbalance. New residency spots have been allocated and have been released for the Match. The balancing act of choosing which specialties to select for spots, along with the geographic regions for these spots to cover the healthcare workforce shortages is sensitive and requires careful planning, forethought, and direction from various stakeholders.

Given the various modalities of funding depending on the specialty, it is imperative that we continue to seek out and implement new and innovative strategies to pay for residency spots. With projected shortages in mind, it is essential now more than ever that we continue to search for alternative funding mechanisms for residency spots.

Finally, it is crucial that we remain flexible. The ever evolving and changing landscape of medicine requires flexibility in our approach to the creation of residency spots.

RECOMMENDATIONS

Your Governing Council recommends that the following resolved clause be amended by substitution, replacing the original resolved clause with updated language and adding an additional resolved addressing payment models, and that the remainder of the report be filed:

1. RESOLVED, that our AMA-RFS support flexible preferential distribution of new residency slots based on specialty, geographic need and expected shortages and be it further;
2. RESOLVED, that our AMA-RFS support the development and implementation of sustainable payment models that allow for further residency training positions to be created.

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RELEVANT AMA POLICY

H200.955 Revisions to AMA Policy on the Physician Workforce

It is our American Medical Association policy that:

1. Any workforce planning efforts, done by our AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.
2. Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research… [CME Rep. 2, I-03Reaffirmation I-06Reaffirmation I-07Reaffirmed: CME Rep. 15,

A-10Reaffirmation: I-12Reaffirmation A-13Appended: Res. 324, A-17Appended: CME Rep. 01, A-19Reaffirmation: I-22Reaffirmed in lieu of: Res. 218, A-25]

D305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education

1. Our American Medical Association will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997)... [Sub. Res. 314, A-07… Modified: Res. 310, A-24]

H310.997 Accreditation of Graduate Medical Education Programs

a. Our American Medical Association believes that accreditation and certification programs in graduate medical education should be designed and operated to objectively evaluate the educational quality and content of such programs and to assure a high level of professional training, achievement, and competence.
b. Our AMA believes that accreditation and certification programs in graduate medical education should not be administered as a means of regulating or restricting the number of physicians entering any specialty or field of medical practice.
c. Our AMA believes that qualified physicians who possess the essential prerequisites are entitled to compete for training and subsequently to practice in the specialty or type of practice of their choice upon successful completion of their training. [Res. 14, A-82Reaffirmed: CLRPD Rep. A, I-92Reaffirmed: CME Rep. 2, A-03Reaffirmed: CME Rep. 2, A-13Modified: CME Rep. 01, A-23]

H310.916 Funding to Support Training of the Health Care Workforce

1. Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs.
2. Our AMA strongly advocates that:
    a. There be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions.
    b. There be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions.
3. Our AMA will advocate to appropriate federal agencies, and other relevant stakeholders to oppose the diversion of direct and indirect funding away from ACGME-accredited graduate medical education programs. [Sub. Res. 913, I-09Appended: Res. 917, I-15Appended: Res. 309, I-20Reaffirmed: Res. 305, A-21]

H305.988 Cost and Financing of Medical Education and Availability of First-Year Residency Positions

1. Our American Medical Association believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education.
2. Our AMA believes in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future… [CME Rep. A, I-83…Reaffirmation: A-22]

D200.985 Strategies for Enhancing Diversity in the Physician Workforce

1. Our American Medical Association, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following:
    a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school.
    b. Diversity or minority affairs offices at medical schools.
    c. Financial aid programs for students from groups that are underrepresented in medicine.
    d. Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas… [CME Rep. 1, I-06… Reaffirmed: CME Rep. 06, A-25]

D305.958 Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy

1. Our American Medical Association will ensure that actions to bolster the physician workforce must be part of any comprehensive federal health care reform.
2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US.
3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997… [Sub. Res. 314, A-09…Reaffirmed: Res. 215, I-24]

H200.954 US Physician Shortage

1. Our AMA explicitly recognizes the existing shortage of physicians in many specialties and areas of the US.
2. Our AMA supports efforts to quantify the geographic maldistribution and physician shortage in many specialties.
3. Our AMA supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US… [Res. 807, I-03…Reaffirmed: Res. 237, I-25]

H310.917 Securing Funding for Graduate Medical Education

1. Our AMA continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities).
2. Our AMA continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation.
3. Our AMA encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs.
4. Our AMA encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs. [CME Rep. 3, I-09… Reaffirmed: CME Rep. 01, A-25]

H305.929 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs

1. It is AMA policy that:
    a. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.
    b. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality

of medical education and the quality of and access to care in teaching institutions are preserved.'

c. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.
d. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions…. [CME Rep. 7, A-05… Reaffirmed: Res. 310, A-24]

H465.988 Educational Strategies for Meeting Rural Health Physician Shortage

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association recommends that:
    a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
    b. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
    c. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians… [CME Rep. C, I-90…Reaffirmed: BOT Rep. 07, I-24]

D305.964 Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion

Our American Medical Association will work to support increased federal funding for training of public health physicians through the Epidemic Intelligence Service program and work to support increased federal funding for preventive medicine residency training programs. [Res. 301, A-08; Reaffirmed: CME Rep. 01, A-18; Reaffirmed: CME Rep. 03, I-18; Reaffirmed: CSAPH Rep. 2, I-21]

D200.982 Diversity in the Physician Workforce and Access to Care

1. Our American Medical Association will continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools.
2. Our AMA will continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs.
3. Our AMA will continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting. [CME Rep. 7, A-08; Reaffirmation A-13; Reaffirmation: A-16; Reaffirmed: CME Rep. 5, A-21; Reaffirmation: Res. 240, A-24; Reaffirmed: Res. 308, I-25]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: D
(A-26)

Introduced by: RFS Governing Council

Prepared by: RFS Ad Hoc Committee on Internal Operating Procedures (IOPs) Revisions

Subject: Ranked Choice Voting

Referred to: Reference Committee

Introduction

This report, prepared by the AMA Resident and Fellow Section (RFS) Ad Hoc Committee on Internal Operating Procedures (IOP) Revisions (hereafter referred to as "the IOP committee"), examines the feasibility, implications, and implementation of ranked choice voting (RCV) for RFS elections as directed by the Assembly. It describes the current RFS election system, reviews comparative models and prior AMA experience, and assesses operational, administrative, and governance considerations of adopting RCV. Its scope is limited to internal RFS elections and endorsements governed by the RFS IOPs.

Methods

The IOP Committee was formed, as directed by the Assembly, to review and recommend the implementation of RCV within the RFS. The Committee's process involved reviewing relevant documents, comparing RFS practices with other sections, and gathering input from various stakeholders.

Specifically, the Committee first analyzed the resolution that led to this task, as well as the existing RFS IOPs that govern procedures such as elections and nominations. A key part of the analysis involved comparing the AMA Medical Student Section (MSS), which already uses RCV. This included reviewing the MSS RCV implementation report to identify best practices for the RFS. The Committee also reviewed the A-25 Board of Trustees report on RCV in the House of Delegates.

To gather more qualitative data and assess feasibility, the Committee held two separate focus groups. The first focus group included RCV experts and individuals who were involved in implementing RCV in the MSS. The second focus group was conducted with the current RFS Governing Council to discuss the practical aspects and feasibility of adopting RCV. The information collected informed the final description of the current system, the assessment of RCV's feasibility for the RFS, and the resulting implementation recommendations.

The Committee acknowledged certain limitations in its methodology. It relied primarily on qualitative data, governing documents, and comparative experience (such as the MSS) rather than quantitative election data. Furthermore, the focus group participants were selected experts and leaders, which means they may not fully represent the opinions or perspectives of the entire RFS membership. Despite these limitations, the Committee believes its methods were sufficient to develop practical, governance-focused recommendations.

Findings

Electoral Theory

The electoral process is a central element of democracy and representation, aggregating individual preferences into a single collective decision. The way this is accomplished is discussed in social choice theory, which posits various fairness criteria that should be inherent to a voting system to optimize individual interests[1].

For decisions involving only two options, simple majority rule, or the system in which the winner of the election is the candidate who wins more than 50% of the vote, is the fairest voting system. However, when there are more than two options, there is no ideal voting system, and as such, many different electoral processes have emerged over time as viable ways to promote fairness, democracy, and representation in a variety of contexts[2,3]. These systems are summarized below:

Voting System	Candidate Selection	Winner Determination
Plurality	Voters choose one candidate	Candidate with the highest number of votes wins
Majoritarian	Voters choose one candidate	Candidate with an absolute majority wins
Approval Voting	Voters choose as many candidates as they wish	Candidate with the highest number of votes wins
Positional Voting	Voters rank candidates	Candidate selection can be variable

Ranked Choice Voting (RCV)

In RCV, the candidate with the absolute majority of first-rank votes wins the election, a system similar to a majoritarian one. If this criterion is not met, the candidate with the fewest first-rank votes is removed from consideration, and the ballot is retabulated using the voters' next-highest-ranked candidate. RCV prioritizes majority support by sequentially narrowing the field to identify a candidate with majority backing.

Although the literature on RCV remains relatively limited due to its still-nascent implementation across jurisdictions, existing studies highlight potential benefits. A study of eleven California cities using RCV in single-member municipal elections found a significant increase in the proportion of minority candidates entering races (approximately a nine-percentage-point increase) as well as a higher likelihood of women and minority women being elected[4]. Another frequently cited advantage is the mitigation of "vote-splitting," whereby ideologically similar candidates divide voter support and potentially distort electoral outcomes. By enabling voters to rank candidates, RCV may better capture majority preferences and reduce the likelihood that third-party or lower-viability candidates influence election results by siphoning votes from more competitive, ideologically aligned contenders[5]. Lastly, RCV has illustrated increased voter turnout and engagement[6].

However, RCV also introduces notable challenges, including increased administrative complexity and the risk of ballot exhaustion, in which ballots become inactive due to incomplete ranking[7]. Some scholars argue that ranking-based ballots may be unfamiliar to voters accustomed to single-choice systems and may disproportionately impact voters who identify from underrepresented communities, raising concerns about equity and accessibility[8].

Collectively, these findings suggest that while RCV offers meaningful theoretical and practical advantages, its effectiveness is highly contingent on implementation quality, voter education, and broader institutional context. A summary of these advantages and disadvantages is listed below:

Topic	Pros	Cons
Candidate Diversity	● Improves representation of historically underrepresented candidates ● Lowers structural and strategic barriers to entry ● Encourages broader candidate participation	● Effects on diversity outcomes may vary by implementation design
Electoral Fairness and Equity	● Reduces vote-splitting ● More accurately captures voter preference rankings and majority support ● Increases voter turnout ● Incentivizes candidates to campaign beyond their known voter base ● Disincentivizes negative campaign tactics	● Increases ballot complexity and voter cognitive burden ● Increases risk of ballot exhaustion ● May exacerbate existing inequities in voter access and participation if voter education is insufficient
Administrative Impact	● Improves efficiency by consolidating election rounds into a single process ● Eliminates the need for separate runoff elections	● Increases administrative complexity in ballot design, vote tabulation, and election management ● Requires up-front investments in voter education, staff training, and voting infrastructure

Current Election System in the RFS

The current election system of the RFS is governed by Section V of the IOPs, which establishes a majority-based voting system for all RFS governing council seats, endorsements, delegate, and alternate delegate positions. These procedures are intended to ensure fairness, transparency, and broad representation across the Section's membership, in alignment with the AMA Bylaws that govern all Sections.

Elections occur during the RFS Business Meetings, which take place immediately prior to the AMA House of Delegates meetings. At the Interim Meeting, the Assembly elects the Chair-Elect, Sectional Delegates, and Alternate Delegates to the AMA House of Delegates, and votes on endorsements for RFS members seeking election to some AMA Councils. At the Annual Meeting, the Assembly elects the Vice Chair, Speaker, Vice Speaker, Delegate, Alternate Delegate, Member-at-Large, and votes on endorsements for RFS members seeking election to the AMA Board of Trustees and some AMA Councils.

Nominations are solicited in advance of the meeting, though additional nominations may be made from the floor. Only credentialed delegates and alternate delegates to the RFS Business Meeting are eligible to vote. Voting occurs at various times throughout the meeting.

The RFS currently uses a majority voting system for all contested elections. Each position appears on a separate ballot, with candidates listed alphabetically. Each voter casts one vote per position. To be elected, a candidate must receive a majority (greater than 50 percent) of legal votes cast. If no candidate receives a majority on the first ballot, a runoff election is held between the two candidates with the highest vote totals. Uncontested races are elected by acclamation, except for endorsement votes in which the Assembly has the ability to endorse no candidates. This majority-runoff structure applies to all Governing Council offices and RFS endorsements for HOD elections. In sectional delegate and alternate delegate elections, the top vote-getters are elected and do not need a majority of legal votes cast. In certain races, unsuccessful candidates from the preceding election may choose to stand for the subsequent related position. All aspects of the balloting process are overseen by the Rules Committee and AMA Staff, who prepare, distribute, collect, and tabulate ballots and certify the results.

This structure can necessitate multiple rounds of voting, particularly in races with several candidates, prolonging business sessions and introducing strategic voting considerations. The greatest concern with this system is a decline in voter turnout across multiple rounds of voting. Barriers exist to attendance at the entire RFS business meeting. Credentialed voters for leadership elections must do so by a certain time in the morning prior to the first round of elections, which limits the ability to fill or substitute voting positions. While voting occurs electronically, announcements of additional voting rounds are not always heard by members outside the assembly room. The pool of voters reliably decreases as competing meetings and events occur throughout the RFS business meeting. As such, the system presents an opportunity for modernization through the consideration of ranked choice voting, which could streamline elections, maintain majority outcomes without requiring runoffs, and more accurately capture delegate preferences in multi-candidate contests.

Ranked Choice Voting in the AMA

Ranked choice voting (RCV) has been considered at the American Medical Association (AMA) organizational level, most recently through a Board of Trustees (BOT) report at the 2025 Annual Meeting. In that report, the BOT evaluated the potential adoption of RCV for elections of the AMA House of Delegates (HOD) and recommended against it. The BOT cited concerns about complexity, administrative burden, scalability, and the potential for confusion among a large and diverse electorate, concluding that the current HOD election system adequately meets the Association's needs.

While the Committee acknowledges the BOT’s conclusions with respect to HOD elections, it does not believe that those conclusions are directly applicable to elections conducted within the Resident and Fellow Section. RFS elections differ materially from HOD elections in scale, scope, and operational context. RFS elections involve a substantially smaller electorate, take place over several instances during a single business meeting, and are governed by section-specific Internal Operating Procedures. The Committee therefore determined that the BOT’s analysis of RCV at the HOD level does not preclude its feasibility or appropriateness for internal governance.

Importantly, RCV has already been implemented within the AMA by the Medical Student Section (MSS), providing a relevant comparator. The MSS adopted RCV through amendments to its Internal Operating Procedures and has used its instant runoff system once since implementation. In that instance, the absence of automated tabulation software required manual vote counting by MSS Speakers and staff. While the process was time-intensive, it did not delay reporting of election outcomes; approximately 1.5 hours elapsed between ballot entry and results reporting. Since the initial implementation of ranked choice voting in the MSS, other elections have either involved only two candidates or resulted in a clear majority on the first tabulation, obviating the need for instant runoff retabulation.

The MSS experience demonstrates that RCV can be implemented within an AMA Section without compromising election integrity or delaying results, even without specialized software. It also underscores that the operational burden associated with RCV is episodic rather than routine, arising primarily in multi-candidate races without an initial majority. The Committee views this experience as particularly instructive for the RFS, where multi-candidate races are common and where sequential runoff elections have historically required multiple rounds of voting during Business Meetings.

Strategies for RCV Implementation in the RFS

In its investigation, the committee found that the greatest identified barriers to ranked choice voting include (1) initial introduction and socialization of the system to the section, and (2) organizational support, including funding, to implement a ranked choice voting system.

RCV is an electoral system that fewer members of the section will be familiar with and will require some education and introduction from section leadership before its implementation. Introduction of ranked-choice voting may ultimately result in a shift in the culture surrounding campaigning and elections. Because RCV is an instant-runoff system, there will be no opportunity to campaign between elimination rounds. This will shift outreach and organization to the campaign period ahead of elections.

Organizational support from the AMA remains a potential barrier to implementing RCV. Historically, the MSS has encountered challenges obtaining funding support for an automated software system. In its investigation, the Committee noted resources for open-source software systems, including no-cost options that would mitigate the costs of implementing a ranked-choice voting system.

Discussion

The Committee's findings suggest broad alignment among electoral theory, comparative section experience, and stakeholder perspectives on the potential benefits of implementing RCV within the RFS. Across both focus groups, participants consistently emphasized that the core values of RFS elections include fairness, majority rule, transparency, and meaningful participation by credentialed voters. While the current majority-runoff system satisfies majority rule in principle, stakeholders identified structural and logistical limitations that may undermine representativeness in practice, particularly in multi-candidate races conducted over time in the Assembly.

A dominant theme across both focus groups was concern about voter attrition across sequential runoff rounds. Credentialed voters are most reliably present for initial ballots, with participation declining as meetings progress due to competing obligations, credentialing constraints, and limited ability to re-engage voters outside the Assembly room. Participants highlighted that this attrition may result in later rounds of voting reflecting the preferences of a smaller and potentially less representative electorate. RCV was viewed as a mechanism to address this concern by capturing voters' full preference order on a single ballot.

Participants also identified efficiency and administrative burden as key considerations. While the current system can require multiple ballots and repeated tabulation, RCV's instant runoff structure was consistently described as better aligned with the operational realities of RFS Business Meetings. Experience from the MSS demonstrated that, even when hand tabulation was required, RCV did not delay results or compromise election integrity, though it did require additional effort from section leadership and staff. This experience informed the Committee's recognition that while RCV implementation carries upfront costs, particularly related to software access and staff coordination, these challenges are manageable and may ultimately reduce time spent on prolonged elections.

Education and socialization emerged as a central theme. RCV is less familiar to many members and would require deliberate voter education to ensure confidence in the process. However, MSS experience suggested that voters adapt quickly once provided with clear instructions, and confusion during implementation was minimal. Governing Council members underscored the importance of integrating education into existing structures, such as orientation sessions, pre-election briefings, and real-time guidance during Business Meetings. This informed the Committee's conclusion that successful implementation depends not only on procedural changes to the IOPs but also on sustained education and communication led by Section leadership.

There is also an anticipated cultural impact of RCV on campaigning and candidate behavior. RCV incentivizes candidates to engage more broadly with the electorate, articulate platforms, and seek second- and third-choice support rather than relying solely on existing networks or endorsement cascades. While participants acknowledged the possibility of strategic behavior, such as informal cross-endorsement or coordinated campaigning, most felt these dynamics already exist under the current system and would not fundamentally worsen under RCV. There was strong consensus that existing professional norms within the RFS, rather than additional prescriptive campaign rules, remain the most appropriate mechanism for maintaining civility and fairness. However, campaign rules were outside the scope of this report and were therefore not examined in detail. Future reports should examine this if it is of interest to the Section.

The focus groups also identified important implementation considerations for paired or sequential offices, such as Speaker/Vice Speaker and Delegate/Alternate Delegate. Participants highlighted the need for clarity regarding candidate intentions, drop-down decisions, and ballot design to avoid reintroducing sequential politicking or undermining the efficiency gains of RCV. These discussions reinforced the importance of codifying procedures within the IOPs to reduce ambiguity, promote consistency, and ensure that the transition to RCV does not inadvertently recreate the challenges it is intended to resolve.

Finally, Governing Council participants raised awareness of the broader organizational context, including potential scrutiny of IOP changes and alignment with AMA governance norms. The Committee views the proposal as an opportunity for the RFS to model thoughtful, evidence-based governance reform. The Committee concluded that a well-documented, carefully scoped implementation, grounded in member input and aligned with existing Section authority, positions the RFS to strengthen its internal democratic processes while remaining consistent with its role within the AMA.

Taken together, these findings support the Committee's recommendations to adopt ranked choice voting for RFS elections and endorsements. The evidence also suggests that RCV may promote candidate diversity, given lower barriers to entry. The proposed approach reflects a balance between theoretical rigor, practical feasibility, and the lived experience of section leaders and members. By addressing known limitations of the current system while preserving core democratic principles, the Committee believes that RCV offers a viable and appropriate modernization of the RFS election process.

Recommendations

Based on the report prepared by the RFS Ad Hoc Committee on RFS Internal Operating Procedures (IOPs) Revisions, your RFS Governing Council recommends the following:

1. RESOLVED, that our AMA-RFS adopt ranked choice voting with instant runoff tabulation for all RFS Governing Council elections and endorsements, consistent with the directive of the Assembly; and be it further

2. RESOLVED, that our AMA-RFS provide education to RFS Assembly voters at each Assembly meeting on the use of ranked choice voting, including pre-meeting materials and brief instruction immediately prior to elections; and be it further

3. RESOLVED, that our AMA-RFS coordinate with AMA staff to ensure feasible, accurate, and timely ballot distribution and vote tabulation; and be it further

4. RESOLVED, that our AMA-RFS conduct a structured review following the first election cycle using ranked choice voting to assess implementation, voter experience, and any unintended consequences; and be it further

5. RESOLVED, that our AMA-RFS amend Internal Operating Procedure 5.G pertaining to elections and endorsements by addition and deletion to read as follows:

G. Method of Election and Endorsement.

1. Voter Eligibility.
   a) All credentialed RFS representatives as defined in Section IX.E of this document shall be eligible to vote:
      1. Credentialed RFS alternate representatives shall only be eligible to vote if voting in lieu of a credentialed RFS representative or if credentialed as an at-large representative.
2. Governing Council Elections.
   ~~a) Uncontested elections. If after the call for nominations there is only one candidate for an office, the race for that office shall be considered uncontested and the election shall be by acclamation.~~
   ~~b) Contested elections. If after the call for nominations there is more than one candidate for an office, that race for that office shall be considered contested.~~
   c) Method of Election ~~of~~ for the Chair-Elect, Vice Chair, Delegate, Alternate Delegate, Speaker, Vice Speaker, and Member At-Large. ~~Initial ballots shall include the following offices as appropriate, if contested: Chair-Elect, Vice Chair, Delegate, Speaker, and Member At-Large.~~
      a. Candidates for each office shall be listed on the ballot in alphabetical order.
      b. For the office of Delegate and Speaker, candidates shall declare prior to balloting whether they intend to be considered for related positions (Alternate Delegate or Vice Speaker) if not elected to the primary position. Only candidates who have made such a declaration shall be eligible for consideration for those positions during the same election cycle. Declarations shall be binding for the duration of the election cycle and communicated to the Assembly prior to balloting.
      c. If after the call for nominations there is only one candidate for an office, the race for that office shall be considered uncontested and the election shall be by acclamation.
      d. If after the call for nominations there is more than one candidate for an office, that race for that office shall be considered contested and shall use ranked-choice with instant runoff voting as described below:
         i. The ballot shall give voters the option of ranking candidates in order of preference.

ii. When a candidate receives a simple majority of votes, voting will conclude.
iii. If no candidate receives a simple majority on the first ballot, an instant runoff tabulation shall be performed. The instant runoff tabulation shall be conducted in rounds. In each round, each voter's ballot shall count as a single vote for whichever continuing candidate the voter has ranked highest. The candidate with the fewest votes after each round shall be eliminated.
iv. In the event of a tie, the candidate who received the greatest number of "first rank" votes will win. If the number of "first rank" votes is also a tie, then the contest will be decided by a coin flip.

~~e. Voting representatives shall get up to one vote per office on the ballot. No votes shall be counted for a specific office if there is more than one vote for that office on the ballot.~~
~~f. The candidate who receives a majority of legal votes cast for a given office shall be elected to that office. If no candidate receives a majority of legal votes cast for a given office, a runoff election shall be held between the candidates receiving the first and second largest number of legal votes cast.~~
~~g. Runoff elections for each office shall abide by the same procedures as their original election.~~

~~d)~~ Method of ~~Election of~~ for ~~Alternate Delegate. After the election of the Delegate, all unsuccessful candidates who were nominated for the office of Delegate, and who choose to be a candidate for Alternate Delegate, shall be placed on a ballot for the election of the Alternate Delegate. Additionally, any candidate who was nominated for the office of Alternate Delegate shall also be placed on the same ballot. Voting for the office of Alternate Delegate shall abide by procedures outlined in Section V.G.2.c. Election of Alternate Delegate shall use the ranked choice voting system described in V.G.1.b.1. If there is only one candidate for Alternate Delegate, the race shall be considered uncontested and the election shall be by acclamation, which shall be held immediately after the call for nominations.~~

~~e)~~ Method of ~~Election of~~ for ~~Vice Speaker. After the election of the Speaker, all unsuccessful candidates who were nominated for the office of Speaker, and who choose to be a candidate for Vice Speaker, shall be placed on a ballot for the election of the Vice Speaker. Additionally, any candidate who was nominated for the office of Vice Speaker shall also be placed on the same ballot. Voting for the office of Vice Speaker shall abide by procedures outlined in Section V.G.2.c.~~

3. Endorsement for resident/fellow position on the Board of Trustees and elected Councils.
   a) Only one RFS member may be endorsed at the RFS Business Meeting for each position. The endorsement shall be for a single election cycle. The credentialed delegates may choose not to endorse any candidate.
   b) The ballot shall contain the name of each candidate, listed in alphabetical order, as well as an option to select none of the

candidates. On the ballot, affirmative votes may be cast for one candidate or no candidate for each position.

