REFERRAL CHANGES AND OTHER REVISIONS
2025 Interim Meeting

REVISED REPORTS

- BOT 08 – On the Ethics of Human Lifespan Prolongation
- BOT 10 – Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients
- BOT 14 – AMA Efforts on Medicare Payment Reform and Increasing Transparency of AMA Medicare Payment Reform Strategy
- BOT 15 – Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research Report

RESOLUTIONS WITH ADDITIONAL SPONSORS
(Additional sponsors underlined)

- Res. 001 - Clarifying Conscientious Objection (New England Delegation, Resident and Fellow Section)
- Res. 009 – Gender Equity in Disability Insurance for Physicians (New England Delegation, Resident and Fellow Section)
- Res. 210 – PBM Divestiture and Transparency (Florida, South Carolina, Tennessee, Oklahoma, Medical Student Section)
- Res. 232 - Safeguarding Access to IVF Amid Restorative Reproductive Medicine Legislation (American Society for Reproductive Medicine, The Endocrine Society, American Association of Clinical Endocrinology, American Society for Reproductive Medicine)
- Res. 310 – Remedying the Harms of AMA's Role in the Flexner Report (Resident and Fellow Section, Underrepresented in Medicine Advocacy Section)
  (If accepted for business by the House)
- Res. 812 – Discontinue Review Choice Demonstration Project for Inpatient Rehabilitation Hospital Admissions (American Academy of Physical Medicine and Rehabilitation, Association of Academic Physiatrists)
- Res. 926 – Establishment of Federal and State Offices of Men's Health (American Urological Association, American Association of Clinical Urologists, Washington, California, Arizona)

ORDER OF BUSINESS
SECOND SESSION

Saturday, November 15, 2025; 12:30 PM

1. Call to Order by the Speaker – Lisa Bohman Egbert, MD
2. Report of the Rules and Credentials Committee – Tate Hinkle, MD
3. Presentation Correction and Adoption of Minutes from the June 2025 Annual Meeting
4. Referral Changes and Other Revisions
5. Acceptance of Business

--REPORTS--

Report(s) of the Board of Trustees - David H. Aizuss, MD, Chair

01	Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis	B
02	Laser Surgery	B
03	Stark Law Self-Referral Ban	B
04	Addressing and Reducing Patient Boarding in Emergency Departments (EDs)	B
05	Addressing the Unregulated Body Brokerage Industry	E&B
06	Information Blocking Rule	B
07	Codification of the Chevron Deference Doctrine	B
08	On the Ethics of Human Lifespan Prolongation	E&B
09	2025 AMA Advocacy Efforts	Info. Report
10	Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients	E&B
11	Supporting Diversity in Research	E&B
12	Support For Doula Care Programs	B
13	Antidiscrimination Protections for LGBTQ+ Youth in Foster Care	B
14	AMA Efforts on Medicare Payment Reform and Increasing Transparency of AMA Medicare Payment Reform Strategy	Info. Report
15	Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research Report	B
16	Preservation of Medicaid	B
17	Establishing an Advisory Committee on AI/AN Affairs	Info. Report
18	Published Metrics for Hospitals and Hospital Systems	J
19	Addressing the Historical Injustices of Anatomical Specimen Use	E&B
20	AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates	Info. Report
21*	Specialty Society Representation in the House of Delegates - Five-Year Review	EB
22*	Physician Assistant and Nurse Practitioner Movement Between Specialties	B

23*	Accreditation Council for Continuing Medical Education Observer Status in the House of Delegates	F
24*	Amending Vaccine-related Policies	K

Report(s) of the Council on Constitution and Bylaws - Jerry P. Abraham, MD, MPH, Chair

01	Bylaws Review Report	E&B
02	Bylaws Clarifications Subsequent to A-25 House of Delegates Meeting	E&B
03	Credentialing of Temporary Delegates and Alternate Delegates	E&B

Report(s) of the Council on Ethical and Judicial Affairs - Rebecca Brendel, MD, Chair

01	Amendment to Opinion 1.1.1 "Patient-Physician Relationships"	E&B
02	Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	E&B
03	Ethical Impetus for Research in Pregnant and Lactating Individuals	E&B

Opinion(s) of the Council on Ethical and Judicial Affairs - Rebecca Brendel, MD, Chair

01	Contracts to Deliver Health Care Services	Info. Report
02	Organ Transplantation Allocation Decisions	Info. Report

Report(s) of the Council on Long Range Planning and Development - Jan Kief, MD, Chair

01	Private Practice Physicians Section Five-Year Review	F
02	Evaluation of the Structure of the AMA House of Delegates	F

Report(s) of the Council on Medical Education - Kelly J. Caverzagie, MD, FACP, FHM, Chair

01	Additional Pathways for International Medical Graduates	C

Report(s) of the Council on Medical Service - Betty Chu, MD, MBA, Chair

01	Health Savings Account Reform	J
02	Telehealth Licensure	J
03	Payment Models to Sustain Rural Hospitals	J
04	Payment for Biosimilars	J

Report(s) of the Council on Science and Public Health - Padmini Ranasinghe, MD, MPH, Chair

01	Drug Shortages: 2025 Update	Info. Report
02	Regulation of Ionizing Radiation Exposure for Health Care Professionals	K
03	Plastic Pollution Reduction	K

Report(s) of the HOD Committee on Compensation of the Officers - Jessica Krant, MD, Chair

01	Report of the House of Delegates Committee on the Compensation of the Officers	F

Report(s) of the Speakers - Lisa Bohman Egbert, MD, Speaker; John H. Armstrong, MD, Vice Speaker

01	Online Reference Committees	F
02	Election Committee Review of Election Rules for Clarification	F
03	Speaker Recorded Interviews for AMA Elections	Info. Report

--EXTRACTION OF INFORMATIONAL REPORTS--

Report(s) of the Board of Trustees

09 2025 AMA Advocacy Efforts

14 AMA Efforts on Medicare Payment Reform and Increasing Transparency of AMA Medicare Payment Reform Strategy

17 Establishing an Advisory Committee on AI/AN Affairs

20 AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates

Opinion(s) of the Council on Ethical and Judicial Affairs

01 Contracts to Deliver Health Care Services

02 Organ Transplantation Allocation Decisions

Report(s) of the Council on Science and Public Health

01 Drug Shortages: 2025 Update

Report(s) of the Speakers

03 Speaker Recorded Interviews for AMA Elections

--INTRODUCTION OF RESOLUTIONS--

001	Clarifying Conscientious Objection	E&B
002	Ensuring Ethical Use of Wearable Recording Devices in Clinical Encounters	E&B
003	Report on Gender-Based Pay Equity in Medicine	E&B
004	Patient Options to Restrict Secondary Use of Their Healthcare Data	E&B
005	Preserving Autonomy in the Patient-Physician Relationship	E&B
006	Amendment to AMA Bylaws to Enable Continuity of Leadership	E&B
007	Improving Protection for Reproductive Health Information	E&B
008	Health Plan In-Network Steering of Pathology/Laboratory Services	E&B
009	Gender Equity in Disability Insurance for Physicians	E&B
010*	Clarifying the Medical Student Section's and Resident and Fellow Section's Abilities to Fill Temporary Vacancies in Accordance with the AMA Bylaws	E&B
201	Model State Legislation incorporating Medical Malpractice Tort Reform Based on Utah H.B. 503 (2025)	B
202	Deepfake Technology and Harm to Physicians and Patients	B
203	Restore and Enhance Federal Loan Programs for Medical Education	B
204	Addressing Anti-Physician Contractual Provisions	B
205	Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care	B
206	Restore Funding to USAID	B
207	Support for a Federal Tax Incentive for Volunteer Community Preceptors	B
208	Centralization of Medicare Provider Data Sources	B
209	Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians	B
210	PBM Divestiture and Transparency	B

211	Access to, and Retention of, Electronic Medical Records	B
212	Acknowledging Flexibility on Buprenorphine Mono-product Use for Opioid Use Disorder Opioid Use Disorder	B
213	Pathways to U. S. Permanent Residency for H-1B Physicians	B
214	Physician Visa Protection and Pathway to Serve Underserved Communities	B
215	Extending the Medicaid Work Requirement Exemption up to 12 Months Postpartum	B
216	Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs	B
217	Protecting Access to Public Service Loan Forgiveness (PSLF), Income-Driven Repayment (IDR), and Direct Plus Loans for Graduate or Professional Students (Grad PLUS Loans)	B
218	Amend AMA Policy D-160.921 on Sensitive Locations to Protected Areas	B
219	Addressing the Harms and Misleading Nature of Medicare Advantage Plans	B
220	Medicare Should not Unfairly Penalize Physicians	B
221	Not-for-Profit Status	B
222	Tackling Administrative Waste—Let Us Be Part of the Solution to Putting Our Health System on a Sustainable Path	B
223	Halt the Rollout of New Payment Models by the Center for Medicare & Medicaid Innovation (CMMI)—A New Administration Offers an Opportunity	B
224	Recoupment by CMS Recovery and Audit Contractors (RAC)—Due Process	B
225	Federal Legislation to Prohibit the Corporate Practice of Medicine	B
226	Transparency with the Term “Emergency Department”	B
227	Call for Immediate and Aggressive Action by the AMA to Reverse Medicaid Cuts Impacting Seniors	B
228	Support Permanent Funding and Expansion of Native Hawaiian Healthcare	B
229	Protection of Medicaid Beneficiaries’ Private Health Information from Immigration Enforcement	B
230	Banning Non-compete Agreements in States	B
231	Ensuring Equitable and Timely Medical Licensure for Physicians Providing Abortion and Gender-Affirming Care	B
232	Safeguarding Access to IVF Amid Restorative Reproductive Medicine Legislation	B
233	Renewing Mental Health Infrastructure in the School System	B
234	Study on Impact of Inflation Reduction Act on Oncology, Other Physician Practices	B
236	Deceptive Advertising in Accredited Allied Health Professional, Non-Physician Graduate Programs	B
237	Protecting and Improving Rural Health	B
301	Preventing Sleep Deprivation and Supporting Medical Student Wellness	C
304	Systemic Exclusion of IMGs from Residency Programs	C
305	Paid Sick Leave and Flexible Work Arrangements for Caregivers of Individuals with Special Needs, Chronic Illness, or Elderly Parents	C
306	Support for Paid Prenatal Leave	C
307	Integrating Artificial Intelligence (AI) Literacy Into UME, GME, and CME	C
308	Enhancing the Pathway for Black Male Medical Students	C
311	Gender and URiM Disparities in Surgical Training Volumes	C

313*	Hardship for International Medical Graduates from Palestine	C
601	Reimagining and Modernizing the U.S. Healthcare Delivery System	F
602	Standardizing the Appointment Process for AMA Councils	F
603*	Upholding Professional Integrity and Ethical Leadership through Continued Publication of the AMA Journal of Ethics	F
604*	Sustaining Ethical Leadership Through Continued Support of the AMA Journal of Ethics	F
802	Patient Choice of Physician	J
804	Medicare Advantage Filing Limit	J
805	Shared Medical Appointments	J
806	Insurance Coverage for Colonoscopy Preparation Cost	J
807	Protecting Hospitals and Patients from Inappropriate Denials of Inpatient Admissions	J
808	No Prior Authorization for Inexpensive Medications	J
809	Ensuring Patient Safety and Physician Oversight in the Integration of Hospital Inpatient Virtual Nursing	J
811	Non-Medical Switching	J
812	Discontinue Review Choice Demonstration Project for Inpatient Rehabilitation Hospital Admissions	J
813	Increased Regulation of For-Profit Healthcare Insurance	J
814	Mandate for Insurance Companies to Assist in the Transition of Patients to Alternative Participating Physicians Upon Contract Termination	J
815	Mandating Health Insurers to Provide a Real-Time Online Tool for Coverage and Payment Policies, Integrated into Electronic Health Records (EHRs)	J
816	Prohibit Arbitrary Time Limits on Preauthorizations	J
817	Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service	J
818	Universal Out-of-Network Benefits	J
819	Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS	J
821	Improving Access to Emergency Ophthalmologic Surgical Care	J
822	Improving Home or Community-Based Services Waiver Waiting List Management	J
823	Accountability in the Use of Augmented Intelligence for Prior Authorization	J
824	Equitable Payment and Increased Access for In-Office Pediatric Lead Screening and Testing	J
825	Ensuring Coverage for In-Office Point-of-Care (POC) Testing in Outpatient Medical Practices	J
826	Increase National Immunization Rates by Advocating for Equitable Vaccine Payments	J
827	Opposition to Prior Authorization in Medicare Fee-for-Service, Burdensome Administrative Requirements	J
828	Creating a Public Scorecard on Insurer Delays in Care and Payment Caused by Prior Authorization	J
829	Publicize Insurer Financial Gains from Delayed Care and Payment Caused by Prior Authorization	J

901	Distinction Between Healthful and Unhealthful “Ultraprocessed” Foods	K
903	Nitrous Oxide Inhalant Abuse	K
904	Supporting Certification of the Public Health Workforce	K
905	Standardizing Brain Death Policies	K
906	Rethink the Medicare Annual Wellness Visit	K
907	In-Office Dispensing of Generic Medications	K
908	Support of Access to Insulin-Detemir	K
909	Clinical Significance of Sleepiness	K
911	Safeguarding NIH-Funded and Other Women’s Health Research in Peer-Reviewed Publishing	K
912	Increasing Access through Federated Healthcare Data Architecture	K
917	Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup	K
918	Remove Outdated Barriers to Genetic Testing	K
919	Strengthening Trust through AMA-Based Leadership for Evidence-Based Vaccines (STABLE Vaccines)	K
920	Alcohol and Aging: Educating Physicians and Advocating for Safer Warnings	K
921	Prioritizing Deprescribing in Seniors	K
922	Addressing Health Impacts of Indian Boarding Schools	K
923	Enhancing Disaster Preparedness Mechanisms for People with Disabilities	K
924	Preserving Access to Gamete Donation and Gestational Carriers and Protecting Parental Rights	K
925	Evidence-Based Vaccine and Preventive Services Recommendations	K
926	Establishment of Federal and State Offices of Men’s Health	K
927	Battlefield Acupuncture – An Educational Call to Arms	K
929	Protecting Access to Evidence-based Psychotropic Medication for the Treatment of Pediatric Mental Illness	K
930	Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing	K
931	Preserving Evidence-Based, Equitable Grooming Standards in Military Service	K
932	Shared Decision-Making and Low Dose CT Lung Cancer Screening in Clinical Practice	K
933	Addressing Gaps in National Healthcare Safety Network (NHSN) Data Quality	K

