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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(I-25)

Introduced by: American College of Emergency Physicians

Subject: Ensuring Medical Liability Insurance Transparency and Continuity

Referred to: Reference Committee B

Whereas, timely and reliable medical liability insurance coverage is essential for the protection of physicians and patients, ensuring patient access to care; and

Whereas, recent closures of hospitals and of large physician staffing companies have resulted in physicians being left without adequate support, timely notification, or assistance in transitioning their practices when their employer-provided medical liability insurance was discontinued, thereby jeopardizing physician livelihoods and disrupting continuity of patient care[1,2,3]; and

Whereas, current processes for notifying physicians of policy changes, cancellations, or missed payments are inconsistent, leading to situations where physicians may unknowingly practice without coverage, putting both patients and physicians at risk; and

Whereas, immediate notification—defined as within three (3) business days—by medical liability insurance carriers would provide physicians the necessary opportunity to address coverage gaps or administrative errors in a timely manner; and

Whereas, AMA policy D-215.980 “Support Before, During, and After Hospital Closure or Reduction in Services” recognizes the significant impact of hospital closures, but does not yet explicitly address physician group closures, which can similarly disrupt continuity of care, patient safety, and physician employment; and

Whereas, expanding AMA policy to include physician group closures would strengthen advocacy and support for physicians and patients affected by abrupt practice disruptions; and

Whereas, occurrence-based medical liability insurance provides lifetime coverage for any claim arising from an incident that occurred during the policy period, regardless of when the claim is filed, thereby ensuring comprehensive long-term protection for physicians and their patients; and

Whereas, claims-made medical liability insurance covers claims only if both the alleged incident and the filing of the claim occur while the policy is active, but when coupled with a pre-paid tail policy (extending protection for claims filed after the policy ends), this structure offers equivalent comprehensive coverage and financial security to occurrence-based insurance; and

Whereas, both occurrence-based coverage and claims-made coverage with a pre-paid tail eliminate coverage gaps, reduce financial uncertainty, and provide continuity of protection, making them the gold standard for medical liability insurance; therefore be it

RESOLVED, that our American Medical Association advocate for legislation requiring immediate (within 3 business days) notification by the medical liability insurance carrier to the covered physician for any policy changes, cancellation, or missed payment (Directive to Take Action); and be it further

RESOLVED, that our AMA recognize that occurrence-based medical liability insurance or claims-made medical liability insurance with a pre-paid tail is the gold standard for medical liability coverage (New HOD Policy); and be it further

RESOLVED, that our AMA policy D-215.980 "Support Before, During, and After Hospital Closure or Reduction in Services" be amended so as to include physician group closures. (Modify Current HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/30/25

REFERENCES

1. "Steward Health Care raided its own medical malpractice insurance company," The Boston Globe, Spotlight Investigations, September 2024, https://apps.bostonglobe.com/metro/investigations/spotlight/2024/09/steward-hospitals/steward-traco/.
2. Janis M. Orlowski, "Displaced Hahnemann Residents and Attending Physicians May Soon Lose Liability Insurance," AAMC News, January 7, 2020, https://www.aamc.org/news/displaced-hahnemann-residents-and-attending-physicians-may-soon-lose-liability-insurance.
3. "The Disappearing Tail of Physician," EM Workforce (Substack), April 15, 2025, https://emworkforce.substack.com/p/the-disappearing-tail-of-physician.

RELEVANT AMA POLICY

D-215.980 Support Before, During, and After Hospital Closure or Reduction in Services

1. Our American Medical Association will work with appropriate federal and state bodies to assure that whenever there is a threatened, or actual, hospital closure a process be instituted to safeguard the continuity of patient care and preserve the physician-patient relationship. Such a process should:
    a. assure adequate capacity exists in the immediate service area surrounding the hospital closure, including independent health resources, physicians, and support personnel to provide for the citizens of that area;
    b. allow that in said circumstances, restrictive covenants, records access, and financial barriers which prevent the movement of physicians and their patients to surrounding hospitals should be waived for an appropriate period of time; and
    c. ensure financial reserves exist, and are sufficient to cover any previous contractual obligations to physicians, e.g., medical liability tail coverage.
2. Our AMA will proactively offer support to physicians, residents and fellows, patients, and civic leaders affected by threatened or actual healthcare facility closures, change in ownership, or significant reductions in services via provision of information, resources, and effective, actionable advocacy. Res. 719, A-24

H-435.998 Equitable Risk Classification in Medical Liability Premiums

Our American Medical Association supports the concept that premiums for medical liability insurance should reflect the costs and risks of providing that insurance to each category insofar as feasible based on accepted underwriting principles. Further, the policy of the AMA is that physicians who practice part-time should be entitled to reduced professional liability insurance premiums. Res. 15, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed and Appended: CMS Rep. 12, A-02; Reaffirmation I-03; Reaffirmed: CMS; Rep. 4, A-13; Reaffirmed: BOT Rep. 09, A-23

D-435.978 Loss of Medical Staff Privileges for Lack of "Tail Coverage"

1. Our American Medical Association advocates for better disclosures by professional medical liability insurance carriers to their policyholders about the continuing financial health of the carrier; and advocate that carriers create and maintain a listing of alternate professional liability insurance carriers in good financial health which can provide physicians replacement tail or other coverage if the carrier becomes insolvent.
2. Our AMA supports model medical staff bylaw language stating: "Where continuous professional liability insurance coverage is a condition of medical staff membership, a temporary loss of professional liability insurance coverage (whether or not limited to "tail" coverage) is not grounds for immediate termination of medical staff membership. The Medical Executive Committee shall determine the length and other conditions of an individual waiver of the coverage requirement." BOT Action in response to referred for decision Res. 537, A-04; Modified: CMS Rep. 1, A-14; Reaffirmed: BOT Rep. 09, A-24

H-230.995 Medical Liability Insurance Coverage as Mandatory Requirement for Hospital Staff Appointment

1. Each hospital medical staff should determine for itself whether or not it will require professional **liability insurance** coverage as a condition for membership on the hospital medical staff.

2. Our AMA also believes that, if equity demands that voluntary staff members should have **insurance** coverage so that the burden of financial loss would not fall entirely upon the hospital, then salaried hospital physicians should likewise be covered by adequate **insurance** or protected financially through self-**insurance** mechanisms established by the hospital, so that the burden would not fall unfairly upon the members of the voluntary medical staff.

3. Our AMA will seek federal legislation that would amend the federal bankruptcy code such that medical **liability** premiums that are contractually paid by a hospital on behalf of physician employees shall be considered a priority claim in bankruptcy filings and paid immediately out of the proceeds of the bankrupt hospital's estate.

BOT Rep. T, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 11, A-03; Reaffirmation A-04; Appended: Res. 230, I-10; Reaffirmed: BOT Rep. 04, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(I-25)

Introduced by: Mississippi

Subject: Increasing the Use of Retired Physicians in Teaching Students and Residents

Referred to: Reference Committee C

Whereas, in the teaching of medical students and residents, experience plays a significant role in passing on important aspects of patient care and medical treatment; and

Whereas, when physicians retire from active or full practice, they often seek ways to continue to contribute to their communities and profession; and

Whereas, the teaching of medical students and residents is a critical place where retired physicians could continue to contribute their skills and experience to a new generation of physicians and patients; and

Whereas, throughout the country, especially in rural based programs, medical schools and residency programs struggle to find qualified and experienced faculty and teachers; and

Whereas, there are often administrative hurdles and roadblocks which prevent retired physicians from fully participating in teaching programs at schools and residencies; therefore be it

RESOLVED, that our American Medical Association explore with the appropriate stakeholders creative and innovative ways to increase opportunities and decrease hurdles for retired physicians to participate fully as medical faculty at medical schools and residency training programs. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/22/25

RELEVANT AMA POLICY

H-200.972 Primary Care Physicians in Underserved Areas

1. Our American Medical Association should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
    a. encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care;
    b. encourage the affiliation of these family health clinics with local medical schools and teaching hospitals;
    c. advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies;
    d. encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence;
    e. urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations;
    f. encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations and
    g. urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.
2. Our AMA supports efforts to:
    a. expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and
    b. increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas. [CMS Rep. I-93-2 Reaffirmation A-01 Reaffirmation I-03 Modified: CME Rep. 13, A-06 Reaffirmed: CMS Rep. 01, A-16 Modified: CME Rep. 04, I-18 Appended: Res. 206, I-19 Reaffirmation: I-22 Reaffirmed: BOT Rep. 11, A-23 Reaffirmed: Res. 724, A-23 Reaffirmed: BOT Rep. 07, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(I-25)

