**AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION (A-26)**

Report of Reference Committee

Tristan Mackey, MD, Chair

---

Your Reference Committee recommends the following consent calendar for acceptance:

**RECOMMENDED FOR ADOPTION**

1. Report A – Sunset Mechanism (2015)

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

3. Report C – Residency Slots and Shortages

4. Report D – Ranked Choice Voting

5. Report F – RFS Endorsements in AMA House of Delegates Elections

6. Report G – Stronger Recognition and Promotion of Accommodations for Neurodivergent Learners

7. Report H – Disparities in Preliminary and Transitional Year GME Funding

8. Resolution 4 – Advancing Physician Payment and Medicare and Medicaid Access for Street Medicine

9. Resolution 6 –Recognition of Moral Injury in the Physician Workforce

10. Resolution 7 – Eliminating Tax Barriers to Equitable Clinical Trial Participation

11. Resolution 12 – Supporting a Common Legal Framework for Medical Capacity Holds

**RECOMMENDED FOR ADOPTION AS AMENDED**

12. Resolution 8 – FDA Regulation of Unapproved Synthetic Peptides

13. Resolution 10 – Enhancing Equity in House of Delegates Resolution Processes

14. Resolution 13 – Research the Community Health Impacts of Data Centers

15. Resolution 15 – Ensuring Evidence-Based Nutrition Guidance in Public Health and Clinical Practice

**RECOMMENDED FOR ADOPTION IN LIEU OF**

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

17. Resolution 1 – Minimum Standards for Public Health Leaders

18. Resolution 2 – Immediate Action to Prevent Further Immigrant Deaths

19. Resolution 9 – Ensuring Affordable Coverage: Opposing HSAs as a Substitute for Comprehensive Health Insurance

20. Resolution 11 – Modernize the Medicare Primary Care Exception to Ensure Appropriate Reimbursement for Services Provided by Residents

**RECOMMENDED FOR REFERRAL**

21. Resolution 5 – Promoting Safety Through Revision of Resident Work Hour Limits

**RECOMMENDED FOR NOT ADOPTION**

22. Resolution 3 – AMA's Affirmative Commitment to Defending Democracy with Action

23. Resolution 14 – Motivational Interviewing Curriculum for Physicians to Address Vaccine Hesitancy

# RECOMMENDED FOR ADOPTION

(1) REPORT A - SUNSET MECHANISM (2015)

**RECOMMENDATION:**

**Recommendation in Report A be adopted and the remainder of the report be filed.**

The Sunset Mechanism 2015 RFS Positions contains a list of recommended actions regarding internal position statements last reviewed from the RFS 2013 fiscal year. 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.

Your Reference Committee heard minimal testimony regarding Report A but the testimony that was heard was positive. Your Section Delegates testified regarding the logistics of the sunset mechanism and provided further information about the present report explaining that it is larger than past reports given an audit that revealed additional items which had not been reviewed to date. Your Reference Committee's review of the proposed actions within the report found that they were all reasonable and noncontroversial. We appreciate the Section Delegate's extensive work on this report. Given the strong testimony in support, your Reference Committee recommends Report A be adopted and the remainder of the report be filed.

(2) REPORT B – IMPLEMENTATION OF REPORT E (A-24): INCLUSION OF ALL PASSED RESOLUTIONS IN THE RFS DIGEST OF ACTIONS: TEN YEAR LOOKBACK

**RECOMMENDATION:**

**Recommendation in Report B be adopted and the remainder of the report be filed.**

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.

Your Reference Committee heard limited testimony regarding Report B. Testimony provided in support emphasized the value of the report as an informational summary of the findings and recommendations of the ad hoc committee. Your Reference Committee heard no opposition to Report B and believes the proposed next steps are reasonable and noncontroversial. Therefore, your Reference Committee recommends Report B be adopted and the remainder of the report be filed.

(3) REPORT C – RESIDENCY SLOTS AND SHORTAGES

**RECOMMENDATION:**

**Recommendations in Report C be <u>adopted</u> and the remainder of the report be <u>filed</u>.**

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.