--RESOLUTIONS NOT FOR CONSIDERATION--

235	Ensuring Medical Liability Insurance Transparency and Continuity	B
302	Increasing the Use of Retired Physicians in Teaching Students and Residents	C
303	Expanding Graduate Medical Education to Address Rural Primary Care Shortage	C
309	Reasonable Workplace Accommodations for Residents and Fellows During Pregnancy	C
310	Remedying the Harms of AMA’s Role in the Flexner Report	C
312*	Promoting the Equitable Evaluation of Non-Research Domains in Trainee Selection	C
801	Excessive Cost of Multi-State DEA Licensure	J
803	Ensuring Physician Input in the Development of Alternative Payment Models (APMs)	J
810	Opposing Unilateral Downcoding of Physician Services by Insurance Companies	J

820	Establishing an AMA "First Responder Team" for Real-Time Physician Advocacy Against Adverse Insurance Company Actions	J
902	Advocating for Improvements in Systems of Care for Autism	K
910	Increasing Funding for Gynecological Cancer Research	K
913	Establish AMA Policy and Project to Compile and Distribute JAMA Patient Pages to Enhance Public Medical Literacy	K
914	Develop Climate-Conscious Resources for Physicians	K
915	Reduce Environmental Impact of Medical Journals	K
916	Studying the Environmental Impact of Ambient Clinical Intelligence Use	K
928	AMA's Continued Support for COVID-19 Vaccination in Pregnant Individuals and Children	K
934*	Partnership with the Administration to Reduce Harmful Chemicals in Food and Align with European Safety Standards	K

**Contained in Meeting Tote*

Report of the AMPAC Board of Directors

Presented by: John W. Poole, MD
Chair

On behalf of the AMPAC Board of Directors, I am pleased to present this report to the House of Delegates on our activities this election cycle. The country continues to face a myriad of challenges in health care, including many that directly impact physician practices and their patients. Physicians face major roadblocks to providing quality care, including lagging Medicare payments that fail to keep pace with inflation, limited Medicaid access for their patients, burdensome prior authorization requirements, and rising prescription drug costs. Additional challenges include steep new H-1B visa fees for foreign-born physicians and restrictions on medical student loans and repayment options. These obstacles reinforce our commitment to AMPAC's core mission–supporting federal candidates who work with physicians to strengthen patient care. We also continue to invest in developing physician advocates through our political education programs, which equips them with all the tools necessary to engage effectively in campaigns or run for office themselves.

AMPAC Membership Fundraising

AMPAC's fundraising has shown strong growth throughout the 2025–2026 election cycle. As of November 1, total receipts are $981,362, reflecting a 24% increase over the same point in the previous cycle, with hard dollar contributions up 29%. Overall Capitol Club membership has grown by 3% this year, including 52 Capitol Club Diamond contributors giving $5,000 annually. This strong performance underscores the impact of AMPAC's renewed strategic initiatives aimed at enhancing visibility and engagement. Key efforts include a website refresh, data-driven microtargeting, a physician testimonial video campaign, a new quarterly newsletter, and expanded outreach from the AMPAC Board to strengthen partnerships with state medical societies and specialty HOD delegates. These efforts are making a measurable difference in positioning AMPAC for long-term success.

We appreciate the members of the House of Delegates who have contributed to AMPAC this year, particularly those giving at the Capitol Club major donor level. The continued support of HOD members is essential to amplifying the AMA's collective voice and driving meaningful progress. Influence does not happen by chance, it requires strategy, relationships, and the unified strength of physicians working together, which is what AMPAC makes possible. It also requires that as members of the HOD we demonstrate our leadership by contributing to AMPAC–hopefully at the Capitol Club level. Currently, overall HOD participation stands at 51%, with state delegations at 61% and specialty delegates at 38%. We encourage Delegation members who have not yet contributed for 2025 to consider doing so, there is still time, and contributions can be made by visiting the AMPAC booth or www.AMPAConline.org

We are also pleased to announce the upcoming Capitol Club Luncheon on Sunday, November 16 at 12:00 p.m. All current Diamond, Platinum, Gold, and Silver Capitol Club contributors are invited to this ticketed event, with tickets available at the AMPAC booth. Our special guest speaker will be Mike Allen, co-founder and executive editor of *Axios*, who will share insider insights on the key political issues shaping Washington and the nation. We will also be announcing the lucky winner of this year's AMPAC "Chase the Northern Lights" Sweepstakes, who will enjoy a trip for two to Iceland.

As we look ahead to 2026, AMPAC remains focused on strengthening advocacy and ensuring the voice of medicine continues to be heard. Join us and help shape a stronger future for our profession and our patients.

Political Action

AMPAC's political engagement is currently focused on the early contribution phase of the 2026 election cycle. During this period, contributions have been strategically directed toward incumbent candidates who are proven advocates for medicine, hold leadership roles within their parties, serve on influential committees, or occupy positions critical to advancing pro-medicine policies on Capitol Hill. Additionally, AMPAC has authorized early support for physician candidates in open-seat races where a clear choice has emerged, informed by insights from state medical society PACs and internal staff assessments.

Despite the partisan gridlock frequently highlighted in the media, AMPAC continues to provide critical relationship-building opportunities for AMA lobbyists and local physicians. These efforts include attending political events and engaging with lawmakers and candidates who play pivotal roles in shaping health care policy and legislation. As the year draws to a close, the pace of contributions is expected to accelerate in response to the growing need for direct engagement with key legislators.

Emerging areas of strategic focus include assessing the impact of ongoing redistricting efforts across several states and early primary contests in 2026, where competitive races are already underway.

Although the broader political environment presents significant challenges, AMPAC remains well-positioned to participate in critical races nationwide and to effectively communicate the AMA's priorities—particularly on Medicare payment reform and other pressing issues impacting America's physicians.

Political Education Programs

The 2025 Campaign School took place September 11 – 14, at the AMA offices in Washington, DC. Interest in the political education programs remains strong with 22 registrants for this year's program. Of these, two participants are currently running for Congress in California and Pennsylvania. The Campaign School is renowned for its use of a simulated campaign for the U.S. House of Representatives. During the three-day program participants were placed into campaign teams and our team of bipartisan political experts walked them through what they learned in real-time exercises on strategy, vote targeting, social media, paid advertising, and public speaking. The program was capped off with a keynote session from U.S. Senator John Barrasso, MD (R-WY) who spoke with the participants about his experiences as a physician legislator and the importance of having more physicians at the legislative table. The program once again received high marks with 100% of participants rating the Campaign School as "extremely valuable" in helping them understand the basic elements of a successful political campaign.

Planning is currently underway for the 2026 Candidate Workshop. As always, the political education programs remain a member benefit with registration fees heavily discounted for AMA members. Program dates will be announced soon on AMPAConline.org.

Conclusion

On behalf of the AMPAC Board of Directors, I would like to thank all members of the House of Delegates who support AMPAC and the work we do. Your continued involvement in political and grassroots activities ensures organized medicine is a powerful voice in Washington, DC.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (I-25)

James F. Arens, MD

Introduced by: American Society of Anesthesiologists and Texas Medical Association

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Whereas, James F. Arens, MD, a distinguished leader in American medicine and past president of the American Society of Anesthesiologists (ASA), passed away peacefully on July 27, 2025, at his home in Brenham, Texas; and

Whereas, Dr. Arens' exemplary career spanned military, academic, and organized medicine leadership, including service as President of the American Board of Anesthesiology, the American Board of Medical Specialties, and the ASA, as well as presidencies of the Louisiana, Mississippi, and Texas Societies of Anesthesiologists; and

Whereas, Dr. Arens served as Chair of the Departments of Anesthesiology at the University of Mississippi Medical Center, the University of Texas Medical Branch at Galveston, MD Anderson Cancer Center, and the University of Texas Health Science Center at Houston; and

Whereas, he played a pivotal role in the advancement of medical education and patient safety through his 19-year leadership of the ASA Committee on Practice Parameters, shaping national standards and guidelines; and

Whereas, Dr. Arens was instrumental in the establishment of the Critical Care Medicine certification pathway for anesthesiologists, and proudly held Certificate Number One from the American Board of Anesthesiology; and

Whereas, his contributions were recognized by the highest honors of his profession, including the ASA Distinguished Service Award (1997), the Distinguished Service Awards of the Texas Society of Anesthesiologists and the American Board of Medical Specialties, and the AMA Distinguished Service Award (2008); and

Whereas, Dr. Arens inspired generations of physicians through his mentorship, scholarship, and humanity, remembered by his trainees for his 'Three A's of Success'—Availability, Ability, and Affability; therefore be it

RESOLVED, that our American Medical Association express its deep appreciation for the life, service, and leadership of James F. Arens, MD, whose lifelong dedication to medicine and education strengthened the profession and improved the lives of countless patients; and be it further

RESOLVED, that the AMA transmit this memorial resolution to his family with gratitude and sympathy, in recognition of his enduring contributions to American medicine.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (I-25)

Thomas Stautzenbach, MA, MBA, CAE

Introduced by: American Academy of Physical Medicine and Rehabilitation

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Whereas, Thomas Stautzenbach passed away on September 15, 2025, at sunrise in his home in Hendersonville, North Carolina, five weeks after a diagnosis of pancreatic cancer; and

Whereas, Tom served as Executive Director and CEO of the American Academy of Physical Medicine and Rehabilitation from 2005 to 2024; and

Whereas, for two decades, Tom devoted his professional career to AAPM&R and to the specialty of PM&R with a profound and unassuming sense of duty that inspired countless physician leaders, volunteers, colleagues, and team members; and

Whereas, Tom led with integrity and vision, thoughtfully supporting PM&R and helping the Academy to thrive; and

Whereas, Tom had a way of listening to all the voices in the room, stepping back, and summarizing with a wise question that led toward unique solutions; and

Whereas, after receiving a Bachelor of Business Administration in 1987 and a Master of Business Administration and Master of Hospital and Health Administration in 1989, all from the University of Iowa, Tom dedicated his entire career to healthcare, first in hospital management and consulting and then leading professional societies; and

Whereas, from 1993, he managed professional health care associations in the role of executive director, initially with Smith, Bucklin & Associates, serving as the executive director of multiple medical, surgical and dental professional associations and providing consulting services to a variety of non-profit association sectors; and

Whereas, while working at AAPM&R, he helped lead organizations across the house of medicine by volunteering on the Board of Directors for the Council of Medical Specialty Societies (CMSS) and attending leadership meetings at our American Medical Association; and

Whereas, he was a dedicated member of his community, volunteering at JOURNEYS' PADS shelter program and serving on the Board of Trustees of the Interfaith House (The Boulevard) and the Board of Trustees of First Presbyterian Church of Arlington Heights; and

Whereas, Tom will be greatly missed by his family, his colleagues at AAPM&R, and the medical community; therefore be it

RESOLVED, that our American Medical Association House of Delegates recognize the contributions made by Mr. Thomas Stautzenbach to organized medicine and his dedication to the many medical professionals and colleagues with whom he worked; and be it further

RESOLVED, that our AMA extend its most heartfelt condolences to Mr. Stautzenbach’s family and present them with a copy of this resolution.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION (I-25)

Richard Sloan Wilbur, MD, JD, FCLM

Introduced by: Illinois and the American College of Legal Medicine

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Whereas, the death of Richard Sloan Wilbur, MD, JD, FCLM, on Aug. 6, 2025, was a profound loss to his family, friends and the medical profession; and

Whereas, Dr. Wilbur of Lake Forest, Illinois, was born in 1924 and passed away peacefully in 2025 at the age of 101; and

Whereas, Dr. Wilbur's education was accelerated by both his aptitude and the outbreak of World War II. He began studies at Stanford at age 16, earning both a bachelor's degree and a medical degree by 1944. During the War, he joined the U.S. Navy, working as a doctor; and

Whereas, in 1951, he married Betty Lou and after further medical education and residencies, practiced medicine at the Palo Alto Clinic for 15 years. The Wilbur family raised their three sons in nearby Los Altos Hills, California; and

Whereas, Dr. Wilbur became increasingly involved in medical administration and governance, attending his first AMA meeting in 1962. Later, Governor Ronald Reagan appointed Dr. Wilbur in 1967 to a commission on efficiency and cost control in government healthcare. In 1969, he was recruited as Deputy Executive Vice President of the AMA and relocated his family to Lake Forest, Illinois; and

Whereas, in 1971, President Richard Nixon appointed Dr. Wilbur as the Assistant Secretary of Defense for Health and Environment. At the Department of Defense, his efforts focused on combating drug use by servicemen returning from Vietnam through screening and treatment, ending the draft for doctors by increasing incentives for physicians in the military health system and banning the use of Agent Orange and directing its safe disposal. For his service to the nation, the DoD awarded Dr. Wilbur its Medal for Distinguished Service and he was admitted to the National Academy of Medicine; and

Whereas, in 1990, at the age of 66, he earned a law degree from John Marshall Law School to better work on medical-legal issues. He was a longtime AMA supporter and HOD member, most recently serving as delegate for the American College of Legal Medicine. He attended his last AMA in June 2025 and was a familiar face at many Illinois delegation meetings, earning him "honorary Illinois delegate" status; therefore be it

RESOLVED, that our American Medical Association recognize Dr. Richard Sloan Wilbur's passing with a moment of silence; and be it further

RESOLVED, that our AMA record this resolution in the minutes of this meeting and a copy of this resolution be sent to the family of Richard Sloan Wilbur, MD, JD, FCLM.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Supplementary Report of Committee on Rules and Credentials

Presented by: Tate Hinkle, MD, Chair

Saturday, November 15, 2025

Madam Speaker, Members of the House of Delegates:

The Committee on Rules and Credentials met Friday, November 14, to discuss Late Resolutions 1001, 1002, 1003, 1004, and 1005. The sponsors of the late resolutions met with the committee and were given the opportunity to present for the committee's consideration the reason the resolution could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting.

Recommended for acceptance:

- Late 1001 – Preserve Coverage for Peripheral Nerve Blockade in Chronic Pain
- Late 1003 – Oppose Unfair Hospital Privilege Decision Based on Insurance Plan Participation
- Late 1005 – Enhancing Healthcare System Preparedness to Address Veteran-Specific Health Disparities

Recommended against acceptance:

- Late 1002 – Further Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations
- Late 1004 – Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness

Madam Speaker, this concludes the Supplementary Report of the Committee on Rules and Credentials. I would like to thank Barbara J. Arnold, MD, Andrea Hillerud, MD; Cheryl Hurd, MD; Helene Nepomuceno, MD; Kevin C. Reilly, Sr, MD; and Erin Shriver, MD; and on behalf of the committee those who appeared before the committee.