~~c) A candidate must receive a majority of legal votes to be endorsed. If there are more than two candidates, and if no candidate receives a majority of votes, a runoff election shall be held between the candidates receiving the first and second highest number of votes. If there are two candidates, and neither candidate receives a majority of votes, then the candidate receiving the highest number of votes shall enter a final runoff election against the option for no candidate. If the remaining candidate does not receive a majority of votes, then no candidate will be endorsed.~~ A candidate shall be endorsed using ranked-choice with instant runoff voting as described below:

A. The ballot shall give voters the option of ranking candidates in order of preference, inclusive of the option for endorsing no candidates.
B. When a candidate (or preference for no endorsement) receives a simple majority of votes, voting will conclude.
C. If no option receives a simple majority on the first ballot, an instant runoff tabulation shall be performed. The instant runoff tabulation shall be conducted in rounds. In each round, each voter's ballot shall count as a single vote for whichever continuing option the voter has ranked highest. The option with the fewest votes after each round shall be eliminated.
D. In the event of a tie, the option which received the greatest number of “first rank” votes will win. If the number of “first rank” votes is also a tie, then the contest will be decided by a coin flip.

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AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: E
(A-26)

Introduced by: RFS Governing Council

Prepared by: RFS Committee on Legislation and Advocacy & Committee on Public Health

Subject: (I-25) RFS Emergency Resolution 1: Ensuring That Our AMA Remains Free from Medical Misinformation, Political Manipulation, and Commercial Self-Promotion

Referred to: RFS Reference Committee

INTRODUCTION

On behalf of the American Medical Association Resident & Fellows Section (AMA-RFS) Committee on Legislation and Advocacy, we submit this report to highlight our recommendations regarding "(I-25) RFS Emergency Resolution 1: Ensuring That Our AMA Remains Free from Medical Misinformation, Political Manipulation, and Commercial Self-Promotion."

BACKGROUND

This Emergency Resolution was drafted by members of RFS on or around November 13, 2025 after learning, on the first day of I-25, that the AMA invited Mehmet Oz, MD (Dr. Oz), the current administrator of the Centers for Medicare & Medicaid Services (CMS) to speak at the House of Delegates. The resolved clauses state as follows: "that our AMA will not extend symbolic legitimacy to individuals whose public actions undermine the scientific and ethical foundations of medicine and public health," and "our AMA-RFS immediately forward this resolution to the AMA House of 3 Delegates at the 2025 Interim Meeting."

Dr. Oz was confirmed by the US Senate on April 3. He works with the Trump administration and Robert F. Kennedy Jr. (RFK Jr.; Health and Human Services Secretary) to implement policy related to CMS including (1) allowing Immigration and Customs Enforcement (ICE) access to the personal data of 79 million Medicaid enrollees[1] and (2) advocating for FDA approval of leucovorin for autistic children at the September 22 press conference alongside RFK Jr. and Trump,[2] and (3) advising judicious acetaminophen use in pregnancy under medical supervision in a *Politico* op-ed alongside Jay Bhattacharya, MD and Marty Makary, MD.[3]

The resolution's authors write that "physicians must not misuse their medical authority for commercial, partisan, or non-evidence-based messaging", especially on disseminating public health disinformation. They note concern about the AMA's tacit approval of the administration's public health policy by platforming Dr. Oz, especially policies that are in direct opposition to the AMA's policies and values.

The Board of Trustees, including John Whyte, MD, and Bruce Scott, MD, personally came to both the AMA's Medical Student Section (MSS) and Resident and Fellow Section (RFS) meetings to share their rationale for inviting Dr. Oz to the interim gathering of the House of Delegates. They argue for a pragmatic lens – noting that Dr. Oz is currently a crucial stakeholder for the AMA's policy interests on Medicare and Medicaid. They noted that security protocols were present before the decision to invite Dr. Oz and provided the structure of Dr. Oz's speaking slot. They also provided concerned AMA members the opportunity to submit

questions and concerns that moderators would then present in a curated form in a question and answer format to Dr. Oz before the House of Delegates.

Testimony provided at our RFS meeting suggested that while the intent of the resolution is to underscore the discrepancy between AMA values and the positions of the Trump administration, there was significant concern about the excessively inflammatory language in the resolution language and its ability to divide the house of medicine along political lines.

DISCUSSION

Inviting a controversial speaker is challenging[4], especially ones whose actions and values conflict with the AMA's. The decision by the AMA to invite Dr. Oz shares some similarity with inviting speakers with controversial views at college campuses, who balanced free speech and academic freedom with protection against discrimination and ensuring safety. Academics noted similar concerns as the resolution's authors of legitimizing harmful beliefs and misinformation by inviting said speakers. As federal government stakeholders, Dr. Oz and RFK Jr. are important in deciding and supporting the AMA's policies, including Medicaid and Medicare, prior authorizations, fair physician reimbursement, augmented intelligence, vaccines, and public health. AMA leadership recognizes that Dr. Oz and other federal government officials are important drivers of change.

As noted by AMA leadership, security protocols were present before they invited Dr. Oz[4]. However, free speech is not the same as academic freedom – anyone presenting professional credentials as a physician like Dr. Oz has an implicit obligation to advocate for patients in their public actions. Other professions like law and academia have dismissed lawyers and academics clearly unfit to serve their profession. As a profession, we have the power to do the same democratically. We have an ethical obligation of nonmaleficence to address misinformation and disinformation. Our AMA Principles of Medical Ethics includes, as part of "the essentials of honorable behaviors for the physician"[5]:

> II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
>
> V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
>
> VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

Our AMA Principles of Medical Ethics also explicitly addresses false advertising by a physician[6] and ethical conduct in the media[7].

There are significant concerns regarding transparency in the decision to invite Dr. Oz. Members of RFS and MSS felt blind-sided by the announcement of Dr. Oz to speak, learning on the first day of I-25 of his planned arrival. While this timing does not change what Dr. Oz said on November 16 nor his values, providing the AMA body with an opportunity to offer input on potential speakers would promote greater transparency, and would allow for more thoughtful dialogue and deliberation over weeks and months rather than over a single weekend.

CONCLUSION

Overall, based on our report, we find that (1) the decision to invite a speaker should serve the AMA's values and priorities, (2) allow a more democratic conversation to better inform this decision, and (3) recognize that speakers should be announced with ample time to provide public comment and open question and answering for that individual.

RECOMMENDATION

Your RFS Governing Council recommends that the following recommendation be adopted and the remainder of the report be filed:

RESOLVED, Our AMA should allow our members to send comments and concerns to the leaders who invite speakers to our meetings with at least a 6–8-week notice.

References:

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Relevant AMA Policy

Addressing Public Health Disinformation Disseminated by Health Professionals D-440.914

Our American Medical Association will collaborate with relevant health professional societies and other stakeholders:

1. On efforts to combat public health disinformation disseminated by health professionals in all forms of media.
2. Address disinformation that undermines public health initiatives.
3. Implement a comprehensive strategy to address health-related disinformation disseminated by health professionals that includes:
    a. Maintaining our AMA as a trusted source of evidence-based information for physicians and patients.
    b. Ensuring that evidence-based medical and public health information is accessible by engaging with publishers, research institutions and media organizations to develop best practices around paywalls and preprints to improve access to evidence-based information and analysis.
    c. Addressing disinformation disseminated by health professionals via social media platforms and addressing the monetization of spreading disinformation on social media platforms.
    d. Educating health professionals and the public on how to recognize disinformation as well as how it spreads.
    e. Considering the role of health professional societies in serving as appropriate fact-checking entities for health-related information disseminated by various media platforms.

f. Encouraging continuing education to be available for health professionals who serve as fact-checker to help prevent the dissemination of health-related disinformation.
g. Ensuring licensing boards have the authority to take disciplinary action against health professionals for spreading health-related disinformation and affirms that all speech in which a health professional is utilizing their credentials is professional conduct and can be scrutinized by their licensing entity.
h. Ensuring specialty boards have the authority to take action against board certification for health professionals spreading health-related disinformation.
i. Encouraging state and local medical societies to engage in dispelling disinformation in their jurisdictions.

Policy Timeline: Res. 411, I-21 → Modified: BOT Rep. 15, A-22

AMA Principles of Medical Ethics II, V, and VII

AMA Code of Medical Ethics — Advertising & Publicity (9.6.1)

AMA Code of Medical Ethics — Ethical Misconduct of Physicians in the Media (8.12)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: F
(A-26)

Introduced by: RFS Governing Council

Prepared by: RFS Ad Hoc Committee on Internal Operating Procedures (IOPs) Revisions

Subject: RFS Endorsements in AMA House of Delegates Elections

Referred to: Reference Committee

Executive Summary

Background: The American Medical Association Resident and Fellow Section (AMA RFS) Assembly tasked this report to the RFS Ad Hoc Internal Operating Procedures (IOPs) Standing Committee following referral of a resolution requesting further study of RFS endorsement practices in American Medical Association House of Delegates (HOD) elections. The charge of this report was to examine how endorsements are utilized across the House and to assess whether the RFS should consider modifying its current endorsement policies. At present, the RFS endorses candidates only for leadership positions specifically designated for residents and fellows, and its IOPs prohibit endorsements for other HOD offices. In contrast, several sections and delegations within the House have established formal endorsement processes, including the Medical Student Section (MSS) and the Young Physicians Section (YPS), prompting discussion about whether similar mechanisms should be considered within the RFS.

Methods: The RFS Ad Hoc Internal Operating Procedures Standing Committee conducted a mixed-methods review including analysis of AMA documents (including bylaws, election rules, publicly available materials describing endorsement processes, and RFS IOPs), comparison of endorsement practices across sections and delegations, and interviews with key informants.

Results: Interview findings demonstrated that endorsement structures vary widely across the House, but commonly include candidate applications, interviews, and voting processes often requiring supermajority support. Interview participants emphasized that while endorsements can sometimes influence close races, their greatest value lies in structured candidate engagement and deliberation, which allow sections and delegations to assess alignment with their priorities and strengthen relationships within the House.

Discussion: The analysis identified several key tensions relevant to the RFS: endorsements can amplify trainee influence and elevate resident and fellow priorities, but they also introduce political considerations, relational risk, and administrative burden. These issues may be particularly salient for trainees given their role within professional hierarchies and frequent caucus turnover.

Conclusion: Based on these findings, the Committee recommends that the RFS Assembly vote on whether to establish a formal mechanism for endorsements in AMA HOD elections. Importantly, this mechanism would provide the authority to issue endorsements but would not obligate the Section to do so in any given election cycle. If adopted, our proposed framework places endorsement authority with the RFS Delegation, requiring a two-thirds supermajority of the full delegation for approval. The framework also assigns the RFS Governing Council responsibility for administering the endorsement process, including coordinating candidate applications, engagement, and interviews. Additional safeguards include limits on the number of

endorsements per race, disclosure of conflicts of interest by participants in deliberations, and clearly defined procedures for withdrawal of endorsement.

INTRODUCTION

Endorsements are a longstanding feature of American Medical Association (AMA) House of Delegates (HOD) elections. Delegations, specialty societies, and professional interest groups frequently endorse candidates for elected AMA leadership, including the Board of Trustees, President-Elect, Speaker, and Vice Speaker of the House, and the AMA Councils. These endorsements signal organizational priorities, coordinate voting behavior, and identify candidates aligned with a constituency's values and interests.

AMA endorsement practices have recently evolved, with sections and caucuses such as the Young Physicians Section (YPS) and the Medical Student Section (MSS) establishing formal processes. Given this trend, members of the Resident and Fellow Section (RFS) are questioning whether they should similarly create a formal mechanism to endorse candidates in HOD elections for positions not reserved for residents or fellows.

Current AMA Rules Regarding Endorsements

Endorsements within the AMA HOD election process are governed by election rules established by the Office of House of Delegates Affairs and the AMA Bylaws. Endorsing groups must pre-submit their endorsement processes and timelines. Candidates must meet deadlines to seek endorsements, which must be reported to the HOD Office within prescribed times for official listing. Endorsements are communicated via candidate materials, caucuses, and placards. Endorsement practices vary significantly across groups regarding decision-making, eligibility, voting thresholds, endorsement limits, and qualifications. While endorsements are a common feature of HOD elections, they are not binding and do not formally obligate delegates to vote in accordance with any organization’s recommendation.

Current RFS Endorsement Practices

The Resident and Fellow Section currently has a limited endorsement framework defined in its Internal Operating Procedures (IOPs). The RFS Assembly endorses candidates for the designated resident and fellow seats on the AMA Board of Trustees and elected AMA Councils through a process outlined in Section V of the RFS IOPs. Outside of these designated positions, the RFS does not currently endorse candidates in HOD races. Section XIII.D of the RFS Internal Operating Procedures explicitly states that the Resident and Fellow Section does not endorse candidates for positions who are not members of the Resident and Fellow Section. Given the increasing prevalence of endorsement processes among other AMA sections, the Committee was tasked with examining whether modifications to the Section’s IOPs should be considered and, if so, what governance structure would be most appropriate for the Section.

METHODS

To inform this analysis, the Committee used a mixed-methods approach that combined document review, comparative governance analysis, and semi-structured interviews. Data sources included (1) the current RFS Internal Operating Procedures (IOPs), (2) AMA Bylaws and Election Rules related to House of Delegates (HOD) elections and endorsements, (3) publicly available materials describing endorsement processes from other Sections and caucuses, and (4) structured interviews with key informants. A total of 14 individuals were interviewed across the following groups:

- Current and former members of the Medical Student Section (MSS), including individuals who developed and implemented the MSS endorsement process and those currently administering it

- Members of the Young Physicians Section (YPS), including Governing Council members involved in their endorsement process
- Individuals involved in HOD campaign operations, including campaign advisors and experienced election participants
- Individuals familiar with the drafting and intent of the current RFS IOPs
- RFS Governing Council, Caucus, and Assembly members

The objective of this approach was to understand (1) how endorsement processes have developed in other groups, (2) how those processes function in practice, (3) the perceived benefits and risks of endorsement activity, and (4) potential implications for the RFS should it expand its endorsement practices. Interview questions explored the rationale for adopting or declining endorsement processes; the perceived risk–benefit calculus underlying endorsement decisions; governance structures used to make endorsements; the perceived impact of endorsements on campaign dynamics and election outcomes; and organizational burdens, reputational considerations, and relationship effects associated with endorsement activity. Interviews were intended to surface themes rather than generate quantitative conclusions. Findings were synthesized across informant groups to identify areas of convergence and divergence.

FINDINGS

Documentation Review

The results of policy and document review are summarized in **Appendix I**. In total, 11 AMA sections, 7 specialty organizations, 4 specialty section councils, 10 state societies, 5 regional delegations, and 3 miscellaneous groups were included for document review.
Across all groups reviewed, common endorsement process elements included candidate applications or letters of interest, interviews or questionnaires, and voting thresholds—most frequently a supermajority of 2/3 or 3/4. Most groups required some organizational affiliation from candidates. Final endorsement authority is typically vested in a governing council, an executive committee, or a full delegate body; only a minority of groups specify their complete process in publicly available documents. Of the 11 AMA sections reviewed, only 4 (MSS, YPS, APS, and LGBTQ+) currently offer endorsements; 2 (IPPS, PPPS) explicitly prohibit them. Only one section (MSS) has a formal process for withdrawal of endorsement. Full details appear in **Appendix I.**

Key Informant Interviews

For the interviews, several consistent thematic domains emerged across informant groups. While perspectives varied, particularly regarding the overall desirability of endorsements, there was substantial convergence around the operational, relational, and governance implications of endorsement activity.

<u>Theme #1: Endorsements as Sectional Identity Work</u>

Participants consistently described endorsements as a public declaration of alignment, not only with an individual candidate but with a set of values, priorities, and expectations. As one participant described, it is “a way to signal our values and also keep candidates accountable.” The decision to endorse, or not, was understood as shaping how the section is perceived by candidates and peer groups across the House.

<u>Theme #2: Influence as Contingent, Not Deterministic</u>

Informants did not converge on a single assessment of the impact of endorsements. Instead, endorsements were described as conditionally influential, depending on factors specific to each race. Participants with campaign experience emphasized that endorsements from large,

cohesive voting blocs may matter in close contests. As one noted, “One vote can make a huge difference.” At the same time, several informants questioned whether endorsements are determinative under the current election, endorsement, and interview rules. Interview performance, candidate authenticity, and interpersonal engagement were frequently described as more decisive factors. The prevailing interpretation across interviews was not that endorsements lack influence, but that their influence is situational rather than uniformly predictive.

Theme #3: Deliberation as the Core Mechanism of Value

Informants consistently emphasized that the primary value of endorsement processes lies in candidate engagement rather than in the formal endorsement itself. Interviews, questionnaires, and subsequent deliberation were described as the most meaningful components of the process. Participants highlighted interviews as opportunities to clarify alignment, test policy knowledge, evaluate leadership style, and articulate group needs. As one participant stated, “The most important part is the interview and the discussion afterward—not the rubber stamp.” Notably, this theme cut across both endorsement-supportive and endorsement-skeptical informants. Even those who questioned the value of formal endorsements affirmed the importance of structured candidate engagement. This suggests that deliberation itself, rather than endorsement, may be the central mechanism through which sections exert influence.

Theme #4: Endorsements as Political Acts

Participants uniformly acknowledged that endorsements are political acts that can generate both leverage and risk. Supporters emphasized that endorsement creates accountability when endorsed candidates prevail. However, informants also recognized the reciprocal risk: failure to endorse a candidate who later wins may affect future collaboration.

For the RFS specifically, this theme was amplified by concerns regarding hierarchical power dynamics. Residents and fellows operate within institutional structures where candidates may hold supervisory or reputational authority. Endorsements were therefore seen not only as political acts within the House, but as decisions that may intersect with professional hierarchies. The data suggest that endorsements cannot be disentangled from broader considerations of relational risk and political strategy.

Theme #5: Endorsement as an Opportunity for Leadership Development

Beyond electoral strategy, informants described endorsement processes as mechanisms for leadership development and institutional integration. Participation in endorsement deliberations and campaigns was framed as a pathway for learning governance strategy, coalition-building, and political negotiation. Engagement in campaigns was not merely characterized as networking but as socialization into House dynamics. As one participant noted, endorsement processes create “an opportunity for people within the section to get involved in campaigns and build relationships across the House.”

Theme #6: Governance Considerations

Questions regarding who holds authority, such as the Governing Council, RFS caucus, sectional delegates, elected or appointed committees, or hybrid structures, were central to discussions of fairness and transparency. Participants articulated tension between efficiency and representational participation. Centralized models were described as more agile and confidential. Broader delegate-driven models were viewed as more democratic but potentially less nimble. Supermajority thresholds (2/3rds), endorsement caps tied to open seats, and discretionary authority were all discussed as mechanisms to enhance legitimacy.

Theme #7: Structural Barriers

Timing emerged as a structural constraint. Endorsement windows tied to placard deadlines compress deliberation and may result in endorsement decisions being made by a body that differs from the body ultimately voting. Participants expressed differing priorities: some favored early visibility for strategic impact, while others prioritized alignment between the endorsing body and the voting delegation.

Theme #8: Absence of a Shared Normative Theory of Endorsements

Perhaps most significantly, interviews revealed no shared philosophical foundation for endorsements. While many informants viewed endorsements as a normal feature of House governance, others articulated principled opposition, arguing that elections should rely solely on merit-based evaluation through interviews. As one interviewee stated, “If I had my ideal situation, no one would endorse any candidate.” This signals the absence of a unified theory regarding endorsements. For some, endorsement represents responsible exercise of voting power. For others, it represents unnecessary politicization. The endorsement debate, therefore, reflects competing normative visions of institutional purpose.

DISCUSSION

This analysis demonstrates that endorsement practices vary widely across the AMA. Four overarching tensions emerge from the findings:

Identity vs. Neutrality - Endorsements function as institutional identity work. For some informants, endorsement represents a natural extension of collective voting power. For others, it risks unnecessary politicization.

Influence vs. Risk - Endorsements may matter in close races, but they operate within structural constraints and regulated environments. At the same time, endorsements carry relational risk as well as individual risk. They expend political capital and may alter post-election dynamics with winning and losing candidates alike. For a trainee section, these risks may be amplified by professional hierarchies, especially for trainees who are a part of groups who are involved in the election where the RFS were to make an endorsement. The decision to expand endorsements, therefore, requires weighing conditional electoral influence against relational and reputational costs.

Legitimacy vs. Efficiency - The comparative review reveals substantial variation in endorsement governance models across the AMA. Some groups centralize authority within governing councils or executive committees; others vest decision-making in broader delegate bodies; several require supermajority thresholds. Questions of who votes, what threshold applies, and how transparency is ensured are foundational to internal cohesion. Timing constraints further complicate this calculus. Endorsement windows and placard deadlines may not align with caucus turnover, potentially creating representational misalignment between the endorsing body and the voting delegation. One consideration is using an intermediate; an elected and/or appointed sub-group of the RFS Delegation to make decisions (or recommendations; i.e. a “slate”) for endorsements. This balance could ensure that there is a dedicated group (higher “efficiency”) doing the work while still allowing a broader democratization check (final approval by the full RFS delegation).

Process Value vs. Outcome Value - One of the most consistent findings was that the value of endorsements lies primarily in structured candidate engagement. Interviews, deliberation, and discussion were viewed as the most meaningful mechanisms of influence and leadership development. This suggests that the RFS may derive substantial benefit from candidate engagement processes even independent of formal endorsements. It also raises the possibility that endorsement reform should consider whether the primary goal is to issue endorsements or

to formalize candidate engagement. Finally, it is also critical to understand that there is no quantitative data regarding outcomes of endorsements that your Committee was able to find. Therefore, we are not able to claim that endorsements (or lack thereof) make a significant impact on the outcome of HOD elections.

RFS-Specific Considerations

Interns, residents, and fellows occupy a unique position within the AMA House of Delegates as both physicians and trainees. Uniquely, RFS members operate within professional hierarchies, which may place us in a comparatively vulnerable position when engaging in electoral politics. In addition, the RFS experiences rapid leadership turnover, with caucus membership and section leadership changing frequently, often every one to two years as trainees graduate and transition to independent practice. This turnover can limit institutional memory, complicate the development of sustained political strategy, and create potential misalignment between the individuals who participate in endorsement decisions and those ultimately voting in House elections. These structural factors suggest that endorsement activity for a trainee section carries distinct governance, relational, and strategic considerations that differ from those faced by more stable delegations. One specific consideration would be using an elected and/or appointed committee to do the work around endorsements.

During the 2025 Interim Meeting of the RFS Assembly, this topic was discussed extensively. Members broadly agreed that the question of endorsements is complex and warrants careful consideration due to the potential for unintended consequences. Table 1 (below) summarizes key themes from the RFS Assembly discussion and incorporates perspectives from the interviews above, analyzed specifically through the lens of the RFS.

Potential Advantages	Potential Disadvantages
Amplification of political influence. Endorsements may enhance the RFS's visibility and voting power in House elections.	**Political influence may be inconsistent.** Outcomes may depend more heavily on candidate interviews, personal relationships, and independent delegate voting behavior. Additionally, caucus turnover may also create misalignment between endorsing members and those voting.
Advancement of trainee priorities. Endorsements allow the RFS to support candidates aligned with its priorities and to elevate the visibility of these issues during elections (including justice, equity, diversity, and inclusion; health care access and coverage; trainee rights and well-being; medical education; and scope of practice).	**Risk of issue prioritization bias.** Emphasis on trainee priorities may narrow the evaluation of candidates' broader leadership qualifications or create perceived expectations of alignment during campaigns.
Leadership development. Participation in endorsement deliberations exposes residents and fellows to governance strategy, coalition-building, and campaign dynamics within the House.	**Competing trainee time commitments.** Participation in endorsement processes and additional campaign engagement may require substantial time from RFS members with demanding clinical schedules and may divert attention from substantive policy participation during the House of Delegates.
Relationship-building across the House. Candidates seeking endorsement engage directly with RFS leaders, strengthening networks and mentorship opportunities. Endorsement processes may also facilitate deeper and more influential campaign engagement and collaboration with candidates.	**Relational risk.** Residents and fellows operate within professional hierarchies and may endorse or oppose candidates who are supervisors, mentors, or influential institutional leaders. Additionally, relationships may be strained with attending physicians assisting with delegation seat procurement and funding.
Elevated candidate engagement. Formal endorsement processes may increase the stakes and influence of candidate interactions, allowing the RFS to more rigorously evaluate priorities, leadership style, and alignment with trainee values.	**Administrative considerations.** Managing applications, interviews, conflicts of interest, voting procedures, and timelines requires substantial organizational effort from volunteer trainee leaders.
Strengthened internal deliberation. Endorsement discussions may encourage robust debate within the section, helping clarify shared priorities and fostering collective decision-making among RFS members.	**Risk of internal section division.** Endorsement decisions may create disagreement within the section and potentially fragment caucus cohesion within the House of Delegates on other policy matters.
Potential influence after elections. Endorsed candidates who are elected may be more responsive to trainee priorities or collaborative with RFS initiatives.	**Political capital expenditure.** Endorsements require choosing sides; backing unsuccessful candidates may reduce political leverage. Relationships may be strained with candidates who are not endorsed but later win.

Table 1. Summary of Potential Benefits and Risks of RFS Participation in AMA House of Delegates Election Endorsements.

CONCLUSION

Key Decision Points

The Committee identified several key governance decisions necessary to operationalize an endorsement process within the RFS. The table below summarizes the options considered, the advantages and disadvantages of each approach, and the Committee's recommended implementation language for inclusion in the RFS Internal Operating Procedures.

DECISION #1: WHETHER THE RFS SHOULD HAVE A MECHANISM TO ENDORSE CANDIDATES IN AMA HOD ELECTIONS OUTSIDE OF RESIDENT/FELLOW DESIGNATED SEATS

PROS	CONS
Allows the Section to signal priorities and values; aligns RFS with other AMA sections that issue endorsements; increases opportunities to elevate trainee priorities	Introduces political considerations into Section governance; potential relational risk with candidates who are not endorsed
COMMITTEE RECOMMENDATION: The RFS should, via Assembly action on this report, decide whether or not to give the Section the ability to endorse in HOD elections.	
RATIONALE The Committee found that many peer sections already endorse candidates and that endorsements can serve as a mechanism to elevate resident and fellow priorities within AMA leadership. Providing the authority to endorse allows the Section to participate more fully in the political processes of the House of Delegates while retaining discretion not to endorse when appropriate. That being said, ultimately the Committee believes that it should be up to the Section whether or not to move forward with endorsements.	