Introduced by: Utah

Subject: Expanding Graduate Medical Education to Address Rural Primary Care Shortage

Referred to: Reference Committee C

Whereas, the state of Utah currently has the lowest number of primary care physicians per capita in the U.S. [1], with shortages even worse in Utah's rural communities [2]; and

Whereas, the number of medical students graduating from MD and DO programs in Utah has experienced explosive growth in the last decade [3], with continued growth in Undergraduate Medical Education (UME) expected [4]; and

Whereas, Utah is experiencing a large and growing deficit in Graduate Medical Education (GME) residency training positions relative to UME graduates [5], requiring students to leave Utah for residency training and reducing the likelihood of their return to Utah to practice [6]; and

Whereas, Utah has the fourth lowest number of primary care GME residency training positions per capita in the U.S. [7]; and

Whereas, the U.S. Centers for Medicare and Medicaid Services (CMS) is phasing out section 1115 demonstration authority to support Medicaid-funded workforce initiatives, eliminating a critical source of GME funding for states [8]; and

Whereas, the American Medical Association (AMA) is supportive of legislation that seeks to expand new GME slots nationwide and codify the Rural Residency Planning and Development Program [9]; and

Whereas, geographically expansive states like Utah have unique barriers to obtaining federal GME funding focused on rural primary care workforce development, including the Rural Residency Planning and Development Program [10]; and

Whereas, Utah's primary care physician shortages are anticipated to worsen without intentional support, especially in rural areas; and

Whereas, many other geographically expansive states face similar issues related to primary care physician supply and GME funding for training for primary care physicians; therefore be it

RESOLVED, that our American Medical Association lobby accreditation organizations and federal partners to create pathways and federal funding options for the development of rural primary care residency programs that allow hybrid training in urban and rural settings in geographically expansive states. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/24/25

REFERENCES

[1] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-primary-care-workforce-report-2024.pdf
[2] https://ruralhealth.utah.gov/wp-content/uploads/2021-PCNA.pdf
[3] https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard, Undergraduate Medical Education Data, Percent Change in Medical School Enrollment, accessed 8/12/2025.
[4] https://news.byu.edu/medical-school
[5] https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard, Graduate Medical Education Data, Percent Change in Residents and Fellows by Location, Training, and Degree, accessed 8/12/2025.
[6] https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard, Physician Retention Data, Physician Retention by Location, accessed 8/12/2025.
[7] https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard, Graduate Medical Education Data, Resident and Fellow Density by Location, Training and Degree, accessed 8/12/2025.
[8] https://www.medicaid.gov/resources-for-states/downloads/workforc-ltr-to-states.pdf
[9] https://www.ama-assn.org/education/gme-funding/congress-revives-bill-add-14000-gme-slots-over-seven-years
[10] https://www.ruralhealthinfo.org/assets/6011-28274/rrpd-fy-24.png

RELEVANT AMA POLICY

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

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.

AMA Policy – US Physician Shortage H-200.954

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.

4. Our AMA encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations.

5. Our AMA encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations.

6. Our AMA encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations.

7. Our AMA will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas.

8. Our AMA will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification.

9. Our AMA will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need.

10. Our AMA continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and

11. Our AMA continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.

12. Our AMA will:
    a. promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians;
    b. work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and
    c. monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

13. Our AMA will work to augment the impact of initiatives to address rural physician workforce shortages.

14. Our AMA supports opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas.

AMA Policy – Educational Strategies for Meeting Rural Health Physician Shortage H-465.988

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.
    d. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
    e. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
    f. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.

g. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
h. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
i. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
j. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
k. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
l. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.

3. Our AMA will:
a. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and
b. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.

4. Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.

5. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs.

AMA Policy – Enhancing Rural Physician Practices H-465.981

1. Our American Medical Association supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status.

2. Our AMA encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements.

3. Our AMA will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result.

4. Our AMA supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.

5. Our AMA will undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities.

AMA Policy – Access to and Quality of Rural Health Care H-465.997

1. Our American Medical Association believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or

state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources.

2. In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued.

AMA Policy – Improving Rural Health H-465.994

1. Our American Medical Association:
   a. supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health,
   b. urges physicians practicing in rural areas to be actively involved in these efforts, and
   c. advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.

2. Our AMA will work with other entities and organizations interested in public health to:
   a. Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
   b. Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
   c. Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
   d. Advocate for adequate and sustained funding for public health staffing and programs

3. Our American Medical Association will work with relevant stakeholders to develop a national strategy to eliminate rural cancer disparities in screening, treatment, and outcomes and achieve health equity in cancer outcomes across all geographic regions.

4. Our AMA calls for increased federal and state funding to support research on rural cancer disparities and equity in care, access, and outcomes and development of interventions to address those disparities.

5. Our AMA advocates for evidence-based collaborative models for innovative telementoring / teleconsultation between health care systems, academic medical centers, and community physicians to improve access to cancer screening, diagnosis, treatment, rehabilitation, and patient services in rural areas.

AMA Policy – Primary Care Physicians in Underserved Areas H-200.972

1. Our American Medical Association should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:
   a. encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care;
   b. encourage the affiliation of these family health clinics with local medical schools and teaching hospitals;
   c. advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies;
   d. encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence;
   e. urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations;

f. encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations and
g. urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.

2. Our AMA supports efforts to:
a. expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and
b. increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(I-25)

Introduced by: Resident and Fellow Section

Subject: Reasonable Workplace Accommodations for Residents and Fellows During Pregnancy

Referred to: Reference Committee C

Whereas, a 2020 systematic review by the Association of American Medical Colleges (AAMC), which analyzed 15 years of research on pregnancy among surgical residents, reported complication rates ranging from 25% to 82%, compared to 5% to 19% in the general U.S. population;[1] and

Whereas, a substantial body of evidence links night shifts, irregular hours, and long working hours during pregnancy to significant risks for both maternal and fetal health, with multiple systematic reviews highlighting the dangers of unrestricted scheduling during pregnancy;[2-8] and

Whereas, concerns about the risks of night shifts, irregular hours, and long working hours during pregnancy have been documented in the literature since the 1970s,[9] yet organized medicine has made minimal regulatory progress to protect pregnant trainees; and

Whereas, while some individual training programs have established internal policies to safeguard pregnant residents,[10-13] many training programs still fail to provide such accommodations;[14] and

Whereas, in a study of 167 emergency medicine residency programs regarding scheduling practices for pregnant residents, 60% of programs expressed that guidelines from graduate medical education organizations would be "very" or "extremely" useful in standardizing and improving policies;[14] and

Whereas, recent federal legislation, the Pregnant Workers Fairness Act, now mandates reasonable accommodations for pregnant employees, including modifications to work schedules;[15-16] and

Whereas, our AMA has existing policy encouraging the creation of written guidelines regarding schedule accommodations for pregnant residents, such as avoiding night call or modifying rotation schedules (H-405.960); however, existing policy does not obligate programs to include any such accommodations, or provide guidance to do so; and

Whereas, our AMA further emphasizes the importance of flexible staffing and scheduling in training programs to allow for coverage without overburdening other physicians (H-405.960); and

Whereas, our AMA has a longstanding commitment to reducing infant mortality and preterm birth risks (D-245.994), as well as supporting workplace policies that minimize exposure to known reproductive hazards during pregnancy (H-420.960); and

Whereas, recognizing that residency training itself has been implicated as a risk factor for adverse pregnancy outcomes,[1,17-19] it is imperative for our AMA to extend its advocacy to protect our own pregnant colleagues; and

Whereas, pregnant residents continue to experience significant stigmatization and discrimination, in part due to perceived detrimental effects on peer residents and their training programs due to accommodations during pregnancy,[20] which often leaves pregnant trainees feeling compelled to adhere to demanding schedules, even when such schedules compromise their health;[21] and

Whereas, our AMA is uniquely positioned to lead by collaborating with specialty organizations and working alongside the regulatory bodies within medicine (e.g. Accreditation Council for Graduate Medical Education (ACGME), American Board of Internal Medicine, American Board of Surgery, etc.) with the power to shape the training environment, to advocate for equitable working conditions that do not put pregnant trainees and their fetuses at risk; therefore be it