Tate Hinkle, MD, Chair
American Academy of Family Physicians

Barbara J. Arnold, MD
California

Andrea Hillerud, MD
Minnesota

Cheryl Hurd, MD
American Psychiatric Association

Helene Nepomuceno, MD
Resident and Fellow Sectional Delegate

Kevin C. Reilly, Sr, MD
Radiological Society of North America

Erin Shriver, MD
American Society of Ophthalmic Plastic and Reconstructive Surgery

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1001
(I-25)

Introduced by: American Society of Regional Anesthesia and Pain Medicine, American Society of Interventional Pain Physicians, American Academy of Pain Medicine, International Pain and Spine Intervention Society, Pain and Palliative Section Caucus, American Society of Anesthesiologists, American Association of Neurological Surgeons, Congress of Neurosurgeons, American Academy of Physical Medicine and Rehabilitation, California Medical Association, Montana Medical Association, Washington, North American Spine Society

Subject: Preserve Coverage for Peripheral Nerve Blockade in Chronic Pain

Referred to: Reference Committee J

Whereas, multiple Medicare Administrative Contractors (MACs) have released draft Local Coverage Determinations (LCDs), "Peripheral Nerve Blocks and Procedures for Chronic Pain," that would newly deem many peripheral nerve blockade (PNB) procedures "not reasonable and necessary," with five of seven MACs (CGS, NGS, Noridian, Palmetto, WPS) issuing aligned proposals; examples identified for noncoverage include genicular, suprascapular, pudendal, thoracic and other peripheral nerve blocks and denervations; and these changes are now out for public comment, signaling a substantial shift in Medicare coverage policy[1,2,3,4,5].; and

Whereas, it is estimated that up to 36.5% of all U.S. adults aged 18 and over experience chronic non-spinal pain potentially targeted by these PNBs[6].; and

Whereas, restricting coverage for established PNB procedures (e.g., trigeminal, stellate ganglion, occipital, genicular) would significantly limit physicians' ability to deliver appropriate, evidence-based, non-opioid care consistent with American Medical Association (AMA) policy supporting access to the full range of multidisciplinary and interventional pain treatments[7].; and

Whereas, peripheral nerve blockade enables targeted, localized analgesia and can reduce reliance on systemic opioids in appropriate settings; national guidance emphasizes prioritizing non-opioid and multimodal strategies, and federal evidence reviews note that PNBs can reduce opioid consumption and improve pain control in selected populations, although effects vary by indication and technique[8,9,10,11].; and

Whereas, beyond therapeutic benefit, PNBs are widely used as diagnostic and prognostic tools that guide escalation to radiofrequency ablation (RFA), peripheral nerve stimulation (PNS), Spinal Cord Stimulation (SCS), and surgical interventions, with practice standards commonly requiring a successful prognostic block before genicular RFA and emerging data supporting block-guided selection for neuromodulation[12,13].; and

Whereas, the CDC Clinical Practice Guideline for Prescribing Opioids for Pain (2022), AMA Substance Use and Pain Task Force (2021), and Pain Management Best Practices Inter-Agency Task Force Report (2022) underscores a multimodal, multidisciplinary approach to pain management, within which interventional options such as PNBs may play an important role when clinically appropriate[7,8,14]; and

Whereas, removing coverage for these procedures would undermine effective, compassionate, and patient-centered care for chronic pain, reduce access to evidence-based non-opioid therapies, and risk reversing progress toward safer, multimodal pain care envisioned by federal guidance and existing AMA policy.; therefore be it

RESOLVED, that our American Medical Association advocate for the withdrawal of the draft Local Coverage Determinations issued by Medicare Administrative Contractors that restrict coverage of peripheral nerve blockade procedures for chronic pain (Directive to Take Action).; and be it further

RESOLVED, that our AMA advocate to the Centers for Medicare & Medicaid Services (CMS) and the Medicare Administrative Contractors to preserve—and, where supported by evidence, expand—coverage of peripheral nerve blockade and all associated therapies (Directive to Take Action).; and be it further

RESOLVED, that our AMA reaffirm and apply existing AMA policy—H-185.931 “Workforce and Coverage for Pain Management” and H-120.922 “Improved Access and Coverage to Non-Opioid Modalities to Address Pain”—to oppose efforts that limit the use of peripheral nerve blockade and associated interventional pain procedures as evidence-based treatment options. (Reaffirm HOD Policy)

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

Received: 11/13/25

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RELEVANT AMA POLICY

H-185.931 Workforce and Coverage for Pain Management
1. Our AMA supports efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, including non-opioid options and interventional approaches when appropriate, with a focus on achieving improvement in function and activities of daily living.
2. Our AMA supports guidance on pain management for different clinical indications developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted, such as through medical journals, medical societies, and other appropriate outlets.
3. Our AMA will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain.
4. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits.
5. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, as well as an expanded behavioral health workforce to improve the availability of services to address the psychological, behavioral, and social aspects of pain and pain management within multidisciplinary pain clinics. Patients and their caregivers should be involved in the decision-making process.
6. Our AMA supports an expanded availability of comprehensive multidisciplinary pain medicine clinics for patients in both urban and rural areas, and an improvement in payment models for comprehensive multidisciplinary pain clinics services such that such services can become more financially viable.
[CMS/CSAPH Rep. 1, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmed: BOT Rep. 19, A-16; Reaffirmed in lieu of Res. 117, A-16; Modified: BOT Rep. 38, A-18; Reaffirmed in lieu of: Res. 228, I-18; Reaffirmation: A-19]

H-120.922 Improved Access and Coverage to Non-Opioid Modalities to Address Pain
1. Our American Medical Association will advocate for increased access and coverage of non-opioid treatment modalities including pharmaceutical pain care options, interventional pain management procedures, restorative therapies, behavioral therapies, physical and occupational therapy, and other evidence-based therapies recommended by the patient's physician.
2. Our AMA will advocate for non-opioid treatment modalities being placed on the lowest cost-sharing tier for the indication of pain so that patients have increased access to evidence-based pain care as recommended by the HHS Interagency Pain Care Task Force; and
3. Our AMA will encourage the manufacturers of pharmaceutical pain care options to seek United States Food and Drug Administration approval for additional indications related to non-opioid pain management therapy.
[Res. 218, A-19; Reaffirmed: CSAPH Rep. 01, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1002
(I-25)

Introduced by: American Society of Plastic Surgeons

Subject: Further Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations

Referred to: Reference Committee F

Whereas, our American Medical Association Board of Trustees is charged through its duties and privileges to conduct the affairs, work and activities of the AMA and to exercise broad oversight and guidance for the AMA with respect to the management systems of the AMA through its oversight of the AMA's Executive Vice President; and

Whereas, current policy G-600.071 and current practice yield authority to BOT on AMA action in urgent situations, and further allow the BOT to make a determination of what it deems best represent the interests of patients, physicians, and the AMA; and

Whereas, current policy does not yield primary authority to or allow the independent authority to AMA management on AMA action in urgent situations or the determination of what best represents the interests of patients, physicians, and the AMA; and

Whereas, notable major AMA efforts to lobby and negotiate with Congress have resulted in legislative packages that profoundly negatively impacted health system financing and physician reimbursement, [1-9] administrative burden in clinical settings, [1,2] and the widespread loss of coverage for patients; [8,9] and

Whereas, the results of these efforts suggest opportunity to strengthen the processes that underpin the BOT's (1) duty to implement the charges delivered by the House in its capacity as the legislative and policymaking body of the AMA, and (2) duty to oversee AMA management's management and direction of day-to-day duties of the AMA, including advocacy activities; and

Whereas, there is currently no clear AMA policy requiring the BOT to be informed or consulted, let alone appropriately directly involved, in times of direct negotiation with federal policymakers or their representatives on matters that have significant impact on the economic or clinical experience of patients or physicians; therefore be it

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

> 4. In furtherance of its duties to (1) conduct the affairs, work and activities of the AMA consistent with the policy actions and directives adopted by the House of Delegates and (2) serve as the principle planning agent for the AMA, which focuses on the AMA's goals and objectives and involves decision-making over allocation of resources and strategy development; and in furtherance of each AMA Trustee's individual charges to provide oversight and guardianship of the pursuit of the AMA's vision and purpose, safeguard the integrity of the AMA through good governance practices, and function as effective representatives of the AMA in presenting the AMA's policies and positions, our AMA

Board of Trustees shall develop such processes as the BOT deems appropriate to ensure the BOT is apprised on a weekly basis of AMA activity related to the policy actions and directives adopted by the House of Delegates that occurred through:

a. AMA representatives' meetings with national or federal stakeholders or policymaking entities;
b. formal correspondences, comments, or testimony delivered by the AMA to national or federal stakeholder or policymaking entities;
c. correspondences addressed to the BOT and received from the leadership of entities in organized medicine, the federal government, or any other relevant sector; and
d. any developments with respect to new or existing federal policy concepts, new or existing federal policy negotiations, or new or existing federal policy proposals when any such concepts, negotiations, or proposals involve transformational national health policies.

5. Our AMA BOT will work with the Executive Vice President to develop such processes as the BOT deems appropriate and in furtherance of the best interests of the AMA to ensure that the BOT is directly informed and consulted prior to the onset of and throughout the course of any negotiations between AMA representatives and federal policymakers on transformational changes to national health policies, such as alteration of the methodology for reimbursing physicians under any component of the public sector payer apparatus or the sunsetting or creation of any program that is likely to impact more than half of all Medicare or Medicaid participating providers.

~~4.~~ 6. In urgent situations, the Board of Trustees will exercise its authority to take appropriate action. The Board shall make decisions that it deems to best represent the interests of patients, physicians, and to advocate for science and public health. The Board will take into consideration existing AMA policy, recommendations from AMA policy staff, and input solicited or obtained from the House of Delegates or its Councils and Sections to inform its position on the interests of patients, physicians, and the AMA. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.

~~5.~~ 7. Our AMA considers transformational occurrences, including public health phenomena, sudden changes to national health policies, and sudden disruptions of health and science funding, to be urgent situations worthy of AMA Board of Trustees advocacy and action.

~~6.~~ 8. Our AMA considers sudden federal funding cuts to foundational institutions of science research and public health to be urgent situations and requests the Board of Trustees take immediate action to respond responsibly, clearly, and expediently as an advocate for science, health care, and public health.

~~7.~~ 9. Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input.
(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 10/27/25

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RELEVANT AMA POLICY

G-600.071 Actions and Decisions by the AMA House and Policy Implementation
1.AMA policy on House actions and decisions includes the following:

a. Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (i) correcting factual errors in AMA reports, (ii) rewording portions of a report that are objectionable, and (iii) rewriting portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible.
b. A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be amended by means of a positive action of the House specifically intended to change that policy.
c. Minor editorial changes to existing policies are allowed for accuracy, so long as such changes are reported to the House of Delegates so as to be transparent. Editorially amended policies, however, do not reset the sunset clock.

2. AMA policy on implementation of policy includes the following:

a. Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and report recommendations and specific actions that have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted.
b. Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions.

c. Any resolution which is adopted by our AMA House remains the policy of the Association until amended, rescinded or sunset by the House.

3. Except as noted herein and consistent with the AMA Bylaws, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates.

4. In urgent situations, the Board of Trustees will exercise its authority to take appropriate action. The Board shall make decisions that it deems to best represent the interests of patients, physicians, and to advocate for science and public health. The Board will take into consideration existing AMA policy, recommendations from AMA policy staff, and input solicited or obtained from the House of Delegates or its Councils and Sections to inform its position on the interests of patients, physicians, and the AMA. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.

5. Our AMA considers transformational occurrences, including public health phenomena, sudden changes to national health policies, and sudden disruptions of health and science funding, to be urgent situations worthy of AMA Board of Trustees advocacy and action.

6. Our AMA considers sudden federal funding cuts to foundational institutions of science research and public health to be urgent situations and requests the Board of Trustees take immediate action to respond responsibly, clearly, and expediently as an advocate for science, health care, and public health.

7. Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input. [Res. 45, I-89Res. 609, I-95Res. 605, I-98Reaffirmed: Sunset Report and Modified: BOT Rep. 15, A-00 Consolidated: CLRPD Rep. 3, I-01Appended: BOT Rep. 19, A-04Modified: CCB/CLRPD Rep. 1, A-12Appended: Res. 618, A-19Modified: Res. 602, A-25]

HOD C- Article IV
The House of Delegates is the legislative and policymaking body of the Association. It is composed of elected representatives and others as provided in the Bylaws. The House of Delegates transacts all business of the Association not otherwise specifically provided for in this Constitution and Bylaws and elects the officers except as otherwise provided in the Bylaws. [Last modified 2017]

B-4.7 Trustee
Each Trustee is charged with providing oversight and guardianship of the AMA?s financial health and the pursuit of the AMA?s purpose and vision. Each Trustee:

4.7.1 Shall act to safeguard the integrity of the AMA through good governance practices.

4.7.2 Shall function as effective representative of the AMA in presenting the AMA?s policies and positions.

4.7.3 Shall provide leadership and guidance in promoting the core tenet of professionalism and in promoting AMA membership.

4.7.4 May serve on councils or committees when specifically provided for in the Bylaws.

B-5.3 Duties and Privileges
In addition to the rights and duties conferred or imposed upon the Board of Trustees by law and custom and elsewhere in the Constitution and Bylaws, the Board of Trustees shall:

5.3.1 Management. Manage or direct the management of the property and conduct the affairs, work and activities of the AMA consistent with the policy actions and directives adopted by the House of Delegates, except as may be otherwise provided in the Constitution or these Bylaws.

5.3.1.1 The Board is the principal governing body of the AMA and it exercises broad oversight and guidance for the AMA with respect to the management systems and risk management program of the AMA through its oversight of the AMA's Executive Vice President.

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

5.3.2 Planning. Serve as the principal planning agent for the AMA.

5.3.2.1 Planning focuses on the AMA's goals and objectives and involves decision-making over allocation of resources and strategy development. Planning is a collaborative process involving all of the AMA's Councils, Sections, and other appropriate AMA components.

5.3.2.2 The House of Delegates and the Council on Long Range Planning and Development have key roles in identifying and making recommendations to the Board regarding important strategic issues and directions related to the AMA's vision, goals, and priorities.

5.3.3 Fulfillment of House of Delegates Charge. Review all resolutions and recommendations adopted by the House of Delegates to determine how to fulfill the charge from the House. Resolutions and recommendations pertaining to the expenditure of funds also shall be reviewed. If it is decided that the expenditure is inadvisable, the Board shall report, at its earliest convenience, to the House the reasons for its decisions.

5.3.3.1 In determining expenditure advisability, the Board will consider the scope of the proposed expenditure and whether it is consistent with the AMA's vision, goals, and priorities. Where the Board recommends that a proposed expenditure is not prudent and is inadvisable, the Board will present alternative actions, if feasible, in its report to the House.