DECISION #2: DECISION-MAKING BODY FOR ENDORSEMENTS

PROS	CONS
Ensures legitimacy and representation of the Section; decisions made by elected trainee representatives	Larger voting body may require more coordination
COMMITTEE RECOMMENDATION: Endorsements (including the decision NOT to endorse) should be determined by the RFS Delegation (Sectional Delegates and Alternate Delegates) in addition to the RFS Delegate and Alternate Delegate	
RATIONALE The Committee concluded that endorsement decisions should rest with the members of the Delegation to ensure legitimacy and transparency. Vesting authority in the RFS Delegation reflects the existing governance structure through which the Section conducts its business in the House of Delegates. It could be considered by the Delegation if they want to assign this	

role to a committee, composed of members of the RFS Delegation.

DECISION #3: VOTING THRESHOLD REQUIRED FOR ENDORSEMENT

PROS	CONS
Supermajority ensures a strong consensus and protects the credibility of endorsements	May make endorsements more difficult in competitive races
COMMITTEE RECOMMENDATION: Require a two-thirds (2/3) supermajority of the full RFS Delegation	
RATIONALE The Committee determined that a higher threshold was necessary to ensure endorsements reflect broad consensus across the Section and not only those present or participating in a particular vote. Requiring a supermajority of the full RFS Delegation ensures that endorsements represent the collective position of the Section's elected representatives.	

DECISION #4: ADMINISTRATIVE BODY OVERSEEING THE ENDORSEMENT PROCESS

PROS	CONS
Provides structure and logistical coordination; allows candidate vetting prior to vote	Requires additional coordination
COMMITTEE RECOMMENDATION: The RFS Governing Council should administer the endorsement process, including, but not limited to, timelines, candidate materials, and interviews, in accordance with HOD Election Rules.	
RATIONALE The Committee determined that the Governing Council, or their designee(s) (i.e. a committee) is best positioned to administer the logistical aspects of the endorsement process, including coordinating candidate materials and interviews. However, the final decision to endorse should remain with the RFS Delegation to maintain democratic legitimacy. Interviews and candidate materials allow members to better understand candidates' perspectives and priorities. Informants interviewed during this process consistently reported that these interactions were among the most valuable aspects of endorsement processes.	

DECISION #5: LIMIT ON NUMBER OF ENDORSEMENTS PER RACE

PROS	CONS
Maintains the value and clarity of endorsements	Limits flexibility if multiple strong candidates exist
COMMITTEE RECOMMENDATION: Limit endorsements to no more than the number of available positions	

RATIONALE
Limiting endorsements helps preserve the signaling value of an endorsement and aligns with practices used by several other AMA sections. This approach avoids diluting the impact of endorsements by endorsing too many candidates in a single race.

DECISION #6: DISCLOSURE OF CONFLICTS OF INTEREST

PROS	CONS
Protects credibility and transparency	N/A
COMMITTEE RECOMMENDATION: During endorsement deliberations, require disclosure of voting members in campaign involvement	
RATIONALE While campaign involvement is allowed (and encouraged), establishing clear disclosure expectations helps maintain the integrity of the endorsement process and protects the credibility of the Section's decisions.	

DECISION #7: WITHDRAWAL OF ENDORSEMENT

PROS	CONS
Allows flexibility if the candidate withdraws, becomes ineligible, or is involved in a controversy	Could create political controversy if misused
COMMITTEE RECOMMENDATION: Allow withdrawal only in limited circumstances via a ¾ vote of the full RFS Delegation	
RATIONALE The Committee determined that endorsement withdrawal should be limited to extreme circumstances and therefore, should have a higher threshold.	

DECISION #8: DURATION OF ENDORSEMENT

PROS	CONS
Prevents outdated endorsements from persisting across election cycles	Candidates must reapply in future elections
COMMITTEE RECOMMENDATION: Endorsements apply to a single election cycle	
RATIONALE Limiting endorsements to a single election cycle ensures that endorsements remain relevant	

and reflect current evaluation of candidates.

RECOMMENDATIONS

The AMA-RFS Governing Council recommends that the following be adopted in lieu of RFS Resolution 5-I-25, and the remainder of the report be filed:

RESOLVED, that the Resident and Fellow Section amend its Internal Operating Procedures by substitution of Section XIII.D to read as follows:

XIII.D. Endorsements for AMA House of Delegates Elections Not Covered by Section V
The Resident and Fellow Section (RFS) may endorse candidates for elected offices within the American Medical Association (AMA) House of Delegates that are not the designated resident/fellow positions governed under Section V of these Internal Operating Procedures.

1. **Authority**
    a. Endorsements issued on behalf of the Section shall be determined by the RFS Delegation, defined as all RFS Sectional Delegates and Alternate Delegates, including the RFS Delegate and Alternate Delegate. Prior to considering endorsements in any election cycle, the RFS Delegation may determine by simple majority vote of the full Delegation whether to issue endorsements for that cycle.

2. **Voting Threshold.**
    a. An endorsement shall require the affirmative vote of two-thirds (2/3) of the full RFS Delegation, as defined in XIII.D.1.a, not only those present at a particular vote

3. **Administration of the Endorsement Process.**
    a. The RFS Governing Council or their designee(s) shall administer the endorsement process in accordance with AMA House of Delegates Election rules and timelines, including the solicitation of candidate applications, coordination of candidate interviews, and preparation of materials for consideration by the RFS Delegation, as defined in XIII.D.1.a

4. **Limit on Endorsements.**
    a. The RFS shall not endorse more candidates than the number of available positions for the office being contested. If more candidates meet the two-thirds (2/3) endorsement threshold than the number of endorsements permitted, the RFS Delegation, as defined in XIII.D.1.a, shall conduct runoff votes among those candidates until the number of endorsed candidates does not exceed the number of available positions.

5. **Conflict of Interest.**
    a. Members with direct involvement in a candidate's campaign shall disclose such involvement during deliberations.

6. **Withdrawal or Lapse of Endorsement.**
    a. An endorsement may be withdrawn by a three-fourths (3/4) vote of the full RFS Delegation, as defined in XIII.D.1.a. Endorsements apply only to the election cycle for which they are granted.

REFERENCES
HOD Election Rules
HOD Candidate Information Page

APPENDIX I

Table 1. Summary of endorsement processes for other AMA sections.

Section	Candidate Eligibility	Positions Endorsed	Candidate Engagement Process	Candidate Selection Process	Governance Documents
MSS	No restrictions	Endorses for all positions; offers as many endorsements as there are open spots	Candidate completes basic application form and interviews with MSS Caucus	MSS Caucus determines if they are offering endorsements through supermajority (2/3) vote; MSS Caucus decides on specific endorsements through supermajority (2/3) vote; MSS Caucus can withdraw endorsements through supermajority (2/3) vote	IOPs specifically outline endorsement process
YPS	Must meet AMA definition of young physician; other candidates considered on GC discretion	Endorses for all positions; offers as many endorsements as there are open spots	Candidate completes application form, submits CV, and can submit optional photo that is reviewed by committee appointed by GC	GC-appointed committee reviews candidate applications with a rubric and decides on endorsement; committee includes GC member for passive GC approval	IOPs specifically outline endorsement process
IMGS*	Preference given to IMG physician members	Endorses for all positions; offers as many endorsements as there are open spots	Candidate completes questionnaire, submits CV, and submits letter of sponsorship that is reviewed by GC	Section GC determines endorsement through unspecified mechanism	IOPs specifically outline endorsement process
OMSS	N/A	None	Candidate meets with candidate interview committee to relay information to the section	None	IOPs do not mention endorsements
APS	Must be a current or former member of APS	Endorses for all positions; does not specify how many endorsements are given per position	Candidate completes endorsement request form that is reviewed by section staff and GC	Section GC determines endorsement through simple majority vote	IOPs specifically outline endorsement process
UMAS	N/A	None	None	None	IOPs do not mention endorsements
IPPS	N/A	None	Candidate meets with candidate interview committee to relay information to the section	None	IOPs specifically state section will not endorse

PPPS	N/A	None	Candidate meets with candidate interview committee to relay information to the section	None	IOPs specifically state section will not endorse
SPS	N/A	None	None	None	IOPs do not mention endorsements
WPS	N/A	None	None	None	IOPs do not mention endorsements
LGBTQ+	No restrictions	Endorses for all positions; does not specify how many endorsements are given per position	Candidate completes position-specific questionnaire that is reviewed by the membership and engagement committee	Membership and engagement committee provides preliminary recommendations for endorsements through an unspecified mechanism; GC approves final endorsements through an unspecified mechanism	IOPs do not mention endorsements

*Of note, IMGS currently does not offer endorsements per updates to their bylaws in 2024 and 2025; this document refers to their previous process.

Table 2. Summary of endorsement processes for specialty societies.

Society	Candidate Eligibility	Positions Endorsed	Candidate Engagement Process	Candidate Selection Process	Governance Documents
AAFP	Must be a member of AAFP	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits request for endorsement and provides supporting documentation	Endorsements are determined by the AAFP AMA Executive Committee and then the AAFP Board of Directors through an unspecified mechanism	Governance documents not publicly available
AAO	Must be ophthalmologist or ophthalmology trainee	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits cover letter, CV, and endorsement form	Candidate selection process is not specified	Governance documents do not mention endorsements
AACU	No restrictions	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate meets with the society to request endorsement; details of this meeting are not specified	Candidate selection process is not specified	Governance documents do not mention endorsements

ACEP	Must be an emergency medicine physician	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits CV and cover letter; candidate is interviewed by entire delegation	Endorsements are determined by a vote of the entire delegation; voting parameters are not specified	Governance documents do not mention endorsements
ACP	Must be a member of ACP in good standing	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits cover letter, sponsoring letter, and CV to organization staff	Candidate selection process is not specified	Governance documents do not mention endorsements
ACR	Must be a member of ACR	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits letter of interest and CV to organization staff and delegation chair	Endorsements are determined by a supermajority (3/4) electronic vote of the entire delegation	Governance documents do not mention endorsements
ASBrS	Must be a member of ASBrS	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits letter of interest, CV, and letters of support; candidate completes endorsement forms; candidate may be interviewed by delegation	Candidate selection process is not specified	Governance documents do not mention endorsements

Table 3. Summary of endorsement processes for specialty section councils.

Section Council	Candidate Eligibility	Positions Endorsed	Candidate Engagement Process	Candidate Selection Process	Governance Documents
Dermatology	Must be a board-certified dermatologist or dermatopathologist, or a board-eligible dermatologist in training	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits cover letter and CV; candidate may be interviewed; details of the interview are not specified	Endorsements are determined by a supermajority (2/3) vote of the members of the section council	Governance documents not publicly available
Pain & Palliative	No restrictions	Does not specify which positions are endorsed or how many	Candidate submits a brief summary of qualifications for consideration	Candidate selection process is not specified	Governance documents not publicly available

		endorsements are offered per position			
Radiology	Must be a member of radiology section council	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits request for endorsement and CV to section council officers	Endorsements are determined by a supermajority (3/4) electronic vote of the entire delegation	Governance documents not publicly available
Emergency Medicine	Must be an emergency medicine physician	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits cover letter and CV; candidate is interviewed by several members of the delegation	Endorsements are determined by a vote of the entire delegation; voting parameters are not specified	Governance documents not publicly available

Table 4. Summary of endorsement processes for state societies.

Section	Candidate Eligibility	Positions Endorsed	Candidate Engagement Process	Candidate Selection Process	Governance Documents
CA	Must be an active member of CMA	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits letter of interest and CV to CMA staff	Endorsements are determined by delegation leadership and CMA Executive Committee through an unspecified mechanism	Governance documents not publicly-available
CT	Must have significant ties to CT or New England	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits letter of interest and CV to state society executive director; candidate interviews with North Eastern Delegation as per NED protocols	Candidate selection process is not specified	Governance documents not publicly-available
FL	Must be a member of FMA; must currently work, have previously worked, or trained in FL	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits letter of interest to FMA staff; candidate interviews with FMA delegation	Candidate selection process is not specified	Governance documents not publicly-available
ID	Must be in good standing with IMA	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits a summary of qualifications to the IMA Board of Trustees	Candidate selection process is not specified	Governance documents not publicly-available

KY	Must be a member of KMA or, with approval, a member of the AMA South Eastern Delegation	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits a request for endorsement to KMA staff	Candidate selection process is not specified	Publicly-available governance documents do not mention endorsements
GA	Must be an active member of MAG	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate notifies MAG delegation chair; candidate interviews with voting members of the delegation	Endorsements are determined by supermajority (3/4) secret ballot vote by the entire delegation	Governance documents not publicly available
NY	Must be a member of MSSNY	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits letter of interest and CV to Candidate Selection Committee; candidate interviews with Candidate Selection Committee	Endorsements are determined by the Candidate Selection Committee through an unspecified process	Publicly-available governance documents do not mention endorsements
MI	Must be a member of MSMS and work in MI	Endorses for all positions; does not specify how many endorsements are given per position	Candidate submits letter of interest, CV, and summary of expected support from other organizations; candidate may participate in interviews	Endorsements are determined by delegation leadership through an unspecified process	Publicly-available governance documents do not mention endorsements
WA	Must be an active member of WSMA	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits letter of interest and CV to WSMA staff	Endorsements are determined by WSMA delegation leadership and Executive Committee through an unspecified process	Publicly-available governance documents do not mention endorsements
WI	No restrictions	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate contacts society leadership; candidate participates in an interview	Candidate selection process is not specified	Publicly-available governance documents do not mention endorsements

Table 5. Summary of endorsement processes for regional delegations.

Section	Candidate Eligibility	Positions Endorsed	Candidate Engagement Process	Candidate Selection Process	Governance Documents
Great Lakes	Must be a delegate or alternate delegate	Does not specify which positions are endorsed	Candidate submits CV, letter of interest, and letter of support from	Candidate selection process is not specified	Governance documents not publicly available

	from a Great Lakes state, or must reside or work in a Great Lakes state with support of that state's delegation	or how many endorsements are offered per position	their state delegation chair; candidate participates in interviews		
North Eastern	Must be a member of the North Eastern Delegation	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate completes political candidates form; candidate participates in interviews	Political Candidates Committee recommends candidates to endorse; finale endorsements are determined by supermajority (2/3) vote of the entire NED delegation	Governance documents specifically outline endorsement process
North Central	Must live or practice in a North Central state	Endorses for all positions; provides one endorsement per position	Candidate participates in standardized interview with North Central Executive Committee	Endorsements are determined by simple majority vote of North Central Executive Committee	Governance documents not publicly available
PacWest Congress	Must be a member of a PacWest state	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits CV and letter of support from their state or specialty society; candidate participates in interview with PacWest Candidate Committee	Candidate selection process is not specified	Governance documents not publicly available
South Eastern	Must reside in and be a member of a South Eastern Delegation state society	Endorses for all positions; provides as many endorsements as there are open slots for each position	Candidate requests endorsement through their state society board; candidate interviews with Candidate Evaluation Committee	Candidate Evaluation Committee evaluates candidates using a standard scale and recommends candidates to endorse; final endorsements are determined by vote of the South Eastern Delegation Board; voting parameters are not specified	Governance documents specifically outline endorsement process

Table 6. Summary of endorsement processes for miscellaneous groups.

Section	Candidate Eligibility	Positions Endorsed	Candidate Engagement Process	Candidate Selection Process	Governance Documents
SSS	Must be sponsored by a member	Endorses for all positions; provides endorsement for as	Candidate submits letter of interest, letter of support from their specialty society, CV, and	Endorsements are determined by a supermajority (2/3) vote of the entire SSS membership	Governance documents specifically outline endorsement process

	organization of the SSS	many candidates as are approved by the SSS assembly	photo; candidates can speak at the SSS assembly meeting for up to 4 minutes		
Mobility Caucus	Must be a member of a mobility caucus society	Endorses for all positions; provides as many endorsements as there are open slots for each position	Candidate submits letter of support from their specialty society, letter of interest, and CV for Candidate Strategy Committee to review	Candidate Strategy Committee recommends candidates for endorsement; final endorsements are determined by a supermajority (2/3) vote of the Executive Committee	Governance documents not publicly available
NMA	Must demonstrate past and ongoing support for NMA principles	Does not specify which positions are endorsed or how many endorsements are offered per position	Candidate submits letter of interest	Candidate selection process is not specified	Governance documents not publicly available

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: G
(A-26)

Introduced by: RFS Governing Council

Prepared by: RFS Committee on Medical Education (CME) and Justice, Equity, Diversity, and Inclusion Committee (JEDI)

Subject: Stronger Recognition and Promotion of Accommodations for Neurodivergent Learners

Referred to: Reference Committee

INTRODUCTION

At the Interim 2025 (I-25) RFS Assembly, RFS Resolution 8, "Stronger Recognition and Promotion of Accommodations for Neurodivergent Learners," asked the AMA to create learning policies for neurodivergent learners given there are currently none. The resolution, with the following resolved clause, was referred for study:

> RESOLVED, that our AMA recognizes and promotes more explicitly transparent and learner-centered processes for neurodivergent learners seeking accommodations including but not limited to: (1) emphasizing that each learner has unique strengths and needs that require shared decision-making to ensure the most appropriate accommodations; (2) providing or directing AMA members to education and resources on how to teach, work with, and/or evaluate neurodivergent learners, and (3) advocating for programs, in cooperation with their institution's accommodation offices, to proactively identify and incorporate resources that facilitate support for neurodivergent learners (e.g., neuropsychologists, occupational therapists (OT), speech and language pathology (SLP) therapists, Disability Resource Professionals (DRPs).

The RFS Reference Committee recommended Referral with the following rationale:

> "Your Reference Committee recommends that Resolution 8 be referred. Mixed testimony was heard on this item and referral garnered substantial support. Testimony demonstrated desire for increasing resources and support for neurodivergent learners, though there was much divided discussion on whether language can be better optimized to achieve these asks. Given that the majority testimony agreed with the intent of the resolution but advised closer analysis before submission to HOD, your Reference Committee recommends that Resolution 8 be referred."

During the RFS assembly, the item was extracted, but ultimately still referred to study. The Assembly voted to agree with the RFS Reference Committee recommendation to refer to the resolution for a report. This report is written in direct response to these calls for accommodations for neurodivergent learners with the following questions for consideration:

1. How are neurodivergent learners defined?
2. What is currently being done institutionally to advocate for and support neurodivergent learners?
3. What are the optimal processes and resources for supporting neurodivergent learners seeking accommodations?

In the following background and subsequent discussion, we provide an overview of current residency practices to accommodate neurodivergent learners. We consider the responsibility of institutions to provide adequate accommodations. We describe potential areas in which our AMA could expand its involvement.

BACKGROUND

Defining Neurodivergent Learners

"Neurodivergence" refers to natural variations in human brain function, where individuals learn and process information differently[1]. It is an umbrella term that includes autism spectrum disorder (ASD), attention-deficit/hyperactivity disorder (ADHD), dyslexia, and dyspraxia, as well as individuals without criteria for a formal clinical diagnosis. These differences can involve cognitive processing, social communication, executive functioning, and sensory perception, with an estimated 15-20% of the global population considered neurodivergent[1].

Neurodivergence may affect the way individuals engage with clinical environments. While medicine is a cognitively and sensorially demanding field, neurodivergence is not synonymous with "disability" or "impairment," and does not inherently restrict one's capability as a physician. However, there are gaps in current AMA policy that should be addressed to provide better support, not just for neurodivergent learners, but all learners. This report examines the lived and structural barriers faced by neurodivergent physician learners, and evidence-based institutional strategies that promote equitable participation in medical education and clinical practice.

Barriers for Neurodivergent Learners

The cognitive and emotional demands of medicine require sustained attention, complex reasoning, rapid decision-making, and emotional regulation, leaving little space for cognitive variation. Neurodivergent learners must navigate hierarchical training systems, high-stakes clinical environments and interpersonal dynamics while maintaining patient safety. As a result, they frequently encounter disproportionate barriers that affect performance and success[2].

For example, ADHD-related inattention, impulsivity, and hyperactivity may interfere with rotating schedules, multitasking, and administrative burden. As another example, learners with ASD have wide variation in social communication, sensory processing, and cognitive style[3], resulting in interpreting language literally, confusion with unwritten social norms, and difficulty synthesizing rapid verbal instructions during rounds. All of these could be misinterpreted as disengagement or unprofessionalism. Ultimately, these individuals report higher stress levels compared to their neurotypical colleagues.

School and workplace environments may exclude and stigmatize neurodivergent learners, as their actions are met with negative reactions. In order to avoid negative stigma, neurodivergent learners often hide their behaviors and personify 'neurotypical behaviors.' This can lead to burnout, mental stress, and feeling disconnected from themselves. Challenges faced by neurodivergent learners include written exams, which affect those with dyslexia, managing social situations, and planning independent self-study[4,5]. Neurodiversity adds value to medical education and healthcare systems. Diverse workplaces perform better by incorporating a wider range of perspectives[5].

In 2022 and 2023, 5.9% of residency-match registered learners self-reported a disability[6], and are required to have "reasonable accommodations" in Accreditation Council for Graduate Medical Education (ACGME) accredited training programs. While the ACGME provides resources and guidance for programs to draft disability policies[7], there is no oversight of the outcome of these policies. Institutions ultimately determine what constitutes reasonable accommodations, how accessible processes are, and whether these policies are publicly

available[8,9]. Accommodations for disabilities may include wheelchair accessible space, scheduled breaks, flexible time for medical appointments, and a flexible jeopardy pool. Although many institutions provide accommodations for trainees with disabilities, support is often fragmented across multiple offices, reflecting trainees' dual roles as learners and employees. This lack of coordination creates administrative burden, unclear accountability, and inconsistent access, underscoring the need for centralized, clearly defined systems.

Unlike traditional disabilities, neurodivergence is not necessarily a medical diagnosis, complicating eligibility for accommodations. At the extreme example, prior to starting medical training, neurodivergent learners in medical training could be required to provide documentation of an objective neurocognitive evaluation, which may cost thousands of dollars, and take several months to complete. This testing may not be sensitive enough to detect neurodivergence[1]. Additionally, fear of stereotypes and stigma related to disability labels[10,11,12] may lead neurodivergent learners in medical training to avoid obtaining a diagnosis, disclosing their condition, and completing accommodation requests.

<u>Existing Structures for Trainees with Disabilities</u>

Supporting neurodivergent learners in medical training requires shifting from reactive, individual accommodations, towards a proactive, inclusive training design. Currently, the burden falls largely on neurodivergent learners in medical training to adapt to neuro-normative expectations. In order to transform teaching hospitals, medical training should allow for learning contexts where neurodivergent learners in medical training are seen, understood, and enabled to thrive[4]. Organizational culture and leadership are equally critical in shaping inclusive training environments[13]. Trainees are more likely to succeed in environments that promote belonging, psychological safety, and responsive leadership. Program leadership can support this by prioritizing attentive supervision, addressing individual and structural barriers, and fostering a culture where trainees feel comfortable seeking support and engaging in learning. Institution-wide efforts should include collaboration with neurodiverse trainees and allies, along with neurodiversity-inclusive hiring and visible role models to enhance representation and support career advancement[14].

In the absence of standardized frameworks for the training of neurodivergent physicians, the AGME may draw from evidence-based practices from other clinical or educational settings. Universal Design for Learning (UDL), is a model that shifts from reactive accommodation towards proactive inclusivity through multiple-modality learning (verbal explanations, written text, visual diagrams), supporting self-regulation and persistence by giving graded autonomy[15,16,4]. It is an evidence-based approach to improve learning for students of all types. While it is common for programs to have available mental health resources, neurodivergent learners in medical training would benefit from multidisciplinary support from neurodiversity-affirming mental health support and neuropsychiatrists, who can help trainees understand their cognitive profiles which can inform tailored learning and workflow strategies[17,18,19].

Collaboration with occupational health and occupational therapy services may help trainees address factors such as fatigue management, task organization, ergonomics, and sensory sensitivities in high-demand clinical settings[20]. SLP services may offer structured approaches to communication, including clarity in interpersonal communication, pragmatic language use, and strategies for high stakes clinical interactions[21]. Programs may also consider developing proactive consultation models, where trainees can engage with support services without requiring formal disability disclosure, thereby lowering the threshold for accessing assistance[22,23].

DISCUSSION

The goal of this report is to provide evidence to support the creation of policies at sponsoring institutions to support neurodivergent physicians in training during their graduate medical education. This is especially crucial for many reasons. First and foremost, cognitive diversity is essential in solving complex problems facing the world[24]. Neurodivergent learners deserve fit-for-purpose learning environments and experiences and should not shoulder the burden of educating their educators about their differences and needs[4]. Neurodivergent learners often mask their differences, by learning and substituting their natural responses for learned neurotypical behavior in an attempt to avoid negative responses from others. Masking these differences can lead to burnout, psychological stress, dissociation from one's own identity, among others[4]. Accommodations for neurodivergent learners in medical training are crucial to supporting trainee well-being, preventing burnout, among others. Providing a supportive environment with well-educated preceptors can improve outcomes for neurodivergent learners in medical training.[25]

As awareness of neurodiversity grows within medical education, ACGME programs increasingly face the responsibility of ensuring training environments are accessible to learners with diverse cognitive and learning profiles. Evidence from medical education research suggests that improving transparency of accommodation processes, integrating disability expertise into training programs, and adopting inclusive educational design principles may improve learning environments for neurodivergent learners in medical training while maintaining rigorous clinical training standards[26]. Existing scholarship in disability inclusion and medical education suggests several evidence-based strategies that residency programs and national organizations could adopt to improve accessibility for neurodivergent learners in medical training. Research examining disability disclosure among resident physicians found that many trainees who require accommodations do not request them due to concerns about stigma, lack of knowledge about available resources, or uncertainty about institutional procedures[27].