RESOLVED, that our American Medical Association work with relevant stakeholders to support the implementation of the following guidelines for all residency training programs:

a) Programs should provide evidence-based accommodations for pregnant trainees, such as opting out of night shifts during the first and third trimesters and attending scheduled medical appointments, and should implement them in such a way that they do not place an increased burden of work on other trainees; and
b) Scheduling for pregnant physicians in the third trimester should prioritize rotations with easily cancellable/coverable shifts to minimize departmental disruption in the event of medical necessity or early delivery;

(Directive to Take Action) and be it further

RESOLVED, that our AMA supports evidence-based policies and procedures which prioritize the safety and well-being of pregnant physicians. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/29/25

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RELEVANT AMA POLICY

Policies for Parental, Family and Medical Necessity Leave H-405.960

Our American Medical Association adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include:
    a. duration of leave allowed before and after delivery;
    b. category of leave credited;
    c. whether leave is paid or unpaid;
    d. whether provision is made for continuation of insurance benefits during leave, and who pays the premium;
    e. whether sick leave and vacation time may be accrued from year to year or used in advance;
    f. how much time must be made up in order to be considered board eligible;
    g. whether make-up time will be paid;
    h. whether schedule accommodations are allowed; and
    i. leave policy for adoption.
3. Our AMA policy is expanded to include physicians in practice, reading as follows:
    a. residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled;
    b. staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and
    c. physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA recommends that medical practices, departments, and training programs strive to provide 12 weeks of paid parental, family, and medical necessity leave in a 12-month period for their attending and trainee physicians as needed, with the understanding that no parent be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth,

abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements:
    a. leave policy for birth or adoption;
    b. duration of leave allowed before and after delivery;
    c. duration of leave allowed after abortion or stillbirth;
    d. category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability);
    e. whether leave is paid or unpaid;
    f. whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance;
    g. extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life;
    h. how time can be made up in order for a resident physician to be considered board eligible;
    i. what period of leave would result in a resident physician being required to complete an extra or delayed year of training;
    j. whether time spent in making up a leave will be paid; and
    k. whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements:
    a. leave policy for birth or adoption;
    b. duration of leave allowed before and after delivery;
    c. extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life;
    d. how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays;
    e. what period of leave would result in a medical student being required to complete an extra or delayed year of training; and
    f. whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
9. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
10. 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.
11. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
12. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
13. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
14. In order to accommodate leave protected by the federal Family and Medical Leave Act, our

AMA encourages all specialties within the American Board of Medical Specialties (ABMS) to allow graduating residents to extend training after the traditional residency completion date while still maintaining board eligibility, in the event of leave beyond six weeks. Our AMA encourages specialty boards to develop flexible policies for board certification for those physicians who take leave beyond the minimum of six weeks of family or medical leave (per ABMS policy) and whose residency programs are able to certify that residents meet appropriate competencies for program completion.

15. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
16. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
17. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.
18. Medical schools are encouraged to develop clear, equitable parental leave policies and determine how a 12-week parental, family, or medical leave may be incorporated with alternative, timely means of completing missed curriculum while still meeting competency requirements necessary to complete a medical degree.
19. Our AMA opposes any discrimination related to physicians taking protected leave during training and/or medical practice for medical, religious, and/or family reasons.
20. Our AMA will encourage relevant stakeholders to survey physicians and medical students who have taken family leave, in an effort to learn about the experiences of various demographic groups and identify potential disparities in career progression trends.

[CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22; Modified: CME Rep. 01 and Res. 306, I-23; Modified: Res. 302, I-24]

Improving and Standardizing Pregnancy and Lactation Accommodations for Medical Board Examinations H-275.915

1. Our American Medical Association supports and will advocate for the implementation of a minimum of 60 minutes of additional, scheduled break time for all test takers who are pregnant and/or lactating during all medical licensure and certification examinations.
2. Our AMA supports the addition of pregnancy comfort aids, including but not limited to ginger teas, saltines, wastebaskets, and antiemetics, to any medical licensure or certification examination's pre-approved list of Personal Item Exemptions (PIEs) permitted in the secure testing area for all test takers who are pregnant and/or lactating.

[Res. 321, A-22]

Infant Mortality D-245.994

1. Our AMA will work with appropriate agencies and organizations towards reducing infant mortality by providing information on safe sleep positions and preterm birth risk factors to physicians, other health professionals, parents, and child care givers.
2. Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevalence of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparative effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives. [Res. 410, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

Effects of Work on Pregnancy H-420.960

1. Our American Medical Association supports the right of employees to work in safe workplaces that do not endanger their reproductive health or that of their unborn children.
2. Our AMA supports workplace policies that minimize the risk of excessive exposure to toxins with known reproductive hazards irrespective of gender or age.
3. Our AMA encourages physicians to consider the potential benefits and risks of occupational activities and exposures on an individual basis and work with patients and employers to define a healthy working environment for pregnant people.
4. Our AMA encourages employers to accommodate increased physical requirements of pregnant people; recommended accommodations include varied work positions, adequate rest and meal breaks, access to regular hydration, and minimizing heavy lifting.
5. Our AMA acknowledges that future research done by interdisciplinary study groups composed of obstetricians/gynecologists, occupational medicine specialists, pediatricians, and representatives from industry can best identify adverse reproductive exposures and appropriate accommodations.

[CSA Rep. 9, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-12; Modified: CSAPH Rep. 1, A-22]

Research into Preterm Birth and Related Cardiovascular and Cerebrovascular Risks in Women D-420.992

1) Our AMA will advocate for more research on ways to identify risk factors linking preterm birth to cardiovascular or cerebrovascular disease in pregnant women.

[Res. 504, A-17; Modified: Speakers Rep. 02, I-24]

Reducing Inequities and Improving Access to Insurance for Maternal Health Care H-185.917

1) Our American Medical Association acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color.
2) Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust.
3) Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.
4) Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers.
5) Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be:
    a) Informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories),
    b) Carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections.
    c) Lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.
6) Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.

7) Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.
8) Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.
9) Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.
10) Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.
11) Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives.
12) Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care.

[Joint CMS/CSAPH Rep. 1, I-21]

Parental Leave and Planning Resources for Medical Students D-295.308

1. Our American Medical Association will work with key stakeholders to advocate that parties involved in medical training (including but not limited to residency programs, administration, fellowships, away rotations, physician evaluators, and research opportunities) do not discriminate against students who take family/parental leave.
2. Our AMA encourages medical schools to create comprehensive informative resources that promote a culture that is supportive of their students who are parents, including information and policies on parental leave and relevant make up work, options to preserve fertility, breastfeeding, accommodations during pregnancy, and resources for childcare that span the institution and the surrounding area.

[Res. 307, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(I-25)

Introduced by: Resident and Fellow Section

Subject: Remedying the Harms of AMA's Role in the Flexner Report

Referred to: Reference Committee C

Whereas, the publication of Abraham Flexner's 1910 report ("The Flexner Report"), funded by the AMA and the Carnegie Foundation, caused the closure of all but two historically Black medical schools, depleting the health workforce of over 35,000 Black physicians over the ensuing century[1-2]; and

Whereas, historically Black medical schools have a transformational role in diversifying the health workforce, representing only 2.4% of medical schools in the country while producing 14% of Black medical graduates[3]; and

Whereas, diversification of the physician workforce is critical for the health of the nation, yet our workforce is far from representative[4-7]—even if the proportion of Black, Hispanic, and Indigenous medical students were immediately doubled, it would take 66, 92, and 51 years, respectively, to reach parity with national demographics[8-9]; and

Whereas, our American Medical Association (AMA) has "[recognized] the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations" (H-350.960); and

Whereas, our AMA policy directs our organization to "advocate for and promote racism-conscious, reparative, community engaged interventions at the health system, organized medical society, local, and federal levels which seek to identify, evaluate, and address the health, economic, and other consequences of structural racism in medicine" (H-65.943); and

Whereas, our AMA has committed to "[taking] a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community" (D-200.985); and

Whereas, our AMA has highlighted an obligation for physicians to acknowledge the spillover effects of the Flexner Report, hold ourselves and other responsible parties accountable for the Report's impacts, and strive to remedy the direct harms caused[10-12]; and

Whereas, the Department of Education provided upwards of $100 million to Historically Black Graduate Institution programs each year in 2023 and 2024 for developing, maintaining, and improving key infrastructure for these institutions,[13] and any disruptions to this and other federal funding sources would significantly impact historically Black medical schools; therefore be it