5.3.4 Publication. Within the policies adopted by the House of Delegates, provide for the publication of The Journal of the American Medical Association and such specialty journals, periodicals, and other publications and electronic media information as it may deem to be desirable in the best interests of the public and the medical profession.

5.3.5 Election of Secretary. Select a Secretary from one of its members annually.

5.3.6 Selection of Executive Vice President. Select and evaluate an Executive Vice President.

5.3.6.1 The Executive Vice President is the chief executive officer of the AMA and as such is responsible for AMA management and performance in accordance with the vision, goals, and priorities of the AMA. The Executive Vice President is both a key leader for the organization and the bridge between AMA management and the Board of Trustees.

5.3.6.2 The Executive Vice President shall manage and direct the day-to-day duties of the AMA, including advocacy activities, and perform the duties commonly required of the chief executive officer of a corporation.

5.3.6.3 The Executive Vice President shall ensure that there is an active and effective risk management program.

5.3.6.4 No individual who has served as an AMA Officer or Trustee shall be selected or serve as Executive Vice President until 3 years following completion of the term of the AMA office.

5.3.7 Finances. Maintain the financial health of the AMA. The Board shall:

5.3.7.1 Oversee the development and approve the annual budget for the AMA, consistent with the AMA's vision, goals, and priorities.

5.3.7.2 Ensure that the AMA's resource allocations are aligned with the AMA's plan and budget.

5.3.7.3 Evaluate membership dues levels and make related recommendations to the House of Delegates.

5.3.7.4 Review and approve financial and business decisions that significantly affect the AMA's revenues and expenses.

5.3.7.5 Have the accounts of the AMA audited at least annually.

5.3.8 Financial Reporting. Make proper financial reports concerning AMA affairs to the House of Delegates at its Annual Meeting.

5.3.9 Appointment of Committees. Appoint such committees as necessary to carry out the purposes of the AMA.

5.3.9.1 An advisory committee will be constituted for purposes of education and advocacy.

5.3.9.1.1 It will have a governing council and a direct reporting relationship to the Board.

5.3.9.1.2 An advisory committee will not have representation in the House of Delegates.

5.3.9.1.3 An advisory committee will operate under a charter that will be subject to review and renewal by the Board at least every four years.

5.3.9.2 An ad hoc committee will be constituted as a special committee, workgroup or taskforce.

5.3.9.2.1 It will operate for a specific purpose and for a prescribed period of time.

5.3.10 Committee Vacancies. Fill vacancies in any committee where such authority is not delegated elsewhere by these Bylaws.

5.3.11 Litigation. Initiate, defend, settle, or otherwise dispose of litigation involving the interests of the AMA.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1003
(I-25)

Introduced by:	New York, California, Connecticut, Maine, Missouri, New Hampshire, New Mexico, North Dakota, South Carolina, Virginia, Wisconsin, and the American Association of Neurological Surgeons, American College of Emergency Physicians, American College of Radiology, American Society of Anesthesiologists, and Congress of Neurological Surgeons
Subject:	Oppose Unfair Hospital Privilege Decision Based on Insurance Plan Participation
Referred to:	Reference Committee B

Whereas, private Health Insurers have deliberately used their regional monopoly powers to push unacceptably low rates on physicians, thus creating artificially narrow networks; and

Whereas, such practice creates the appearance of physician shortages and lack of access to physicians in a reasonable time, all to the sole benefit and profit of insurers; and

Whereas, many health plans continue to narrow their networks through arbitrarily dropping participating physicians from their networks; and

Whereas, many health plans misrepresent the adequacy of their physician networks by listing physicians who are not participating or unable to accept new patients[1]; and

Whereas, these actions further demonstrate the disingenuous tactics of health plans that limit physicians from participating in their networks; and

Whereas, on October 1, 2025, Anthem Blue Cross/Blue Shield announced that it would be penalizing hospitals which involve out of network physicians in a patient's care with up to 10% payment penalty, effective January 1, 2026[2]; and

Whereas, many hospitals facing financial challenges might be pressured into preventing out of network physicians from having staff privileges at these hospitals; and

Whereas, more practices will be forced into employment models or a different geographic area; and

Whereas, this new policy has the potential to exacerbate already challenging patient access to care issues at hospitals facing physician shortages; and

Whereas, this policy was announced to be implemented in 11 states but could spread to many other states and many other insurers, if it is not vigorously opposed; therefore be it

RESOLVED, that our American Medical Association advocate for legislation, regulation, or other intervention to prevent health insurers from threatening hospitals and other facilities with payment cuts, administrative or penalty fee imposition, network termination, or other negative

financial policies, if an out of network physician is involved in the treatment of care for a patient at these hospital or facilities (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborates with specialty societies and state medical societies to develop model legislation to oppose such unfair and coercive business practices which undermine patient access and physician practices. (Directive to Take Action)

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

Received: 11/7/25

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1004
(I-25)

Introduced by: Virginia

Subject: Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness

Referred to: Reference Committee B

Whereas, our American Medical Association encourages hospitals to incorporate disaster plans that address barriers to staff responses during disasters, as stated in H-225.941; and

Whereas, critical medical treatments such as dialysis, chronic oxygen therapy, chemotherapy, and radiation therapy are essential for patient survival and require coordinated planning during emergencies; and

Whereas, interdisciplinary models of cooperative planning involving city/regional authorities, hospitals, physicians, medical equipment providers, and transportation companies can enhance disaster preparedness and response; therefore be it

RESOLVED, that our American Medical Association develop model state legislation and guidelines for incorporating critical medical treatment planning into emergency/disaster preparedness plans (Directive to Take Action); and be it further

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

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

Received: 10/31/25

RELEVANT AMA POLICY

Hospital Disaster Plans and Medical Staffs H-225.941
Our AMA encourages: (1) appropriate stakeholders to examine the barriers and facilitators that medical staffs will encounter following a natural or other disaster; and (2) hospitals to incorporate, within their hospital disaster plans, workplace and personal preparedness efforts that reduce barriers to staff responses during a natural or other disaster, both within their institutions and across the community.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1005
(I-25)

Introduced by: American Academy of Family Physicians

Subject: Enhancing Healthcare System Preparedness to Address Veteran-Specific Health Disparities

Referred to: Reference Committee K

Whereas, the Joint Commission's National Performance Goals effective January 2026 (NPG.04.01.01 Element of Performance 3) now explicitly includes "Veterans" (previous and current active-duty service members, National Guard, and Reservists) among the sociodemographic characteristics that hospitals may use to stratify quality and safety data for identifying healthcare disparities, and requires written action plans to address identified disparities (Element of Performance 4); and

Whereas, Veterans and Service Members experience disproportionately high rates of post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), military sexual trauma (MST), depression, chronic pain, substance use disorders, and suicide, conditions often compounded by unique service-related exposures such as Agent Orange, burn pits, contaminated water, blast injuries, and other environmental toxins; and

Whereas, failure to identify military service history in clinical settings contributes to misdiagnosis, inappropriate treatment, missed opportunities for accessing earned benefits, and preventable morbidity and mortality, while the simple question “Have you served in the military?” serves as a critical gateway to culturally competent, trauma/exposure-informed, and Veteran-competent care; and

Whereas, our American Medical Association has a professional obligation to equip the healthcare workforce with the knowledge, protocols, and resources necessary to deliver equitable, evidence-based care addressing Veterans' unique health needs resulting from military service; therefore be it

RESOLVED, that our American Medical Association actively advocate for federal, state, and local legislation and regulatory action requiring healthcare systems to develop and implement standardized protocols for identifying Veterans in patient populations, including documenting military service history (deployment locations and occupational exposures), and stratifying quality and safety data by Veteran status, in accordance with Joint Commission accreditation standards (Directive to Take Action); and be it further

RESOLVED, that our AMA actively advocate with medical education accrediting bodies to require medical schools, residency programs, and continuing medical education providers to incorporate training on military service-related health conditions, occupational exposure assessment, and Veteran-specific screening protocols into curricula and licensure requirements to improve preparedness of the healthcare workforce (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for, and facilitate, robust collaboration with Veterans Service Organizations, medical specialty societies, and state public health authorities to

develop, disseminate, and promote adoption of evidence-based clinical guidelines for Veteran-specific health conditions (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for inclusion of Veteran health considerations in all relevant health equity initiatives, community health needs assessments, and population health frameworks, at all levels of government, recognizing that systematic identification, documentation, and management of service-connected conditions are critical to addressing health disparities for those who have served. (Directive to Take Action)

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

Received: 11/7/25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-25)

Agenda
Reference Committee on Ethics and Bylaws
In Person Hearing
Mark Casanova, MD, Chair

RECOMMENDED FOR ADOPTION

1. BOT Report 08 - On the Ethics of Human Lifespan Prolongation [REVISED]
2. BOT Report 11 - Supporting Diversity in Research
3. BOT Report 19 - Addressing the Historical Injustices of Anatomical Specimen Use
4. CEJA Report 01 - Amendment to Opinion 1.1.1 “Patient-Physician Relationships”
5. CEJA Report 03 - Ethical Impetus for Research in Pregnant and Lactating Individuals
6. Resolution 005 - Preserving Autonomy in the Patient-Physician Relationship
7. Resolution 006 - Amendment to AMA Bylaws to Enable Continuity of Leadership
8. Resolution 008 - Health Plan In-Network Steering of Pathology/Laboratory Services

RECOMMENDED FOR ADOPTION AS AMENDED

9. BOT Report 05 - Addressing the Unregulated Body Brokerage Industry
10. BOT Report 10 - Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients [REVISED]
11. CCB Report 03 - Credentialing of Temporary Delegates and Alternate Delegates [REVISED]
12. Resolution 003 - Report on Gender-Based Pay Equity in Medicine
13. Resolution 007 - Improving Protection for Reproductive Health Information

RECOMMENDED FOR REFERRAL

14. CCB Report 01 - Bylaws Review Report
15. CCB Report 02 - Bylaws Clarifications Subsequent to A-25 House of Delegates Meeting
16. CEJA Report 02 - Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization
17. Resolution 002 - Ensuring Ethical Use of Wearable Recording Devices in Clinical Encounters
18. Resolution 004 - Patient Options to Restrict Secondary Use of Their Healthcare Data
19. Resolution 009 - Gender Equity in Disability Insurance for Physicians

RECOMMENDED FOR NOT ADOPTION

20. Resolution 001 - Clarifying Conscientious Objection

RECOMMENDATION NOT YET DETERMINED

21. BOT 21 - Specialty Society Representation in the House of Delegates - Five-Year Review
22. Res 010 - Clarifying the Medical Student Section's and Resident and Fellow Section's Abilities to Fill Temporary Vacancies in Accordance with the AMA Bylaws

Please send amendments and any documentation to:
referencecommitteeeb@ama-assn.org

Livestream of Reference Committee Hearing: Zoom Link

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-25)

Agenda

Reference Committee B

In-Person Hearing

Dr. Sara Coffey, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 01 — Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis
2. Board of Trustees Report 02 — Laser Surgery
3. Board of Trustees Report 03 — Stark Law Self-Referral Ban
4. Board of Trustees Report 04 — American Medical Association (AMA) Efforts on Addressing and Reducing Patient Boarding in Emergency Departments (EDs)
5. Board of Trustees Report 06 — Information Blocking Rule
6. Board of Trustees Report 07 — Codification of the Chevron Deference Doctrine
7. Board of Trustees Report 12 — Support For Doula Care Programs
8. Board of Trustees Report 15 — Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research Report
9. Board of Trustees Report 16 — Preservation of Medicaid
10. Resolution 202 — Deepfake Technology and Harm to Physicians and Patients
11. Resolution 204 — Addressing Anti-Physician Contractual Provisions
12. Resolution 210 — PBM Divestiture and Transparency
13. Resolution 212 — Acknowledging Flexibility on Buprenorphine Mono-product Use for Opioid Use Disorder
14. Resolution 218 — Amend AMA Policy D-160.921 on Sensitive Locations to Protected Areas
15. Resolution 225 — Federal Legislation to Prohibit the Corporate Practice of Medicine
16. Resolution 226 — Transparency with the Term “Emergency Department”
17. Resolution 228 — Support Permanent Funding and Expansion of Native Hawaiian Healthcare
18. Resolution 230 — Banning Non-compete Agreements in States
19. Resolution 236 — Deceptive Advertising in Accredited Allied Health Professional, Non-Physician Graduate Programs

RECOMMENDED FOR ADOPTION AS AMENDED

20. Board of Trustees Report 13 — Antidiscrimination Protections for LGBTQ+ Youth in Foster Care
21. Resolution 201 — Model State Legislation incorporating Medical Malpractice Tort Reform Based on Utah H.B. 503 (2025)
22. Resolution 207 — Support for a Federal Tax Incentive for Volunteer Community Preceptors
23. Resolution 215 — Extending the Medicaid Work Requirement Exemption up to 12 Months Postpartum
24. Resolution 227 — Call for Immediate and Aggressive Action by the AMA to Reverse Medicaid Cuts Impacting Seniors
25. Resolution 229 — Protection of Medicaid Beneficiaries’ Private Health Information from Immigration Enforcement

26. Resolution 231 — Ensuring Equitable and Timely Medical Licensure for Physicians Providing Abortion and Gender-Affirming Care
27. Resolution 232 — Safeguarding Access to IVF Amid Restorative Reproductive Medicine Legislation
28. Resolution 233 — Renewing Mental Health Infrastructure in the School System
29. Resolution 234 — Study on Impact of Inflation Reduction Act on Oncology, Other Physician Practices

RECOMMENDED FOR ADOPTION IN LIEU OF

30. Resolution 203 — Restore and Enhance Federal Loan Programs for Medical Education
    Resolution 217 — Protecting Access to Public Service Loan Forgiveness (PSLF), Income-Driven Repayment (IDR), and Direct Plus Loans for Graduate or Professional Students (Grad PLUS Loans)
31. Resolution 213 — Pathways to U. S. Permanent Residency for H-1B Physicians
    Resolution 214 — Physician Visa Protection and Pathway to Serve Underserved Communities

RECOMMENDED FOR REFERRAL

32. Resolution 205 — Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care
33. Resolution 209 — Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians
34. Resolution 211 — Access to, and Retention of, Electronic Medical Records
35. Resolution 220 — Medicare Should not Unfairly Penalize Physicians
    Resolution 223 — Halt the Rollout of New Payment Models by the Center for Medicare & Medicaid Innovation (CMMI) — A New Administration Offers an Opportunity
36. Resolution 221 — Not-for-Profit Status

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

37. Resolution 206 — Restore Funding to USAID
38. Resolution 208 — Centralization of Medicare Provider Data Sources
39. Resolution 216 — Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs
40. Resolution 219 — Addressing the Harms and Misleading Nature of Medicare Advantage Plans

Note: During the reference committee hearing, supplemental material and amendments may be sent to **RefComB@ama-assn.org**.

Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should only be presented orally to the Committee.

When you email your amendment, you will receive a response, indicating that staff has received it. If you do not receive a response, we did NOT receive it, and you must resend. Amendments must be formatted correctly with strikethroughs and underlines.

A Zoom webinar link is provided below. Registration is required to view the meeting via Zoom. The link is view-only. Testimony cannot be accepted via Zoom.

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41. Resolution 222 — Tackling Administrative Waste—Let Us Be Part of the Solution to Putting Our Health System on a Sustainable Path
42. Resolution 224 — Recoupment by CMS Recovery and Audit Contractors (RAC)—Due Process
43. Resolution 237 — Protecting and Improving Rural Health

RECOMMENDATION NOT YET DETERMINED

44. Board of Trustees Report 22 — Physician Assistant and Nurse Practitioner Movement Between Specialties
45. *LATE 1003/Resolution 238— Oppose Unfair Hospital Privilege Decision Based on Insurance Plan Participation*
46. *LATE 1004/Resolution 239 — Incorporating Critical Medical Treatment Planning into Emergency/Disaster Preparedness*

RECOMMENDATION AGAINST CONSIDERATION

47. *Resolution 235 — Ensuring Medical Liability Insurance Transparency and Continuity*

** Items in italics will be considered based on HOD action at the Second Opening Session.*

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-25)

AGENDA

Reference Committee C, In-Person Hearing

November 15, 2025 in Potomac C

Rose Berkun, MD, Chair

RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 1 - Additional Pathways For International Medical Graduates

RECOMMENDED FOR ADOPTION AS AMENDED

2. Resolution 301 - Preventing Sleep Deprivation And Supporting Medical Student Wellness

3. Resolution 304 - Systemic Exclusion Of IMGs From Residency Programs

4. Resolution 305 - Paid Sick Leave And Flexible Work Arrangements For Caregivers Of Individuals With Special Needs, Chronic Illness, Or Elderly Parents

5. Resolution 306 - Support For Paid Prenatal Leave

6. Resolution 307 - Integrating Artificial Intelligence (AI) Literacy Into UME, GME, And CME

7. Resolution 308 - Enhancing The Pathway For Black Male Medical Students

8. Resolution 311 - Gender And URiM Disparities In Surgical Training Volume

RECOMMENDATION NOT YET DETERMINED

9. Resolution 313 - Hardship for International Medical Graduates from Palestine

RECOMMENDED AGAINST CONSIDERATION

10. Resolution 302 – Preventing Sleep Deprivation and Supporting Medical Student Wellness

11. Resolution 303 - Increasing the Use of Retired Physicians in Teaching Students and Residents

12. Resolution 309 - Reasonable Workplace Accommodations for Residents and Fellows During Pregnancy

13. *Resolution 310 - Remedying the Harms of AMA's Role in the Flexner Report*

14. *Resolution 312 - Promoting the Equitable Evaluation of Non-Research Domains in Trainee Selection*

Notes:

- *Items in italics will be considered based on HOD action at the Second Opening Session.*
- Amendments and supplemental material must be sent to referencecommitteec@ama-assn.org
- For technical assistance, email HODMeetingSupport@ama-assn.org or call 800-337-1599.
- Handbook and Not For Consideration items
- Online Reference Committee
- Preliminary Report
- Zoom link

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-25)

AGENDA
Reference Committee F
In-Person Hearing

Robert A. Gilchick, MD, MPH, Chair

RECOMMENDED FOR ADOPTION

1. Council on Long Range Planning and Development Report 1 – Private Practice Physicians Section Five-Year Review

2. Report of the House of Delegates Committee on the Compensation of the Officers

RECOMMENDED FOR ADOPTION AS AMENDED

3. Speakers' Report 2 – Election Committee Review of Election Rules for Clarification

RECOMMENDED FOR REFERRAL

4. Resolution 601 – Reimagining and Modernizing the U.S. Healthcare Delivery System

RECOMMENDED FOR NOT ADOPTION

5. Council on Long Range Planning and Development Report 2 – Evaluation of the Structure of the AMA House of Delegates

6. Speakers' Report 1 – Online Reference Committees

7. Resolution 602 – Standardizing the Appointment Process for AMA Councils

RECOMMENDEDATION NOT YET DETERMINED

8. Board of Trustees Report 23 – Accreditation Council for Continuing Medical Education Observer Status in the House of Delegates

9. Resolution 603 – Upholding Professional Integrity and Ethical Leadership through Continued Publication of the AMA Journal of Ethics

** Items in italics will be considered based on HOD action at the Second Opening Session.*

Please email amendment language or additional information to referencecommitteef@ama-assn.org.

Zoom Link:
https://events.zoom.us/ev/AgpP2z-nJUKf8AHvEH0bWAVKdtTJcwUn4i_2Yf_avFZBbHFqBlRL~AlRQvLgeoeEu05EIhsRrlt0cka10usZvfrkGgZ0_2tnsqrcjXJ6XodWDNw

10. Resolution 604 – Sustaining Ethical Leadership Through Continued Support of the AMA Journal of Ethics

RECOMMENDED AGAINST CONSIDERATION

11. Resolution 605 – Further Enabling AMA BOT Expediency for Actions, Advocacy, and Responses During Urgent Situations

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-25)

Agenda

Reference Committee J
In-Person Hearing

Mary Campagnolo, MD MBA, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 18 – Published Metrics for Hospitals and Hospital Systems
2. Resolution 802 – Patient Choice of Physician
3. Resolution 804 – Medicare Advantage Filing Limit
4. Resolution 809 – Ensuring Patient Safety and Physician Oversight in the Integration of Hospital Inpatient Virtual Nursing
5. Resolution 811 – Non-Medical Switching
6. Resolution 812 – Discontinue Review Choice Demonstration Project for Inpatient Rehabilitation Hospital Admissions
7. Resolution 814 – Mandate for Insurance Companies to Assist in the Transition of Patients to Alternative Participating Physicians Upon Contract Termination
8. Resolution 819 – Update the Status of Virtual Credit Card Policy, EFT Fees, and Lack of Enforcement of Administrative Simplification Requirements by CMS
9. Resolution 821 – Improving Access to Emergency Ophthalmologic Surgical Care
10. Resolution 822 – Improving Home or Community-Based Services Waiver Waiting List Management
11. Resolution 827 – Opposition to Prior Authorization in Medicare Fee-for-Service, Burdensome Administrative Requirements
12. Resolution 828 – Creating a Public Scorecard on Insurer Delays in Care and Payment Caused by Prior Authorization
13. Resolution 829 – Publicize Insurer Financial Gains from Delayed Care and Payment Caused by Prior Authorization

RECOMMENDED FOR ADOPTION AS AMENDED

14. Council on Medical Service Report 1 – Health Savings Account Reform
15. Council on Medical Service Report 2 – Telehealth Licensure
16. Council on Medical Service Report 3 – Payment Models to Sustain Rural Hospitals
17. Council on Medical Service Report 4 – Payment for Biosimilars
18. Resolution 805 – Shared Medical Appointments
19. Resolution 806 – Insurance Coverage for Colonoscopy Preparation Cost

Amendments and supplemental materials MUST be sent to referencecommitteej@ama-assn.org. Please include the Resolution or Report number in the subject line. Do not send testimony to this email address. This address is only operational for the duration of the Reference Committee A hearing.

Note: Items in *italics* will be considered based on HOD action at the Second Opening Session. At the beginning of the reference committee hearing, the chair will identify those items that will **not** be discussed in the hearing, and these items will **not** be considered by the reference committee.

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20. Resolution 807 – Protecting Hospitals and Patients from Inappropriate Denials of Inpatient Admissions
21. Resolution 808 – No Prior Authorization for Inexpensive Medications
22. Resolution 815 – Mandating Health Insurers to Provide a Real-Time Online Tool for Coverage and Payment Policies, Integrated into Electronic Health Records (EHRs)
23. Resolution 816 – Prohibit Arbitrary Time Limits on Preauthorizations
24. Resolution 817 – Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service
25. Resolution 823 – Accountability in the Use of Augmented Intelligence for Prior Authorization
26. Resolution 824 – Equitable Payment and Increased Access for In-Office Pediatric Lead Screening and Testing
27. Resolution 825 – Ensuring Coverage for In-Office Point-of-Care (POC) Testing in Outpatient Medical Practices
28. Resolution 826 - Increase National Immunization Rates by Advocating for Equitable Vaccine Payments

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

29. Resolution 813 – Increased Regulation of For-Profit Healthcare Insurance
30. Resolution 818 – Universal Out-of-Network Benefits

RECOMMENDATION NOT YET DETERMINED

31. *LATE 1001: Preserve Coverage for Peripheral Nerve Blockade in Chronic Pain*

RECOMMENDED AGAINST CONSIDERATION

32. *Resolution 801 – Excessive Cost of Multi-State DEA Licensure*
33. *Resolution 803 – Ensuring Physician Input in the Development of Alternative Payment Models (APMs)*
34. *Resolution 810 – Opposing Unilateral Downcoding of Physician Services by Insurance Companies*
35. *Resolution 820 – Establishing an AMA "First Responder Team" for Real-Time Physician Advocacy Against Adverse Insurance Company Actions*

Amendments and supplemental materials MUST be sent to referencecommitteej@ama-assn.org. Please include the Resolution or Report number in the subject line. Do not send testimony to this email address. This address is only operational for the duration of the Reference Committee A hearing.

Note: Items in *italics* will be considered based on HOD action at the Second Opening Session. At the beginning of the reference committee hearing, the chair will identify those items that will **not** be discussed in the hearing, and these items will **not** be considered by the reference committee.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-25)

AGENDA

Reference Committee K
In-Person Hearing

Samuel Huang, MD, Chair

RECOMMENDED FOR ADOPTION

1. CSAPH 02 - Regulation of Ionizing Radiation Exposure for Health Care Professionals
2. Resolution 901 - Distinction Between Healthful and Unhealthful “Ultraprocessed” Foods
3. Resolution 920 - Alcohol and Aging: Educating Physicians and Advocating for Safer Warnings
4. Resolution 921 - Prioritizing Deprescribing in Seniors
5. Resolution 922 - Addressing Health Impacts of Indian Boarding Schools
6. Resolution 923 - Enhancing Disaster Preparedness Mechanisms for People with Disabilities
7. Resolution 924 - Preserving Access to Gamete Donation and Gestational Carriers and Protecting Parental Rights
8. Resolution 926 - Establishment of Federal and State Offices of Men's Health
9. Resolution 927 - Battlefield Acupuncture - An Educational Call to Arms
10. Resolution 929 - Protecting Access to Evidence-base Psychotropic Medications for the Treatment of Pediatric Mental Illness
11. Resolution 932 - Shared Decision-Making and Low Dose CT Lung Cancer Screening in Clinical Practice

RECOMMENDED FOR ADOPTION AS AMENDED

12. CSAPH 03 - Plastic Pollution Reduction
13. Resolution 905 - Standardizing Brain Death Policies
14. Resolution 907- In-Office Dispensing of Generic Medications
15. Resolution 911- Safeguarding NIH-Funded and Other Women's Health Research in Peer-Reviewed Publishing
16. Resolution 912 - Increasing Access through Federated Healthcare Data Architecture
17. Resolution 933 - Addressing Gaps in National Healthcare Safety Network (NHSN) Data Quality

RECOMMENDED FOR ADOPTION IN LIEU OF

18. Resolution 919 - Strengthening Trust through AMA-Based Leadership for Evidence-Based Vaccines (STABLE Vaccines)
    Resolution 925 - Evidence-Based Vaccine and Preventive Services Recommendation

Zoom link to hearing (view only webinar)
https://events.zoom.us/ejl/AgpP2z-nJUKf8AHvEH0bWAVKdtTJcwUn4i_2Yf_avFZBbHFqBIRL~A8NQZPqbRF8J1_SJ-D6qg5QWXNoUUPqPY-eyK36YJmgwVeW7XZ-dnsmBjuiZB7EqI8z-IbqoUiKtY2i_6ctI-_ipjC7XkEIK0VUCs-B0d37Q

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19. Resolution 931 - Preserving Evidence-Based, Equitable Grooming Standards in Military Service

RECOMMENDED FOR REFERRAL

20. Resolution 906 - Rethinking the Medicare Annual Wellness Visit
21. Resolution 918 - Remove Outdated Barriers to Genetic Testing
22. Resolution 930 - Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing

RECOMMENDED FOR NOT ADOPTION

23. Resolution 904 - Supporting Certification of the Public Health Workforce
24. Resolution 908 - Support of Access to Insulin-Detemir

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

25. Resolution 903 - Nitrous Oxide Inhalant Abuse
26. Resolution 909 - Clinical Significance of Sleepiness
27. Resolution 917 - Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup

RECOMMENDATION NOT YET DETERMINED

28. BOT 24 – Amending Vaccine-related Policies
29. *Late 1005/Resolution 935 - Enhancing Healthcare System Preparedness to Address Veteran-Specific Health Disparities*

RECOMMENDED AGAINST CONSIDERATION

30. *Resolution 902 - Advocating for Improvements in Systems of Care for Autism*
31. *Resolution 910 - Increasing Funding for Gynecological Cancer Research*
32. *Resolution 913 - Establish AMA Policy and Project to Compile and Distribute JAMA Patient Pages to Enhance Public Media Literacy*
33. *Resolution 914 - Develop Climate-Conscious Resources for Physicians*
34. *Resolution 915 - Reduce Environmental Impact of Medical Journals*
35. *Resolution 916 - Studying the Environmental Impact of Ambient Clinical Intelligent Use*
36. *Resolution 928 - AMA's Continued Support for COVID-19 Vaccination in Pregnant Individuals and Children*
37. *Resolution 934 - Partnership with the Administration to Reduce Harmful Chemicals in Food and Align with European Safety Standards*

** Items in italics will be considered based on HOD action at the Second Opening Session.*

Zoom link to hearing (view only webinar)
https://events.zoom.us/ejl/AgpP2z-nJUKf8AHvEH0bWAVKdtTJcwUn4i_2Yf_avFZBbHFqBlRL~A8NQZPqbRF8J1_SJ-D6qg5QWXNoUUPqPY-eyK36YJmgwVeW7XZ-dnsmBjuiZB7EqI8z-lbqoUiKtY2i_6ctl-_ipjC7XkEIK0VUCs-B0d37Q