Your Reference Committee heard positive testimony on Report C, with no opposition expressed and no amendments offered. Your Reference Committee believes the recommendations of this report reasonably address the concerns that led to the original resolution's referral, while remaining consistent with existing AMA policy supporting expanded GME funding and residency positions. Therefore, your Reference Committee recommends Report C be adopted and the remainder of the report be filed.

(4) REPORT D – RANKED CHOICE VOTING

**RECOMMENDATION:**

**Recommendations in Report D be <u>adopted</u> and the remainder of the report be <u>filed</u>.**

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.

Your Reference Committee heard limited positive testimony regarding Report D with no opposition shared. Your Reference Committee believes the Committee did a thorough analysis of the pros and cons of Ranked Choice Voting, specifically for the RFS and of the proposed bylaws amendments needed to implement Ranked Choice Voting for the Section. We feel that this was an excellent exploration into the concerns that led to the referral of the original resolution and that the Committee fully addressed the needs of the Assembly’s concerns with this report. Therefore, your Reference Committee recommends Report D be adopted and the remainder of the report be filed.

(5) REPORT F – RFS ENDORSEMENTS IN AMA HOUSE OF DELEGATES ELECTIONS

**RECOMMENDATION:**

**Recommendations in Report F be adopted and the remainder of the report be filed.**

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, 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 Caucus 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, 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 Caucus, 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 Caucus, 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 Caucus, as defined in XIII.D.1.a. Endorsements apply only to the election cycle for which they are granted.

Your Reference Committee heard limited testimony on this item. The main point raised in testimony was regarding the possible need for a pilot period of this process and the allowance for a re-evaluation afterward. We discussed the merits of adding in a pilot period, likely as an additional and separate resolved clause rather than as an IOP itself and ultimately decided against this for several reasons. First, given that this report solely serves to amend our section's IOPs, it is not possible to put a time constraint or intention to possibly revoke these same amendments within the amended language, as this language should be able to be used and interpreted for years to come and without these constraints. Secondly, it is difficult to even add this constraint into this report as certain aspects of the IOP revision process is currently on hold or delayed within the organization as well as within the Council on Constitution and Bylaws and our Board, who has vocalized a plan to standardize IOPs across all AMA Sections. Finally, we felt that the language of the IOP as written allows enough flexibility to our caucus and those overseeing it (i.e. the RFS Section Delegates) to decide when to enact this process, the best way in which to go about that, and the solicitation of feedback regarding improvements in this process, which would negate the need for an external pilot phase and re-evaluation of the entire IOP as opposed to how this process is operationalized.

With regard to the involvement of our section and assembly as a whole in the evaluation and transparency of this process, your Reference Committee notes that our Section Delegates publish a report after each meeting which detail our caucus' actions within the House, including detailed vote counts of each vote taken by the caucus, and we felt that this would serve as an excellent forum for our members to be informed about this process and how it is being enacted. Finally, your Reference Committee editorially updated the voting members of the RFS referred to in this text to “RFS Caucus,” rather than the “RFS Delegation,” as this is the most appropriate name since we are not theoretically a delegation as that term is commonly used within the House. Given the aforementioned reasons, your Reference Committee recommends that Report F be adopted with editorial changes, and the remainder of the report be filed.

(6) REPORT G – STRONGER RECOGNITION AND PROMOTION OF ACCOMMODATIONS FOR NEURODIVERGENT LEARNERS

**RECOMMENDATION:**

**Recommendations in Report G be adopted and the remainder of the report be filed.**

RECOMMENDATIONS
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.

Your Reference Committee heard positive testimony on Report G, including from the author of the original referred resolution, with no opposition expressed and no amendments offered. Testimony noted that the proposed substitute language was responsive to the intent of the original resolution and appropriately addressed support for neurodivergent learners in medical training. Your Reference Committee found the report to be well written and provides a clear path forward regarding accommodation processes, faculty education, and collaboration with disability resource offices, without significantly restating current AMA policies. With only supportive testimony received, your Reference Committee recommends Report G be adopted, and the remainder of the report be filed.