RESOLVED, that our American Medical Association partner with relevant public and private sector organizations and community stakeholders to make a transformative financial investment into the opening of new medical schools and sustainability of existing medical schools affiliated with Historically Black Colleges & Universities (HBCUs), Tribal Colleges & Universities (TCUs),

and other Minority Serving Institutions (MSIs), remedying the harms of the 1910 Flexner Report in regards to the diversity of the physician workforce, and advancing population health equity (Directive to Take Action); and be it further

RESOLVED, that our AMA prioritize our organization's efforts to bolster diversity, equity, and inclusion across the medical education continuum, as part of our strategic commitments to remedying the harms of the 1910 Flexner Report, diversifying the physician workforce, and advancing population health equity. (Directive to Take Action)

Fiscal Note: Major - To Be Determined

Received: 9/29/25

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RELEVANT AMA POLICY

Redressing the Harms of Misusing Race in Medicine H-65.943

1. Our American Medical Association recognizes the exacerbation of health and economic inequities due to race-based algorithms as a manifestation of racism within the medical field.
2. Our AMA will 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 race-based medicine.
3. Our AMA advocates for and promotes racism-conscious, reparative, community engaged interventions at the health system, organized medical society, local, and federal levels which seek to identify, evaluate, and address the health, economic, and other consequences of structural racism in medicine. [Res. 014, A-23]

Underrepresented Student Access to US Medical Schools H-350.960

1. Our American Medical Association recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population.
2. Our AMA supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.
3. Our AMA recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination.
4. Our AMA is committed to promoting truth and reconciliation in medical education as it relates to improving equity.
5. Our AMA recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations.
6. Our AMA will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine.
7. Our AMA will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school.
8. Our AMA will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants.
9. Our AMA will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine.
10. Our AMA will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, encouraging state and local governments to make quality elementary and secondary education available to all.

[Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21; Appended: Res. 305, I-22]

Promising Practices Among Pathway Programs to Increase Diversity in Medicine D-350.980

Our American Medical Association will establish a task force to guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education.

[CME Rep. 5, A-21]

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

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.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population.
13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

[CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22; Modified: Res. 320, A-23]

Racism as a Public Health Threat H-65.952

1. Our American Medical Association acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of:
    a. The causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism.
    b. How to prevent and ameliorate the health effects of racism.
4. Our AMA:
    a. supports the development of policy to combat racism and its effects.
    b. encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

[Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22; Reaffirmed: Res. 320, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 801
(I-25)

Introduced by: Michigan

Subject: Excessive Cost of Multi-State DEA Licensure

Referred to: Reference Committee J

Whereas, many physicians seek licensure in multiple states due to locum tenens work, telehealth work, and/or coverage of patients who seek jobs or education in other states; and

Whereas, many physicians seek medical licensure and Drug Enforcement Administration (DEA) licensure in multiple states to legally provide these services across state lines; and

Whereas, a DEA license is a federal license; and

Whereas, DEA licensure requires a separate application and the full DEA licensure fee for each state in which licensure is desired; and

Whereas, obtaining a multi-state DEA licensure application is inconvenient and expensive despite DEA licensure being a federal (national) license; and

Whereas, the DEA has been encouraging improved access to controlled substances utilized as medications for opioid use disorder to reduce opioid-related overdoses as a federal concern; and

Whereas, the DEA has changed the educational requirements for obtaining an initial or a renewed DEA license to reflect this concern with a one-time attestation for this educational requirement at the federal level; and

Whereas, the time and monetary expense of obtaining DEA licensure in multiple states may limit access rather than encourage access to controlled substances utilized as medications for opioid use disorder; therefore be it

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

Fiscal Note: Minimal – less than $1,000

Received: 9/3/25

RELEVANT AMA POLICY

One Fee One Number D-100.975
1. Our AMA will work with the Drug Enforcement Administration (DEA) and Congress to move toward a system in which individual physician DEA registration numbers are person-specific rather than site-specific within a state. Additionally, the AMA will work with the DEA to ensure that the full DEA registration fee is paid only once, when the provider initially registers. Following the initial registration, provider should only pay a small re-registration fee every three years to fund the work of the Diversion Control Program.

2. Our AMA will work with the DEA, Congress and state licensing boards to explore changes to the DEA registration system so that a single DEA registration number can be used by physicians who prescribe, dispense, and/or administer controlled substances in multiple states. Our AMA will explore the possible development of a national DEA standard which would be greater than or equal to the most stringent state requirements for controlled substances. Providers could choose whether they would like to apply for the national DEA standard, or, more likely for those practicing in a single state, remain registered with the DEA under their single state requirements.

3. Our AMA continues to monitor implementation of the National Provider Identifier (NPI) system and work with physicians and payers to ensure proper and prompt payment for physician claims. Additionally, the AMA will monitor physician privacy concerns associated with the public consumption of the NPI database.

One Fee, One Number D-100.980
Our AMA will work with the appropriate agencies to require only one federal DEA number that would be physician-specific and not site-specific.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 803
(I-25)

Introduced by: Integrated Physician Practice Section

Subject: Ensuring Physician Input in the Development of Alternative Payment Models (APMs)

Referred to: Reference Committee J

Whereas, AMA policy D-385.950 "CMMI Payment Reform Models" and H-330.894 "Demonstration Project Regarding Medicare Part D" are against mandatory and for voluntary Center for Medicare and Medicaid Innovation (CMMI) models; and

Whereas, AMA policy H-385.901 "Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payments for Pediatric Health Care and Specialty Populations" advocates for CMMI models that serve specialties and policies not served by current models; and

Whereas, the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), was intended to improve the efficiency and effectiveness of healthcare using proposed solutions from frontline stakeholders[1]; and

Whereas, to date, there have been no PTAC recommended models that have been tested or implemented by CMMI[2,3]; and

Whereas, CMMI has not been transparent about why PTAC recommended models are rejected for testing or implementation[4]; and

Whereas, CMMI has recently signaled its new strategic direction, which includes amongst others, "increas[ing] independent provider participation in value-based payment programs;"[5] therefore be it

RESOLVED, that our American Medical Association seek meaningful and transparent involvement of physicians who could potentially be CMMI APM model participants throughout the model development process, prior to approval for testing or implementation. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/10/25

REFERENCES
1. Physician-Focused Payment Model Technical Advisory Committee. PTAC frequently asked questions. Office of the Assistant Secretary for Planning and Evaluation, United States Department of Health and Human Services. https://aspe.hhs.gov/collaborations-committees-advisory-groups/ptac/ptac-faqs Accessed May 23, 2025.
2. Raths, D. (2024, April 11). Surgeon leader to Congress: Make CMMI test physician-developed APMs. Healthcare Innovation. https://www.hcinnovationgroup.com/policy-value-based-care/alternative-payment-models/news/55017602/surgeon-leader-to-congress-make-cmmi-test-physician-developed-apms Accessed May 23, 2025.
3. Berlin, J. (April 2020). Going nowhere: APM committee resignations cast doubt on payment model's future. Texas Medical Association. https://www.texmed.org/Template.aspx?id=53087 Accessed May 23, 2025
4. Raths, D. (2019, Nov 20). PTAC members resign, frustrated with HHS rejection of payment model proposals. Healthcare Innovation. https://www.hcinnovationgroup.com/policy-value-based-care/alternative-payment-models/news/21115452/ptac-members-resign-frustrated-with-hhs-rejection-of-payment-model-proposals Accessed May 23, 2025.
5. Centers for Medicare & Medicaid Services. (2025). CMS Innovation Center 2025 strategy to make America healthy again. https://www.cms.gov/priorities/innovation/about/strategic-direction Accessed May 23, 2025.

RELEVANT AMA POLICY

CMMI Payment Reform Models D-385.950
Our AMA will: (1) continue to advocate against mandatory Center for Medicare and Medicaid Innovation (CMMI) demonstration projects; (2) advocate that the Centers for Medicare and Medicaid Services seek innovative payment and care delivery model ideas from physicians and groups such as medical specialty societies to guide recommendation of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and work of the CMMI to propose demonstration projects that are voluntary and can be appropriately tested; and (3) advocate that CMMI focus on the development of multiple pilot projects in many specialties, which are voluntary and tailored to the needs of local communities and the needs of different specialties. Citation: Res. 213, A-21

Demonstration Project Regarding Medicare Part D H-330.894
1. Our American Medical Association will continue its policy of promoting beneficiary choice and market based options in the context of the Medicare prescription drug benefit program (Part D).
2. Our AMA encourages the development of voluntary models under the auspices of the CMS Innovation Center (CMMI) to test the impact of offering Medicare beneficiaries additional enhanced alternative health plan choices that offer lower, consistent, and predictable out-of-pocket costs for select prescription drugs.