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Reference Committee B

Report(s) of the Board of Trustees

01	Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis	B
02	Laser Surgery	B
03	Stark Law Self-Referral Ban	B
04	Addressing and Reducing Patient Boarding in Emergency Departments (EDs)	B
06	Information Blocking Rule	B
07	Codification of the Chevron Deference Doctrine	B
12	Support For Doula Care Programs	B
13	Antidiscrimination Protections for LGBTQ+ Youth in Foster Care	B
15	Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research Report	B
16	Preservation of Medicaid	B
22*	Physician Assistant and Nurse Practitioner Movement Between Specialties	B

Resolutions

201	Model State Legislation incorporating Medical Malpractice Tort Reform Based on Utah H.B. 503 (2025)	B
202	Deepfake Technology and Harm to Physicians and Patients	B
203	Restore and Enhance Federal Loan Programs for Medical Education	B
204	Addressing Anti-Physician Contractual Provisions	B
205	Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care	B
206	Restore Funding to USAID	B
207	Support for a Federal Tax Incentive for Volunteer Community Preceptors	B
208	Centralization of Medicare Provider Data Sources	B
209	Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians	B
210	PBM Divestiture and Transparency	B
211	Access to, and Retention of, Electronic Medical Records	B
212	Acknowledging Flexibility on Buprenorphine Mono-product Use for Opioid Use Disorder Opioid Use Disorder	B
213	Pathways to U. S. Permanent Residency for H-1B Physicians	B
214	Physician Visa Protection and Pathway to Serve Underserved Communities	B
215	Extending the Medicaid Work Requirement Exemption up to 12 Months Postpartum	B
216	Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs	B
217	Protecting Access to Public Service Loan Forgiveness (PSLF), Income-Driven Repayment (IDR), and Direct Plus Loans for Graduate or Professional Students (Grad PLUS Loans)	B
218	Amend AMA Policy D-160.921 on Sensitive Locations to Protected Areas	B
219	Addressing the Harms and Misleading Nature of Medicare Advantage Plans	B

220	Medicare Should not Unfairly Penalize Physicians	B
221	Not-for-Profit Status	B
222	Tackling Administrative Waste—Let Us Be Part of the Solution to Putting Our Health System on a Sustainable Path	B
223	Halt the Rollout of New Payment Models by the Center for Medicare & Medicaid Innovation (CMMI)—A New Administration Offers an Opportunity	B
224	Recoupment by CMS Recovery and Audit Contractors (RAC)—Due Process	B
225	Federal Legislation to Prohibit the Corporate Practice of Medicine	B
226	Transparency with the Term "Emergency Department"	B
227	Call for Immediate and Aggressive Action by the AMA to Reverse Medicaid Cuts Impacting Seniors	B
228	Support Permanent Funding and Expansion of Native Hawaiian Healthcare	B
229	Protection of Medicaid Beneficiaries' Private Health Information from Immigration Enforcement	B
230	Banning Non-compete Agreements in States	B
231	Ensuring Equitable and Timely Medical Licensure for Physicians Providing Abortion and Gender-Affirming Care	B
232	Safeguarding Access to IVF Amid Restorative Reproductive Medicine Legislation	B
233	Renewing Mental Health Infrastructure in the School System	B
234	Study on Impact of Inflation Reduction Act on Oncology, Other Physician Practices	B
236	Deceptive Advertising in Accredited Allied Health Professional, Non-Physician Graduate Programs	B
237	Protecting and Improving Rural Health	B

**Contained in Meeting Tote*

Reference Committee C

Report(s) of the Council on Medical Education

01 Additional Pathways for International Medical Graduates

Resolutions

301 Preventing Sleep Deprivation and Supporting Medical Student Wellness

304 Systemic Exclusion of IMGs from Residency Programs

305 Paid Sick Leave and Flexible Work Arrangements for Caregivers of Individuals with Special Needs, Chronic Illness, or Elderly Parents

306 Support for Paid Prenatal Leave

307 Integrating Artificial Intelligence (AI) Literacy Into UME, GME, and CME

308 Enhancing the Pathway for Black Male Medical Students

311 Gender and URiM Disparities in Surgical Training Volumes

313* Hardship for International Medical Graduates from Palestine

**Contained in Meeting Tote*

Reference Committee on Ethics and Bylaws

Report(s) of the Board of Trustees

05 Addressing the Unregulated Body Brokerage Industry
08 On the Ethics of Human Lifespan Prolongation
10 Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients
11 Supporting Diversity in Research
19 Addressing the Historical Injustices of Anatomical Specimen Use
21* Specialty Society Representation in the House of Delegates - Five-Year Review

Report(s) of the Council on Constitution and Bylaws

01 Bylaws Review Report
02 Bylaws Clarifications Subsequent to A-25 House of Delegates Meeting
03 Credentialing of Temporary Delegates and Alternate Delegates

Report(s) of the Council on Ethical and Judicial Affairs

01 Amendment to Opinion 1.1.1 "Patient-Physician Relationships"
02 Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization
03 Ethical Impetus for Research in Pregnant and Lactating Individuals

Resolutions

001 Clarifying Conscientious Objection
002 Ensuring Ethical Use of Wearable Recording Devices in Clinical Encounters
003 Report on Gender-Based Pay Equity in Medicine
004 Patient Options to Restrict Secondary Use of Their Healthcare Data
005 Preserving Autonomy in the Patient-Physician Relationship
006 Amendment to AMA Bylaws to Enable Continuity of Leadership
007 Improving Protection for Reproductive Health Information
008 Health Plan In-Network Steering of Pathology/Laboratory Services
009 Gender Equity in Disability Insurance for Physicians
010* Clarifying the Medical Student Section's and Resident and Fellow Section's Abilities to Fill Temporary Vacancies in Accordance with the AMA Bylaws

**Contained in Meeting Tote*

Reference Committee F

Report(s) of the Council on Long Range Planning and Development

01 Private Practice Physicians Section Five-Year Review
02 Evaluation of the Structure of the AMA House of Delegates
23* Accreditation Council for Continuing Medical Education Observer Status in the House of Delegates

Report(s) of the HOD Committee on Compensation of the Officers

01 Report of the House of Delegates Committee on the Compensation of the Officers

Report(s) of the Speakers

01 Online Reference Committees
02 Election Committee Review of Election Rules for Clarification

Resolutions

601 Reimagining and Modernizing the U.S. Healthcare Delivery System
602 Standardizing the Appointment Process for AMA Councils
603* Upholding Professional Integrity and Ethical Leadership through Continued Publication of the AMA Journal of Ethics
604* Sustaining Ethical Leadership Through Continued Support of the AMA Journal of Ethics

**Contained in Meeting Tote*

Reference Committee J

Report(s) of the Board of Trustees

18 Published Metrics for Hospitals and Hospital Systems

Report(s) of the Council on Medical Service

01 Health Savings Account Reform
02 Telehealth Licensure
03 Payment Models to Sustain Rural Hospitals
04 Payment for Biosimilars

Resolutions

802 Patient Choice of Physician
804 Medicare Advantage Filing Limit
805 Shared Medical Appointments
806 Insurance Coverage for Colonoscopy Preparation Cost
807 Protecting Hospitals and Patients from Inappropriate Denials of Inpatient Admissions
808 No Prior Authorization for Inexpensive Medications
809 Ensuring Patient Safety and Physician Oversight in the Integration of Hospital Inpatient Virtual Nursing
811 Non-Medical Switching
812 Discontinue Review Choice Demonstration Project for Inpatient Rehabilitation Hospital Admissions
813 Increased Regulation of For-Profit Healthcare Insurance
814 Mandate for Insurance Companies to Assist in the Transition of Patients to Alternative Participating Physicians Upon Contract Termination
815 Mandating Health Insurers to Provide a Real-Time Online Tool for Coverage and Payment Policies, Integrated into Electronic Health Records (EHRs)
816 Prohibit Arbitrary Time Limits on Preauthorizations
817 Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service
818 Universal Out-of-Network Benefits
819 Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS
821 Improving Access to Emergency Ophthalmologic Surgical Care
822 Improving Home or Community-Based Services Waiver Waiting List Management
823 Accountability in the Use of Augmented Intelligence for Prior Authorization
824 Equitable Payment and Increased Access for In-Office Pediatric Lead Screening and Testing
825 Ensuring Coverage for In-Office Point-of-Care (POC) Testing in Outpatient Medical Practices
826 Increase National Immunization Rates by Advocating for Equitable Vaccine Payments
827 Opposition to Prior Authorization in Medicare Fee-for-Service, Burdensome Administrative Requirements
828 Creating a Public Scorecard on Insurer Delays in Care and Payment Caused by Prior Authorization
829 Publicize Insurer Financial Gains from Delayed Care and Payment Caused by Prior Authorization

Reference Committee K

Report(s) of the Council on Science and Public Health

02 Regulation of Ionizing Radiation Exposure for Health Care Professionals
03 Plastic Pollution Reduction

Resolutions

901 Distinction Between Healthful and Unhealthful "Ultraprocessed" Foods
903 Nitrous Oxide Inhalant Abuse
904 Supporting Certification of the Public Health Workforce
905 Standardizing Brain Death Policies
906 Rethink the Medicare Annual Wellness Visit
907 In-Office Dispensing of Generic Medications
908 Support of Access to Insulin-Detemir
909 Clinical Significance of Sleepiness
911 Safeguarding NIH-Funded and Other Women's Health Research in Peer-Reviewed Publishing
912 Increasing Access through Federated Healthcare Data Architecture
917 Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup
918 Remove Outdated Barriers to Genetic Testing
919 Strengthening Trust through AMA-Based Leadership for Evidence-Based Vaccines (STABLE Vaccines)
920 Alcohol and Aging: Educating Physicians and Advocating for Safer Warnings
921 Prioritizing Deprescribing in Seniors
922 Addressing Health Impacts of Indian Boarding Schools
923 Enhancing Disaster Preparedness Mechanisms for People with Disabilities
924 Preserving Access to Gamete Donation and Gestational Carriers and Protecting Parental Rights
925 Evidence-Based Vaccine and Preventive Services Recommendations
926 Establishment of Federal and State Offices of Men's Health
927 Battlefield Acupuncture – An Educational Call to Arms
929 Protecting Access to Evidence-based Psychotropic Medication for the Treatment of Pediatric Mental Illness
930 Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing
931 Preserving Evidence-Based, Equitable Grooming Standards in Military Service
932 Shared Decision-Making and Low Dose CT Lung Cancer Screening in Clinical Practice
933 Addressing Gaps in National Healthcare Safety Network (NHSN) Data Quality

REVISED

REPORT OF THE BOARD OF TRUSTEES

B of T Report 08-I-25

Subject: On the Ethics of Human Lifespan Prolongation

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2024 Interim Meeting, the House of Delegates (HOD) adopted policy D-140.947, "On the Ethics of Human Lifespan Prolongation," which directs our AMA to:

> undertake an evaluation of the ethics of extension of the human lifespan, currently considered to be 120 years, with the goal of providing guidance and/or guidelines for clinical practice, research and potential regulatory challenges.

This report provides background and ethical analysis in fulfillment of the directive.

BACKGROUND

Investment in longevity research has surged in recent years, increasing from half of a billion dollars in 2013 to $6.2 billion in 2021.[1] This longevity market includes not only longevity biotech firms and startups, but also regenerative medicine providers, AI-driven drug discovery platforms, biomarker discovery and diagnostic platforms, and novel therapeutic technologies, such as stem cell-, gene-, and immunotherapy. These technologies are often aimed at ultimately improving the human lifespan and healthspan. While life expectancy is a statistical measure of the average years of life someone can expect to live, the human lifespan refers to the maximum length of life a person can potentially achieve, while healthspan refers to the portion of life a person spends in a healthy state free of chronic diseases and disability. The interdisciplinary field of research dedicated to studying the biological mechanisms of aging and how they contribute to age-related diseases is known as geroscience.[2]

With the advent of modern medicine, life expectancy has nearly doubled in the U.S. since 1900, reaching an average of approximately 78.4 years in 2023.[2,3] Unlike life expectancy, the human lifespan appears to be biologically fixed, with a ceiling around 125 years.[4] However, some people believe that this biological limit can be overcome. Often referred to as radical life extension, some adherents believe that the human lifespan might someday be extended to 150 years, 300 years, or even thousands of years.[4] Importantly, a central goal of radical life extension is to increase not only the human lifespan but also the human healthspan. In the U.S., the lifespan-healthspan gap has been increasing over the past two decades, meaning that while life expectancy has increased, there has also been growth in the number of years people live impacted by chronic disease or disability.[5] Successful radical life extension would thus enable humans to live beyond their current biological limits and do so while experiencing optimal health.

Proponents of radical life extension often view disease, aging, and even death as obstacles to overcome, and argue that such technologies will ease human suffering and drive innovations in

disease prevention and treatment.[2] Opponents typically cite concerns regarding demographics and sustainability, questions of equitable access and social justice, and fears of negative social impacts as views on aging and death change.[4,6,7] Because the technology for radical life extension is still hypothetical, any ethical analysis and debate is inherently speculative; however, as the possibility of such technology increasingly moves from the realm of science fiction to scientific reality, it is important that ethical guidance related to its development, clinical use, and regulation be established.

ETHICS ANALYSIS & DISCUSSION

Achieving radical life extension technologies would represent a profound scientific development with wide-ranging societal impacts. The potential to eradicate chronic diseases and disability while also extending lifespans would represent an enormous reduction in human harm and illness. However, the development of such technologies also has the potential to drastically increase existing inequalities and destabilize existing social norms. Much of the ethical debate regarding whether radical life extension technologies should be developed utilizes a utilitarian approach, arguing that only if the benefits to society are greater than the harms should such innovations be pursued.[8,9]

Aging as a Disease & the Scope of Biomedical Research

Proponents of radical life extension advocate a certain pathologization of aging, representing it as a disease that should be treated. In contrast, critics typically represent aging as a natural part of human life and argue that biomedical interventions should focus on shrinking the human healthspan-lifespan gap rather than on increasing longevity.[6,9] Currently, the Food and Drug Association (FDA) considers aging a natural process and does not recognize aging as a disease, which makes it difficult to get FDA approval for drugs that specifically target aging.[10] However, researchers have found ways to still pursue studies of geroscience. For example, Metformin, an FDA-approved first-line treatment for type 2 diabetes, is also being investigated for its potential not to delay aging specifically but to delay the onset of age-related diseases.[11] If current trials are successful, it could lead to a paradigm shift in how aging is recognized by the FDA and pave the way for the approval of drugs that directly target aging and not just individual diseases. The World Health Organization (WHO) has already begun to move in this direction with regard to the deterioration associated with aging, implying that againg is a disease by including “aging associated decline in intrinsic capacity” as a disease code in their 11th edition of the International Classification of Diseases (ICD).[10] As scientific pressure grows in the US, the FDA is likely to revisit the issue and reevaluate their stance towards aging. If the FDA does change its position, however, the question will remain whether (and how much) funding for clinical research should be diverted from other pursuits towards studies on how to slow or prevent aging.