(7) REPORT H – DISPARITIES IN PRELIMINARY AND TRANSITIONAL YEAR GME FUNDING

**RECOMMENDATION:**

**Recommendations in Report H be <u>adopted</u> and the remainder of the report be <u>filed</u>.**

RECOMMENDATIONS
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.

Your Reference Committee heard only positive testimony on this report and found it to be thorough and well written. Despite an acknowledged lack of primary data regarding IRP, the authors offered an actionable path forward to help address what is clearly a major challenge for some residents. With only positive testimony received, your Reference Committee recommends that Report H be adopted and the remainder of the report be filed.

(8) RESOLUTION 4 – ADVANCING PHYSICIAN PAYMENT AND MEDICARE AND MEDICAID ACCESS FOR STREET MEDICINE

**RECOMMENDATION:**

**Resolution 4 be adopted.**

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.

Your Reference Committee heard limited but favorable testimony regarding Resolution 4. Testimony expressed support for the adoption of the resolution and noted that the resolved clauses were well written, clearly articulated the issue at hand, and identified an important gap in current policy that aligns well with the RFS Strategic Focus Areas. Your Reference Committee heard no opposition and believes the proposed policy appropriately addresses the identified need. Therefore, your Reference Committee recommends Resolution 4 be adopted.

(9) RESOLUTION 6 – RECOGNITION OF MORAL INJURY IN THE PHYSICIAN WORKFORCE

**RECOMMENDATION:**

**Resolution 6 be adopted.**

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.

Your Reference Committee heard overwhelming supportive testimony for Resolution 6, with significant support in particular for the recognition of moral injury as a separate entity which requires independent and concerted efforts to address. One amendment was proffered and discussed; however, overwhelming testimony and discussion highlighted the importance of the recognition of moral injury as a separate entity from burnout, among others, and therefore establish it as a separate and distinct policy of its own rather than incorporate it into current burnout policy. Some concerns were noted about the third resolved clause asking for a study while the others were asking for action and thought that these asks might be premature. Your Reference Committee discussed the merits of the third resolved clause and feels that it is not asking for a study to define or delineate the existence of moral injury but rather to operationalize the AMA and medicine against moral injury after understanding how far reaching the issue is. Therefore, we feel that all three resolved clauses are necessary and do not conflict with one another. For these reasons, your Reference Committee elected to keep original language and recommends that Resolution 6 be adopted.

(10) RESOLUTION 7 – ELIMINATING TAX BARRIERS TO EQUITABLE CLINICAL TRIAL PARTICIPATION

**RECOMMENDATION:**

**Resolution 7 be <u>adopted</u>.**

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.

Your Reference Committee heard only positive testimony on Resolution 7. In discussion, your Reference Committee noted that the underlying sources presented in the resolution indicated several significant factors limiting participation in studies which may restrict the impact that this intervention may have by itself to improve representation of disadvantaged groups. However, your Reference Committee believes that exempting study compensation from taxation would likely only benefit participants and that overall, the recommendations offered in the resolutions were evidence based. Therefore, your Reference Committee recommends that Resolution 7 be adopted.

(11) RESOLUTION 12 – SUPPORTING A COMMON LEGAL FRAMEWORK FOR MEDICAL CAPACITY HOLDS

**RECOMMENDATION:**

**Resolution 12 be <u>adopted</u>.**

RESOLVED, that our 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.

Your Reference Committee heard overwhelming supportive testimony on Resolution 12. Your Reference Committee agrees and recognizes the importance and timeliness of this well-written resolution. Therefore, your Reference Committee recommends Resolution 12 be adopted.