To address these concerns, residency programs should improve access to accommodations by providing standardized written guidance describing the process for requesting support, expected timelines for review, and confidentiality protections. At a broader policy level, national medical organizations should promote consistency by developing model guidelines for residency accommodation processes, which individual programs could adapt to local institutional requirements[8].

Another frequently cited recommendation is the implementation of faculty education programs focused on neurodiversity and disability inclusion; however, no standardized training presently exists[28]. Studies examining neurodivergent learners in medical education identify lack of faculty awareness as a major barrier to effective support[29]. When educators are unfamiliar with neurodivergent learning styles, this can lead to misunderstandings in clinical training environments due to differences in communication styles and information processing[30]. Developing shared educational resources or training modules for faculty on neurodiversity in medical education through the AMA and other professional organizations can further support this initiative.

Additionally, educational scholars increasingly recommend adopting a UDL to benefit a wider range of learners[4]. UDL emphasizes presenting educational content through multiple formats, clearly outlining learning objectives, and offering flexible approaches to demonstrating competency. UDL has been proposed for enhancing learning in medical education to improve accessibility for learners with diverse cognitive processing styles while benefiting the broader trainee population.

Evidence also suggests that effective accommodation planning often requires specialized expertise in disability and learning differences. DRPs, neuropsychologists, occupational therapists, and SLPs may assist in identifying appropriate strategies to support cognitive processing, executive functioning, and communication challenges that neurodivergent learners in medical training may experience [31]. However, research examining disability support in medical education found that only a small proportion of institutions employ dedicated disability resource professionals with expertise in supporting medical learners[29]. Collaboration between ACGME offices and these professionals should be investigated to further improve accommodations for neurodivergent learners. At a broader policy level, national medical organizations may help facilitate the integration of multidisciplinary expertise into residency accommodation processes.

CONCLUSION

Neurodivergent learners comprise a significant part of the medical trainee workforce; yet existing systems within ACGME are insufficiently equipped to support their needs. Existing accommodations for disabilities provide a valuable foundation but require careful tailoring to the needs of neurodivergent learners in medical training. The evidence reviewed in this report highlights the need for transparent, standardized, and learner-centered accommodation processes, expanded faculty education on neurodiversity, and greater integration of multidisciplinary expertise to support trainees effectively. Among the most well-supported opportunities for improvement is faculty development, particularly in fostering inclusive teaching practices, adaptive supervision, and psychologically safe learning environments.

Furthermore, shifting from reactive models to proactive, inclusive educational design—such as Universal Design for Learning (UDL)—may help address barriers to learning regardless of neurodivergence. Advancing these efforts could reduce barriers and stigma while strengthening the physician workforce by fostering a more diverse and inclusive training environment, ultimately improving patient care. However, data on existing institutional resources for neurodivergent learners remain limited, and some needs may be addressed through better utilization of current structures; therefore, we aim to avoid being overly prescriptive in recommending specific resources. The evidence presented in this report underscores the importance of accommodations, faculty education, and innovative strategies to support neurodivergent learners in medical training.

RECOMMENDATION

Your RFS Governing Council recommends that the following resolved clause be adopted in lieu of the original resolved clause in Resolution 8 and the remainder of the report be filed:

RESOLVED, that our AMA support efforts to improve accessibility and transparency of accommodation processes for neurodivergent learners in medical training by:

(1) Encouraging residency and fellowship programs to provide clear guidance regarding procedures for requesting educational accommodations;
(2) Promoting faculty education and educational resources on teaching, supervising, and evaluating neurodivergent learners; and
(3) Encouraging collaboration between graduate medical education programs and institutional disability resource professionals and related specialists to support individualized accommodation planning for neurodivergent learners in medical training.

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RELEVANT AMA AND AMA-RFS POLICY

60.002R A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities

That our AMA-RFS support working with relevant stakeholders to study available data on medical trainees with disabilities and consider revision of technical standards for medical education programs. (Resolution 11, A-18)

260.008R Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education
That our AMA-RFS support: (1) the right of medical students and residents to form groups and meet onsite to further their medical education or enhance patient care – without regard to their gender, sexual orientation, race, religion, disability, ethnic origin, national origin or age...(Resolution 5, A-05) (Reaffirmed Report E, A-16) (Reaffirmed Report D, I-16)

294.014R Americans with Disabilities Act and Resident Training Files
That our AMA-RFS support working with appropriate entities to ensure that all residency program directors and department chairs are advised of the Americans with Disabilities Act (ADA) and its legal ramifications pursuant to disclosure of training files. (Resolution 7, A-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

Evaluate Barriers to Medical Education for Trainees with Disabilities D-90.990
1. Our American Medical Association urges that all medical schools and graduate medical education (GME) institutions and programs create, review, and revise technical standards, concentrating on replacing “organic” standards with “functional” standards that emphasize abilities rather than limitations, and that those institutions also disseminate these standards and information on how to request accommodations for disabilities in a prominent and easily found location on their websites.
2. Our AMA urges all medical schools and GME institutions to:
a. Make available to students and trainees a designated, qualified person or committee trained in the application of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and available support services. b. Encourage students and trainees to avail themselves of any needed support services. c. Foster a supportive and inclusive environment where students and trainees with disabilities feel comfortable accessing support services[...]. [CME Rep. 2, I-21; Appended - BOT Action in response to referred for decision: Res. 314, A-21; Appended: Res. 302, I-23]

Advocacy for Physicians and Medical Students with Disabilities D-615.977
Our AMA will: (1) establish an advisory group composed of AMA members who themselves have a disability to ensure additional opportunities for including physicians and medical students with disabilities in all AMA activities; (2) promote and foster educational and training opportunities for AMA members and the medical community at large to better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which accommodations may not be immediately apparent; (3) develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians and medical students to manage their own disability-related needs in the workplace; and (4) communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws protections and reasonable accommodations for physicians and medical students with visible and invisible disabilities. [BOT Rep. 19, I-21]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: H
(A-26)

Introduced by: RFS Governing Council

Prepared by: RFS Committee on Legislative Advocacy and RFS Committee on Medical Education

Subject: Disparities in Preliminary and Transitional Year GME Funding

Referred to: Reference Committee

INTRODUCTION

At the 2025 AMA Interim meeting, RFS Resolution 10 asked the AMA to ensure residents who complete a preliminary year and then enter a full residency program remain eligible for full Centers for Medicare & Medicaid Services (CMS) Graduate Medical Education (GME) funding for the entire duration of their training, and that health systems fully fund these residents through completion of a board-eligible program. The I-25 Reference Committee recommended Alternate Resolution 10 which amended existing D305.929 to include programs with a preliminary year in full Medicare direct medical education funding eligibility requirements, in lieu of Resolution 10. Additionally, the Resident and Fellow Section's (RFS) reference committee reaffirmed policy D-305.967 in place of Resolved clause number 2. Resolution 10 was extracted for debate by the RFS assembly and was subsequently referred for further study. The RFS Assembly stated concerns over the complexity and inconsistent application of funding structures affecting preliminary and transitional year residents, necessitating a detailed, peer-reviewed report before action can be taken.

Below is the language of the original Resolution 10 from I-25:

> RESOLVED, that our American Medical Association (AMA) support that a preliminary year resident entering a subsequent full residency be eligible for GME funds from the Centers for Medicare & Medicaid Services (CMS) for the duration of their program comparable to their peers; and be it further
>
> RESOLVED, that our AMA work with other stakeholders to ensure all health systems fully fund trainees in full residency programs with a path to board certification.

BACKGROUND

<u>Why do medical students and residents join a preliminary year (PY) or transitional year (TY) program?</u>

The American Association of Medical College (AAMC) notes that more medical school students and graduates are becoming unmatched.[1] The number of medical school seats have outpaced the number of residency spots, which disadvantages osteopathic (DO) students and international medical graduates (IMGs). A significant number of unmatched students and physicians enter standalone Preliminary Year (PY) and Transitional Year (TY) programs to complete a PGY-1 intern year, which serve as opportunities to improve their clinical skills and network while re-entering the match.

PY programs contain a broad-based clinical PGY-1 year. A medical school graduate may match via the NRMP into a PY program alone or may simultaneously match into a specialized program

to continue on to as a PGY-2. Several specialties require a PY program prior to entering into the specialized PGY-2 year (i.e. anesthesiology, dermatology, diagnostic and interventional radiology, neurology, physical medicine & rehabilitation, and radiation oncology). PY programs usually include Medicine-Preliminary, Surgery-Preliminary, and TY programs. OB/GYN-Preliminary and Pediatrics-Preliminary are rare.

TY programs are PY programs designed for unmatched medical school graduates.[2] TY programs provide multispecialty exposure including surgery and internal medicine to "enter a specialty where a thorough understanding of pathology, physiology and surgical procedures are necessary."[3] During each year spent in a TY program, participants can continue to enroll in NRMP and re-enter the match to join a residency program as a PGY-1.

How does the federal government fund residency spots?

Centers for Medicare & Medicaid Services (CMS) provides hospital funding for residents and fellows through Medicare. Graduate Medical Education (GME) funding for resident positions is determined by federal regulation CFR 42 § 413.79, last updated August 11, 2004[4]. Direct GME (DGME) funding supports resident salary, benefits, and teaching costs, using the Initial Residency Period (IRP) to determine funding.[4] IRP is the expected duration for a resident to complete their first primary specialty and become board certified.[5] During the IRP, residents have 100% DGME funding. For all years after IRP, residents and fellows have 50% DGME funding[5]. Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency that advises the U.S. Congress on issues affecting the Medicare program. MedPAC's 2001 report argues that the IRP should discourage "any unnecessary lengthening of training by individual residents and residency programs as well as multiple specialization and perpetual training."[6] For example, categorical internal medicine residents have an IRP of 3 years, whereas neurological surgery residents have an IRP of 7 years. DGME funding does not account for actual time taken to become board certified. In contrast, Indirect Medical Education (IME) funding reimburses the hospital's expenditure from training residents and fellows and is not affected by the IRP. This mechanism has been present without significant adaptations since the early 2000s.

How do federal funding rules apply to PY and TY programs?

MedPAC recognizes that the IRP-based federal funding may disadvantage certain applicants. Such applicants include Medicine-Preliminary interns, residents/fellow/attending physicians wanting to switch specialties, and residents/fellows who take an unexpectedly longer time to become board certified (e.g. extended leaves of absence).[6] Programs who consider these applicants will not receive full DGME funding. For example, a Medicine-Preliminary applicant who enters a 3-year Family Medicine categorical program will receive only two years of full DGME funding. In contrast, a Surgery-Preliminary applicant will have all three years fully funded. Given that programs have a funding incentive to minimize the number of years without full DGME years, programs may rank the Surgery-Preliminary applicant higher than the Medicine-Preliminary applicant for budgetary reasons. This is the primary regulatory mechanism that the original authors of RFS resolution 10 argue drives inequity and unmatched rates. As a result, system-level design - not trainee merit - financially drives opportunity and training continuity.

DISCUSSION

The goal of the original resolution is to make it explicit that PY trainees are not inadvertently disadvantaged by a residency funding system that has not seen significant change since the 2000s. When we consider that PY-medicine interns looking to transition to specialties requiring PY programs will not have all of their residency training years funded because they would be bound by the anticipated IRP of 3 years for being in internal medicine, the argument that the

current system disadvantages post-PY applicants makes sense. The absence of full DGME funding provides a financial incentive for the system to select an applicant who cannot have their residency training fully funded by Medicare. However, data on how the presence or absence of full DGME funding affects the way an applicant is viewed by residency programs is limited.

The original resolution focuses recommendations on PY trainees, citing a perceived disparity in GME funding whereby TY trainees are not subject to the same reductions because they fall outside of the IRP; however, this distinction is not supported by available evidence. Under CMS policy, the IRP is determined based on residency training and limits the duration of full direct GME funding, and time spent in non–board-certifying programs is still counted toward the IRP once established.[4,6] Educational and policy analyses further demonstrate that GME funding is constrained by IRP rules regardless of pathway, with no clear exemption for transitional year training.[1,5] As a result, both PY and TY trainees may face similar downstream reductions in funding when entering categorical or advanced programs. Therefore, restricting advocacy to preliminary year trainees alone overlooks a broader group affected by the same structural limitations, and policy efforts should include both preliminary and transitional year pathways to ensure equitable funding and support for diverse training trajectories.

What is the AMA's position on residency funding?

The AMA has existing policies supporting the equitable distribution of training resources and expansion of DGME funding for residency programs. AMA Policy D-305.967 advocates on multiple fronts for the maintenance and expansion of GME funding, including for the full scope of residency activities for board certification. AMA Policy H-305.929 explicitly states that full Medicare direct medical education funding should be available *for the number of years required for initial board certification.* It further proposes that in specialties with a documented need, such as physician shortage, there should be opportunities to extend the period of full funding.

CONCLUSION

The current Medicare GME funding framework was established through the IRP framework, which has remained largely unchanged since the 2000s. While this system was designed to discourage unnecessary prolongation of training, its application has created unintended financial barriers for residents who complete PY or TY programs before entering categorical residencies, unlike their counterparts who do not pursue PY or TY programs.

These disparities arise from structural features of the funding system rather than differences in trainee qualifications or performance. As unmatched rates increase and more graduates pursue PY or TY positions as a pathway into residency training, the implications of IRP-based funding limitations may become increasingly relevant for trainees and sponsoring institutions. At present, however, there is limited empirical evidence describing how often funding considerations influence program recruitment decisions or how these policies affect specific trainee populations.

Existing AMA policy strongly supports the preservation, stability, and expansion of GME funding and emphasizes equitable distribution of training resources to meet the nation’s worsening physician shortage. The concerns raised in Resolution 10 highlight the need for continued examination of how decades-long federal funding mechanisms interact with today's training pathways. Further evaluation of these policies, through engagement with stakeholders such as CMS, ACGME, and training institutions, may help clarify the scope of the issue and identify potential approaches that ensure trainees pursuing board-eligible programs are not disadvantaged by structural and financial limitations.

Given the shared funding constraints faced by both preliminary and transitional year trainees under current Medicare GME policy, we recommend that the RFS adopt internal policy supporting legislative and regulatory advocacy, as well as engagement with key stakeholders, to ensure that trainees in both pathways have their training fully funded. Currently, however, we do not believe there is sufficient evidence to support advancement to broader AMA House of Delegates action. We therefore recommend continued study of this issue by appropriate AMA Councils to better characterize the downstream effects on trainee equity, program decision-making, and match outcomes, and to inform future policy development.

RECOMMENDATION

Your RFS Governing Council recommends that the following recommendations be adopted and the remainder of the report be filed:

RESOLVED, that our American Medical Association (AMA) RFS support legislative and regulatory efforts and engagement with stakeholders to ensure that preliminary and transitional year residents who matches into a specialty be eligible for full GME funding from the Centers for Medicare & Medicaid Services (CMS) for the duration of their training program; and be it further

RESOLVED, that our AMA study the impact of current Initial Residency Period (IRP)-based GME funding policies on residency applicant selection, match outcomes, and career trajectories, including impacts on graduates of preliminary and transitional year programs and on populations disproportionately represented among unmatched applicants, such as international medical graduates (IMGs) and osteopathic (DO) graduates, and report back.

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RELEVANT AMA AND AMA-RFS POLICY

D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education

1. Our American Medical Association will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).

4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA:
    a. recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed.
    b. will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda.
    c. will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to

meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.

18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will:
    a. encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans.
    b. strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation.
    c. encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.
35. Our American Medical Association will ask federal agencies that fund graduate medical education (including but not limited to the Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the Department of Defense, the Health Resources and Services Administration, and others) to issue an annual report detailing the quantity of total GME funding for each year including how Direct GME funds are allocated on a per resident or fellow basis, for the previous year.

H-305.929 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs
1. It is AMA policy that:
A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.
B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.
C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.
D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.
E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.
F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.
G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.
H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into

account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.
I. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.
2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.
3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.
4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.
5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

H-310.917 Securing Funding for Graduate Medical Education

1. Our AMA continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities).
2. Our AMA continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation.
3. Our AMA encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs.
4. Our AMA encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

H-200.949 Principles of and Actions to Address Primary Care Workforce

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation’s current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to

reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 1
(A-26)

Introduced by: Hari Iyer, MD

Subject: Minimum Standards for Public Health Leaders

Referred to: Reference Committee

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

Whereas, candidates or nominees whose organizations or employers explicitly oppose medical practice and science can be accurately described as anti-medicine; and

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

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

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

Whereas, Casey Means has stated that hormonal birth control has “horrific health risks for women,” refuses to commit to recommending the measles vaccine, and equivocates over whether vaccines cause autism–all in direct contradiction to medical evidence and expert recommendations and guidance[7-10]; and

Whereas, in spite of the generational harm to public health and medical science that will continue to reverberate as a result of RFK Jr.’s leadership of HHS, proven tools are available to restore trust in vaccines under the right leadership[11-12]; therefore be it

RESOLVED, that our American Medical Association (AMA) vocally oppose candidates or nominees for positions in the federal government who explicitly oppose medical practice and science, including those who persistently refuse to take vocal and evidence-based positions in support of vaccination; and be it further

RESOLVED, that our AMA work with stakeholders to actively and in good faith educate candidates or nominees for positions in the federal government who refuse to take vocal, evidence-based positions on vaccinations; and be it further

RESOLVED, that our AMA launch major public-facing campaigns in opposition to anti-medicine candidates or nominees for the highest positions in government; and be it further

RESOLVED, that our AMA call for the impeachment and removal of Robert F. Kennedy, Jr., from the most powerful position in American health care, Secretary of Health and Human Services for his persistent pattern of reckless disregard for medical science and human life; and be it further

RESOLVED, that our AMA urgently oppose nominees for United States Surgeon General who demonstrate a pattern of nonadherence to high-quality scientific evidence in their public works and statements and lack appropriate medical credentials, including completing residency training; and be it further

RESOLVED, that our AMA study the records of RFK Jr. and Casey Means in order to educate the public on their positions and their impacts on public health and health care by way of public-facing campaigns; and be it further

RESOLVED, that our AMA reaffirm our strong support for improving the health of all Americans, including by enhancing nutrition and prevention efforts in health care; and be it further

RESOLVED, that this resolution be immediately forwarded to the AMA House of Delegates at the 2026 Annual Meeting.

Fiscal Note: Moderate

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RELEVANT AMA POLICY

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

1. On efforts to combat public health disinformation disseminated by health professionals in all forms of media.
2. Address disinformation that undermines public health initiatives.
3. Implement a comprehensive strategy to address health-related disinformation disseminated by health professionals that includes:
    1. Maintaining our AMA as a trusted source of evidence-based information for physicians and patients.
    2. Ensuring that evidence-based medical and public health information is accessible by engaging with publishers, research institutions and media organizations to develop best practices around paywalls and preprints to improve access to evidence-based information and analysis.

3. Addressing disinformation disseminated by health professionals via social media platforms and addressing the monetization of spreading disinformation on social media platforms.
4. Educating health professionals and the public on how to recognize disinformation as well as how it spreads.
5. Considering the role of health professional societies in serving as appropriate fact-checking entities for health-related information disseminated by various media platforms.
6. Encouraging continuing education to be available for health professionals who serve as fact-checker to help prevent the dissemination of health-related disinformation.
7. Ensuring licensing boards have the authority to take disciplinary action against health professionals for spreading health-related disinformation and affirms that all speech in which a health professional is utilizing their credentials is professional conduct and can be scrutinized by their licensing entity.
8. Ensuring specialty boards have the authority to take action against board certification for health professionals spreading health-related disinformation.
9. Encouraging state and local medical societies to engage in dispelling disinformation in their jurisdictions.

Medical and Public Health Misinformation Online D-440.915

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

AMA Code of Medical Ethics 8.7 Routine Universal Immunization of Physicians

As professionals committed to promoting the welfare of individual patients and the health of the public and to safeguarding their own and their colleagues' well-being, physicians have an ethical responsibility to encourage patients to accept immunization when the patient can do so safely, and to take appropriate measures in their own practice to prevent the spread of infectious disease in health care settings. Conscientious participation in routine infection control practices, such as hand washing and respiratory precautions is a basic expectation of the profession. In some situations, however, routine infection control is not sufficient to protect the interests of patients, the public, and fellow health care workers. In the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues, or threatens the availability of the health care workforce, particularly a disease that has potential to become epidemic or pandemic, and for which there is an available, safe, and effective vaccine, physicians have a responsibility to accept immunization absent a recognized medical contraindication or when a specific vaccine would pose a significant risk to the physician's patients. Physicians who are not or cannot be immunized have a responsibility to voluntarily take appropriate action to protect patients, fellow health care workers and others. They must adjust their practice activities in keeping with decisions of the medical staff, institutional policy, or public health policy, including refraining from direct patient contact when appropriate. Physician practices and health care institutions have a responsibility to proactively develop policies and procedures for responding to epidemic or

pandemic disease with input from practicing physicians, institutional leadership, and appropriate specialists. Such policies and procedures should include robust infection control practices, provision and required use of appropriate protective equipment, and a process for making appropriate immunization readily available to staff. During outbreaks of vaccine-preventable disease for which there is a safe, effective vaccine, institutions' responsibility may extend to requiring immunization of staff. Physician practices and health care institutions have a further responsibility to limit patient and staff exposure to individuals who are not immunized, which may include requiring unimmunized individuals to refrain from direct patient contact.

AMA Principles of Medical Ethics: I,II
Nonmedical Exemptions from Immunizations H-440.970

1. Our American Medical Association believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in their group and the community at large.
2. Therefore, our AMA:
    1. Supports the immunization recommendations of national medical specialty societies as well as those of the Advisory Committee on Immunization Practices (ACIP) as of May 1, 2025, for all individuals without medical contraindications.
    2. Supports legislation eliminating nonmedical exemptions from immunization.
    3. Encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance.
    4. Encourages physicians to grant vaccine exemption requests only when medical contraindications are present.
    5. Encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common.
    6. Recommends that states have in place:
        1. an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP as of May 1, 2025, or national medical specialty society guidelines).
        2. policies that permit immunization exemptions for medical reasons only.
3. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to:
    1. Eliminate non-medical exemptions from mandated immunizations.
    2. Limit medical vaccine exemption authority to only licensed physicians.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 2
(A-26)

Introduced by: Hari Iyer, MD

Subject: Immediate Action to Prevent Further Immigrant Deaths

Referred to: Reference Committee

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

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

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

Whereas, there has been a massive increase in children detained by Immigration and Customs Enforcement (ICE)[3]; and

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

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

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

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

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

Whereas, for instance, our AMA HOD enacted H-440.793 Mass Deportation as a Public Health Issue at I-24 in direct response to contemporary and anticipated policy announcements and changes to oppose mass detention and recognizes the major harms of mass deportation; and

Whereas, the current presidential administration campaigned explicitly on mass deportation, then went on to aggressively enact that mass deportation policy agenda[1-10]; and

Whereas, no AMA statement or letter has enacted this policy or the spirit of this policy, while top political leaders have repeatedly taken action that our AMA explicitly opposes toward their mass

deportation agenda with demonstrably harmful effects on patients and health care workers[11-18]; and

Whereas, our AMA has authored or signed on to advocacy letters or published statements related to immigration enforcement at hospitals, reports regarding the return of family detention, opposing the disqualification of DACA recipients for ACA tax credits, and multiple letters regarding physician visa issues[11-18]; and

Whereas, if advocacy for existing AMA policy were marginally successful, with the sole impact of slowing or reversing the impact of certain recent immigration policies, deaths and major life disruption for patients and physicians alike plausibly could have been avoided[1-10]; and

Whereas, in the recent past AMA vocally and courageously advocated for medical deferred action, allowing seriously ill individuals to remain in the US and avoid deportation for treatment, for sick children in 2019 and for improved conditions in immigration detention but has stopped in spite of the passage of more extensive HOD immigration policy since that time[11-18]; and

Whereas, in the recent past, our AMA vocally and courageously spoke out against family separation, boldly denouncing “the travesty of family separation sanctioned under the unconstitutional zero tolerance policy” and sent a letter to DHS, HHS, and DOJ on June 19, 2018 opposing the zero tolerance policy[14-15]; and

Whereas, on June 20, 2018, the day after our AMA sent our aforementioned letter–the President signed an executive order to begin the process of ending the policy of family separation, though he did not end the Zero Tolerance policy; at that point already 4,000 families had been separated and devastating visuals of children in cages spread widely[19]; and

Whereas, In the face of multiple forms of opposition, including “mass outrage,” the President “had no choice politically” but to relent, in part driven by increased public awareness facilitated in part by our AMA’s trusted voice and recent HOD debate[20-21]; and

Whereas, AMA's code of medical ethics honors the role of physicians and nurses in providing care and advocacy to those in need as moral acts that foster patient trust in health professionals [22-23]; and

Whereas, our past vocal and effective advocacy related to conditions in immigration detention, family separation, public charge policies that inhibit access to care, the protection of DACA recipients, etc. has effectively stopped, though our policy remains the same or stronger[11-18]; and

Whereas, our AMA Constitution and Bylaws states "5.3.1.2 Board of Trustees actions should be based on policies and directives approved by the House of Delegates. In the absence of specifically applicable House policies or directives and to the extent feasible, the Board shall determine AMA positions based on the tenor of past policy and other actions that may be related in subject matter"; and

Whereas, physicians and medical students across the country dedicate significant time from busy schedules to write, review, debate, and pass “specifically applicable” House policies that are demonstrably feasible to implement; and

Whereas, the good faith interpretation of AMA's legal duty of obedience requires honoring the explicit will of the HOD, especially as expressed through policies passed immediately before,

during, or after current events that invoke the plain advocacy principles laid out in such HOD policy[24]; and

Whereas, after vocal immigration advocacy that began less than ten years ago and started to drop off in 2023 per a review of our immigration letters, our AMA remains well-respected and trusted which made our voice along with others lead to overturning of family separation policy[11-18,25]; and

Whereas, UNIDOS MN has created a simple resource to inform health care workers in regard to protecting the legal rights of patients under their care and this has been utilized to develop hospital guidelines at Hennepin County Medical Center, for example[26-27]; and

Whereas, California organizations including the ACLU of Southern California have created a similar resource to the above that provides an additional option for consideration[27]; and

Whereas, states have begun to take action to protect immigrants in health care facilities since the rescission of the sensitive locations policy[28]; and

Whereas, health care facilities have the ability to set policies on, for instance, where law enforcement agents can go within the nonpublic areas of their facilities and create protocols to ensure a warrant is presented prior to entering these premises and states can require and standardize these policies in health care facilities[28]; therefore be it

RESOLVED, that our American Medical Association (AMA) will encourage increased awareness and efforts among physicians and health care organizations to facilitate home visits and other creative efforts including but not limited to telemedicine to address immigration-related barriers to care; and be it further

RESOLVED, that our AMA will endorse, disseminate, and encourage the use of “Know Your Rights” tools for physicians and health care workers at all health care facilities to educate themselves and colleagues regarding the rights patients and health care workers have when interfacing with immigration enforcement officials; and be it further

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

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

RESOLVED, that our AMA supports and encourages physicians, including those in organized medical staffs, and other health care worker efforts to enact the above at their local institutions to protect patients from immigration enforcement actions; and be it further

RESOLVED, that our AMA will advocate in a timely manner for the principles laid out in all HOD policies related to deportation, immigration detention, and health and safety for migrants, when federal policy proposals, laws, or other high-profile actions affirmatively contradict these

policies, as was the clear expectation with the initial passage of these HOD policies; and be it further

RESOLVED, that our AMA reaffirms that unfailingly and unflinchingly following HOD policy–especially when relevant, recent, and immediately timely–constitutes the legal duty of care of the American Medical Association with regard to HOD policy unless and until a policy is sunset or overturned; and be it further

RESOLVED, that this resolution be immediately forwarded to the AMA House of Delegates at the 2026 Annual Meeting.