Equality of Access and Social Justice

A primary ethical concern regarding radical life extension is the possibility that it would exacerbate inequality.[9,12,13] Critics argue that radical life extension technologies would be unethical if they were only available to wealthy individuals. In this view, because such technologies would likely be quite expensive, at least initially, only some members of society would be able to benefit from them.[12] Additionally, there is concern that a focus on longevity technologies would tie up limited resources for improving health in other domains and, as a result, other issues that impact health would be ignored (such as education, pollution, and climate change).[14] Opponents also claim that health research should focus on closing current healthspan-lifespan gaps, rather than on increasing

human longevity.[15] On the other hand, proponents argue that combating aging may in fact be far more cost-effective because aging is the most significant risk factor for disability and most prevalent chronic diseases. They also suggest that while radical life extension technologies are likely to be expensive and not widely available to everyone at first, there is no reason to believe that this situation would persist for long.[9] Some even advocate that, eventually, everyone globally should have access to any interventions that promote healthy aging regardless of socio-economic status.[9]

When weighing the benefits and burdens of radical life extension, the question becomes one of equity, and more specifically, how much social inequality society is willing to accept. There is general agreement that developing longevity technologies would be unethical if doing so greatly increased inequalities over a long period of time, creating two castes of people (those who can access such technologies and those who cannot). However, there is less agreement regarding whether increasing inequalities in the immediate would be unethical if the long-term results were that everyone benefited and lived longer, healthier lives.

Demographic and Resource Concerns

Another important ethical concern has to do with the demographic implications of people living longer. If people die less frequently, populations are likely to grow larger, resulting in a society that consists of an older populous.[15] Increased longevity could also result in longer reproductive years and lead to people having more children. This jump in population could in turn place an unsustainable strain on available resources.[4] Alternatively, some critics have voiced concerns that radially extending life might result in a decreased sense of purpose and thus lead to reductions in social commitments and engagement, eventually leading to decreases in childbearing and reproduction.[7]

Changing Social Values and Norms

Concerns regarding the demographic impact of radical life extension highlight the fact that such innovations would initiate radical social changes. The potential impacts on social values and norms are perhaps the most common yet most amorphous ethical concerns. If radical life extension were to be achieved, it would mean a collision of far more generations than exists in parallel today, which could lead to generational divides and contentions over status and social roles.[6] A rising share of older voters could lead to growing political tensions, as policies favoring the young shift to policies that favor the old.[16] Alternatively, extending the years of youth could lead to a devaluation of the elderly as fundamentally inadequate or defective.[12,14] These tensions could be exacerbated if a generation feels that there is no need to make room for younger generations. Other concerns include fears that radical life extension would diminish the sacredness of life;[4] that altering the human lifespan beyond its biological limits would represent a reconstruction of what it means to be human;[17] and that the slowing of successive generational cycles could lead to the slowing of cycles of innovation and adaptation.[7]

CONCLUSION

Because research on radical life extension is currently situated within a capitalist enterprise, longevity projects and issues of inequality are inherently interconnected.[12] Moreover, the possibility of radical life extension has attracted heavy involvement by the ultra-wealthy, including Larry Page (cofounder of Google) and Jeff Bezos (Amazon's founder), both of whom have significantly invested in longevity research (conducted by Calico Labs and Altos Labs,

respectively).[14] Such investments have raised concerns that should these technologies prove successful, they will only be accessible to a select few and will fuel an ever increasing social divide. If radical life extension were achieved, it would also require significant changes within society to ensure that the future elderly are as healthy and as supported as possible. There would also be a need to ensure that social institutions such as education, jobs, health insurance, and social security are able to support the longer lives of the young.[16]

If radical life extension becomes a reality, society is likely to be divided into the Haves (those who extend their lives), the Have-nots (those who would like to but can't afford to extend their lives), and the Will-nots (those who refuse to extend their lives). Proponents recognize the potential benefits of radical life extension but emphasize that these advancements should be pursued with careful attention to minimizing harm, the significant benefits to the Haves justify pursuit of radical life extension.[8] The argument in favor hinges on the belief that it is always ethical to seek to alleviate suffering and improve the human condition, and this is exactly what radical life extension would achieve.[7] However, issues of equity and ethics should be considered. Over the long term, it should be a goal for these innovative treatments to be distributed equitably within the United States and across the globe.[4] What this would look like in practice, however, and how much inequity is socially acceptable in pursuit of radical life extension, is still up for debate.

Due to the currently hypothetical nature of radical life extension technology, developing specific guidelines or regulations at this time presents a challenge, as the technology itself and any impacts it may have remain purely theoretical. However, as is the case with any emerging medical technology, all research on radical life extension should adhere to the appropriate ethical standards set forth by the AMA *Code of Medical Ethics* and the research ethics outlined in the World Medical Association's Declaration of Helsinki. Furthermore, regardless of the form such technology may take or the duration of extended life it may grant, radical life extension, if it were to become a reality, should be made accessible in an ethical, equitable, and just manner.

RECOMMENDATIONS

The Board of Trustees recommends that Policy D-140.947 be rescinded as having been accomplished by this report and the remainder of the report be filed.

Fiscal Note: Minimal – less than $500

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REVISED

REPORT OF THE BOARD OF TRUSTEES 10 (I-25)
Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients
(Reference Committee E&B)

EXECUTIVE SUMMARY

At the 2024 American Medical Association (AMA) Interim Meeting, Resolution 004, "Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients", was introduced by the LGBTQ Section and referred for report back at the 2025 Interim Meeting. The resolution directs the promotion of inclusive gender, sex, and sexual orientation options on medical documentation and proposes amendments to Policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation", to recommend broader reforms to EHR systems to better serve transgender and gender-diverse individuals.

This report provides detailed information about efforts taken and challenges presented by the AMA, physicians, practices, EHR vendors, and other stakeholders to address the needs of transgender and gender-diverse individuals. This includes the following considerations:

1. Linking cancer screenings and preventive services to a patient's current anatomical inventory reduces the risk of care gaps. This approach builds on Health Level 7 standards that distinguish "Sex for Clinical Use" from legal sex and gender identity, which is already supported in many EHRs.
2. Gaps exist in how health information technology vendors handle gender and sex data and work collaboratively to ensure systems treat all patients equitably. Structured and standardized fields for sexual orientation and gender identity (SOGI) and organ data are necessary for both research and patient safety.
3. Leveraging personal health records may ease the documentation burden on physicians by allowing patients to input and manage aspects of their identity data directly, so long as interoperability and privacy safeguards are in place.
4. Gender-inclusive data capabilities in EHR systems must be implemented at no added cost to providers, aligning with broader health equity goals without increasing administrative strain.
5. Patient data collection must be opt-in and based on informed consent. Patients should have the ability to opt out without compromising access to care or services. This is especially critical given privacy concerns and legal inconsistencies across states.

Further collection of gender-affirming care data risks exposing patients, families, and physicians to civil liability and criminal prosecution, as current EHRs lack reliable data segmentation and may inadvertently disclose information in states where such care is banned. This report underscores a growing consensus that inclusive EHR documentation enhances clinical safety and patient well-being, while also raising privacy concerns. Despite expanded SOGI and organ inventory fields in EHRs, usage and training remain inconsistent. The report recommends not adopting Resolution 004 (I-24) but supporting the use of "chosen name" over "preferred name"; reaffirming Policy H-315.967; and engaging relevant stakeholders to improve EHR usability for this patient population with strong privacy protections and ensure respectful and up-to-date AMA terminology.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-I-25

Subject: Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

INTRODUCTION

At the 2024 Interim meeting of the American Medical Association (AMA) the House of Delegates (HOD), Resolution 004, "Improving Usability of Electronic Health Records for Transgender and Gender Diverse Patients," was referred for report back at the Interim 2025 meeting. This resolution was introduced by the LGBTQ Section and called for the following:

> RESOLVED, that our American Medical Association amend Policy H-315.967 "Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation" by addition and deletion to read as follows:
>
> **Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, H315.967**
>
> Our AMA: (1) supports the voluntary inclusion of a patient's ~~biological sex~~current clinical sex, sex assigned at birth, current gender identity, legal sex on identification documents, sexual orientation, ~~preferred~~ gender pronoun(s), ~~preferred~~ chosen name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner, with efforts to improve visibility and awareness of transgender and gender diverse patients' chosen name and pronouns in all relevant EHR screens and to de-emphasize or conceal legal name except when required for insurance and billing purposes; (2) Will advocate for the inclusion of an organ inventory encompassing medical transition history and a list of current present organs in EHRs, with efforts to link organ-specific examinations and cancer screenings to the current organ inventory rather than sex or gender identity; (~~2~~3). Will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (~~3~~4) Will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (~~4~~5) Will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each

encounter; and (~~5~~6) Will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians automatically. (7) Will advocate for patient informed consent regarding how gender identity and related data will be used with the ability to opt out of recording aforementioned data without compromising patient care; (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA supports the use of the term "chosen name" over "preferred name," recognizing the value of the term "chosen name" to transgender and gender diverse patients (New HOD Policy).

While testimony on this resolution was mostly supportive, there were concerns about terminology and minors' privacy.

This report seeks to advance proposals aligned with best practices for inclusive health documentation, including adoption of the term, "chosen name", and the development of an organ inventory within EHRs—documenting both a patient's medical transition history and current present organs—to ensure anatomically appropriate preventive care, screenings, and treatment. Building on these priorities, the report emphasizes the importance of ensuring that transgender and gender-diverse patients' chosen names are visible across health records, while also acknowledging the challenges to adopting the resolution given the current health care information technology (IT) and political landscape. It further highlights the need for inclusive and standardized data collection practices, equitable treatment in health care technology systems, and expanded use of personal health records to reduce the administrative burden on physicians.

BACKGROUND

Sexual orientation and gender identity (SOGI) data is information collected by health care organizations about a person's sexual orientation and gender identity to help providers and researchers better understand gender-diverse patients, enable culturally-responsive, patient-centered care, and monitor and improve access to quality care.[1] The AMA supports the voluntary, culturally sensitive inclusion of patient data on sex, gender identity, and sexual orientation in medical records[2,3], and is committed to equitable, inclusive care for transgender and gender-diverse patients. In medical contexts, the terminology used to refer to transgender patients' names carries significant weight. Specifically, the term "chosen name" is preferred over "preferred name" due to its affirmation of identity and the mental health benefits associated with its use.[4] Policy H-315.967 underscores the idea of informed consent, including transparent discussions on who can access a patient's data and how it will be used, extending beyond clinical interventions to data privacy and sharing policies. Focus groups revealed that transgender patients appreciated two-step gender identity questions in EHRs, but expressed concern about privacy and desired greater control, including opt-out options, especially in contexts where data might be shared.[5] Guidance on collecting sexual orientation and gender identity emphasizes offering an opt-out ("Choose not to disclose") option.[6] Patients must be informed about why data is collected, how it will be used, and that refusal will not affect their treatment. A recent study showed that patients of sexual and gender minority expect informed consent before capturing SOGI data, prefer to choose when and how to share it, and are more comfortable when staff understand its relevance and patients have the option to decline.[7]

The term “clinical sex” goes beyond a medically convenient label; it’s a contextual, biologically informed data element designed to ensure precise, safe, and inclusive health care. It is important to recognize that ongoing efforts have aimed to make EHRs more inclusive and clinically relevant by bridging the gap between patient identity, clinical accuracy, and respectful care. Sex for Clinical Use (SFCU) and Sex Parameter for Clinical Use (SPCU) are standardized health data elements that captures the sex classification most relevant to a specific clinical context (e.g., lab reference ranges, imaging studies, and medication dosing), as defined by the Health Level 7 (HL7) Gender Harmony Project.[8] SFCU/SPCU reflects the biological characteristics relevant to clinical care—such as anatomy, hormones, organs, chromosomes—as opposed to legal sex, sex assigned at birth, or gender identity. The HL7 Fast Healthcare Interoperability Resources standard includes an extension usable in patient portal or laboratory resources.[9] It supports the four-value schema: male, female, specified, and unknown. Health care providers are encouraged to adopt practices that respect and affirm patients' identities. The addition of SOGI fields over the last ten years have already established a basis of improving health care for the gender-expansive patient population.[10] This includes updating EHRs to distinguish between legal and chosen names, ensuring that staff are trained to use patients' chosen names and pronouns, and creating an inclusive environment that acknowledges and supports transgender patients.

EHR systems have been required to be capable of collecting SOGI data since a ruling by the Center of Medicare and Medicaid Services (CMS) in 2015[11], but reliability of these infrastructures have remained questionable by gender-diverse communities. Studies have shown that over 60 percent of adult EHRs are missing SOGI information[12], impeding the ability to identify and address health disparities within LGBTQ+ populations. Most EHRs now support distinct fields for legal sex, sex assigned at birth, gender identity, organ inventories (e.g., presence/absence of uterus, prostate, etc.), and context-specific sex fields that inform lab reference ranges, clinical decision support, and alerts.[13] This ensures correct testing and screening, and supports health equity and interoperability. Organ inventories are proven tools to ensure equitable, anatomy-based care. They are increasingly supported by leading EHR vendors and adopted by institutions like Epic[14], Geisinger[15], Allscripts[16], Department of Veterans Affairs[17], and Fenway Health.[17] Recommendations from the LGBTQ Primary Care Toolkit endorse voluntary SOGI and organ inventory disclosure through patient portals or clinic tablets[18], with clear messaging that patients may update or decline to provide this information—supporting autonomy and mental comfort. Successful integration depends on standardizing data, aligning workflows, providing training, and addressing anatomical complexity. Continued expansion is essential to close care gaps for transgender, gender-diverse, and all individuals with diverse anatomical realities.[19] While further EHR modifications[20] and staff training[21] to promote collection of more inclusive data have been a continued suggestion amongst those in the medical community, the quantifiable impact of these changes has yet to be determined.

DISCUSSION

Referring to a transgender individual's "chosen name" acknowledges their self-identified name as their actual name, not merely a preference. The term "preferred name" can imply that the name is optional or less legitimate, which may undermine the individual's identity. Queering Medicine, a grassroots advocacy organization for improving health outcomes, notes that the term "preferred name" is considered offensive by many in the transgender and nonbinary communities, as it suggests that others have the discretion to use or ignore it.[22] Additionally, using a transgender person's chosen name has been linked to significant reductions in mental health risks. A study

published in the *Journal of Adolescent Health* found that transgender youth who could use their chosen name in multiple contexts experienced 71 percent fewer symptoms of severe depression, 34 percent less instances of reported suicidal ideation, and 65 percent reduction in suicide attempts.[23] Ensuring the correct terminology is being used in the clinician's office is the first step increasing the patient's comfort, ensuring mutual trust, and improving health outcomes.