# RECOMMENDED FOR ADOPTION AS AMENDED

(12) RESOLUTION 8 – FDA REGULATION OF UNAPPROVED SYNTHETIC PEPTIDES

**RECOMMENDATION A:**

**Resolution 8 be amended by addition of a Third Resolved clause to read as follows:**

**RESOLVED, that our American Medical Association (AMA) submit comments to the Food and Drug Administration (FDA) regarding the July 2026 Pharmacy Compounding Advisory Committee review of synthetic peptide products, advocating for evidence-based regulatory oversight, third-party testing, and demonstration of safety and efficacy prior to marketing, compounding, or clinical use.**

**RECOMMENDATION B:**

**Resolution 8 be adopted as amended.**

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.

Your Reference Committee heard unanimously supportive testimony on Resolution 8 with a suggestion for amendment by the addition of a resolved clause containing specific language for our AMA to submit comments to the Food and Drug Administration during their July 2026 Pharmacy Compounding Advisory Committee review period. Your Reference Committee felt that requesting specific action in a timely fashion from our AMA has precedent in current AMA policy and would result in more meaningful and timely action on this topic. We also discussed the merits of immediately forwarding this item and since the deadline for the comment period closes shortly after our Annual meeting, we agreed that the item meets the threshold for being immediately forwarded. Given the timeliness of this resolution and actionable amendment, your Reference Committee recommends Resolution 8 be adopted as amended.

(13) RESOLUTION 10 – ENHANCING EQUITY IN HOUSE OF DELEGATES RESOLUTION PROCESSES

**RECOMMENDATION A:**

**Resolution 10 be amended by addition with a change in title to read as follows:**

**ENHANCING EQUITY IN THE HOUSE OF DELEGATES RESOLUTION PROCESSES BY REMOVAL OF THE RESOLUTIONS COMMITTEE AND BROADENING OF THE INTERIM MEETING'S FOCUS**

**RESOLVED, that our American Medical Association (AMA) rescind the Resolution Committee as defined in Bylaw 2.13.3~~.~~, "Resolution Committee," by amendment by deletion to read as follows:**

~~**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 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;**~~ **and be it further**

**RECOMMENDATION B:**

**Resolution 10 be amended by addition of a Second Resolve clause to read as follows:**

**RESOLVED, that our AMA remove constraints on the scope of business at Interim Meetings, which is regulated by the Resolution Committee, by amending AMA Bylaw B-2.12.1.1, "Business of the Interim Meeting," by deletion to read as follows:**

~~**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.**~~

**RECOMMENDATION C:**

**Resolution 10 be adopted as amended with a change in title.**

RESOLVED, that our American Medical Association (AMA) rescind the Resolution Committee as defined in Bylaw 2.13.3.

Your Reference Committee heard solely supportive testimony on this, in addition to the historical context offered by our Section Delegates. We recognize that this has been a past priority of our section and one for which we have advocated for before in the House. We would like to first recognize that in the whereas clauses, this issue is inappropriately characterized as the resolutions committee in its current iteration has long been a staple of the Interim meetings, where it has served the purpose of screening items out that do not meet the advocacy and legislation focus of that meeting, described in the bylaws. While the special meetings that took place in the early 2020s due to COVID-19 did utilize a body known as the "resolutions committee," this body served a different purpose and functioned using different mechanisms than the resolutions committee that is currently preserved in the Bylaws. If it is the will of the Assembly to forward this issue to the House at an upcoming meeting, then your Reference Committee would recommend including both the Bylaw that stipulates the formation and function of the resolution committee, as well as the one that establishes that the Interim meetings must be limited only to advocacy and legislation, as these two bylaws are interdependent. Specifically, without the restrictions that exist at the interim meetings, the resolutions committee has no function, and without the resolutions committee, the ability to appropriately screen items is no longer operational.

Therefore, we would recommend striking both bylaws, as we feel that the true root of this issue is the fact that the Interim meetings are currently restricted to a certain type of business, which can be argued is now somewhat antiquated by the fact that our business efficiency has significantly improved with the addition of online reference committees, preliminary reports, and other modernization efforts that have significantly reduced the time spent on business at meetings. In addition to including this second stricken Bylaw, which mirrors prior items that were sent to the House, we would also recommend a title change that would better indicate

the true intent of this resolution. Your Reference Committee appreciates the authors for bringing this important issue to our section's business meeting and recommend Resolution 10 be adopted as amended with a change in title.