Fiscal Note: Moderate

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RELEVANT AMA POLICY

Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children H-60.905
1. Our AMA objects to policies separating undocumented, immigrant parents or guardians from children.
2. Our AMA only supports the practice of administering psychotropic drugs to immigrant children when there has been evaluation by appropriate medical personnel, and with parental or guardian consent or court order except in the case of imminent danger to self or others.
3. Our AMA (a) supports education for immigration officials regarding increased risk of sexual assault and sexual trauma amongst unaccompanied minor immigrant children, as well as the emotional decompensation in this immigrant population due to these abuses and other traumas, and (b) encourages policies designed to decrease incidence of sexual assault, increase reporting and timely access to treatment services, and decrease stress and emotional trauma.
Citation: Res. 003, I-18;

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
1. Our AMA opposes;
    1. any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants;
    2. any policies, regulations, or legislation requiring physicians, other health care providers, and healthcare entities to collect and report data regarding an individual patient's legal resident status;
    3. proof of citizenship as a condition of providing health care; and
    4. withholding federal funds if health care institutions fail to comply with policies which mandate collection of a patient’s immigration status.
2. Our AMA opposes any legislative proposals that would criminalize the provision of health care to undocumented residents.

Citation: Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14; Modified: BOT Rep. 09, A-24; Modified: Res. 011, A-25;

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823
1. That our American Medical Association advocates for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
    1. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
    2. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
    3. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
    4. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.

5. The public option is financially self-sustaining and has uniform solvency requirements.
6. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
7. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
    1. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
    2. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
    3. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
    4. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
    5. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
    6. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
    7. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
    8. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
4. Our AMA:
    1. will advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections.
    2. will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions.
    3. supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status.
    4. recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.
5. Our American Medical Association supports federal and state efforts to provide subsidies for undocumented immigrants to purchase health insurance, including by extending eligibility for premium tax credits and cost-sharing reductions to purchase Affordable Care Act (ACA) plans.

Citation: CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22; Reaffirmed: CMS Rep. 5, I-23; Appended: Res. 817, I-24;

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

1. Our AMA supports protecting the human right to seek asylum.

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

Citation: Res. 004, A-25;

Oppose Mandatory DNA Collection of Migrants H-65.955
Our American Medical Association opposes the collection and storage of the DNA of refugees, asylum seekers, and undocumented immigrants for nonviolent immigration-related crimes without non-coercive informed consent.
Citation: Res. 220, I-19;

Immigration Status is a Public Health Issue D-350.975
1. Our American Medical Association declares that immigration status is a public health issue that requires a comprehensive public health response and solution.
2. Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.
3. Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.
4. Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities.

Citation: Res. 904, I-22; Reaffirmed: Res. 210, A-23;

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

Citation: Res. 018, A-17; Modified: Res. 229, I-25;

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

Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court H-65.958
Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations focus solely on the health and well-being of the children; and (2) condemn the use of

confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent.
Citation: Res. 013, A-19;

Care of Women and Children in Family Immigration Detention H-350.955

1. Our AMA recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.
5. Our AMA will advocate for the preferential use of alternatives to detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies.
6. Our AMA advocates for the implementation of evidence-based, child-centered, and trauma-informed policies across all detention centers, ensuring detained minors have access to developmentally appropriate socioemotional care, including physical contact, and for all detained people, free, unfettered communication access including regular in-person communication, phone calls, and letters.
7. Our AMA supports efforts to address and mitigate concerns and accusations of child abuse and neglect in detention centers.

Citation: Res. 002, A-17; Appended: Res. 218, A-21; Reaffirmed: Res. 234, A-22; Appended: Res. 415, A-25;

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921

1. Our American Medical Association advocates for and supports legislative efforts to designate healthcare facilities as protected areas by law.
2. Our AMA will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as protected areas where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur.
3. Our AMA encourages healthcare facilities to clearly demonstrate and promote their status as protected areas.
4. Our AMA opposes the presence of ICE enforcement at healthcare facilities.

Citation: Res. 232, I-17; Reaffirmed in lieu of the first resolve: Res. 234, A-25; Modified: Res. 218, I-25;

Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992

1. Our American Medical Association will take immediate action by releasing an official statement that acknowledges that the health of unaccompanied immigrant children without proper documentation is a humanitarian issue.
2. Our AMA urges special consideration of the physical, mental, and psychological health in determination of the legal status of unaccompanied minor children without proper documentation.
3. Our AMA will immediately meet and work with other physician specialty societies to identify the main obstacles to the physical health, mental health, and psychological well-being of unaccompanied children without proper documentation.
4. Our AMA will participate in activities and consider legislation and regulations to address the unmet medical needs of unaccompanied minor children without proper documentation status, with issues to be discussed to include the identification of:
    1. The health needs of this unique population, including standard pediatric care as well as mental health needs.
    2. Health care professionals to address these needs, to potentially include but not be limited to non-governmental organizations, federal, state, and local governments, the US military and National Guard, and local and community health professionals.
    3. The resources required to address these needs, including but not limited to monetary resources, medical care facilities and equipment, and pharmaceuticals.

4. Avenues for continuity of care for these children during the potentially extended multi-year legal process to determine their final disposition.

Citation: Res. 5, I-15; Reaffirmed: BOT Action in response to referred for decision: Res. 003, I-18; Reaffirmed: Res. 210, A-23;

Mass Deportation as a Public Health Issue H-440.793

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

Citation: Res. 931, I-24;

Medicaid Dialysis Policy for Undocumented Patients H-290.957

Our American Medical Association will work with the Centers for Medicare and Medicaid Services and state Medicaid programs to cover scheduled outpatient maintenance dialysis for undocumented patients with end stage kidney disease under Emergency Medicaid.
Citation: Res. 121, A-21;

Consideration of the Health and Welfare of U.S. Minor Children in Deportation Proceedings Against Their Undocumented Parents D-60.966

Our AMA: (1) supports that the mental health, physical well-being, and welfare of U.S. citizen minors should be taken into consideration in determining whether undocumented parents of U.S. citizen minors may be detained or deported; and (2) will work with local and state medical societies and other relevant stakeholders to address the importance of considering the health and welfare of U.S. citizen minors in cases where the parents of those minors are in danger of detention or deportation.
Citation: Res. 016, A-17;

Opposition of Health Care Entities from Reporting Individual Patient Immigration Status H-373.989

Our AMA supports the collection of de-identified patient information regarding immigration status for funding and research purposes only.
Citation: Res. 011, A-25;

Immigration Status in Medicaid and CHIP D-440.911

Our American Medical Association advocates for the removal of eligibility criteria based on immigration status from Medicaid and CHIP.
Citation: Res. 210, I-23;

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927

Our American Medical Association will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition.
Citation: Res. 254, A-18; Reaffirmed: Res. 259, A-23;

Addressing Immigrant Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of refugees and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific

populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA calls for asylum seekers to receive medically-appropriate care, including vaccinations, in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
4. Our AMA supports efforts to train physicians to conduct medical and psychiatric forensic evaluations for asylum seekers.
5. Our AMA supports medical education that addresses the challenges of life-altering events experienced by asylum seekers.
6. Our AMA urges physicians to provide medically-appropriate care for asylum seekers.
7. Our AMA encourages physicians to seek out organizations or agencies in need of physicians to provide these services.
8. Our AMA encourages provision of resources to assist people seeking asylum, including social and legal services.

Citation: Res. 804, I-09; Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19; Modified: BOT Rep. 08, I-24;

Support of Health Care to Legal Immigrants H-290.983
Our American Medical Association opposes federal and state legislation denying or restricting legal immigrants Medicaid and immunizations.
Citation: Res. 211, A-97; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, A-12; Reaffirmed: CMS Rep. 3, I-21;

Opposing the Detention of Migrant Children H-60.906
1. Our American Medical Association opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children “without unnecessary delay” when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the “least restrictive setting” possible, such as emergency foster care.
2. Our AMA supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children.
3. Our AMA urges continuity of care for migrant children released from detention facilities.

Citation: Res. 004, I-18; Reaffirmed: Res. 234, A-22;

Financial Impact of Immigration on the American Health System H-160.920
Our AMA supports legislative and regulatory changes to require the federal government to make reasonable payments to physicians for the federally mandated care they provide to patients, regardless of the immigration status of the patient.
Citation: CMS Rep. 3, A-07; Reaffirmed: CMS Rep. 01, A-17;

Public Health Care Benefits H-440.903
Our American Medical Association actively lobby the federal and state governments to restore and maintain funding for public health care benefits for all lawfully present immigrants.
Citation: Res. 219, A-98; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, A-12; Modified: CMS Rep. 1, A-22;

Impact of Immigration Barriers on the Nation's Health D-255.980
1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.

4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Citation: Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 210, A-23;

Medical Care Must Stay Confidential H-270.961
Our AMA will strongly oppose any federal legislation requiring physicians to establish the immigration status of their patients.
Citation: Res. 214, A-04; Reaffirmed: CEJA Rep. 8, A-14; Reaffirmed: CEJA Rep. 05, A-24;

Extending Medicaid Coverage for One Year Postpartum D-290.974
Our AMA will work with relevant stakeholders to: (1) support and advocate, at the state and federal levels, for extension of Medicaid and Children's Health Insurance Program (CHIP) coverage to at least 12 months after the end of pregnancy; and (2) expand Medicaid and CHIP eligibility for pregnant and postpartum non-citizen immigrants.
Citation: Res. 221, A-19; Modified: Joint CMS/CSAPH Rep. 1, I-21; Modified: Res. 701, I-21;

Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth D-60.968
Our American Medical Association will work with medical societies and all clinicians to (i) work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services that support their health and well-being, and (ii) secure federal, state, and other funding sources to support those services.
Citation: Res. 8, I-14; BOT Rep. 09, A-24;

Strengthening Supplemental Nutrition Assistance Program (SNAP) H-150.920
1. Our American Medical Association will support allowing the use of SNAP benefits to purchase hot, heated, and prepared foods at SNAP-eligible vendors.
2. Our AMA support expanding SNAP to U.S. territories that currently receive capped block grants for nutrition assistance.
3. Our AMA actively support elimination of the five-year SNAP waiting period for otherwise qualifying immigrants and expansion of SNAP to otherwise qualifying Deferred Action Childhood Arrivals (DACA) recipients.
4. Our AMA advocate for increased federal funding for the Supplemental Nutrition Assistance Program (SNAP) that improves and expands benefits and broadens eligibility.

Citation: Res. 259, A-23;

Visa Complications for IMGs in GME D-255.991
1. Our American Medical Association will
    1. work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice.
    2. promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates.
    3. work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.

3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Citation: Res. 844, I-03; Reaffirmation: A-09; Reaffirmation: I-10; Appended: CME Rep. 10, A-11; Appended: Res. 323, A-12; Reaffirmation: A-19; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 312, A-25;

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 3
(A-26)

Introduced by: Hari Iyer, MD

Subject: AMA's Affirmative Commitment to Defending Democracy with Action

Referred to: Reference Committee

Whereas, the attack on the US Capitol to interfere with the peaceful transfer of power on January 6th, 2021, showed the fragility of democracy and the need for "our vigilance, a shared commitment to truth and justice, and respect for the rule of law[1]"; and

Whereas, AMPAC noted "physicians abhor violence and were shocked and dismayed" by January 6th and noted that AMPAC would "include a review of the recent electoral college certification vote and the violent attacks" in considering campaign contributions in the 2022 election; and

Whereas, AMPAC donated over $110,000 to candidates who voted to overturn the 2020 election in 2020 as well as "$25,000 to the leadership funds of Reps. Kevin McCarthy and Steve Scalise, who both voted to sustain objections to the election[2]; and

Whereas, in May 2021 AMA has launched efforts to acknowledge and reconcile past discrimination on the part of our organization[3]; and

Whereas, our AMA apologized for past discriminatory actions, including the fact that "through the late 1960s, the AMA failed to take action against AMA-affiliated state and local medical associations that openly practiced racial exclusion in their memberships—practices that functionally excluded most African American physicians from membership in the AMA…in the early decades of the 20th century, the AMA listed African American physicians as "colored" in its national physician directory and was slow to remove the designation in response to protests from the National Medical Association (NMA...the AMA was silent in debates over the Civil Rights Act of 1964 and put off repeated NMA requests to support efforts to amend the Hill-Burton Act's "separate but equal" provision, which allowed construction of segregated hospital facilities with federal funds; and

Whereas, at that time our AMA resolved that the "chief aim in this matter is to keep moving forward on a path toward eradication of prejudice and its harmful effects and to achieve equality in society as a whole but especially in health care and public health"; and

Whereas, the civil rights struggle was explicitly committed not only to nondiscrimination but to achieving political and social equality and nondiscrimination through the expansion of our democracy and the right to vote in free and fair elections[4]; and

Whereas, as outlined in our AMA's apology for enabling and facilitating racial discrimination, "[p]olicies and pledges are important, but they are only a beginning. Meaningful actions and measurable outcomes must follow…[a]cknowledging past wrongs lays a marker for understanding and tracking current and future actions"; and

Whereas, at A-24 our HOD passed policy H-65.936 Supporting the Health of our Democracy that supports access to voting; and

Whereas, this occurred in spite of the passage of H-65.947 Support for Democracy at A-22, stipulating that as follows: Our American Medical Association unequivocally supports the democratic process, wherein representatives are regularly chosen through free and fair elections, as essential for maximizing the health and well-being of all Americans. Our AMA will strongly oppose attempts to subvert the democratic process. Our AMA will assert that every candidate for political office and every officeholder in the public trust must support the democratic process and never take steps or support steps by others to subvert it; and

Whereas, either further policy is needed to ensure AMA action to protect patients and physicians against existential threats to democracy or clear existing policy was ignored; and

Whereas, Timothy Snyder, a prominent historian and expert on authoritarianism highlighted the importance of pro-democracy commitments among professionals in his book *On Tyranny* by calling on all of us to "[r]emember professional ethics. When political leaders set a negative example, professional commitments to just practice become more important… Authoritarians need obedient civil servants, and concentration camp directors seek businessmen interested in cheap labor[5]";

Whereas, significant efforts are underway to undermine free and fair elections on the one hand, and defend democracy, on the other hand—and reputable organizations and experts actively monitor such threats[6]; and

Whereas, free and fair elections require "suffrage and candidacy rights among adults are equal, subject to only very limited, clearly justified limits; electors can form their views freely; candidates can campaign freely (without infringing other candidates' or electors' rights); and voting and counting processes are free from corruption or fraud, with the outcome determined by a fair count of the votes alone" and access to the ballot is essential to democracy[7]; and

Whereas, achieving equity and broad access to high quality health care depends on our ability to advocate in our democracy[8]; therefore be it

RESOLVED, that our American Medical Association (AMA) will monitor and identify high-level threats to accessible, free, and fair elections and the peaceable transfer of power in the United States of America; and be it further

RESOLVED, that our AMA will, in response to these threats, consider the preservation of democracy as a fundamental advocacy interest and, in such cases, undertake organization-wide and broad coalitional efforts to vocally and actively support democracy and oppose those who would seek its end; and be it further

RESOLVED, that this resolution be immediately forwarded to the AMA House of Delegates at the 2026 Annual Meeting.

Fiscal Note: Moderate

REFERENCES:

1. January 6th Offers 'a Stark Reminder that Our Democracy is Fragile and Must be Defended.' | ACS
2. Tallying the AMA's checks to the GOP - POLITICO
3. The history of African Americans and organized medicine | American Medical Association

4. The Civil Rights Movement | The Post War United States, 1945 to 1968 | U.S. History Primary Source Timeline | Classroom Materials at the Library of Congress | Library of Congress; The Civil Rights Movement | Gilder Lehrman Institute of American History
5. Lesson 5. Remember professional ethics (podcast).
6. The Trump Administration's Campaign to Undermine the Next Election | Brennan Center for Justice
7. Free and fair elections: what are they and how does the UK compare? | UCL Faculty of Social & Historical Sciences; What Is Democracy, and Why Does Defending It Matter? | Freedom House; Ensuring Access to the Ballot Box
8. Why Democracy is the Best We've Got | Carnegie Council for Ethics in International Affairs

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 4
(A-26)

Introduced by: Dayna Isaacs, MD, MPH

Subject: Advancing Physician Payment and Medicare and Medicaid Access for Street Medicine

Referred to: Reference Committee

Whereas, individuals experiencing homelessness face profound structural barriers to accessing health care, including lack of transportation, identification, stable communication, and continuity within clinic-based systems, resulting in delayed care, fragmented treatment, and worse health outcomes[1]; and

Whereas, street medicine, defined as the direct provision of health care in patients' lived environments, has emerged as an evidence-based, patient-centered model that improves engagement, continuity, and outcomes for people experiencing homelessness, with more than 150 programs operating across the United States[2,3]; and

Whereas, street medicine programs have demonstrated the potential to reduce health care utilization and costs, including reductions in hospital admissions and length of stay among individuals experiencing homelessness[4]; and

Whereas, federal and state policy landscapes are rapidly evolving to recognize and reimburse care delivered outside traditional clinical settings, including federal designation of "non-permanent locations" as reimbursable sites for Medicare and Medicaid services and state Medicaid innovations such as California's AB 543 (2025), creating new opportunities while introducing variability in implementation[5,6]; and

Whereas, significant barriers to access persist, including low Medicaid reimbursement rates, administrative churn due to frequent eligibility redeterminations, delays in enrollment, and work/reporting requirements that disproportionately disrupt coverage for individuals experiencing homelessness, contributing to delayed care and increased acute care utilization[7]; and

Whereas, emerging federal policies, including Medicaid work requirements enacted under H.R.1 (2025), risk further exacerbating coverage instability among this high-risk population; and

Whereas, strategies including presumptive eligibility to facilitate point-of-care enrollment and flexible network access have been shown to improve coverage continuity and access to care for marginalized populations but remain inconsistently implemented and insufficiently aligned with street medicine delivery models[8-9]; and

Whereas, existing AMA policy supports innovative care delivery models, such as street medicine, but does not fully address the evolving reimbursement framework, administrative barriers to Medicaid access, or the need for standardized policies supporting physicians practicing in nontraditional care environments; therefore be it

RESOLVED, that the following American Medical Association (AMA) policy, "Payment for Physicians who Practice Street Medicine H-160.886," be amended by addition to read as follows, and that the title be revised to "Advancing Physician Payment and Medicare and Medicaid Access for Street Medicine":

a. Our American Medical Association supports the development of street medicine programs to increase access to care for populations experiencing homelessness and reduce long-term costs.
b. Our AMA supports the implementation of Medicare and Medicaid payment for street medicine initiatives by advocating for necessary legislative and/or regulatory changes, including submission of a recommendation to the Centers for Medicaid & Medicaid Services asking that it establish a new place-of-service code to support street medicine practices for people eligible for Medicare and/or Medicaid, with "street medicine" defined, in keeping with the Street Medicine Institute, as "the provision of health care directly to people where they are living and sleeping on the streets."
c. Our AMA supports presumptive eligibility and point-of-care Medicaid enrollment for individuals experiencing homelessness, reduced eligibility redeterminations to promote continuous coverage, and access to street medicine services regardless of network assignment.
d. Our AMA supports exemptions or alternative pathways for individuals experiencing homelessness from Medicaid work and reporting requirements, including automatic or data-driven exemptions based on clinical and socioeconomic risk factors.

Fiscal Note: Minimal

REFERENCES

1. Richards J, Kuhn R. Unsheltered Homelessness and Health: A Literature Review. AJPM Focus. 2022;2(1):100043. Published 2022 Oct 29. doi:10.1016/j.focus.2022.100043
2. Withers J. Street medicine: an example of reality-based health care. J Health Care Poor Underserved. 2011;22(1):1-4. doi:10.1353/hpu.2011.0025
3. Hart A. Health care "game-changer"? Feds boost care for homeless Americans. KFF Health News. Published October 18, 2023. Accessed April 6, 2026.
4. USC Street Medicine. About USC Street Medicine. Keck School of Medicine of USC. Accessed April 6, 2026. https://keck.usc.edu/street-medicine/about/
5. https://kffhealthnews.org/news/article/street-medicine-cms-new-reimbursement-code/
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7. Assembly Bill No. 543 (Gonzalez). Medi-Cal: field medicine. 2025–2026 Reg Sess (Cal 2025). Available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202520260AB543
8. Medicaid and CHIP Payment and Access Commission. Effects of Churn on Potentially Preventable Hospital Use. Issue brief. July 2022. https://www.macpac.gov/publication/effects-of-churn-on-potentially-preventable-hospital-use
9. Bradley K, et al. Presumptive Eligibility: Creating a Pathway to Ongoing Medi-Cal Coverage. California Health Care Foundation; October 14, 2022. https://www.chcf.org/wp-content/uploads/2022/10/PresumptiveEligibility.pdf

RELEVANT RFS POSITION STATEMENTS

350.005R Improvement of Care and Resource Allocation for People who are Experiencing Homelessness in the Global Pandemic
That our AMA-RFS support the AMA in supporting training to understand the needs of housing insecure individuals for those who encounter this disenfranchised population through their professional duties; and supporting the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and reaffirming existing policies H-160.903, "Eradicating Homelessness," and H-345.975, "Maintaining Mental Health Services by States," and H-160.978, "The Mentally Ill Homeless", with a title change to "Housing Insecure Individuals with Mental Illness." (Alternate Resolution 11, I-21)

RELEVANT AMA POLICY

Eradicating Homelessness H-160.903

1. Our American Medical Association supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services.
2. Our AMA recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless.
3. Our AMA recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis.
4. Our AMA supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance.
5. Our AMA recognizes the need for an effective, evidence-based national plan to eradicate homelessness.
6. Our AMA encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.
7. Our AMA will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs.
8. Our AMA encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital.
9. Our AMA encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients.
10. Our AMA:
    a. supports laws protecting the civil and human rights of individuals experiencing homelessness, and
    b. opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available.
11. Our AMA recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.
12. Our AMA:
    a. supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties;
    b. supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and
    c. will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.
13. Our AMA encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.

Payment for Physicians who Practice Street Medicine H-160.886

a. Our American Medical Association supports the development of street medicine programs to increase access to care for populations experiencing homelessness and reduce long- term costs.
b. Our AMA supports the implementation of Medicare and Medicaid payment for street medicine initiatives by advocating for necessary legislative and/or regulatory changes, including submission of a recommendation to the Centers for Medicaid & Medicaid Services asking that it establish a new place-of-service code to support street medicine practices for people eligible for Medicare and/or Medicaid, with "street medicine" defined, in keeping with the Street Medicine Institute, as "the provision of health care directly to people where they are living and sleeping on the streets."

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution:5
(A-26)

Introduced by: Ida Vaziri, MD

Subject: Promoting Safety Through Revision of Resident Work Hour Limits

Referred to: Reference Committee

Whereas, resident and fellow duty hour limitations were established to improve patient safety, reduce fatigue-related medical errors, and protect physician well-being by limiting excessive work hours and sleep deprivation[1,2]; and

Whereas, sleep deprivation and fatigue among physicians are associated with impaired cognitive performance, decreased alertness, increased risk of medical errors, and increased risk of occupational and motor vehicle injuries[3,4,5]; and

Whereas, excessive work hours and inadequate recovery time are associated with increased rates of burnout, depression, and suicidal ideation among resident and fellow physicians[6,7]; and

Whereas, current Accreditation Council for Graduate Medical Education (ACGME) duty hour standards limit resident and fellow clinical and educational work hours to 80 hours per week, averaged over a four-week period[2]; and

Whereas, averaging work hours over multiple weeks permits substantial variability in weekly workloads, allowing for periods of excessive work hours and insufficient recovery despite overall compliance with duty hour limits[1]; and

Whereas, extended work hours, prolonged shifts, and increasing weekly work hours are associated with higher rates of medical errors, diagnostic errors, and preventable adverse events in a dose-dependent manner[3,5,8]; and

Whereas, AMA Policy H-310.907 supports limiting resident and fellow work hours to 80 hours per week, averaged over a four-week period; and

Whereas, allowance for averaging work hours over a four-week period undermines the intended patient safety and physician well-being benefits of duty hour limitations[1]; and

Whereas, consistent application of weekly work hour limits does not reduce total allowable training hours but improves the distribution of work to promote safety and recovery[1]; and

Whereas, national expert bodies, including the Institute of Medicine, have recommended limiting excessive and prolonged work hours to reduce fatigue-related harm in healthcare[1]; and

Whereas, the AMA has historically played a critical role in advocating for physician workforce standards and patient safety policies; and

Whereas, eliminating the averaging of work hours would ensure that existing duty hour limits function as intended and better align with evidence on fatigue, patient safety, and physician well-being; therefore be it

RESOLVED, that our American Medical Association (AMA) amend Policy H-310.907 "Resident/Fellow Clinical and Educational Work Hours" by deletion to read as follows:

Our American Medical Association adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:

7. Our AMA supports the following statements related to clinical and educational work hours:
    a. Total clinical and educational work hours must not exceed 80 hours per week~~, averaged over a four-week period~~ (Note: "Total clinical and educational work hours" includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).