Citation: BOT Action in response to referred for decision Res. 142, A-07; Reaffirmed: CMS Rep. 01, A-17; Appended: CMS Rep. 4, A-22

Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations H-385.901
1. Our American Medical Association supports appropriate demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena.
2. Our AMA will extend ongoing payment reform research, education, and advocacy to address the needs of specialties and patient populations not served by current CMMI models or other Medicare-focused payment reform efforts.
3. Our AMA will support and work with national medical specialty societies that are developing alternative payment models for specific conditions or episodes, target patient populations including pediatric populations, and medical and surgical specialties and continue to advocate that the Centers for Medicare and Medicaid Services, including the Center for Medicare and Medicaid Innovation; state Medicaid agencies; and other payers implement physician-developed payment models.
4. Our AMA will consider improved Medicaid payment rates to be a priority given the critical impact these payment rates have on patient care and patient access to care.
5. Our AMA will support and collaborate with state and national medical specialty societies and other interested parties on the development and adoption of physician-developed alternative payment models for pediatric health care that address the distinct prevention and health needs of children and take long-term, life-course impact into account. Citation: Res. 817, I-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 810
(I-25)

Introduced by: Private Practice Physicians Section

Subject: Opposing Unilateral Downcoding of Physician Services by Insurance Companies

Referred to: Reference Committee J

Whereas, insurance companies, including Cigna and Aetna, have announced new reimbursement policies that authorize downcoding of evaluation and management (E/M) services[1,2]; and

Whereas, these unilateral downcoding practices reduce reimbursement one level below what physicians bill, based on the insurer's internal review, even when the services were performed and documented according to AMA E/M guidelines ; and

Whereas, the policies require physicians to submit full patient records through burdensome reconsideration and appeal processes, shifting administrative costs and burdens onto physicians and their practices; and

Whereas, such unilateral actions directly interfere with the physician's professional judgement, undermine proper valuations of complex cognitive services, and contradict the AMA's long-standing advocacy for fair, accurate physician payment based on CPT® and E/M guidelines; and

Whereas, patients may be harmed if practices are forced to limit services, shorten visits, or withdraw from payer networks due to unsustainable payment policies; and

Whereas, our AMA exists to protect and represent its physician membership against the systematic harassment of our practices by insurance company behaviors; therefore be it

RESOLVED, that our American Medical Association vigorously oppose unilateral downcoding of evaluation and management (E/M) services by insurance companies, including but not limited to Cigna's "Evaluation and Management Coding Accuracy (R49)" program and Aetna's "Claim and Code Review Program (CCRP)" (New HOD Policy); and be it further

RESOLVED, that our AMA advocate the insurers adhere to AMA CPT® and E/M guidelines as the nationally recognized standard for coding and reimbursement, without unilateral reinterpretation (Directive to Take Action); and be it further

RESOLVED, that our AMA work with state medical associations, specialty societies, and regulatory authorities to challenge these payer policies through regulatory, legislative, and when appropriate, legal channels (Directive to Take Action); and be it further

RESOLVED, that our AMA report back on payer downcoding practices, their effects on physicians and patients, and strategies for collective advocacy at the 2026 Annual Meeting. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 9/22/25

REFERENCES

1. Cigna Healthcare. (2025). Evaluation and Management Coding and Accuracy. Reimbursement policy: R49. https://static.cigna.com/assets/chcp/secure/pdf/resourceLibrary/clinReimPolsModifiers/R49_Evaluation_and_Management_Coding_Accuracy.pdf. Accessed September 2, 2025.
2. Aetna. (2023). Claim and Code Review Program (CCRP) update. March, 2023: https://www.aetna.com/health-care-professionals/newsletters-news/office-link-updates-march-2023/90-day-notices-march-2023/claim-code-review-program-update.html. Accessed September 2, 2025.
3. Centers for Medicare & Medicaid Services. Evaluation & management visits. May 23, 2025: https://www.cms.gov/medicare/payment/fee-schedules/physician/evaluation-management-visits. Accessed September 2, 2025.

RELEVANT AMA POLICY

Medicare Guidelines for Evaluation and Management Codes H-70.952

Our AMA (1) seeks Federal regulatory changes to reduce the burden of documentation for evaluation and management services; (2) will use all available means, including development of new Federal legislation and/or legal measures, if necessary, to ensure appropriate safeguards for physicians, so that insufficient documentation or inadvertent errors in the patient record, that does not meet evaluation and management coding guidelines in and of itself, does not constitute fraud or abuse; (3) urges CMS to adequately fund Medicare Carrier distribution of any documentation guidelines and provide funding to Carriers to sponsor educational efforts for physicians; (4) will work to ensure that the additional expense and time involved in complying with documentation requirements be appropriately reflected in the Resource Based Relative Value Scale (RBRVS); (5) continues to advise and educate physicians about the guidelines, any revisions, and their implementation by CMS; and (6) AMA policy is that in medical documentation the inclusion of any items unrelated to the care provided (e.g., irrelevant negatives) not be required.

Citation: Sub. Res. 801, I-97; Reaffirmed: I-00; Reaffirmed: CMS Rep. 6, A-10; Modified: CMS Rep. 01, A-20

Automatic Downcoding of Claims D-320.972

1. Our American Medical Association vigorously opposes health plans using software, algorithms, or methodologies, other than manual review of the patient's medical record, to deny or downcode evaluation and management services, except correct coding protocol denials, based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th revision, codes, and/or modifiers submitted on the claim.
2. Our AMA supports that, after review of the patient’s medical record and determination that a lower level of evaluation and management code is warranted, the explanation of benefits, remittance advice documents, or other claim adjudication notices provide notice that clearly indicates a service was downcoded using the proper claim adjustment reason codes and/or remittance advice remark codes.
3. Our AMA will advocate for legislation to provide transparency and prohibit automated denials, other than National Correct Coding Initiative denials, or downcoding of evaluation and management services based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th Revision, codes, or modifiers submitted on the claim.
4. Our AMA will further evaluate what legislative and/or legal action is needed to bar insurers from automatic downcoding and to provide transparency on all methodology of processing claims.

Citation: Res. 714, A-24
Bundling and Downcoding of CPT Codes H-70.937

Our AMA: (1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers;

(2) makes it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards;

(3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and

(4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers.

Citation: Res. 802, I-98; Reaffirmed: Res. 814, A-00; Modified: Sub. Res. 817; Reaffirmed: BOT Rep. 8, I-00; Reaffirmed: I-01; Reaffirmed: I-04; Reaffirmed: A-06; Reaffirmed: A-07; Reaffirmed: CMS Rep. 01, A-17

Pay-for-Performance Principles and Guidelines H-450.947

1. The following *Principles for Pay-for-Performance and Guidelines for Pay-for-Performance* are the official policy of our AMA.

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.
2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.
4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.
5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.

- Evidence-based quality of care measures must be the primary measures used in any program.
1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
4. Performance measures should be scored against both absolute values and relative improvement in those values.
5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.
6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
7. Performance measures must be selected for clinical areas that have significant promise for improvement.

- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.

- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.

- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.

- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.

- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.

- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.

- Programs must not create conditions that limit access to improved care.
1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.

2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).

- Programs must neither directly nor indirectly encourage patient de-selection.

- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

Physician Participation

- Physician participation in any PFP program must be completely voluntary.

- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.

- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.

- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.

- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
1. Programs should provide physicians with tools to facilitate participation.
2. Programs should be designed to minimize financial and technological barriers to physician participation.

- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.

- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.

- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.

- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).

- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
1. Programs should use accurate administrative data and data abstracted from medical records.
2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.

- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.

- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.

- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.
1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.

- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

- Programs must be based on rewards and not on penalties.

- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.

- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.

- Programs must finance bonus payments based on specified performance measures with supplemental funds.

- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.

- Programs must not reward physicians based on ranking compared with other physicians in the program.

- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.

- Programs must not financially penalize physicians based on factors outside of the physician's control.

- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.

- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance."