(14) RESOLUTION 13 – RESEARCH THE COMMUNITY HEALTH IMPACTS OF DATA CENTERS

**RECOMMENDATION A:**

**The Second Resolve of Resolution 13 be <u>deleted</u>.**

**RECOMMENDATION B:**

**Resolution 13 be <u>adopted as amended</u>.**

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.

Your Reference Committee heard generally supportive testimony on Resolution 13 and recognizes that this is an important issue that aligns well with the RFS Strategic Focus Areas. However, some testimony called for more specificity in the second resolved clause, and we recognize that there is limited evidence at the current time to guide appropriate advocacy by our AMA. Because the first resolved clause calls for a study on the health impacts of data centers and those impacts remain uncertain, your Reference Committee felt that the second resolved clause is somewhat premature and thus should be deleted. Overall, this resolution raises an important issue to address a growing public health concern, and we feel that a study would better inform our advocacy's future actions. Therefore, your Reference Committee recommends Resolution 13 be adopted as amended.

(15) RESOLUTION 15 – ENSURING EVIDENCE-BASED NUTRITION GUIDANCE IN PUBLIC HEALTH AND CLINICAL PRACTICE

**RECOMMENDATION A:**

**The First Resolve of Resolution 15 be amended by deletion to read as follows:**

**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**

**RECOMMENDATION B:**

**Resolution 15 be adopted as amended.**

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.

Your Reference Committee heard generally supportive testimony on Resolution 15. Some testimony raised concern about the inclusion of specific organizations that, while currently a leader in nutrition, may not always exist or be viewed as a leader on this topic. An amendment was proffered to remove the inclusion of specific organizations, and your Reference Committee agrees that the resolution remains strong without limiting prescriptive language. Your Reference Committee recognizes the timeliness and novelty of this resolution and recommends Resolution 15 be adopted as amended.

# RECOMMENDED FOR ADOPTION IN LIEU OF

(16) REPORT E – (I-25) RFS EMERGENCY RESOLUTION 1: ENSURING THAT OUR AMA REMAINS FREE FROM MEDICAL MISINFORMATION, POLITICAL MANIPULATION, AND COMMERCIAL SELF-PROMOTION

**RECOMMENDATION:**

**Alternate Report E be adopted in lieu of Report E and the remainder of the Report be filed.**

**ENSURING THAT OUR AMA REMAINS FREE FROM MEDICAL MISINFORMATION, POLITICAL MANIPULATION AND COMMERCIAL SELF-PROMOTION**

**RESOLVED, that our American Medical Association (AMA) announce at least 6 weeks in advance of a meeting any confirmed or invited guest speakers and subsequently allow our members to send commentary regarding these speakers to the leaders who invite them to our meetings.**

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.

Your Reference Committee heard a plethora of testimony on Report E. Overall, the Report is well-written and addresses the concerns of the original resolution. Testimony requested that the Resolved clause be amended to specify the exact timeline and simplify the intention. Your Reference Committee agrees with this sentiment and proposes a substitute resolved clause that achieves these ends by allowing members to have awareness of speaker selection and creates an opportunity for open discussion on a specific timeline. As such, your Reference Committee recommends Alternate Report E be adopted in lieu of Report E and the remainder of the report be filed.

(17) RESOLUTION 1 – MINIMUM STANDARDS FOR PUBLIC HEALTH LEADERS

**RECOMMENDATION:**

**Alternate Resolution 1 be adopted in lieu of Resolution 1.**

**MINIMUM STANDARDS FOR PUBLIC HEALTH LEADERS**

**RESOLVED, that our American Medical Association (AMA) reaffirm that individuals appointed to federal public health leadership positions should demonstrate adherence to high-quality scientific evidence, support for evidence-based vaccination policy, and qualifications appropriate to the office; and be it further**

**RESOLVED, that our AMA publicly oppose actions, statements, and policies by federal public health leaders that undermine scientific consensus, vaccination confidence, or evidence-based medical practice; and be it further**

**RESOLVED, that our AMA advocate for evidence-based standards and minimum qualifications for federal public health leadership positions, including appropriate clinical and/or public health training, demonstrated scientific integrity, and commitment to evidence-based medicine and public health; and be it further**

**RESOLVED, that our AMA study and publicly report on the impacts of health misinformation and non-evidence-based federal health policies and statements on public health outcomes; 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.**

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.