Fiscal Note: Minimal

REFERENCES

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2. Accreditation Council for Graduate Medical Education. *ACGME Common Program Requirements (Residency).* Updated 2023. Accessed April 5, 2026. https://www.acgme.org
3. Landrigan CP, Rothschild JM, Cronin JW, et al. Effect of reducing interns' work hours on serious medical errors in intensive care units. *N Engl J Med.* 2004;351(18):1838-1848.
4. Barger LK, Cade BE, Ayas NT, et al. Extended work shifts and the risk of motor vehicle crashes among interns. *N Engl J Med.* 2005;352(2):125-134.
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8. Philibert I. Sleep loss and performance in residents and nonphysicians: a meta-analytic examination. *BMJ.* 2005;331(7515):777.

RELEVANT RFS POSITION STATEMENTS

Resident/Fellow Work and Learning Environment 291.020R
That our AMA-RFS support that our AMA: (1) may draft original, modify existing, or oppose legislation and pursue any regulatory or administrative strategies when dealing with resident work hours and conditions, (2) work with organizations such as the Accreditation Council for Graduate Medical Education (ACGME), the Joint Commission, and other appropriate organizations, toward finding solutions to the problem of work hours and conditions which would strengthen current work hours enforcement mechanisms, and (3) encourage the Agency for Healthcare Research and Quality (AHRQ) to examine the link between resident work hours and patient safety and to explore possible solutions to the problem of work hours and conditions. That our AMA-RFS Governing Council report back to the RFS Assembly at A-02. (Report F, I-01) (Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)

RELEVANT AMA POLICY

Resident/Fellow Clinical and Educational Work Hours H-310.907
Our American Medical Association adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as “duty hours”).
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
    a. Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
    b. Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
    c. Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
    d. Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
    a. Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.
    b. Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
    c. Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
    d. Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to clinical and educational work hours:
    a. Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: “Total clinical and educational work hours” includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
    b. Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers’ patients, or continuity clinic during that time.

c. Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
d. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
e. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”
f. Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
g. Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
h. Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
i. Scheduled time providing patient care services of limited or no educational value should be minimized.
j. Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
k. The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.
l. Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
m. Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
n. The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.
o. The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees’ realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.

8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.
9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

Residents and Fellows' Bill of Rights H-310.912

1. Our American Medical Association continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows:
    a. Adequate financial support for and guaranteed leave to attend professional meetings.
    b. Submission of training verification information to requesting agencies within 30 days of the request.
    c. Adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period.
    d. Health insurance benefits to include dental and vision services.
    e. Paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year.
    f. Stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA:
    a. will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds.
    b. encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement).
    c. encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.

8. Our AMA adopts the following “Residents and Fellows’ Bill of Rights” as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS’ BILL OF RIGHTS
Residents and fellows have a right to

A. An education that fosters professional development, takes priority over service, and leads to independent practice.
   With regard to education, residents and fellows should expect:
   1. A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations;
   2. Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities;
   3. Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value;
   4. 24-hour per day access to information resources to educate themselves further about appropriate patient care; and
   5. Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.
   With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
   With regard to evaluation and assessment processes, residents and fellows should expect:
   1. Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work;
   2. To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion;
   3. Access to their training file and to be made aware of the contents of their file on an annual basis; and
   4. Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.
   With regard to the workplace, residents and fellows should have access to:
   1. A safe workplace that enables them to fulfill their clinical duties and educational obligations;

2. Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit;
3. Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.
   1. With regard to contracts, residents and fellows should receive:
      a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance.
      b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
   2. With regard to compensation, residents and fellows should receive:
      a. Compensation for time at orientation.
      b. Compensation, including salary and benefits, commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
   3. With regard to benefits, residents and fellows must be fully informed of and should receive:
      a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program.
      b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues.
      c. Confidential access to mental health and substance abuse services.
      d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks.
      e. Leave in compliance with the Family and Medical Leave Act.
      f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
   With regard to clinical and educational work hours, residents and fellows should experience:
   1. A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME.
   2. At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.

G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations
With regard to reporting violations to the ACGME, residents and fellows should:
    1. Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official.
    2. Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process.
    3. Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.
10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).
11. The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.
12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles, including resident/fellow empowerment and peer-selected representation in institutional leadership.
13. Our AMA encourages development of accreditation standards and institutional policies designed to facilitate and protect residents/fellows who seek to exercise their rights.
14. Our AMA encourages the formation of peer-led resident/fellow organizations that can advocate for trainees' interests, as outlined by the AMA's Residents and Fellows' Bill of Rights, at sponsoring institutions.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 6
(A-26)

Introduced by: Joely Hannan, MD

Subject: Recognition of Moral Injury in the Physician Workforce

Referred to: Reference Committee

Whereas, moral injury describes the psychological wounds sustained by physicians when systemic constraints force them to provide care they know to be inadequate, inequitable, or harmful[1–2]; and

Whereas, moral injury is distinct from burnout; burnout comprises emotional exhaustion, depersonalization, and diminished personal accomplishment attributed to demand-resource mismatches, while moral injury reflects systemic and institutional failures that produce guilt, shame, loss of meaning, and erosion of professional identity when physicians cannot deliver care aligned with their ethical and medical obligations[2–4]; and

Whereas, distinguishing moral injury from burnout is valuable because individual-level burnout interventions such as resilience training, mindfulness, and wellness initiatives have been ineffective at meaningfully addressing physician distress, as moral injury requires systemic solutions that address the organizational and policy conditions generating moral conflicts[5–6]; and

Whereas, the 2025 Physicians for a National Health Program (PNHP) survey found that nearly 50% of practicing physicians often or always felt unable to provide optimal care due to inadequate time or insurance barriers[7]; and

Whereas, the PNHP report further identified that systemic contributors to moral injury include prior authorization requirements, coverage denials, productivity quotas, excessive documentation, and the financialization of healthcare, which obstruct timely, evidence-based, patient-centered care[7]; and

Whereas, moral injury contributes to physician workforce attrition, with 25% of PNHP surveyed physicians currently considering leaving a position due to moral distress and 27% having already left a position for this reason, and a 2021 AMA survey found that one-in-five physicians were planning to retire within two years[7,9]; and

Whereas, moral injury also impacts medical students and residents, with 25% of medical students in the United States considering quitting their studies, and structural sources of moral injury may differ across medical students, residents, fellows, and practicing physicians, such as medical students having ample time to learn about their patients social determinants of health but realizing resources are not available to address these needs, residents studying the most evidence based intervention but finding it inaccessible based on payor status, or attendings spending more time handling authorizations than with their patients; warranting further investigation across all career stages[7,10]; and

Whereas, the 2024 AMA Prior Authorization Physician Survey found that nearly all physicians encountered adverse effects from prior authorization, with 29% reporting that prior authorization has led to a serious adverse event[11]; therefore be it

RESOLVED, that our American Medical Association (AMA) defines moral injury as the harm that occurs when healthcare professionals are compelled by systemic constraints to act in ways that transgress their moral beliefs and professional obligations, including the inability to deliver evidence-based, equitable, and patient-centered care due to institutional, financial, or administrative barriers; and be it further

RESOLVED, that our AMA recognizes moral injury as a distinct and significant threat to the wellbeing of medical students, residents, and physicians; and be it further

RESOLVED, that our AMA study the prevalence, drivers, and impact of moral injury across the continuum of medical training and practice, including medical students, residents, and practicing physicians, and report back with recommendations for systemic interventions.

Fiscal Note: Modest

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RELEVANT RFS POSITION STATEMENTS

Recognizing Moral Injury in Medicine as a Phenomenon Distinct from Burnout 291.038R
That our AMA-RFS study ways to mitigate the effects of moral injury and/or burnout amongst medical students, residents, fellows, and other trainees in the US. (Alternate Resolution 5, I-23); That our AMA-RFS recognizes that moral injury plays a significant role in the development of a physician and trainee burnout. (Report H, A-24)

Intern and Resident Burnout 291.015R
That our AMA-RFS support studying resident burnout to determine: (1) if recommendations can be made on how to recognize burnout, how to treat it, and, if possible, how to prevent it; (2) if it relates to the professionalism core competency for residents; and (3) if recognizing, treating, and possibly preventing burnout could be included in the program requirements for residency program directors. (Resolution 3, A-06) (Reaffirmed Report D, I-16) (Reaffirmed Report H, A-24)

Strategies to Reduce Burnout in Medical Trainees 291.036R

That AMA-RFS policy Intern and Resident Burnout 291.015R be reaffirmed. (Resolution 8, I-18) (Reaffirmed Report H, A-24)

RELEVANT AMA POLICY

Physician and Medical Student Burnout D-310.968

1. Our American Medical Association recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.\
9. Our AMA will continue to:
   a. address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient workflows and regulatory oversight.
   b. develop and promote mechanisms by which physicians in all practice settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.
10. Our AMA supports physicians who are caregivers to alleviate physician burnout.

Programs on Managing Physician Stress and Burnout H-405.957

1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.

Peer Support Groups for Second Victims D-405.980

Our AMA: (1) encourages institutional, local, and state physician wellness programs to consider developing voluntary, confidential, and non-discoverable peer support groups to address the “second victim phenomenon”; and (2) will work with other interested organizations to encourage that any future surveys of physician **burnout** should incorporate questions about the prevalence and potential impact of the “second victim phenomenon” on our physician workforce.

Physician Burnout D-405.972

1. Our American Medical Association will work with Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians.
2. Our AMA will work with hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications.

Curricular Structure Reform to Support Physician and Trainee Well-Being H-295.838

1. Our AMA promotes a systems approach to student well-being and support research into the impact (beneficial or deleterious) of various educational structures and processes, including but not limited to, the use of third-party resources and distance learning, upon learner well-being, self-efficacy, and the skills needed to become a practicing physician.
2. Our AMA discourages burnout prevention programs that impose inflexible requirements, additional time burdens on physicians, residents, fellows, and medical students, mandatory assignments, or punitive measures, except where required by law.
3. Our AMA supports evidence-based burnout prevention programs that allow for voluntary participation, options to complete any expectations or activities flexibly, and recognize the importance of personal time for burnout prevention and wellbeing while maintaining the core pedagogy of medical training.
4. Our AMA encourages funding entities and training programs to support the implementation of evidence-based evaluation strategies for the ongoing assessment and improvement of burnout prevention programs.

Factors Causing Burnout H-405.948

Our American Medical Association recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to **burnout** during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 7
(A-26)

Introduced by: Dayna Isaacs, MD, MPH

Subject: Eliminating Tax Barriers to Equitable Clinical Trial Participation

Referred to: Reference Committee

Whereas, clinical trials are essential to advancing medical knowledge, improving patient outcomes, and ensuring equitable as well as timely access to innovative therapies; and

Whereas, trial participants may receive modest financial compensation intended to offset the burdens of participation, including transportation, time away from work, childcare, and other incidental costs, and the limited duration of a trial prevents participation from being considered regular;[1] and

Whereas, these payments are generally modest (typically small, fixed stipends or reimbursements that offset time, travel, childcare, and other incidental costs associated with research participation), and are not intended to provide financial gain, constitute wages, or function as a primary source of income; rather, they are designed to reduce participation burden and facilitate equitable enrollment, yet are currently treated as taxable income under the Internal Revenue Code's broad definition of "gross income" as "all income from whatever source derived;"[2] and

Whereas, the classification of clinical trial compensation as taxable income creates an often-overlooked structural barrier to participation, particularly among historically marginalized populations, and may deter or prevent enrollment; and

Whereas, prospective data demonstrate that patients with lower annual household income are significantly less likely to participate in cancer clinical trials, with those earning less than $50,000 annually having approximately 32% lower odds of participation compared to higher-income patients, highlighting the impact of financial barriers on equitable trial access;[3] and

Whereas, individuals from low-income backgrounds and those receiving public assistance (e.g., Medicaid, Supplemental Security Income, Supplemental Nutrition Assistance Program) face disproportionate harm, as additional reportable income can jeopardize eligibility for essential benefits tied to income thresholds;[4] and

Whereas, existing federal policy (e.g., the Ensuring Access to Clinical Trials Act of 2015) provides only limited and narrowly defined income exclusions, which are insufficient to prevent loss of benefits or meaningfully mitigate participation barriers;[5] and

Whereas, financial disincentives, including taxation, contribute to persistent underrepresentation of historically marginalized populations in clinical trials, undermining the generalizability, equity, and scientific validity of clinical research;[6] and

Whereas, compensation for clinical trial participation is distinct from earned income and should be considered reimbursement or burden-offset support rather than taxable wages; and

Whereas, the taxation of clinical trial-related compensation imposes a disproportionate financial burden on low- and middle-income individuals, thereby exacerbating existing inequities and serving as a structural barrier to equitable participation in clinical research; therefore be it

RESOLVED, that our American Medical Association (AMA) support exempting clinical trial participant compensation from taxable income and public assistance eligibility determinations, recognizing such payments as reimbursement rather than wages, to promote equitable participation in clinical research.

Fiscal Note: Minimal

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RELEVANT RFS POSITION STATEMENTS

350.007R Increasing Minoritized and Historically Marginalized Group Participation in Clinical Research

That our AMA-RFS support our AMA in amending H-460.911, Increasing Minority Participation in Clinical Research, by addition and deletion to read as follows:

Increasing ~~Minority~~ Minoritized and Historically Marginalized Participation in Clinical Research H-460.911

1. Our AMA advocates that:

a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and historically minoritized populations are ~~minorities~~ is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.

b. The FDA have a page on its web site that details the prevalence of historically minoritized populations ~~minorities~~ and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and

c. Resources be provided to community level agencies that work with historically minoritized populations ~~those minorities~~ who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These historically minoritized populations ~~minorities~~ include African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and American Indian/Alaska Natives ~~Native Americans~~.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of historically minoritized populations ~~minorities~~ in clinical trials:

a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs;

b. Increased outreach to ~~female~~ all physicians to encourage recruitment of ~~female~~ patients from underrepresented groups in clinical trials;

c. Continued ~~minority physician~~ education for all physicians and physicians-in-training on clinical trials, subject recruitment, subject safety, and possible expense reimbursements, and that this education encompass discussion of barriers that currently constrain appropriate recruitment of underrepresented groups and methods for increasing trial accessibility for patients;

d. Support for the involvement of historically minoritized ~~minority~~ physicians in the development of partnerships between minority communities and research institutions; and

e. Fiscal support for minority and underrepresented group recruitment efforts and increasing trial accessibility through optimized patient-centered locations for accessing trials, the ready availability of transportation to and from trial locations, child care services, and ~~transportation, child care,~~ reimbursements~~, and location~~. (Alternate Resolution 2, I-22)

RELEVANT AMA POLICY

Supporting Diversity in Research H-460.875

1. Our American Medical Association supports the use of language interpreters and translators at no cost to individual physicians or practices in clinical trials and health research participation to promote equitable data collection and outcomes.
2. Our AMA encourages Institutional and Research Review Boards (IRBs) to develop and publish standardized guidelines for interpreter services to ensure appropriate enrollment and ongoing participation of clinical research participants with Limited English Proficiency and Deaf or Hard of Hearing people.
3. Our AMA encourages Institutional and Research Review Boards (IRBs) to develop and publish transparent guidelines for improving the diversity of research participants, including:
    a. that eligibility criteria be as inclusive as possible; and
    b. that written justification for exclusion be provided for review; and
    c. that additional accommodations for potential enrollees be considered.
4. Our AMA supports greater inclusion in clinical trials and health research of all peoples and groups that are underrepresented or excluded from such research to promote greater study generalization, health equity, and justice.
5. Our AMA supports community-centered engagement before, during, and after clinical trials and health research to foster and sustain public trust in medicine and science.
6. Our AMA encourages that all study protocols involving human research participants include appropriate funding to support the inclusion of underrepresented and excluded populations.

Increasing Diversity in Stem Cell Biobanks and Disease Models H-460.881

1. Our American Medical Association encourages research institutions and stakeholders to re-evaluate recruitment strategies and materials to encourage participation by underrepresented populations.
2. Our AMA strongly encourages institutional biobanks to collect racially and ethnically diverse samples such that future induced pluripotent stem cell disease models better represent the population.

Sex and Gender Differences in Medical Research H-525.988

Our AMA:
(1) reaffirms that gender and sex exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;
(2) affirms the need to include people of all sexes and gender identities and expressions in studies that involve the health of society at large and publicize its policies;
(3) supports increased funding into areas of women's health and sexual and gender minority health research;
(4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minority communities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minority individuals from diverse cultural and ethnic groups, geographic locations, and socioeconomic status;
(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative; and
(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minority individuals;
(7) supports the FDA’s requirement of actionable clinical trial diversity action plans from drug and device sponsors that include women and sexual and gender minority populations;
(8) supports the FDA's efforts in conditioning drug and device approvals on post-marketing studies which evaluate the efficacy and safety of those products in women and sexual and gender minority populations when those groups were not adequately represented in clinical trials; and

(9) supports and encourages the National Institutes of Health and other grant-making entities to fund post-market research investigating pharmacodynamics and pharmacokinetics for generic drugs that did not adequately enroll women and sexual and gender minority populations in their clinical trials, prioritizing instances when those populations represent a significant portion of patients or reported adverse drug events.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 8
(A-26)

Introduced by: Anthony Sean de Leon, MD, Rosalynn R.Z. Conic, MD, Parul Chhatpar, DO, MPH

Subject: FDA Regulation of Unapproved Synthetic Peptides

Referred to: Reference Committee

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

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

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

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

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

Whereas, the Food and Drug Administration (FDA) evaluates bulk drug substances, including peptides, that may be used in compounding under Section 503A and 503B of the Federal Food, Drug, and Cosmetic Act based on safety and clinical need, and has historically restricted or excluded certain synthetic peptide compounds from inclusion on this list due to safety concerns in human use; and

Whereas, in 2023 the FDA identified 19 synthetic peptide compounds as ineligible for use in compounding pharmacies[9]; and

Whereas, the Secretary of Health and Human Services announced that 14 of these peptides will be reclassified as eligible for use in licensed compounding pharmacies, and has set a FDA panel meeting in July 2026 to do so[10,11]; and

Whereas, adverse events associated with unapproved synthetic peptides remain underreported due to a lack of standardized surveillance, fragmented sourcing, and limited clinician awareness; and

Whereas, the chemical variability, contamination risk, and lack of Good Manufacturing Practice (GMP) oversight in many compounded or imported peptide products introduce significant risks including dosing inconsistency, immunogenic reactions, and unknown long-term effects; and

Whereas, the marketing of unapproved synthetic peptides frequently occurs through direct-to-consumer platforms and social media channels, often bypassing traditional medical oversight and contributing to misinformation regarding safety and efficacy[12]; and

Whereas, physicians and healthcare professionals may face increasing pressure from patients to prescribe or endorse unapproved peptide therapies despite insufficient evidence; and

Whereas, our American Medical Association (AMA) has created policy for specific emerging substances of concern (e.g., for kratom), for working with the FDA to "appropriately oversee the dietary supplement sector" and for advising that the marketing of supplements be clear ["dietary supplement product…cannot be confused with pharmaceutical products"]; therefore be it

RESOLVED, that our American Medical Association (AMA) supports appropriate FDA oversight of synthetic peptides, recommending that unapproved synthetic peptide products undergo regulatory review, third-party testing, and demonstration of safety and efficacy through well-conducted clinical trials before marketing or clinical use; and be it further

RESOLVED, that this resolution be immediately forwarded to the AMA House of Delegates at the 2026 Annual Meeting.

Fiscal Note: Minimal

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RELEVANT RFS POSITION STATEMENTS:

80.005R Regulation of Herbal Preparations: That our AMA-RFS support modification of the Dietary Supplement Health and Education Act (DSHEA) to require that dietary supplements, in order to be marketed: (1) undergo Food and Drug Administration (FDA) pre-approval for evidence of safety; (2) meet criteria established by the United States Pharmacopoeia (USP) for dosage, quality, purity, packaging, and labeling; (3) meet FDA post-marketing requirements to report adverse side effects, including drug interactions and that the AMA encourage efficacy studies on dietary supplements. (Substitute Resolution 11, I-98; Reaffirmed Report D, I-16)

RELEVANT AMA POLICY:

Herbal Products and Drug Interactions D-150.991
Our AMA supports the Food and Drug Administration's efforts to create a publicly accessible database of adverse event and drug interaction information on dietary supplements.
[Citation: Sub. Res. 518, A-04; Modified: CSAPH Rep. 1, A-14; Reaffirmation: A-19; Reaffirmed: CSAPH Rep. 3, I-20]

Regulate Kratom and Ban Over-The-Counter Sales H-95.903
1. Our American Medical Association recommends the safety and efficacy of kratom should be determined through research and clinical trials, and subsequently evaluated by the relevant regulatory entities for its appropriateness for sale and potential oversight via the Controlled Substances Act, before it can be marketed, purchased, or prescribed.
2. Our AMA recommends individuals who are currently using kratom for pain management or other conditions should have access to appropriate medical care to manage their conditions and withdrawal symptoms, if needed.
3. Our AMA recommends individuals who are using kratom only for personal use should not face criminal consequences.
4. Our AMA recommends Kratom should be regulated by the FDA, and its safety and efficacy should be determined through clinical trials before it can be marketed or prescribed as a treatment for any condition.

[Citation: Res. 515, A-23]

Quantitative Labeling of All Drugs H-115.998
The AMA supports efforts to promote the qualitative labeling of all drugs and dietary supplements, requiring both active and inactive ingredients of over-the-counter and prescription drugs and dietary supplements to be listed on the manufacturer's label or package insert.
[Citation: Res. 96, A-84; Reaffirmed by CLRPD Rep. 3 - I-19; BOT Rep. 1, A-95; Reaffirmed: CSA Rep. 8, A-05; Modified: Sub. Res. 504, A-10; Reaffirmation: A-19]

Advertising for Herbal Supplements H-150.946
It is AMA policy that the naming, packaging, and advertising of dietary supplement products be such that they cannot be confused with pharmaceutical products. [Citation: Sub. Res. 504, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmation: A-19]

Dietary Supplements and Herbal Remedies H-150.954
(1) Our AMA supports efforts to enhance U.S. Food and Drug Administration (FDA) resources, particularly to the Office of Dietary Supplement Programs, to appropriately oversee the growing dietary supplement sector and adequately increase inspections of dietary supplement manufacturing facilities.
(2) Our AMA supports the FDA having appropriate enforcement tools and policies related to dietary supplements, which may include mandatory recall and related authorities over products that are marketed as dietary supplements but contain drugs or drug analogues, the utilization of risk-based inspections for dietary supplement manufacturing facilities, and the strengthening of adverse event reporting systems.
(3) Our AMA supports continued research related to the efficacy, safety, and long-term effects of dietary supplement products.
(4) Our AMA will work with the FDA to educate physicians and the public about FDA's Safety Reporting Portal (SRP) and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.
(5) Our AMA strongly urges physicians to inquire about patients' use of dietary supplements and engage in risk-based conversations with them about dietary supplement product use.

(6) Our AMA continues to strongly urge Congress to modify and modernize the Dietary Supplement Health and Education Act to require that:

a. dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy;
b. dietary supplements meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling;
c. FDA establish a mandatory product listing regime that includes a unique identifier for each product (such as a QR code), the ability to identify and track all products produced by manufacturers who have received warning letters from the FDA, and FDA authorities to decline to add labels to the database if the label lists a prohibited ingredient or new dietary ingredient for which no evidence of safety exists or for products which have reports of undisclosed ingredients; and
d. regulations related to new dietary ingredients (NDI) are clarified to foster the timely submission of NDI notifications and compliance regarding NDIs by manufacturers.

(7) Our AMA supports FDA postmarketing requirements for manufacturers to report adverse events, including drug interactions; and legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement.

(8) Our AMA will work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements and supports adequate funding and resources for FTC enforcement of violations of the FTC Act.

(9) Our AMA strongly urges that criteria for the rigor of scientific evidence needed to support a structure/function claim on a dietary supplement be established by the FDA and minimally include requirements for robust human studies supporting the claim.

10) Our AMA strongly urges dietary supplement manufacturers and distributors to clearly label all products with truthful and not misleading information and for the product labeling to:

a. not include structure/function claims that are not supported by evidence from robust human studies;
b. not contain prohibited disease claims;
c. eliminate “proprietary blends” and list and accurately quantify all ingredients contained in the product;
d. require advisory statements regarding potential supplement-drug and supplement-laboratory interactions and risks associated with overuse and special populations; and
e. include accurate and useful disclosure of ingredient measurement.

(11) Our AMA supports and encourages the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies.

(12) Our AMA urges that in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label.

(13) Our AMA will continue its efforts to educate patients and physicians about the risks associated with the use of dietary supplements and herbal remedies and supports efforts to increase patient, healthcare practitioner, and retailer awareness of resources to help patients select quality supplements, including educational efforts to build label literacy.