Citation: BOT Rep. 5, A-05; Reaffirmed: A-06; Reaffirmed: Res. 210, A-06; Reaffirmed in lieu of: Res. 215, A-06; Reaffirmed in lieu of: Res. 226, A-06; Reaffirmed: I-06; Reaffirmed: A-07; Reaffirmed: A-09; Reaffirmed: BOT Rep. 18, A-09; Reaffirmed in lieu of: Res. 808, I-10; Modified: BOT Rep. 8, I-11; Reaffirmed: Sub. Res. 226, I-13; Appended: BOT Rep. 1, I-14; Reaffirmed in lieu of: Res. 203, I-15; Reaffirmed in lieu of: Res. 216, I-15; Reaffirmed: I-15; Reaffirmed; BOT Rep. 20, A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: A-18; Reaffirmed: A-22; Reaffirmed: CMS Rep. 07, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 820
(I-25)

Introduced by: Private Practice Physicians Section

Subject: Establishing an AMA “First Responder Team” for Real-Time Physician Advocacy Against Adverse Insurance Company Actions

Referred to: Reference Committee J

Whereas, our American Medical Association has already established comprehensive policies opposing systemic insurance company processes designed to delay or obstruct legitimate billing claims and payment processing essential to patient care and physician practice operations; and

Whereas, despite these existing policies that guide the AMA legislative and public priorities on a macro level, individual physicians and small practices across the nation remain alone on the frontlines at the point of care, the micro-level defending against often punitive, daily increases in insurance payment hurdles against appropriate claim submissions to major insurers including Untied Healthcare, Cigna, and Aetna to name a few; and

Whereas, small practices have neither the resources, bandwidth, nor national scope to realize the coming storms that a national advocacy organization working in real-time with our practices can realize; and

Whereas, in 2025, our members of the Private Practice Physicians Section have separately reported an exponentially growing number of varied unreasonable and predatory examples of insurance company actions (punitive documentation requirements, “historical alternans” with regard to criteria for authorizations, and much more) which need an advocate in real-time rather than post-mortem; and

Whereas, insurance companies have demonstrated a pattern of mid-treatment coverage interruptions, with documented cases of physicians even being contacted during surgical procedures regarding coverage decisions, forcing providers to make costly decisions to operate out-of-network to avoid financial risk; and

Whereas, our AMA exists to protect and represent its physician membership against the systematic harassment of our practices by insurance company behaviors; and

Whereas, the current system leaves physicians alone with biased insurance company provider representatives, only to rarely adjudicate these complaints months to years later with the patients and the practice often long gone and system-wide changes, whether via the legal, legislative, or public policy routes, are helpful but are too often simply academic postmortems missing the real-time advocacy for which physicians on the frontlines are begging; and

Whereas, one example of many was recently when Optum demanded immediate and full repayment of the loans they provided some practices as a result of the Change Healthcare cybersecurity disaster; an AMA first responder team for physician advocacy against predatory insurance company actions for physicians to engage with would have been ideal here; and

Whereas, a 2024 AMA survey reveals that 93 percent of physicians experienced delays due to prior authorization and 82 percent reported that these processes cause patients to abandon

treatment altogether, with physicians warned that, “there’s good evidence that these kinds of delays literally kill people;” and

Whereas, insurance companies made similar reform pledges in 2018 and 2023 that resulted in little meaningful change and current 2024 pledges lack specific timelines and enforcement mechanisms, demonstrating that voluntary industry self-regulation is ineffective; and

Whereas, when physicians and their practices experience these systematic unpredictable storms of obstructions, their current recourse through state medical societies and insurance company provider representatives proves inadequate, with little to no influence, acknowledgement, response, or expediency in addressing urgent practice-threatening situations; and

Whereas, in countless other professional and activist contexts of American citizenry outside medicine, individuals facing harassment or punishment by larger predatory systems, be it from the government or corporations, members of advocacy organizations took to their representative organizations to provide immediate liaising, defense, and services, to protect their members from predatory intimidation; and

Whereas, small practices facing insurance company harassment have no current mechanism or avenues, let alone ones as capable as the AMA, for real-time advocacy and representation, leaving them vulnerable to financial insolvency while waiting for traditional bureaucratic channels; and

Whereas, the absence of immediate advocacy support against these predators contributes to physician dissatisfaction with our representative organizations as practicing physicians struggle to identify tangible, real-time benefits that address their most pressing daily operational challenges; therefore be it

RESOLVED, that our American Medical Association establish a “first responder team for physician advocacy against adverse insurance company actions” to provide urgent liaison services and advocacy representation for individual physicians and their practices when they are confronted with what appears to be predatory harassment, systematic obstruction, or punitive changes including, but not limited to:

- sudden increased in claim denials,
- arbitrarily onerous documentation requirements,
- mid-treatment coverage interruptions

(Directive to Take Action); and be it further

RESOLVED, that an AMA “first responder team for physician advocacy against adverse insurance company actions” be a pilot program for the first two years of operation that will develop ongoing protocols to prioritize future cases brought to them, catalog them, and then report back to the House of Delegates annually (Directive to Take Action); and be it further

RESOLVED, that an AMA “first responder team for physician advocacy against adverse insurance company actions” will coordinate relevant information and strategy with other existing AMA programs already engaged in implementing existing AMA policy protecting the rights of physicians and their practices from insurance company behaviors. (Directive to Take Action)

Fiscal Note: $393,195 – Establish First Responder Team

Received: 9/22/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 902
(I-25)

Introduced by: New England Delegation

Subject: Advocating for Improvements in Systems of Care for Autism

Referred to: Reference Committee K

Whereas, one in 36 eight-year-old children is currently identified as having autism spectrum disorder (ASD)[1], a disorder that has no cure but has effective treatments to improve quality of life and academic and employment outcomes. Early diagnosis of ASD may allow for earlier and more successful interventions to optimize development and behavior[2]; and

Whereas, there are documented disparities in the age of initial ASD diagnosis of African American, Hispanic, non-English speaking, and immigrant children and primary care child health teams must also be alert to the potential for gender bias in symptom recognition[3, 4]; and

Whereas, there are waiting times ranging from six months to over a year for diagnostic evaluations of children who had positive screens for behaviors and developmental delays suggestive of autism spectrum disorder. In Massachusetts, the Autism Omnibus Act mandates a diagnosis be given by a physician or psychologist. There are specific pediatric subspecialty and child psychiatry workforce issues that along with a surge in demand for ASD evaluations are necessitating an adapted approach to ASD diagnosis centered on the primary care pediatric office. Academic medical centers in the Commonwealth are piloting a number of training projects for primary care pediatric offices to diagnose ASD[7]; and

Whereas, when the pediatric team in the medical home has a longitudinal relationship with families of young children and has received training on autism diagnosis, they can reliably diagnose autism spectrum disorder (ASD), especially when the symptoms present early in childhood[8,9]; and

Whereas, primary care pediatric teams that are clinically trained in the diagnosis of autism spectrum disorders (ASD) may be unable to successfully integrate the evidence-based autism evaluation and complex care coordination into their practices due to significant reimbursement and workflow barriers that make the numerous long visits and administrative time required for diagnosis unprofitable for a private practice or community health center[10]; and

Whereas, the American Academy of Pediatrics (AAP) has been supporting pediatric teams on equitable and sustainable solutions to reduce the barriers to ASD diagnosis and care. The AAP has distributed a “Dear Payer Letter,” which recommends adequate payment and appropriate coverage of diagnostic, therapeutic, and care coordination services for autism in the medical home[11]; therefore be it

RESOLVED, that our American Medical Association advocate for peer reviewed, evidence-based guidance for states on innovative health systems solutions to reduce specific barriers to the diagnosis of autism and complex care coordination in the medical home by primary care team members trained in the diagnosis of autism. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/18/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 910
(I-25)

Introduced by: Women Physicians Section

Subject: Increasing Funding for Gynecological Cancer Research

Referred to: Reference Committee K

Whereas, gynecological cancers, defined as cervical, ovarian, uterine, fallopian tube, vaginal, and vulvar, have high morbidity and mortality due to a multitude of factors including no reliable screening methods for uterine, ovarian, vaginal, or vulvar cancers[1-4]; and

Whereas, gynecological cancers are underfunded compared to other cancer sites[5, 6]; and

Whereas, in 2016, the "Cancer Moonshot" bill aimed to expedite cancer research by allocating $1.8 billion dollars based on a Funding to Lethality Score (FLS), a method to standardize incidence, mortality, and life lost[5, 7]; and

Whereas, FLS is calculated using mortality to incidence ratio (MIR), person-years-of-life lost per incident case, and total amount of funding reported by the NCI[5]; and

Whereas, ovarian, cervical, and uterine cancers ranked 10th, 12th, and 14th, respectively, out of 18 cancer sites for average FLS[5]; and