Your Reference Committee heard substantial testimony on Resolution 1, including multiple speakers in support of the spirit and intent of the resolution. Testimony broadly emphasized the importance of defending evidence-based medicine, vaccination, and scientific integrity in federal public health leadership. However, several speakers expressed concern regarding the adversarial and individual-specific language and encouraged development of language that would support more durable, standards-based advocacy applicable across administrations and future nominees. Additional testimony suggested that reframing the policy around qualifications, scientific integrity, and evidence-based public health leadership would strengthen the long-term credibility, consistency, and sustainability of AMA advocacy while preserving the core intent of the resolution.

Your Reference Committee carefully considered the testimony presented and believes the new language appropriately preserves the resolution's central goals while establishing broader standards for federal public health leadership and advocacy. Further, it maintains recognition of the harms associated with health misinformation and non-evidence-based public health policy statements while avoiding language primarily centered on opposition to specific individuals. Your Reference Committee further discussed whether the resolution should be immediately forwarded to the AMA House of Delegates at the 2026 Annual Meeting and concluded that the issue is timely and warrants immediate consideration. Therefore, your Reference Committee recommends Alternate Resolution 1 be adopted in lieu of Resolution 1.

(18) RESOLUTION 2 – IMMEDIATE ACTION TO PREVENT FURTHER IMMIGRANT DEATHS

**RECOMMENDATION:**

**Alternate Resolution 2 be <u>adopted in lieu of Resolution 2</u>.**

**IMMEDIATE ACTION TO PREVENT FURTHER IMMIGRANT DEATHS**

**RESOLVED, that our American Medical Association (AMA) 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 endorse, disseminate, and encourage the use of "Know Your Rights" tools for physicians, patients, caretakers, and health care workers at all health care facilities to educate themselves and colleagues regarding the rights that patients, caretakers, and health care workers have when interfacing with immigration enforcement officials; and be it further**

**RESOLVED, that our AMA advocate for immigration status and place of birth or national origin to be considered as protected health information; and be it further**

**RESOLVED, that our AMA reaffirm health care facilities are sensitive, protected locations, as outlined in D-160.921, Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare, and further advocate for policies that:**

- **prohibit immigration agents from entering nonpublic, patient-sensitive areas of health care facilities without a warrant signed by a judge**
- **encourage health care facilities to adopt minimum enforceable guidelines for interactions with immigration enforcement authorities**
- **oppose mandated inquiries about patient immigration status in health care facilities**
- **encourage a multidisciplinary approach by physicians, other health care workers, administrators, law enforcement, and lawmakers to protect patients and caretakers from immigration enforcement actions; and be it further**

**RESOLVED, that our AMA reaffirm G-600.071, and will advocate in an urgent, timely manner all HOD policies related to the deportation, detention, and health and safety for all immigrants, migrants, refugees, detainees, and asylum seekers; and be it further**

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

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.

Your Reference Committee heard an overwhelming amount of testimony that was generally in support of the intent and spirit of this item, although many commenters offered a variety of amendments and suggestions for improvement. Your Reference Committee feels that this resolution is of high value and importance to our Section and attempted to maintain the spirit that the original author was seeking, while ensuring that we addressed the raised concerns and offered language that would strengthen this item when it moves forward to the House. We also offered editorial amendments to ensure the appropriate formatting of the resolved clauses. With regards to the second resolved clause, your Reference Committee heard overwhelming support, noting that it would likely be impactful if passed, and we felt that it was appropriate to broaden this language to also include patients and their caretakers. For the third and fourth resolved clauses, your Reference Committee found merit in the arguments offered by a few commenters that recognizing immigration status as protected health information should stand on its own. With regard to the fourth resolved clause, your Reference Committee utilized proposed amendments and concerns to craft language that would further expand on existing AMA policy that regards health care facilities as protected or sensitive

locations, while also addressing concern regarding physician involvement with immigration enforcement at their local institutions.