[Citation: Res. 513, I-98; Reaffirmed: Res. 515, A-99; Amended: Res. 501 & Reaffirmation I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 516, I-00; Modified: Sub. Res. 516, I-00; Reaffirmed: Sub Res. 518, A-04; Reaffirmed: Sub. Res. 405, A-05; Reaffirmation A-05; Reaffirmed in lieu of Res. 520, A-05; Reaffirmation I-09; Reaffirmed in lieu of Res. 501, A-10; Reaffirmation A-11; Reaffirmation I-14; Modified: Res. 511, A-16; Reaffirmation: A-17; Reaffirmation: A-19; Modified: CSAPH Rep. 3, I-20; Reaffirmed: Res. 510, A-24]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 9
(A-26)

Introduced by: Dayna Isaacs, MD, MPH, Anthony Sean de Leon, MD, Neil Rens, MD, MBA, MSc, Elana Sitnik, MD, Oladimeji Lanade, MD, Zachary Dunton, MD, MPH

Subject: Ensuring Affordable Coverage: Opposing HSAs as a Substitute for Comprehensive Health Insurance

Referred to: Reference Committee

Whereas, a Health Savings Account (HSA) is a tax-advantaged savings vehicle used to pay for qualified medical expenses, traditionally paired with high-deductible health plans (HDHPs); and

Whereas, HSAs are often framed as tools that empower patients, yet their triple tax advantages (tax-deductible contributions, tax-free growth, and tax-free withdrawals) overwhelmingly benefit higher-income individuals who have the disposable income to contribute and have higher marginal tax rates, thereby rendering HSAs inherently regressive; and

Whereas, HDHP-HSA arrangements shift financial risk from insurers onto patients, especially harming low-income individuals who are least able to absorb high upfront costs and healthcare-induced financial shocks; and

Whereas, data from the U.S. National Health Interview Survey (2007-2018) demonstrate that Hispanic and Black individuals enrolled in HDHPs were significantly less likely than non-Hispanic White enrollees to have a HSA, a disparity that persisted over time,[1] and further studies corroborate that HSAs exacerbate existing inequities and widen racial and socioeconomic gaps in access to care[2]; and

Whereas, low-income patients enrolled in HDHP-HSA plans frequently delay or forgo essential medical care including preventive care because they cannot meet the high deductible, leading to worsened health outcomes and long-term economic costs[3]; and

Whereas, patients with chronic conditions face disproportionately adverse consequences under HDHPs, including higher rates of preventable complications compared with those in traditional insurance plans, and patients with HDHPs also experience worse overall and cancer-specific survival among cancer survivors, findings associated with cost-related treatment delays, financial stress, and care avoidance[4,5]; and

Whereas, HSAs cannot replace comprehensive health insurance coverage, and proposals to substitute HSAs for insurance subsidies, such as ACA premium tax credits, would further entrench inequities; and

Whereas, shifting healthier, higher-income individuals into HSA-qualified HDHPs may siphon them out of more comprehensive risk pools, driving up premiums for sicker and lower-income patients who remain and contributing to adverse selection, a phenomenon further reinforced by evidence that healthier individuals are more likely to enroll in and remain in HSA-eligible plans while individuals with greater health needs are more likely to disenroll[6]; therefore be it

RESOLVED, that our AMA-RFS recognize that Health Savings Accounts (HSAs), even when paired with insurance plans, are inherently regressive and frequently result in underinsurance, thereby exacerbating health inequities; and be it further

RESOLVED, that our AMA-RFS oppose the use of HSAs as a substitute for health insurance coverage or affordability mechanisms such as premium tax credits.

Fiscal Note: Minimal

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RELEVANT AMA POLICY

Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans D-165.954
Our AMA will: (1) educate physicians about health insurance plan practices that may impact physician billing and collection of payment from patients with health savings accounts (HSAs), health reimbursement arrangements (HRAs), and other forms of consumer-driven health care; and (2) monitor and support rigorous research on the impact of HSAs and HRAs on physician practices, and on levels and appropriateness of utilization, including preventive care, costs, and account savings. [CMS Rep. 3, I-05; Modified: CMS Rep. 1, A-15; Reaffirmed: CMS Rep. 01, A-25]

Health Savings Accounts for Older Americans D-165.962
Our AMA will monitor pending regulations and take appropriate steps to ensure access to Health Savings Accounts by all Medicare eligible individuals. [Sub. Res. 702, A-04; Reaffirmation A-10; Reaffirmed: BOT Rep. 04, A-20]

Aligning Clinical and Financial Incentives for High-Value Care D-185.979
1. Our American Medical Association supports Value-Based Insurance Design (VBID) plans designed in accordance with the tenets of “clinical nuance,” recognizing that
    a. medical services may differ in the amount of health produced.
    b. the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided.
2. Our AMA supports initiatives that align provider-facing financial incentives created through payment reform and patient-facing financial incentives created through benefit design reform, to ensure that patient, provider, and payer incentives all promote the same quality care. Such initiatives may include reducing patient cost-sharing for the items and services that are tied to provider quality metrics.
3. Our AMA will develop coding guidance tools to help providers appropriately bill for zero-dollar preventive interventions and promote common understanding among health care providers, payers, patients, and health care information technology vendors regarding what will be covered at given cost-sharing levels.
4. Our AMA will develop physician educational tools that prepare physicians for conversations with their patients about the scope of preventive services provided without cost-sharing and instances where and when preventive services may result in financial obligations for the patient.

5. Our AMA will continue to support requiring private health plans to provide coverage for evidence-based preventive services without imposing cost-sharing (such as co-payments, deductibles, or coinsurance) on patients.
6. Our AMA will continue to support implementing innovative VBID programs in Medicare Advantage plans.
7. Our AMA supports legislative and regulatory flexibility to accommodate VBID that
    a. preserves health plan coverage without patient cost-sharing for evidence-based preventive services.
    b. allows innovations that expand access to affordable care, including changes needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide pre-deductible coverage for preventive and chronic care management services.
8. Our AMA encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services. [Joint CMS CSAPH Rep. 01, I-18; Reaffirmed: CMS Rep. 06, A-19; Reaffirmed in lieu of: Res. 101, A-19; Reaffirmed: CMS Rep. 2, I-20; Reaffirmation: A-22; Reaffirmed: Res. 219, I-25]

Transparency of Employer Sponsored Health Insurance H-155.961
Our AMA encourages employers to inform employees as frequently as possible, preferably with each payment period (pay stub) but at least annually, of the total cost of health insurance benefits paid on their behalf by the employer in the form of health insurance premiums, direct payments for services and deposits into health savings accounts. [Res. 127, A-07; Reaffirmed: CMS Rep. 01, A-17]

Health Savings Account Reform H-165.818
1. Our American Medical Association supports permitting health savings account (HSA) contributions from family members, employers, or other designated individuals and not limiting HSA contributions to the owner of the high-deductible health plan, provided that annual Internal Revenue Service contribution limits are not exceeded.
2. Our AMA supports contributions to HSAs by individuals who are Medicare enrollees with support for external research and/or demonstration projects to determine how best those distributions can be spent, with special consideration for low-resource Medicare enrollees.
3. Our AMA supports external research and/or demonstration projects on the feasibility and tax integrity of transferring HSA funds between spouses and other family members.
4. Our AMA supports Affordable Care Act (ACA) premium tax credits designed to allow individuals to contribute to HSAs through the application of unused or residual credit amounts.
5. Our AMA supports education on the use of HSAs to Medicare beneficiaries and purchasers of ACA marketplace plans, including those purchasing bronze plans and how that plan compares to purchasing a silver plan with subsidies.
6. Our AMA supports the principle that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability of health insurance such as ACA premium tax credits. [CMS Rep. 01, I-25]

Health Insurance Affordability H-165.828
1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage and household income.
3. Our AMA
    a. encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy; and

   b. supports individual market bronze and silver plans, regardless of actual deductible amount, being treated as HSA-qualified high-deductible health plans, with appropriate guardrails in place (e.g., safe harbor provisions) to ensure low-income enrollees in these plans do not suffer financial hardships.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.
6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace.
9. Our AMA supports that the ACA eligibility firewall not apply to individuals offered employer-sponsored coverage whose household incomes are at or below 200 percent of the federal poverty level, so they can receive federal premium tax credits and cost-sharing assistance if they opt to enroll in a marketplace health plan as an affordable alternative to their employer-based plan.
10. Our AMA supports incrementally lifting the ESI firewall with continual monitoring and consideration of insurance marketplace stability, if and only if there is documentation that marketplace insurance pays sufficiently to ensure physician practice sustainability, and other relevant parameters, with the goal of maximizing the number of individuals able to freely choose the health insurance plan that is best for themselves and their families.
11. Our AMA supports any incremental lifting of the firewall must be paired with a pause to review the relevant parameters, and the ability to pause permanently, or reverse if disruptive effects are detected.
12. Our AMA advocates that physician payments by health insurers participating in the ACA marketplace be sustainable, reflect the full cost of practice and the value of the care provided, include inflation-based updates, and pay fair and equitable rates. [CMS Rep. 8, I-15 Reaffirmed in lieu of: Res. 121, A-16; Reaffirmation: A-17; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed in lieu of: Res. 101, A-19; Reaffirmed: CMS Rep. 01, I-20; Reaffirmed: CMS Rep. 2, I-20; Modified: CMS Rep. 3, I-21; Appended: Res. 701, I-21; Reaffirmed: Res. 826, I-24; Appended: CMS Rep. 02, A-25; Modified: CMS Rep. 01, I-25]

Amend the Patient Protection and Affordable Care Act (PPACA) H-165.833

1. Our AMA continues to advocate to achieve needed reforms of the many defects of the federal Patient Protection and Affordable Care Act (PPACA) law so as to protect the primacy of the physician-patient relationship. These needed changes include but are not limited to:
   a. repeal of the Independent Payment Advisory Board (IPAB);
   b. study of the Medicare Cost/Quality Index;
   c. repeal of the non-physician provider non-discrimination provision;
   d. enactment of comprehensive medical liability reform;
   e. enactment of long term Medicare physician payment reform including permitting patients to privately contract with physicians not participating in the Medicare program;
   f. enactment of antitrust reform to permit independently practicing physicians to collectively negotiate with health insurance companies; and
   g. expanding the use of health savings accounts as a means to provide health insurance coverage.
2. Our AMA will vigorously work to change the PPACA to accurately represent our AMA Policy. [Res. 217, A-11; Reaffirmation A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed in lieu of Res. 215, A-15; Reaffirmed: Res. 206, A-19; Reaffirmed: CMS Rep. 01, I-25; Reaffirmed: CMS Rep. 01, I-25]

Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans H-165.849

1. Our AMA opposes health plan requirements that require physicians to bill patients for out-of-pocket payments and do not allow physicians to collect these payments in a more efficient manner, such as collecting at point-of-service, establishing systems of electronic transfers from a patient's account, or offering cash discounts for expedited payment, particularly for patients enrolled in health savings accounts (HSAs), health reimbursement arrangements (HRAs), and other consumer-directed health care plans.
2. Our AMA will engage in a dialogue with health plan representatives (e.g., America‟s Health Insurance Plans, Blue Cross and Blue Shield Association) about the increasing difficulty faced by physician practices in collecting co-payments and deductibles from patients enrolled in high-deductible health plans. [CMS Rep. 3, I-05; Reaffirmed: CMS Rep. 1, A-15; Appended: BOT Action in response to referred for decision Res. 805, I-16; Reaffirmed: CMS Rep. 09, A-19]

Health Savings Accounts H-165.852

It is the policy of the AMA that:

1. high-deductible health insurance plans issued to families in conjunction with Health Savings Accounts (HSAs) be allowed to apply lower, per-person deductibles to individual family members with the permitted levels for per-person deductibles being the same as permitted levels for individual deductibles, and with the annual HSA account contribution limit being determined by the full family deductible or the dollar-limit for family policies;
2. contributions to HSAs should be allowed to continue to be tax deductible until legislation is enacted to replace the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families;
3. advocacy of HSAs continues to be incorporated prominently in its campaign for health insurance market reform;
4. activities to educate patients about the advantages and opportunities of HSAs be enhanced;
5. efforts by companies to develop, package, and market innovative products built around HSAs continue to be monitored and encouraged;
6. HSAs continue to be promoted and offered to AMA physicians through its own medical insurance programs; and
7. legislation promoting the establishment and the use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health, dental, vision, hearing, and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance. [CMS Rep. 11 - I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 5 and 7, I-99; CMS Rep. 10, I-99; Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed Res. 109 & Reaffirmation A-01; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation A-02; CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; CMS Rep. 6, A-04; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-10; Reaffirmed: CMS Rep. 2, A-11; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed: CMS Rep. 05, A-18; Modified: CMS Rep. 01, I-25]

Flexible Spending Accounts (FSAs) H-165.863

1. Along with other efforts to liberalize the Health Savings Account rules, our AMA places a top priority on allowing employees to roll-over any unexpended funds in a Flexible Spending Account into a Health Savings Account.
2. Our AMA will advocate for a reasonable increase in Section 125 Flex Spending accounts. [Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 5 and 7, I-99; Appended by Res. 220, A-00; Reaffirmation I-00; Res. 120, A-01; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Appended: Res. 121, A-15; Modified: CMS Rep. 1, A-15; Reaffirmed: CMS Rep. 01, A-25]

Principles for Structuring a Health Insurance Tax Credit H-165.865

1. AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits will be guided by the following principles:
    a. Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided.
    b. Tax credits should be refundable.
    c. The size of tax credits should be inversely related to income.
    d. The size of tax credits should be large enough to ensure that health insurance is affordable for most people.
    e. The size of tax credits should be capped in any given year.
    f. Tax credits should be fixed-dollar amounts for a given income and family structure.
    g. The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums.
    h. Tax credits for families should be contingent on each member of the family having health insurance.
    i. Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Health Savings Account, and not for out-of-pocket health expenditures.
    j. Tax credits should be advanceable for low-income persons who could not afford the monthly out-of-pocket premium costs.
2. It is the policy of our AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States Code.
3. Our AMA will support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance. [CMS Rep. 4, A-00; CMS Rep. 5, A-00; Reaffirmation I-00; Reaffirmation A-02; Reaffirmation I-03; CMS Rep. 2, A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmed in lieu of Res. 813, I-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed: CMS Rep. 01, A-24]

Health Savings Accounts in the Medicaid Program H-290.972
It is the policy of our AMA that states offering Medicaid beneficiaries Health Savings Accounts (HSAs) should adhere to the following principles:

A. Make beneficiary participation voluntary;
B. Provide first-dollar coverage of preventive services regardless of whether the beneficiary has met the deductible;
C. Offer positive incentives to reward healthy behavior and offset beneficiary cost-sharing, provided that such incentives do not result in punitive cuts in standard benefits or increased cost-sharing to enrollees who are unable to achieve improvements in personal behavior affecting their health;
D. Set deductibles at 100% of account contributions, but no higher;
E. Allow payments to non-Medicaid providers by beneficiaries to count toward deductibles and out-of-pocket spending limits;
F. Allow the deductible limits for families to be the lower of either the individual or family combined deductible;
G. Ensure that enrollees are protected by standard Medicaid maximum out-of-pocket spending limits;
H. Provide outreach, information, and decision-support that is readily accessible through a variety of formats (e.g., written, telephone, online), and in multiple languages;
I. Encourage HSA enrollees to establish a medical home, in order to assure provision of preventive care services, coordination of care and continuity of care;
J. Prohibit use of HSA funds for non-medical purposes, but consider allowing HSA balances of enrollees who lose Medicaid coverage to be used to purchase private insurance, including the employee share of premium for employer-sponsored coverage;
K. Monitor the impact on utilization and beneficiary financial burden;
L. Test broadening of eligibility to include currently ineligible beneficiary groups; and

M. Ensure that physicians and other providers of health care services have access to up-to-date information verifying beneficiary enrollment and covered benefits, and are paid at point-of-service, or are allowed to use their standard billing procedures to obtain payment from the insurer or account custodian. [CMS Rep. 1, I-06Modified: CMS Rep. 01, A-16; Reaffirmation: A-18; Reaffirmed: CMS Rep. 01, I-25]

Direct Primary Care H-385.912

1. Our AMA supports: (a) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and (b) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.
2. AMA policy is that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense.
3. Our AMA will seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health “plans” and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use HSAs to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty. [Res. 103, A-16; Appended: Res. 246, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 102, A-19; Reaffirmed: CMS Rep. 01, I-25]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 10
(A-26)

Introduced by: Dayna Isaacs, MD, MPH

Subject: Enhancing Equity in House of Delegates Resolution Processes

Referred to: Reference Committee

Whereas, the Resolution Committee was established during the COVID-19 pandemic to help the AMA House of Delegates (HOD) transition to a virtual format and ensure smooth processing of business under extenuating operational challenges; and

Whereas, the Resolution Committee fulfilled a critical role at that time, providing structure and predictability when the HOD was adapting to new virtual technology, compressed timelines, and rapidly evolving public health demands; and

Whereas, although the Committee has continued its work during subsequent Interim Meetings, its charge (e.g. reviewing and determining whether submitted resolutions meet criteria such as timeliness, urgency, and/or appropriateness) has, in practice, generated prolonged procedural debate within the House; and

Whereas, these deliberations, while well-intentioned, often shift focus away from the substance of proposed policies, thereby consuming time that could otherwise be dedicated to meaningful discussion, refinement, and evaluation of resolutions within the traditional Reference Committee process; and

Whereas, delegates may spend more time debating whether a resolution should be discussed than it would take to simply refer it to the appropriate Reference Committee, where expertise, testimony, and amendment processes are already well-established and designed to manage prioritization; and

Whereas, the pre-screening function, though created for practical necessity during the pandemic, may now inadvertently disadvantage smaller delegations and sections that rely heavily on the opportunity to have their unique perspectives heard through the standard Reference Committee process; and

Whereas, under the strong leadership of our HOD Speakers, the introduction of preliminary Reference Committee reports and the streamlined deliberative structure at the 2025 Interim Meeting enabled the HOD to conclude its business a full day ahead of schedule, demonstrating that the current meeting format has adequate capacity to consider all submitted resolutions without the need for an additional pre-screening body; therefore be it

RESOLVED, that our American Medical Association (AMA) rescind the Resolution Committee as defined in Bylaw 2.13.3.

Fiscal Note: Minimal

RELEVANT AMA POLICY

Resolution Committee. B-2.13.3
The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting. 2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates. 2.13.3.2 Size. The committee shall consist of a maximum of 31 members. 2.13.3.3 Term. Service shall commence upon its formation and shall conclude at the end of the meeting for which appointed, unless otherwise directed by the House of Delegates. 2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum. 2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications. 2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1. 2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 11
(A-26)

Introduced by: Jacob Rha, MD, MBA

Subject: Modernize the Medicare Primary Care Exception to Ensure Appropriate Reimbursement for Services Provided by Residents

Referred to: Reference Committee

Whereas, resident clinics serve disproportionately vulnerable patient populations characterized by higher psychosocial complexity, lower socioeconomic status, and greater barriers to care compared to faculty and attending physician patient panels[1,2]; and

Whereas, resident clinics generally experience financial difficulty that can be attributed, in part, to suboptimal coding and billing practices due to poor coding, with outpatient clinics considered to be a net negative cost to health systems[3,4]; and

Whereas, the Medicare Primary Care Exception (PCE) permits teaching physicians to bill for evaluation and management services when residents performed low- and middle- complexity visits in primary care settings without the teaching physician being physically present during the key portion of the service, promoting graduated autonomy in a training context[5,6,7]; and

Whereas, the PCE has implications on billing practices and may contribute to billing for lower complexity visits that would otherwise qualify for higher complexity coding in part, due to in-person supervision requirements, with estimated financial losses of $2,558 per resident and $57,569 per year for an average residency, and up to 72.1% of visits billed at lower complexity that could have been billed at higher complexity[8,9,10]; and

Whereas, temporarily from March 31, 2020 to January 1, 2022 during the COVID-19 Public Health Emergency, Medicare expanded the PCE to cover all patient visits regardless of complexity level, allowing teaching physicians to bill for higher complexity visits under indirect supervision without an in-person assessment required[11]; and

Whereas, studies examining coding and billing patterns during and after the COVID-19 Public Health Emergency noted a significant increase in higher complexity billing code utilization during the expansion period and then a notable decrease in higher complexity billing code utilization after its expiration[12,13]; and

Whereas, the persistent inappropriate use of lower complexity billing codes may result in significant revenue losses in outpatient practices of numerous fields in which the Medicare PCE applies, including family medicine, outpatient internal medicine, geriatric medicine, pediatrics, and obstetrics & gynecology[7]; and

Whereas, limited single-institution data suggests that trainees further along in their training (Post Graduate Year 3) may utilize higher complexity billing codes less frequently than their more junior peers, with potential revenue implications estimated to be greater than $300,000 per fiscal year[13]; and

Whereas, the current regulatory requirement for teaching physicians to be directly present in-person for moderate- or high- complexity visits may therefore influence senior trainees to underutilize higher complexity codes despite delivering higher complexity level of care to avoid supervision requirements[9,11,13]; and

Whereas, underutilization of higher complexity codes may negatively impact clinic sustainability, staffing, productivity metrics (including Relative Value Units), case mix index, audit burden, and resource allocation; and

Whereas, analyses of the PCE by a working group from the Society of General Internal Medicine and by a group of academic teaching physicians offers recommendations for reform, including allowing moderate complexity visits to be eligible for the Primary Care Exception[14,15]; and

Whereas, our American Medical Association is currently actively advocating to the Centers for Medicare & Medicaid Services on modernizing standards for appropriate supervision of residents, including recent changes to the Medicare Physician Fee Schedule permanently allowing virtual supervision of residents providing telehealth services in all training settings, a regulation that was temporarily allowed via the CMS Interim Final Rule issued during the COVID-19 Public Health Emergency[16,17]; therefore be it

RESOLVED, that our American Medical Association (AMA) advocate that the Centers for Medicare & Medicaid Services review and modernize teaching-physician regulations governing the Medicare Primary Care Exception to better align reimbursement with the complexity of care furnished in resident continuity clinics while maintaining appropriate supervision and patient safety safeguards.

Fiscal Note: Moderate

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RELEVANT RFS POSITION STATEMENTS

280.012R: Reimbursement and Residency Training
That our AMA-RFS support: (1) that residents should be allowed to fully participate in the care of all patients, regardless of reimbursement mechanisms; (2) appropriate reimbursement for services that are provided by residents under the degree of supervision appropriate for the level of training and the educational setting; and (3) that programs must continue to provide appropriate supervision of trainees. (Report E, A-95) [See also: AMA Policy H310.979, H-310.981] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

291.026R: Supervision of Residents
That our AMA-RFS support Medicare reimbursement for teaching physicians to ensure (1) more reasonable documentation requirements, (2) clarify and determine reasonable physical presence requirements, (3) expand the limited exception requirements for attending physician supervision to restore training for non-primary care residents at centers located in outpatient centers regardless of hospital affiliation. (Report F, A-97) (Reaffirmed Report D, I-16)

140.001R: Health Care Reform Plan
That our AMA-RFS (1) continue to advocate for health system reform which makes health insurance coverage accessible for all residents within the US; (2) support requiring all children to have health insurance as a strategic priority; (3) advocate for sufficient federal subsidy or tax credit amounts so that all residents can afford to purchase health insurance; (4) support the requirement for private insurers that children up to age 26 could continue family coverage through their parents' plan; (5) support working with the federal government to ensure that if federal programs are to be expanded, that proper checks and balances are in place to ensure that reimbursements reflect the actual cost of care and that patient access is not limited; and (6) support that under the National Health Insurance Exchange (or any similar proposed program) that participating insurers provide high quality, transparent services, and that their reimbursements reflect the actual cost of care. (Report H, I-08) (Resolution 9, I-25)

280.008R: Impact of Medicare Regulations on Residency Training
That the AMA-RFS Governing Council continue to: (1) monitor the issue of Medicare, Medicaid, and private payor reimbursement of teaching physicians for supervising residents; and (2) collect information from residents on the regulations regarding reimbursement of teaching physicians for supervising residents and continue to report back to the AMA-RFS Assembly as appropriate. (Report H, I-97) (Reaffirmed Report D, I-16)

294.011R: Training in Reimbursement Coding in Residency Programs
That our AMA encourage training in practice management, including training on proper reimbursement coding and documentation to better prepare residents for medical practice. (Substitute Resolution 3, A-98) (Reaffirmed Report D, I-16)

370.003R: Improving Utility of Clinical Documentation

That our AMA-RFS advocate that the appropriate institutions determine level of care and reimbursement based more on complexity of medical diagnoses and medical decision making rather than quantity of components in medical documentation. (Resolution 12, I-17)

RELEVANT AMA POLICY

H-385.952: Appropriate Physician Reimbursement by Centers for Medicare & Medicaid Services
Our AMA: (1) opposes both CMS's and local carriers' efforts to reduce or deny physician payments for appropriate services; and (2) will work to assure that all evaluation and management services are appropriately reimbursed. [Reaffirmed: CMS Rep. 01, A-19]

H-385.942: CMS Use of Regulatory Authority to Implement Reimbursement Policy
The AMA urge (1) CMS in the strongest terms possible to solicit the participation and counsel of relevant professional societies before implementing reimbursement policies that will affect the practice of medicine; (2) CMS to make every effort to determine the clinical consequences of such reimbursement policy changes before the revised policies are put in place; and (3) CMS in the strongest terms possible not to misapply either quality measurement data or clinical practice guidelines developed in good faith by the professional medical community as either standards or the basis for changes in reimbursement policies. [Reaffirmed: Res. 105, A-18]

H-200.949: Principles of and Actions to Address Primary Care Workforce
…17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS. [Reaffirmed: Res. 237, I-25]

H-330.939: Reimbursement by Medicare for Psychotherapy Provided by Residents
Our AMA will work with CMS to accomplish regulations for Medicare Part B payment for attending physicians' services that would not require the "physical presence" of the attending physician in the room at the same time that a resident provided psychotherapy. [Reaffirmed: BOT Rep. 09, A-25]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 12
(A-26)

Introduced by: Daniel Resnick, DO, MBA; Dayna Isaacs, MD, MPH

Subject: Supporting a Common Legal Framework for Medical Capacity Holds

Referred to: Reference Committee

Whereas, patients often lack decision-making capacity regarding the need to stay in the hospital for treatment; and

Whereas, loss of decision-making capacity can occur due to both general medical conditions or primary psychiatric disorders; and

Whereas, surrogate decision-making policies, guardianship laws, and practices are complex and vary dramatically across states, courts, and institutions; and

Whereas, physicians, facilities, and other healthcare providers may face legal liability for permitting a patient who lacks decision-making capacity to leave the healthcare setting and subsequently suffer harm; and

Whereas, physicians, facilities, and other healthcare providers can be held liable for unlawful detention of a patient except in situations explicitly authorized by law; and

Whereas, there is currently no comprehensive federal statutory framework that specifically permits physicians or facilities to detain an adult patient who lacks decision-making capacity due to medical causes such as delirium, acute brain injury, dementia, or severe metabolic derangement; and

Whereas, no state has yet adopted a statute to explicitly authorize detention of a patient due to a lack of decision-making capacity due to a medical condition; and

Whereas, states across the country have adopted psychiatric holds that provide clear standards for who qualifies, protections of patient's rights with due process, and appropriate protections for healthcare providers and healthcare systems to use them; and

Whereas, these psychiatric holds are often used incorrectly for patients lacking decision-making capacity due to a condition other than a primary psychiatric condition or related substance use disorder; and

Whereas, healthcare systems across the country rely on institutional policies without any explicit legal framework, standardized protections for patient's rights and due process, standardized qualifications and requirements, or liability protections for those involved; and

Whereas, the lack of standardized legal frameworks for medical capacity holds may result in inconsistent protections of patient rights, with the potential to exacerbate health inequities given that this population includes older adults, patients with cognitive impairment, and those with limited social support; and

Whereas this issue affects all inpatient hospital settings and medical specialties, and appropriate solutions may reduce the inappropriate use of involuntary psychiatric holds; therefore be it

RESOLVED, that the American Medical Association (AMA) study existing laws, institutional practices, and ethical frameworks related to the use of medical holds for patients who lack medical decision-making capacity, with the goal of identifying best practices and informing potential model legislation.