Whereas, ovarian cancer received $97,000 through "Cancer Moonshot", cervical cancer $87,000, and uterine cancer $57,000[5]; and

Whereas, FLS for ovarian, cervical, and uterine cancers are decreasing over time, leading to growing disparities in research funding allocation[5]; and

Whereas, since 2020, NIH funding for ovarian cancer research has decreased from $188 to $171 million[6]; and

Whereas, since 2019, NIH funding for vaginal cancer research has decreased from $4 million to $3 million and is one of the most underfunded cancers by the NIH[6]; and

Whereas, there is no NIH funding allocation specifically for vulvar or fallopian tube cancer research[6]; and

Whereas, despite NIH funding for uterine and cervical cancer research funding increasing to $42 million and to $164 million in 2023, respectively, they remain underfunded compared to other cancer sites with decreasing or lower FLS[5, 6]; and

Whereas, although the FLS for prostate cancer has decreased, NIH funding for prostate cancer research has increased from $263 to $305 million since 2019[5, 6]; and

Whereas, disparities in cancer funding extend beyond reproductive cancers with liver and brain cancer research receiving higher NIH funding despite being less prevalent (0.01% prevalence each) compared to ovarian (0.06%) and uterine (0.07%) cancers in 2022[6]; and

Whereas, in 2023, NIH funding was $189 million for liver cancer research and $427 million for brain cancer research[6]; and

Whereas, underfunding leads to decreased trial enrollment and fewer trials available for patient enrollment, which impacts the number of high-level treatment recommendations[5]; and

Whereas, significant research funding for prostate cancer led to the establishment of prostate-specific antigen (PSA) screening as a widely utilized tool, resulting in a 50% reduction in annual prostate cancer mortality[8, 9]; and

Whereas, although cervical cancer screening advancements, including HPV-DNA testing with Pap smears, have improved detection rates, further research into additional tools such as HPV DNA methylation and liquid-based cytology, may enhance the identification of high-grade cervical lesions[10]; and

Whereas, due to critical underfunding, gynecological cancers remain an area of research with a lack of evidence-based guidelines for screening, diagnosis, and treatment for these conditions; and

Whereas, gynecological cancers disproportionately affect minority and underserved populations, with higher mortality rates due to limited access to preventative care, and treatments, emphasizing the need for increased research funding to address inequities[12]; and

Whereas, the Society of Gynecologic Oncology declared a crisis in gynecologic cancer clinical trial access and outlined a five-step plan to address the crisis, including increased funding for clinical trials[11]; therefore be it

RESOLVED, that our American Medical Association advocates for increased funding to gynecological cancer research from all available resources, both public and private (Directive to Take Action); and be it further

RESOLVED, that our AMA supports increased research efforts into current and the development of new screening methods for gynecological cancers (New HOD Policy); and be it further

RESOLVED, that our AMA supports increasing research to develop screening methods to increase early diagnosis of gynecologic malignancies. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/5/25

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RELEVANT AMA POLICY

D-420.989 Addressing Disparities and Lack of Research for Endometriosis

1. Our American Medical Association will collaborate with stakeholders to recognize endometriosis as an area for health disparities research that continues to remain critically underfunded, resulting in a lack of evidence-based guidelines for diagnosis and treatment of this condition amongst people of color.
2. Our AMA will collaborate with stakeholders to promote awareness of the negative effects of a delayed diagnosis of endometriosis and the healthcare burden this places on patients, including health disparities among patients from communities of color who have been historically marginalized.
3. Our AMA will advocate for increased endometriosis research addressing health disparities in the diagnosis, evaluation, and management of endometriosis.
4. Our AMA will advocate for increased funding allocation to endometriosis-related research for patients of color, especially from federal organizations such as the National Institutes of Health.

[Res. 921, I-23]

D-55.997 Cancer and Health Care Disparities Among Minority Women
Our American Medical Association encourages research and funding directed at addressing racial and ethnic disparities in minority women pertaining to cancer screening, diagnosis, and treatment.
[Res. 509, A-08 Modified: CSAPH Rep. 01, A-18]

H-460.888 Advanced Research Projects Agency for Health (ARPA-H)
Our American Medical Association will urge Congress and the Administration to ensure that while providing adequate funding for the promising research conducted at Advanced Research Projects Agency for Health (ARPA-H), it also provides robust annual baseline increases in appropriations for other research agencies, centers, and institutes, including, but not limited to, the NIH and NCI.
[Res. 519, A-22]

H-55.971 Screening and Treatment for Breast and Cervical Cancer Risk Reduction
1. Our American Medical Association supports programs to screen all at-risk individuals for breast and cervical cancer and that government funded programs be available for low income individuals; the development of public information and educational programs with the goal of informing all at-risk individuals about routine cancer screening in order to reduce their risk of dying from cancer; and

increased funding for comprehensive programs to screen low income individuals for breast and cervical cancer and to assure access to definitive treatment.
2. Our AMA encourages state and local medical societies to monitor local public health screening programs to ensure that they are linked to treatment resources in the public or private sector.
3. Our AMA encourages the Centers for Medicare and Medicaid Services to evaluate and review their current cervical cancer screening policies to ensure coverage is consistent with current evidence-based guidelines.
4. Our AMA supports further research by relevant parties of HPV self-sampling in the United States to determine whether it can decrease health care disparities in cervical cancer screening**.**
[CCB/CLRPD Rep. 3, A-14 BOT Action Sept 2023]

D-450.957 Clinical Guidelines and Evidence Regarding Benefits of Prostate Cancer Screening and Other Preventive Services
Our AMA will: (1) continue to advocate for inclusion of relevant specialty societies and their members in guideline and performance measure development, including in technical expert panels charged with developing performance measures; (2) work with the federal government, specialty societies, and other relevant stakeholders to develop guidelines and clinical quality measures for the prevention or early detection of disease, such as prostate cancer, based on rigorous review of the evidence which includes expertise from any medical specialty for which the recommendation may be relevant to ultimately inform shared decision making; and (3) encourage scientific research to address the evidence gaps highlighted by organizations making evidence-based recommendations about clinical preventive services.
[Res. 225, I-15 Appended: CMS Rep. 06, A-19]

D-425.999 Public and Private Funding of Prevention Research
Our AMA seeks to work in partnership with the Centers for Disease Control and Prevention, the National Institutes of Health, and other Federal Agencies, the Public Health Community, and the managed care community to ensure that there is a national prevention research agenda.
[Res. 418, I-98 Reaffirmed: CSAPH Rep. 2, A-08 Modified: CSAPH Rep. 01, A-18]

H-440.872 HPV Associated Cancer Prevention
1. Our American Medical Association;
    a. strongly urges physicians and other health care professionals to educate themselves, appropriate patients, and patients' parents or caregivers when applicable, about HPV and associated diseases, the importance of initiating and completing HPV vaccination, as well as routine HPV related cancer screening; and
    b. encourages the development and **funding** of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.
2. Our AMA will work with interested parties to intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.
3. Our AMA supports legislation and **funding** for **research** aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers.
4. Our AMA;
    a. encourages the integration of HPV vaccination and appropriate HPV-related cancer screening into all appropriate health care settings and visits;
    b. supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups, 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.
5. Our AMA supports efforts by states to increase HPV vaccine availability and accessibility, and HPV vaccination rates through a combination of policies such as facilitating administration of HPV vaccinations in community-based settings including local health departments and schools, reminder-based interventions, school-entry requirements, and requirements for comprehensive and evidence-based sexual education.

6. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination, according to ACIP recommendations, to people who are incarcerated for the prevention of HPV-associated cancers.
7. Our AMA advocate that racial, ethnic, socioeconomic, and geographic differences in high-risk HPV subtype prevalence be taken into account during the development, clinical testing, and strategic distribution of next-generation HPV vaccines.
8. Our AMA will encourage continued **research** into (a) interventions that equitably increase initiation of HPV vaccination and completion of the HPV vaccine series; (b) the impact of broad opt-out provisions on HPV vaccine uptake; and (c) the impact of the COVID-19 pandemic and vaccine misinformation on HPV vaccine uptake.