Your Reference Committee felt that by encouraging a multidisciplinary approach to this issue, some of the burden was removed from physicians solely accomplishing this task, which was raised as a concern during testimony. While we do understand the frustrations that may exist around the AMA's current advocacy efforts around this topic and the sentiment that not enough action is being taken, we did want to ensure that the final two resolved clauses were both written and operationalized in a way that would not threaten the political capital of our Section but also accomplish the goals of the author. Therefore, your Reference Committee moved to reaffirm policy G600.071, which directly addresses the concerns of the final two resolved clauses and was recently amended at I-25 for this purpose, while also specifically seeking urgent action from the AMA. We feel that there is merit in specifically calling out these priorities for advocacy as they are certainly timely and well supported in testimony. Finally, your Reference Committee discussed the merits of immediately forwarding this item and does agree with the urgency in light of both current issues and the political climate and the fact that several similar items are currently being considered in the House at this meeting. Overall, your Reference Committee feels that this item aligns well with the priorities of our Section, and we offer substitute language to consolidate the asks of the resolution into a more succinct, yet impactful set of asks. Therefore, your Reference Committee recommends that Alternate Resolution 2 be adopted in lieu of Resolution 2.

(19) RESOLUTION 9 – ENSURING AFFORDABLE COVERAGE: OPPOSING HSAS AS A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE

**RECOMMENDATION:**

**Alternate Resolution 9 be <u>adopted in lieu of Resolution 9</u>.**

**ENSURING AFFORDABLE COVERAGE: OPPOSING HSAS AS A SUBSITUTE FOR COMPREHENSIVE HEALTH INSURANCE**

**RESOLVED, that our AMA-RFS support efforts to mitigate inequities resulting from underinsurance and financial barriers to care associated with high-deductible health plan–Health Savings Account (HDHP-HSA) arrangements, particularly among lower-income and medically vulnerable patients.**

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.

Your Reference Committee heard mostly supportive testimony on Resolution 9, with amendments proffered. Significant discussion centered around better reflecting the nuanced

role HSAs play within the healthcare system and the need to improve alignment with existing AMA policy. Your Reference Committee agrees and believes the revised resolved clause strengthens the resolution by focusing on mitigating inequities and harms associated with certain HDHP-HSA arrangements rather than broadly opposing HSAs. Additionally, your Reference Committee recognizes the significant gap that exists in the RFS Position Compendium to guide our caucus' advocacy in the House around HSAs; an issue that has come up repeatedly over the past few meetings. Therefore, your Reference Committee recommends Alternate Resolution 9 be adopted in lieu of Resolution 9.

(20) RESOLUTION 11 – MODERNIZE THE MEDICARE PRIMARY CARE EXCEPTION TO ENSURE APPROPRIATE REIMBURSEMENT FOR SERVICES PROVIDED BY RESIDENTS

**RECOMMENDATION:**

**Alternate Resolution 11 be <u>adopted in lieu of Resolution 11</u>.**

**MODERNIZE THE MEDICARE PRIMARY CARE EXCEPTION TO ENSURE APPROPRIATE REIMBURSEMENT FOR SERVICES PROVIDED BY RESIDENTS**

**RESOLVED, that our American Medical Association (AMA) study the Medicare Primary Care Exception and develop specific, evidence-based advocacy recommendations to CMS for modernizing teaching-physician regulations governing reimbursement in resident continuity clinics while maintaining appropriate supervision and patient safety safeguards.**

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.