Fiscal Note: Minimal

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RELEVANT AMA POLICY

AMA Code of Medical Ethics 2.1.2 Decisions for Adult Patients Who Lack Capacity

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 13
(A-26)

Introduced by: Anthony Sean de Leon, Dayna Isaacs, MD, MPH

Subject: Research the Community Health Impacts of Data Centers

Referred to: Reference Committee

Whereas, data centers (server farms) are large-scale industrial facilities that power augmented intelligence (AI), cloud services (email, storage), and applications, with more than 50% owned and operated by major corporations including Amazon, Microsoft, and Google[1, 2]; and

Whereas, there is growing bipartisan concern about the impacts of data centers on communities and the environment[4-8]; and

Whereas, most new data centers are being built rapidly for anticipated demand rather than actual demand[9]; and

Whereas, these data centers strain local electrical infrastructure that often utilize fossil fuels; and

Whereas, data centers require substantial water resources for cooling and often depend on non-renewable energy generation, contributing to water scarcity, thermal pollution, and contamination in surrounding communities, particularly in water-stressed regions such as California, Arizona, and Texas[10-14]; and

Whereas, data centers, especially ones using non-renewable energy sources such as natural gas, diesel, and fossil fuels, contribute to local air pollution including particulate matter (PM) and nitrogen oxides, which are associated with increased incidence and exacerbation of respiratory diseases such as asthma; and

Whereas, data centers may also contribute to soil and water contamination through fuel storage and generator systems, cooling water discharge, chemical use (e.g., biocides and corrosion inhibitors), and battery storage infrastructure, resulting in potential release of hydrocarbons, heavy metals, and other toxic substances that may impact groundwater, surface water, and surrounding ecosystems[15-19]; and

Whereas, data centers, through HVACs and diesel/gas generators, contribute to local noise pollution, often above 45-55 dBa[1,3, 20]; and

Whereas, neighborhoods near data centers generally are disproportionately socioeconomically vulnerable (e.g., communities of color having higher burden of diesel PM and NO_2)[21-24]; therefore be it

RESOLVED, that our American Medical Association (AMA) study and report on the public health impacts of data center development, including effects on air quality, water resources, soil contamination, energy infrastructure, noise exposure, and health equity; and be it further

RESOLVED, that our AMA advocates for the health of patients and communities near existing and prospective data centers, especially in socioeconomically vulnerable regions.

Fiscal Note: Modest

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RELEVANT AMA POLICY

Noise Pollution H-440.864
Our AMA recognizes noise pollution as a public health hazard, with respect to hearing loss, and supports initiatives to increase awareness of the health risks of loud noise exposure. [Sub. Res. 417, A-08; Reaffirmation A-16]

Pollution Control and Environmental Health H-135.996

Our AMA supports
1. efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and
2. its present activities in pollution control and improvement of environmental health.

[Sub. Res. 40 A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

AMA Position on Air Pollution H-135.998
Our AMA urges that:
1. Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties.
2. Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community.
3. Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends.
4. Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control.

[BOT Rep. L, A-65; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-14; Reaffirmation A-16; Reaffirmed: BOT Rep. 29, A-19]

Air Pollution and Public Health H-135.941
Our AMA supports increased physician participation in regional and state decision-making regarding air pollution across the United States.
[Res. 408, A-08; Reaffirmed in lieu of Res. 509 A-09; Reaffirmed: CSAPH Rep. 01, A-19]

Air Pollution and Public Health D-135.985
Our American Medical Association promotes education among its members and the general public and will support efforts that lead to significant reduction in fuel emissions in all states. Our AMA will declare the need for authorities in all states to expeditiously adopt, and implement effective air pollution control strategies to reduce emissions, and this position will be disseminated to state and specialty societies.
[Res. 408, A-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 01, A-24]

Declaring Climate Change a Public Health Crisis D-135.966
Our American Medical Association declares climate change a public health crisis that threatens the health and well-being of all individuals. Our AMA will protect patients by advocating for policies that:
- Limit global warming to no more than 1.5 degrees Celsius.
- Reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050.
- Support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.

Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge and making a commitment to lower its own greenhouse gas emissions.
Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050.
Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.
Our AMA supports the use of international, federal, regional, and state carbon pricing systems as an important tool to reduce global greenhouse gas emissions and achieve net-zero targets. Our AMA recommends that carbon dividends or energy subsidies for low-income households be a key component of any established carbon pricing system, to reduce the potential economic burden on households with lower incomes.

[Res. 420, A-22; Appended: CSAPH Rep. 02, I-22; Appended: BOT Rep. 11, I-24]

Environmental Contributors to Disease and Advocating for Environmental Justice D-135.997
Our American Medical Association will advocate for the greater public and private funding for research into the environment causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease.
Our AMA asks the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease and environmental racism as a priority public health issues.
Our AMA encourages federal, state, and local agencies to address and remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities.
Our AMA will lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.
[Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of: Res. 505, A-19; Modified: Res. 415, A-23]

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies D-135.969
Our American Medical Association, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels.
[BOT Rep. 34, A-18; Reaffirmed: CSAPH Rep. 2, I-22]

Clean Air H-135.979
Our AMA supports cooperative efforts with the Administration, Congress, national, state and local medical societies, and other organizations to achieve a comprehensive national policy and program to address the adverse health effects from environmental pollution factors, including air and water pollution, toxic substances, the "greenhouse effect," stratospheric ozone depletion and other contaminants.
[Sub. Res. 43, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmed in lieu of Res. 509, A-09; Reaffirmed: CSAPH Rep. 01, A-19]

Clean Air H-135.991
(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.
(2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.
(4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.
(5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health.
[BOT Rep. R, A-82; Reaffirmed: CLRPD Rep. A, I-92; Amended: CSA Rep. 8, A-003; ReaffirmationI-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation I-09; Reaffirmation A-14; Modified: CSAPH Rep. 01, A-24]

Federal Clean Air Legislation H-135.984
1. Our AMA urges the enactment of comprehensive clear ambient air legislation which will lessen risks to human health.
2. Our AMA will: (a) oppose legislative or regulatory changes that would allow power plants to avoid complying with new source review requirements to install air pollution control equipment when annual pollution emissions increase; and (b) work with other organizations to promote a public relations

campaign, strongly expressing our opposition to EPA's Affordable Clean Energy rule and its proposed amendments of the New Source Review requirements under the Clean Air Act.
[Res. 142, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-13; Reaffirmation A-14; Appended: Res. 917, I-18]

Furthering Environmental Justice and Equity H-135.905
Our American Medical Association supports prioritizing greenspace access and tree canopy coverage for communities that received a "D" rating from the Home Owners' Loan Corporation, otherwise known as being "redlined," or those that have been impacted by other discriminatory development, loan servicing, and building practices with full participation by the community residents in these decisions.
Our AMA supports measures to protect frontline communities from the health harms of proximity to historical and current harmful industrial and mining operations, including fossil fuel extraction, refining and combustion, and large-scale agriculture, such as using the best available technology to reduce local pollution exposure, or health safety buffers from industrial operations.
Our AMA supports prioritizing greenspace access and tree canopy coverage for communities that received a "D" rating from the Home Owners' Loan Corporation, otherwise known as being "redlined," or that have been impacted by other discriminatory development and building practice, thereby protecting residents of these communities from displacement.
[Res. 416, A-24 → Modified: CSAPH Rep. 07, A-25]

EPA and Green House Gas Regulation H-135.934
1. Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control green house gas emissions in the United States.
2. Our AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification.
[Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Appended: Res. 523, A-17]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 14
(A-26)

Introduced by: Mariana Colussi-Pelaez MD, Tiffany Bellomo, MD MSc, Elizabeth Conner MD MPH

Subject: Motivational Interviewing Curriculum for Physicians to Address Vaccine Hesitancy

Referred to: Reference Committee

Whereas, vaccine hesitancy is defined by the World Health Organization (WHO) as the delay in acceptance or refusal of safe vaccines despite their availability[1]; and

Whereas, vaccine hesitancy has been named among the top 10 public health threats by the WHO[2]; and

Whereas, the U.S. Centers for Disease Control and Prevention's (CDC's) National Immunization Survey identified that approximately one in five children had parents who reported vaccine hesitancy between 2019 and 2022[3,4]; and

Whereas, between 1994-2014, routine childhood vaccines in the U.S prevented over 1 million deaths, generated 540 billion in direct savings and 2.7 trillion in societal savings[5,6], and even a small decline in vaccination rate can have a large financial impact, for example a 5 percent decrease in measles vaccine coverage could triple annual cases for children aged 2-11 and would cause the public sector an additional 2.1 million dollars annually[7,8]; and

Whereas, the World Health Organization and UNICEF report that as of 2023, global immunization coverage has still not recovered to pre-pandemic levels, with 2.7 million more children un- or under-vaccinated than in 2019, and that rising vaccine misinformation and hesitancy are identified as key drivers of this ongoing threat[9,10]; and

Whereas, motivational interviewing (MI) is a patient-centered, evidence-based technique that is designed to explore different perspectives and encourage behavioral change, and MI aims to drive this behavioral change through emphasis on patient autonomy which creates intrinsic motivation[11]; and

Whereas, a pilot study for a case-based motivational training interviewing training curriculum for preclinic medical students that included a 2 hour didactic session, 3 hour case based practice session, and 3 hour evaluation, was found to be effective in helping students learn the knowledge and skills necessary for delivery of MI in a broad range of clinical cases[12]; and

Whereas, trainees and clinicians equipped with MI skills are better positioned to address vaccine hesitancy through evidence-based, patient-centered communication that respects patient autonomy while promoting informed decision-making; and

Whereas, MI has been shown to be one the most effective approaches during provider-patient interactions to address vaccine hesitancy and research has shown that it is highly successful in influencing health behavior change, including increased acceptance of vaccinations[4,7]; and

Whereas, the American Academy of Pediatrics (AAP) has training programs that focus on improving communication skills for pediatricians through role-playing scenarios with MI to practice addressing vaccine hesitancy with parents[11]; and

Whereas, the AMA RFS, through policies 410.003R and 410.030R supports adherence to scientifically derived, high-quality evidence-based public health recommendations on vaccines and recognizes populations at increased risk of infectious disease complications, reinforcing the importance of physicians providing accurate, evidence-based education to patients about vaccination and prevention of infectious diseases; and

Whereas, the AMA, through policies H-440.830 and D-440.905, supports the development and dissemination of evidence-based educational initiatives and public awareness campaigns on vaccine safety and efficacy, promotes efforts to increase vaccination rates and improve vaccine confidence, and advocates for policies that safeguard the integrity of evidence-based medicine and public health education; and

Whereas, a large component of patient care for physicians in primary care focused specialties involves preventive medicine, which includes counseling on vaccinations; therefore be it

RESOLVED, that our AMA-RFS supports our AMA in advocating for a Motivational Interviewing curriculum for Vaccine Hesitancy for all Physicians, especially those in Primary Care specialties.

Fiscal Note: Minimal

REFERENCES

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RELEVANT RFS POSITION STATEMENTS

410.030R Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cance

410.003R Payment for Vaccines by Medicare. That our AMA lobby for Medicare to pay for both the cost of the vaccine and the cost of administration by physicians of all vaccines covered under Medicare Part D. (Late Resolution 2, A-08)

RELEVANT AMA POLICY

Distribution and Administration of Vaccines H-440.877

It is optimal for patients to receive vaccinations in their medical home to ensure coordination of care. This is particularly true for pediatric patients and for adult patients with chronic disease and co-morbidities. If a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted back to the patient's primary care physician and entered into an immunization registry when one exists to provide a complete vaccination record. All physicians and other qualified health care providers who administer vaccines should have fair and equitable access to all ACIP and national medical specialty society recommended vaccines. However, when there is a vaccine shortage, those physicians and other health care providers immunizing patients who are prioritized to receive the vaccine based upon medical risks/needs according to ACIP and national medical specialty society recommendations must be ensured timely access to adequate vaccine supply.

Physicians and other qualified health care providers should:

Incorporate immunization needs into clinical encounters, as appropriate.

Strongly recommend needed vaccines to their patients in accordance with ACIP recommendations and consistent with professional guidelines.

Either administer vaccines directly or refer patients to another qualified health care provider who can administer vaccines safely and effectively, in accordance with ACIP recommendations as of May 1, 2025, or national medical specialty society guidelines and consistent with state laws.

Ensure that vaccination administration is documented in the patient medical record and an immunization registry when one exists

Maintain professional competencies in immunization practices, as appropriate.

All vaccines should be administered by a licensed physician, or by a qualified health care provider pursuant to a prescription, order, or protocol agreement from a physician licensed to practice medicine in the state where the vaccine is to be administered or in a manner otherwise consistent with state law.

Patients should be provided with documentation of all vaccinations for inclusion in their medical record, particularly when the vaccination is provided by someone other than the patient's primary care physician.

Physicians and other qualified health care providers who administer vaccines should seek to use integrated and interoperable systems, including electronic health records and immunization registries, to facilitate access to accurate and complete immunization data and to improve information-sharing among all vaccine providers.

Vaccine manufacturers, medical specialty societies, electronic medical record vendors, and immunization information systems should apply uniform bar-coding on vaccines based on standards promulgated by the medical community.

Our American Medical Association encourages vaccine manufacturers to make small quantities of vaccines available for purchase by physician practices without financial penalty.

Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875

All persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as of May 1, 2025, or national medical specialty society recommended vaccines as soon as possible following publication of these recommendations.

Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.

Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.

Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of recommended vaccines, and the timely distribution of recommended vaccines to providers).

Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer recommended vaccines.
Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.
Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.
Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.
Until compliance of our AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients.
Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines, including those from national medical specialty societies.

Education and Public Awareness on Vaccine Safety and Efficacy H-440.830
1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; (f) supports state policies allowing minors to override their parent’s refusal for vaccinations; and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.
2. Our AMA: (a) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (b) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.

Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research D-440.905
Topic: Public Health, Policy Subtopic: NA
Meeting Type: Interim, Year Last Modified: 2025
Action: Modified, Type: Directives
Council & Committees: Board of Trustees,
Our AMA affirms that protecting science, clinical integrity, and the patient-physician relationship is central to the organization’s mission.
Our AMA assertively and publicly leads the House of Medicine in collective, sustained advocacy for federal and state policies, proposals, and actions that safeguard public health infrastructure, advance biomedical research, improve vaccine confidence, and maintain the integrity of evidence-based medicine and decision-making processes.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution:15
(A-26)

Introduced by: Tiffany Bellomo, MD MSc, Matthew Townsend, MD, MSc, MPP, Elizabeth Conner, MD, MPH, Janet C Limke, MD

Subject: Ensuring Evidence-Based Nutrition Guidance in Public Health and Clinical Practice

Referred to: Reference Committee

Whereas, the American Medical Association Resident and Fellow Section has existing policies supporting improved nutrition standards across multiple domains, including reform of U.S. agricultural subsidies to promote healthier foods (120.001R), improved nutritional quality and transparency in restaurant offerings (120.005R), enhanced nutrition education among healthcare providers (120.007R), and the implementation of nutrition standards and public health education to address childhood obesity (410.008R); and

Whereas, the American Medical Association has adopted multiple policies supporting improved nutrition standards in schools, food assistance programs, and food labeling systems—including (H-150.960), (H-150.936), (H-150.930), and (H-150.915)—which emphasize improving the nutritional quality of foods available to the public but rely substantially on federal nutrition standards and guidelines to define what constitutes healthy food, creating potential challenges for physicians and public health programs when those federal standards does not fully reflect the strongest or most current scientific evidence; and

Whereas, nutrition recommendations play an essential role in the prevention and management of chronic diseases including cardiovascular disease, diabetes, obesity, and other diet-related conditions,[1–4] and therefore require careful evaluation of high-quality scientific evidence to guide clinical and public health decision-making; and

Whereas, the development of dietary guidelines has historically relied on rigorous, multi-year structured evidence evaluation processes, including those conducted through the United States Department of Agriculture (USDA) Nutrition Evidence Systematic Review process and the Dietary Guidelines Advisory Committee, which synthesize rigorous nutrition science to inform public health recommendations[5–8]; and

Whereas, the USDA and U.S. Department of Health and Human Services appoint national experts to the Dietary Guidelines Advisory Committee, with extensive background checks for financial and ethical conflicts of interest, who then review nutrition science using rigorous protocol-driven methods and with input from other scientific organizations and public comment, with the aim of increasing public trust in U.S. nutrition policy; and

Whereas**,** professional organizations such as the American Society for Nutrition[9] and the Academy of Nutrition and Dietetics[10] represent leading scientific and clinical communities dedicated to advancing nutrition research and translating scientific evidence into clinical and public health practice guidance; and

Whereas, the 2025–2030 Dietary Guidelines for Americans (DGA) introduced substantial departures from the rigorous processes and recommendations of the 2020-2025 and other prior DGAs,[11] and from the 2025 Dietary Guidelines Advisory Committee Scientific Report[8], including rejection of most (30 of 55) recommendations from the Dietary Guidelines Advisory Committee[8], that prompted the creation of a separate report entitled "The Scientific Foundation for the Dietary Guidelines for Americans"; and

Whereas**,** the new 2025–2030 DGAs encourage almost doubling protein intake from the existing Dietary Reference Intake of 0.8 grams of protein daily per kilogram of body weight to 1.2-1.6 g/kg, despite limited evidence that higher protein confers muscle or other health benefits in absence of regular strength training[12]; and

Whereas, the new 2025-2030 DGAs rejected the Dietary Guidelines Advisory Committee recommendation to prioritize "plant-based" over "animal-based" protein sources due to established evidence base linking dietary patterns high in saturated fat and red meat with increased risk of cardiovascular disease, diabetes, and certain cancers, and instead, the DGAs promote higher intakes of animal-source proteins and full-fat dairy products[12]; and

Whereas, despite the aforementioned prior Dietary Guidelines Advisory Committee recommendation to prioritize "plant-based" over "animal-based" protein sources, the inverted food pyramid graphic that accompanies the new 2025–2030 DGAs visually promotes animal protein and saturated fat sources in the prominent upper-left position, while de-emphasizing legumes and nuts and leaving out soy, which is a major source of plant protein[11]; and

Whereas, the Physicians Committee for Responsible Medicine has filed a petition with the Offices of Inspector General for the Department of Health and Human Services and the U.S. Department of Agriculture requesting that the new 2025-2030 DGA be withdrawn and reissued due to concerns of industry influence; and

Whereas, seven of the nine authors of the scientific report underlying the 2025-2030 DGA reported industry ties, including the Texas Beef Council, National Cattlemen's Beef Association, National Pork Board, National Dairy Council, and Atkins Nutritionals, which are organizations that would benefit from dietary guidelines that promote meat, dairy, and low-carbohydrate products)[13]; and

Whereas**,** the American College of Cardiology Nutrition & Lifestyle Work Group has published findings separating Evidence-Based 2025-2030 DGA Recommendations from other recommendations not supported by nutrition science[14]; and

Whereas, the Academy of Nutrition and Dietetics has also published a statement expressing concerns over 2025-2030 DGAs emphases on butter, beef tallow, red meat, and full-fat dairy[15]; and

Whereas, the environmental implications and reduced carbon footprints of plant-forward versus animal-based diets are substantial, with modeling studies estimating that plant-based diets could reduce diet-related land use by 75%, diet-related greenhouse gas emissions by 49%, and water use by >10%[16]; and

Whereas, the DGAs influence numerous public programs—including school meal standards, nutrition assistance programs, military, and other institutional food procurement policies—which can affect the ability of physicians and other health professionals to provide consistent evidence-based nutrition counseling to patients and communities[17]; and

Whereas, physicians play an important role in communicating nutrition guidance to patients and the public and in countering health misinformation that may undermine evidence-based public health recommendations, and rely upon quality evidence-based dietary guidance to inform conversations with patients[18]; and

RESOLVED, that our American Medical Association (AMA) advocates that nutrition recommendations used in clinical practice, state public health policy, and institutional nutrition programs be grounded in evidence-based science and informed by the scientific guidance of leading professional nutrition organizations, such as the American Society for Nutrition and the Academy of Nutrition; and be it further

RESOLVED, that our AMA advocates for strengthened transparency, disclosure, and management of financial and non-financial conflicts of interest in the development of federal dietary guidelines and related scientific reports, including clear public reporting and exclusion of individuals with significant financial or industry-related conflicts of interest from decision-making roles.

Fiscal Note: Modest

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RELEVANT RFS POSITION STATEMENTS

120.001R U.S. Farm Subsidies

That our AMA-RFS support reform and updates to the US Farm Bill including redirecting subsidies in the US Farm Bill that perpetuate caloriedense, nutrition-poor products toward programs that reduce obesity. (Resolution 1, I11)

120.005R Nutritional Guidelines for Restaurants
That our AMA-RFS supports: (1) restaurants serving foods with reduced saturated fat content, (2) consideration of dietary needs when planning menus, and (3) restaurants providing nutritional information on menus and signage. (Report H, I-94) (Reaffirmed Report D, I-16)

120.007R Promoting Nutrition Education Among Healthcare Providers
That our AMA-RFS support the AMA in reaffirming H-465.988 Educational Strategies for Meeting Rural Health Physician Shortage. (Resolution 4, I-18)

410.008R Exercise and Healthy Eating for Children
That our AMA-RFS: (1) support legislation that would require the development and implementation of universal AMA-RFS Position Compendium nutrition standards for all food served in K-12 schools irrespective of food vendor or provider; and (2) spearhead a public health awareness campaign and enhance the K12 curriculum to address and educate the public on the epidemic of childhood obesity and the benefits of exercise and physical fitness for children. (Substitute Resolution 6, A-02) (Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)

RELEVANT AMA POLICY

Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools H-150.960
The AMA supports the position that primary and secondary schools should follow federal nutrition standards that replace foods in vending machines and snack bars, that are of low nutritional value and are high in fat, salt and/or sugar, including sugar-sweetened beverages, with healthier food and beverage choices that contribute to the nutritional needs of the students.

Support for Uniform, Evidence-Based Nutritional Rating System H-150.936
1. Our AMA supports the adoption and implementation of a uniform, nutritional food rating system in the US that meets, at a minimum, the following criteria: is evidence-based; has been developed without conflict of interest or food industry influence and with the primary goal being the advancement of public health; is capable of being comprehensive in scope, and potentially applicable to nearly all foods; allows for relative comparisons of many different foods; demonstrates the potential to positively influence consumers' purchasing habits; provides a rating scale that is simple, highly visible, and easy-to-understand and used by consumers at point of purchase; and is adaptable to aid in overall nutritional decision making.
2. Our AMA will advocate to the federal government - including responding to the Food and Drug Administration call for comments on use of front-of-package nutrition labeling and on shelf tags in retail stores - and in other national forums for the adoption of a uniform, evidence-based nutrition rating system that meets the above-referenced criteria.

National Nutritional Guidelines for Food Banks and Pantries H-150.930
Our AMA: (1) supports the use of existing national nutritional guidelines for food banks and food pantries and (2) will promote sustainable sourcing of healthier food options and the dissemination of user-friendly resources and education on healthier eating for food banks and food pantries.

Public Health Implications of US Food Subsidies H-150.915
Our AMA will study the public health implications of United States Food Subsidies, focusing on:
How these subsidies influence the affordability, availability, and consumption of various food types across different demographics.
Potential for restructuring food subsidies to support the production and consumption of more healthful foods, thereby contributing to better health outcomes and reduced healthcare costs related to diet-related diseases.

Avenues to advocate for policies that align food subsidies with the nutritional needs and health of the American public, ensuring that all segments of the population benefit from equitable access to healthful, affordable food.