[Res. 503, A-07 Appended: Res. 6, A-12 Reaffirmed: CSAPH Rep. 1, A-22 Reaffirmation: A-22 Modified: Res. 916, I-22 BOT Action Sept. 2023 Modified: CSAPH Rep. 02, I -24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 913
(I-25)

Introduced by: New Jersey

Subject: Establish AMA Policy and Project to Compile and Distribute JAMA Patient Pages to Enhance Public Medical Literacy

Referred to: Reference Committee K

Whereas, medical literacy is essential for patients to make informed decisions about their care and improve health outcomes; and

Whereas, the Journal of the American Medical Association (JAMA) has published “JAMA Patient Pages” for years as a trusted source of accessible, evidence-based medical information for patients and the public; and

Whereas, these patient pages cover a wide range of common health conditions, preventive care measures, and treatment options, providing valuable guidance to patients in understandable language; and

Whereas, these patient pages cover a wide range of common health conditions, preventive care measures, and treatment options, providing valuable guidance to patients in understandable language; and

Whereas, existing JAMA Patient Pages represent a substantial, high-quality repository of patient education materials that could be more widely utilized to promote medical literacy; and

Whereas, easily accessible and well-organized patient education materials can support patients in managing their health, understanding treatment options, and fostering effective partnerships with physicians in their care and recovery; and

Whereas, making these patient pages available to the general public in a consolidated, searchable, and freely accessible format would enhance public understanding of medical issues and contribute to health equity by reducing disparities in medical literacy; and

Whereas, our American Medical Association has a long-standing commitment to advancing public health and promoting informed patient decision-making; therefore be it

RESOLVED, that our American Medical Association support publicizing the existence and value of JAMA Patient Pages as a resource for public health education and medical literacy (New HOD Policy); and be it further

RESOLVED, that our AMA support compiling and organizing previously published JAMA Patient Pages into a publicly accessible database or repository for the purpose of improving medical literacy and fostering patient-physician partnerships (Directive to Take Action); and be it further

RESOLVED, that our AMA explores opportunities to promote awareness and utilization and ease of use of JAMA Patient Pages among patients, physicians and healthcare institutions. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 9/26/25

[1]AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 914
(I-25)

Introduced by: New Jersey

Subject: Develop Climate-Conscious Resources for Physicians

Referred to: Reference Committee K

Whereas, climate change poses a significant and immediate threat to public health, with impacts that include increased heat-related illnesses, respiratory conditions, vector-borne diseases, and disruptions to healthcare delivery; and

Whereas, the healthcare sector, including the U.S. healthcare system, is both affected by climate change and a significant contributor to greenhouse gas emissions; and

Whereas, physicians and other healthcare professionals play a vital role in advocating for environmentally sustainable practices within the healthcare system and in educating patients about the health impacts of climate change; and

Whereas, initiatives developed by a national foundation has been very successful at decreasing unnecessary tests, treatments, and procedures; and

Whereas, a national foundation has developed a comprehensive resource, broken down by specialty, focused on the intersection of climate change and healthcare, providing guidance, educational materials, and actionable recommendations to reduce the environmental impact of clinical practices; therefore be it

RESOLVED, that our American Medical Association support compiling and maintaining a resource for U.S. physicians, focused on education physicians and other healthcare professionals about the health impacts of climate change and the role of the healthcare sector in contributing to greenhouse gas emissions (New HOD Policy); and be it further

RESOLVED, that our AMA support providing practical, evidence-based recommendations for reducing the environmental footprint of clinical practices and healthcare systems (New HOD Policy); and be it further

RESOLVED, that our AMA support offering resources and tools to support physicians in advocating for environmentally sustainable policies and practices within their organization and communities (New HOD Policy); and be it further

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

Fiscal Note: Major -

Received: 9/26/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 915
(I-25)

Introduced by: New Jersey

Subject: Reduce Environmental Impact of Medical Journals

Referred to: Reference Committee K

Whereas, the U.S. healthcare system generates a tremendous amount of waste, contributing 8.5% of greenhouse gas emissions and producing 4 billion pounds of waste annually; and

Whereas, there are over 1 million physicians in the United States, each of whom receives, on average, multiple medical journals monthly; and

Whereas, these journals are commonly wrapped in low-density polyethylene (LDPE), a material that, according to the Environmental Protection Agency (EPA), contributed 500,000 tons to U.S. landfills in 2015; and

Whereas, plastics, including LDPE, have been found in human blood, stool, and urine, and are known to cause cell death, allergic reactions, and inflammation; and

Whereas, a majority of physicians in a recent study expressed a preference for digital formats over print versions of medical journals; therefore be it

RESOLVED, that our American Medical Association continue to explore environmentally sustainable practices and that medical journals be provided via electronic-only means by default, and that physicians and other recipients be required to opt in to receive print versions (Directive to Take Action); and be it further

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

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 9/26/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 916
(I-25)

Introduced by: New Jersey

Subject: Studying the Environmental Impact of Ambient Clinical Intelligence Use

Referred to: Reference Committee K

Whereas, ambient clinical intelligence is proving to be an important technology tool for strengthening the physician-patient relationship and reducing physician burnout; and

Whereas, the demand for ambient clinical intelligence tools is significantly increasing and has a projected growth of by 38.62% from 2025 to 2030; and

Whereas, the growth of data centers to support ambient clinical intelligence is also being built to accommodate demand and place a significant strain on the electrical grid with potential public health implications; and

Whereas, data centers, as part of their routine operation, account for 1% of global electricity usage and this percentage is predicted to grow to 21% by 2030; and

Whereas, training a single AI model can emit over 284,000 kg of carbon dioxide; and

Whereas, built data centers come with an additional environmental cost of soil damage in areas where mineral extraction is done, pollution from the manufacturing of data center components and electronic waste from retired hardware, which have grown to more than 50 million pounds annually with only about 20% of it is recycled; and

Whereas the direct impact on public health and infrastructure caused by data centers have been quantified to be as high as $5.4 billion dollars in a 5-year period; therefore be it

RESOLVED, that our American Medical Association in collaboration with state medical societies, develop a framework to study the public health impact and ecological challenges posed by the growth of ambient clinical intelligence (Directive to Take Action); and be it further

RESOLVED, that our AMA support efforts to voluntarily report emissions, water use, and e-waste from data centers to allow for public health entities to anticipate care and coverage costs to affected populations (New HOD Policy); and be it further

RESOLVED, that our AMA works with stakeholders to encourage state and federal legislatures to offer specific tax incentives to ambient clinical intelligence vendors to work toward using 100% sustainable energy sources (Directive to Take Action); and be it further

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

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 9/26/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 928
(I-25)

Introduced by: New Jersey

Subject: AMA's Continued Support for COVID-19 Vaccination in Pregnant Individuals and Children

Referred to: Reference Committee K

Whereas, on May 27, 2025, the CDC removed its recommendation for COVID-19 vaccination in healthy pregnant individuals and children aged 6 months–17 years (1); and

Whereas, pregnancy is a recognized high-risk condition for severe COVID-19 illness and infants born to unvaccinated mothers are more vulnerable in the first six months of life (2); and

Whereas, the AMA has previously demonstrated that the COVID-19 vaccination during pregnancy is safe for both mother and infant with no increase in miscarriage, preterm birth, or adverse fetal outcomes (3); and

Whereas, existing AMA policy D-440.921 ("An Urgent Initiative to Support COVID-19 Vaccination and Information Programs") emphasizes the necessity to promote the integrity of COVID-19 vaccine information; and

Whereas, the AMA does not have existing policy explicitly recommending ongoing Covid-19 vaccination for healthy pregnant individuals and children aged 6 months through 17 years old; therefore be it

RESOLVED, that our American Medical Association calls on the U.S. Centers for Disease Control and Prevention, Health and Human Services, and the Department of Health and Human Services to restore explicit recommendations for COVID-19 vaccination of pregnant individuals and young children aged 6 months to 17 years. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 9/30/25

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2. 2,Grünebaum A, Chervenak FA. Professional Responsibility for COVID-19 Vaccination in Pregnancy. JAMA. Published online June 25, 2025. doi:10.1001/jama.2025.11328
3. What doctors wish patients knew about COVID-19 vaccines and pregnancy. American Medical Association. Published November 12, 2021. https://www.ama-assn.org/delivering-care/public-health/what-doctors-wish-patients-knew-about-covid-19-vaccination

RELEVANT AMA POLICY

An Urgent Initiative to Support COVID-19 Vaccination and Information Programs D-440.921
Our AMA will institute a program to promote the integrity of a COVID-19 vaccination information program by: (1) educating physicians on speaking with patients about COVID-19 infection and vaccination, bearing in mind the historical context of “experimentation” with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about up-to-date, evidence-based information regarding COVID-19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations; (5) educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online; and (6) supporting the public purchase and cost-free distribution and administration of COVID-19 booster vaccine doses.