Your Reference Committee heard overwhelming supportive testimony on Resolution 11. The author provides a clear background and raises important concerns regarding appropriate reimbursement for services provided by residents. Some testimony favored adopting as amended with more specific language to achieve the asks of the authors, however it was also noted that while the original language asks CMS to act, the AMA first needs to develop a concrete, unified position to bring to CMS with authority. Your Reference Committee agrees and recommends Alternate Resolution 11 be adopted in lieu of Resolution 11.

# RECOMMENDED FOR REFERRAL

(21) RESOLUTION 5 – PROMOTING SAFETY THROUGH REVISION OF RESIDENT WORK HOUR LIMITS

**RECOMMENDATION:**

**Resolution 5 be <u>referred</u>.**

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).

Your Reference Committee heard mixed testimony on Resolution 5. There was significant discussion regarding the feasibility of these requirements given variance of clinical schedules and coverage between programs and specialties. Additionally, there was concern regarding which body would be the appropriate one to implement desired changes between programs, with the ACGME being identified as the most likely one to make this change. There was also concern that since the ACGME Common Program Requirements which outline work hour limits are currently undergoing revision and the moment for advocacy to change those has passed, it may be more beneficial to develop a stronger, future-facing policy recommendation that could gain more stakeholder engagement.

Overall, there was overwhelming testimony in support of referral to undertake a deeper examination of the topic and potential unintended consequences, with the goal of producing more refined and thoughtful language to bring to the House. Given the complexity of this ask and need to develop more appropriate recommendations, your Reference Committee recommends Resolution 5 be referred.

# RECOMMENDED FOR NOT ADOPTION

(22) RESOLUTION 3 – AMA'S AFFIRMATIVE COMMITMENT TO DEFENDING DEMOCRACY WITH ACTION

**RECOMMENDATION:**

**Resolution 3 not be adopted.**

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.

Your Reference Committee heard extensive testimony in opposition to this item. Most importantly, concerns were raised about the scope and implementation of the proposed resolved clauses. While your Reference Committee appreciates the importance of the issues raised in this resolution, including the relationship between democratic participation, voting access, and health equity, members expressed concern that the proposed language may be difficult to operationalize and may lack sufficient specificity to guide AMA advocacy efforts as well as the fact that existing AMA policy already commits the AMA to supporting democracy and access to voting. Members were also concerned that our AMA might not be the most appropriate body to accomplish some of the asks of this resolution, especially those in the first resolved clause surrounding how the AMA would operationalize the monitoring and identification of high-level threats. While amendments were proffered to alleviate some of these concerns, your Reference Committee felt that they did not fully mitigate the concerns of the majority, and therefore your Reference Committee recommends Resolution 3 not be adopted.

(23) RESOLUTION 14 – MOTIVATIONAL INTERVIEWING CURRICULUM FOR PHYSICIANS TO ADDRESS VACCINE HESITANCY

**RECOMMENDATION:**

**Resolution 14 not be adopted.**

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.

Your Reference Committee recommends Resolution 14 not be adopted. Mixed testimony was heard on this item with both opposition and proposed amendments, including concerns surrounding the appropriate body to create, store, and maintain this education; the fact that it is already being done well by multiple organizations with genuine educational infrastructure; and whether Motivational Interviewing is the only framework to recommend. Your Reference Committee agrees and has concerns that the issue is not merely a lack of materials but inconsistent integration into training. As such your Reference Committee does not believe this resolution even with the proffered amendment would meaningfully improve access to resources to support physicians with navigating vaccine hesitancy conversations. Therefore, your Reference Committee recommends Resolution 14 not be adopted.

This concludes the report of the RFS Reference Committee. I would like to thank Sheryl Fuehrer, MD, Sham Manoranjithan, MD, Daniel Resnick, DO, MBA, Shireen Saxena, MD, Michael Visenio, MD, MPH, Abbigayle Willgruber, MD, and all those who testified before the Committee.

Tristan Mackey, MD, Chair

Sheryl Fuehrer, MD

Sham Manoranjithan, MD

Daniel Resnick, DO, MBA

Shireen Saxena, MD

Michael Visenio, MD, MPH

Abbigayle Willgruber, MD