Data Interoperability

A lack of documenting gender (and related data like SFCU or organ inventory) can lead to clinical errors, poor patient experiences, and long-term harm. Systems and clinicians who thoughtfully record and use this information provide better, safer, and more affirming care.[24–26] A qualitative study of transgender individuals in Chicago found that structured gender identity fields (e.g., two-step questions) improved perceived provider competence, but also highlighted serious risks around privacy violations, misinterpretation, and compromised safety when disclosures were mishandled.[5] As part of another qualitative study, transgender patients who were asked to discuss their experiences reviewing their EHRs reported experiencing harm via various aspects of EHR documentation, including frequent use of incorrect names, pronouns, or gender; stigmatizing or blaming language in clinical notes; and limited system capabilities that hinder quality, equitable care.[27] According to a US Transgender Survey conducted by the National Center for Transgender Equality, 33 percent of transgender respondents reported a negative experience with a health care provider in the past year.[28] Using the 2015 U.S. Transgender Survey, a study that explored avoidance of health care due to anticipated discrimination among transgender adults found that almost one-quarter of participants (22.8 percent) avoided health care due to anticipated discrimination, deepening gaps in trust and care. Although legislative and regulatory efforts surrounding transgender care are rapidly evolving, several of these entities have, in the past, recommended structured collection of gender identity, sex assigned at birth, and related EHR data fields to protect privacy and support clinical decision-making. For example, a 2011 Institute of Medicine (now the National Academy of Medicine) report titled, "The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding", recommended that SOGI data be collected in EHRs with consideration for privacy concerns.[29] In 2023, the Department of Health and Human Services (HHS) published its SOGI Data Action Plan to improve data collection for the LGBTQ+ community and in turn, support more equitable representation and care.[30] Further, the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) mandated in 2015 that certified EHR systems support the recording and display of gender identity, sex, "name to use", and pronouns, requiring full support for these fields by January 2026.[31]

EHRs not adequately accommodating both legal and chosen names not only creates significant challenges for transgender and gender diverse patients, but for the physicians and practices caring for them as well. Current systems often fail to record patients' names and pronouns appropriately, conflate sex and gender, and treat sex and gender as binary concepts. Many EHRs lack distinct fields for capturing both legal and chosen names, leading to chosen names being reverted to legal names previously stored in the system, repeated misnaming, and confusion during care—even when patients have clearly communicated their chosen name.[32] For example, many EHRs have historically used a single field that mixes administrative sex, clinical sex, gender identity, and pronouns under one category like "sex" or "gender".[33] Even when systems do provide multiple fields for this information, issues arise due to the need for different names in different settings such

as in the case of radiology information systems being linked to other medical records like Medicare. [32] A 2020 study at Rush University found that 76 percent of inpatient records lacked gender identity data, and a 2023 study at an academic medical center in New York found six discrepancies in transgender patients' documented gender identities[34]. Even when features (e.g., multi-part fields and dropdowns for pronouns) exist, they're not uniformly activated or used across vendor installations, meaning many users never see or use them. Additionally, sensitivity for identifying transgender individuals using EHR gender fields was remarkably low for data quality standards. These inconsistencies can result in administrative complications, as insurance billing and certain services (e.g., lab, x-ray, or procedures) all are governed by safety practices, the Health Insurance Portability and Accountability Act (HIPAA), and the Red Flag Rule, thus requiring verification of legal identity.[35] Furthermore, inconsistent documentation across systems can inadvertently expose a patient's transgender identity to providers, family, or friends, particularly in emergent situations, increasing the risk of discrimination and undermining trust in the health care system.[36]

To capture more accurate details, many EHRs enable free-text responses in the EHR SOGI field for patients to indicate their gender identity and pronouns in cases where an applicable option wasn't available. In a study that assessed how well SOGI fields, International Statistical Classification of Diseases and Related Health Problems, 10th Revision codes, and medication records identified gender-expansive patients, researchers reviewed free text responses from participants who selected "Other" in the SOGI field and responses included, "agender", "gender fluid", "gender nonconforming", "gender queer", indications of pronouns other than "he/him" or "she/hers", and "transfeminine" or "transmasculine".[10] However, free-text fields in EHRs have been reported to contribute to data overflow.[37] Information in these fields can become unmanageable for providers and potentially be overlooked. Managing this information also adds to physicians' time in the EHR, contributing to increased burnout. To address this burden, along with noisy SOGI data and incomplete and inconsistent gender identity documentation, researchers developed and validated a deep-learning natural language processing pipeline to accurately predict patient gender identity. Using a list of 109 expert-curated and literature-reported gender-related keywords, their model screened both structured data and free-text notes from over 3,000 patients in a large Boston health system to identify transgender and gender-diverse individuals. Compared with rule-based methods, the deep-learning model achieved substantially higher-accuracy, sensitivity, and precision.[38] However, a key limitation of such models is their reliance on existing EHR data, which may reflect provider biases and system constraints in capturing gender identity. As a result, these models risk reinforcing biases caused by inconsistent or inaccurate documentation, misgendering, and limited data fields. The Boston study experienced this challenge: in some cases, the model misclassified patients as transgender/gender-diverse based solely on procedures like a hysterectomy or vaginectomy, due to insufficient training data. Similarly, errors occurred when patients used they/them pronouns, reflecting an overgeneralization caused by limited training exposure to gender-diverse language.[38]

Without structured and manageable fields for sex assigned at birth, gender identity, SFCU, and organ inventory, clinical decision supports—a health IT tool that provides clinicians with knowledge and person-specific information to enhance care (e.g., computerized alerts, clinical guidelines, reminders, documentation templates, and condition-specific order sets)[39]—may miss important health risks such as cancer screenings, titrated lab interpretation, or medication needs.

Adopting and properly leveraging HL7 Gender Harmony and vendor toolkits is crucial, but must be paired with staff training, governance, and careful configuration to prevent implementation gaps.

Addressing Privacy Concerns

The collection of SOGI data in the United States is crucial for addressing health inequities and ensuring high quality care for LGBTQ+ populations. The terminology used in EHRs to refer to a patient's name—specifically, the distinction between "chosen name" and "preferred name"—has significant implications for privacy, security, and the well-being of gender-diverse individuals.

While HIPAA provides a framework for protecting patient information, it has limitations concerning SOGI data. For instance, certain legal interpretations have allowed for the disclosure of SOGI information without explicit patient consent, especially when such data are collected as part of demographic information rather than clinical record.[40] This was the case in Vanderbilt University Medical Center's (VUMC's) 2023 disclosure of the full medical records of transgender and gender-diverse patients to the Tennessee Attorney General amid an anti-LGBTQ+ political climate. The probe was prompted by claims that VUMC had improperly billed Medicaid for gender-affirming care. This disclosure was made without patient consent and sparked significant backlash, with critics arguing that it jeopardized the safety, privacy, and trust of transgender patients.[40,41]

The case also exposed broader vulnerabilities in federal privacy protections for this patient population. Under the HIPAA Privacy Rule, covered entities may disclose protected health information (PHI) without patient authorization if required by another law (provided such disclosure complies with the requirements of that law). In such cases, health care providers are not liable for these disclosures and often cannot prevent them. This loophole was a key factor in the VUMC case, raising concerns about the adequacy of federal safeguards for this kind of sensitive health data.[41] Compounding the issue, in early 2025, HHS rescinded its 2022 guidance that had previously offered protections for gender-affirming care and patient privacy[42], leaving transgender and gender-diverse patients and their providers with less clarity and even fewer protections to rely on.

Under HIPAA, a patient's name is considered PHI. This designation requires health care providers to implement safeguards to protect the confidentiality and integrity of patient names. However, HIPAA does not specifically address the nuances of chosen names for transgender individuals, potentially leaving gaps in protection when legal and chosen names differ.

The absence of comprehensive federal privacy legislation results in a patchwork of state laws, leading to inconsistent protections for SOGI data. In some states, there are no explicit safeguards against discrimination based on sexual orientation or gender identity, increasing the risk of data misuse. For example, in states without protective laws, individuals may face discrimination in housing, employment, or education if their SOGI information is disclosed.[43] Smaller practices are at higher risk of being unable to protect this data against federal threats, such as digital surveillance and geofencing of reproductive or gender-affirming care sites. Collecting gender and sexual orientation and gender identity data requires strong appropriate technical safeguards and privacy protocols to prevent trauma for LGBTQ+ patients, especially those with past misgendering or being outed in care settings.[44] Fenway Health and the VA implement EHR fields for gender

identity, anatomical inventories, and affirmation history, coupled with staff training, clearly explained data use, and privacy protections. These measures help prevent “re-traumatization” and enhance mental well-being.[15] Respect and transparency around data handling reduce the risk of re-traumatization and support positive patient outcomes. Oregon’s Equity & Inclusion Division highlights that collecting SOGI data demonstrates care and safety for LGBTQ+ individuals.[45] Paired with staff training and community-led input, it helps build trust, especially important in mental health screenings and identity disclosure contexts.

Even when minors can consent to sensitive care (e.g. sexual/mental health), EHR portals often default to giving guardians full access, risking unwanted disclosure of SOGI data.[46] A 2023 JAMA Pediatrics survey showed that approximately 50 percent of young adults avoid portal use and omit sensitive information for fear parents might see it, citing threats to their physical well-being if revealed to be transgender.[47] While collecting minors' SOGI data supports personalized care, privacy protections are often insufficient, leading to coerced disclosures, harmful breaches, and emotional risk. The Privacy Rule allows parents to access their minor children’s medical records as their personal representative when access isn’t inconsistent with state or other law. Exceptions to this are when parental consent is required by law; when the minor is directed by the court to obtain care; and when—and to the extent that—the parent agrees that the minor and provider may have a confidential relationship.[48] Additionally, even when state law permits confidential care, legislation like the 21st Century Cures Act still pose challenges. For example, the Cures Act’s open notes policy can unintentionally expose minors’ sensitive information to parents.[49] While the Cures Act builds on HIPAA to improve access to electronic health information, it doesn’t override HIPAA’s core privacy protections which allows disclosure of PHI for billing without consent.[50] Though data is limited, AMA physicians report such disclosures are common due to the lack of alternative workflows. Protecting minor privacy must extend to payers’ billing systems, not just providers and EHR vendors.[51] More robust technical, legal, and workflow standards must be researched to aid data collection and improve current systems.

Historical and ongoing discrimination against LGBTQ+ individuals fosters a climate of mistrust, making individuals hesitant to share SOGI information. Concerns about confidentiality breaches and potential repercussions can lead to underreporting or refusal to disclose such data, hindering efforts to gather accurate information for public health and policy-making purposes. Using "preferred name" instead of "chosen name" can inadvertently suggest that the name is optional or less legitimate, potentially leading to misidentification and privacy breaches. For transgender patients, being addressed by their legal name rather than their chosen name can result in unintended disclosure of their gender identity, especially in environments where they may not have disclosed this information. This misidentification can lead to emotional distress and a reluctance to seek necessary medical care–broadening the health disparity gap.

Unstable Political Landscape

The current political landscape in the United States has introduced a series of legislative and executive actions that have significant adverse effects on the rights and well-being of gender-diverse individuals and the physicians that care for them.

As of early 2025, 27 states have enacted bans on gender-affirming care for minors, with 26 of these 27 states prohibiting hormone therapy and surgeries for minors, and one state (Arizona) prohibiting

only surgical care.[52] Such bans are typically enforced by criminal, civil, and professional penalties for providers who furnish gender-affirming care services, as well as sometimes penalties for parents of children who support their children's access to this care.[53] Notably, these restrictions do not apply to services provided for purposes other than gender affirmation, such as treatments for disorders of sexual development and precocious puberty. As of July 2025, 40.1 percent (120,400) of trans youth aged 13-17 are living in the 27 states that have passed bans on gender-affirming care.[54] Despite the protections afforded in states with "shield laws" designed to protect access to abortion and gender-affirming care, these laws are currently being challenged.[55–57] Given the strong correlation between transgender individuals and mental health, state-level anti-transgender policies exacerbate these issues. Public health experts warn that such policies not only harm individual well-being but also strain health care systems and exacerbate inequities.[58] The denial of gender-affirming care and the erosion of legal protections necessitate urgent attention and intervention.

On January 20, 2025, Executive Order 14168 was signed, mandating federal agencies to recognize only a binary definition of sex based on biological attributes assigned at birth. This order rescinded federal recognition of transgender identities, ceased funding for gender-affirming care, and prohibited the use of gender self-identification on federal documents.[59] Additionally, it called for a reevaluation of Title VII protections concerning gender identity. Subsequent directives led to the removal of federal data sets and resources related to sexual orientation and gender identity from government websites, hindering research and public health initiatives aimed at addressing the needs of LGBTQ+ populations. These events reflect a broader trend of institutional censorship affecting educational resources related to gender diversity.

The politicization of transgender rights has broad societal implications, including intensified stigma and marginalization, and the undermining of the rights, health care access, and well-being of these communities. These challenges underscore the urgent need for informed advocacy and policy reform, especially efforts that address how inadequate privacy protections leave LGBTQ+ individuals vulnerable. Navigating the shifting political landscape requires careful attention to evolving attitudes—as well as emerging knowledge and best practices—from LGBTQ+ communities and their providers.

CONCLUSION

Aligning medical documentation with the needs of transgender and gender-diverse patients is a critical step toward addressing long-standing health inequities. This report highlights the importance of supporting the voluntary, culturally sensitive inclusion of gender identity, "chosen names", and organ inventories to promote safer, more accurate, and affirming care. Many EHR vendors have already made strides in supporting this type of data collection, but more research is likely needed on specific efforts and impact of use across the health care system.

Affirming practices—such as using "chosen names" and linking screenings to anatomy rather than gender identity—are supported by strong clinical and mental health evidence, but ongoing challenges highlight the need for robust privacy protections. While some federal protections have been rolled back or face legal threats, laws like HIPAA and state confidentiality statutes still mandate safeguards, though they may be limited in their protection of transgender patients. Smaller practices may also lack the resources to implement optimal data protections. Informed consent and the option to opt out without compromising care are essential to maintaining patient trust.

In addition, there is a lack of consensus and consistent use of key terms such as clinical sex, raising concerns about the longevity of this resolution if adopted. Improving the usability of EHRs for transgender and gender diverse patients requires ongoing collaboration among the LGBTQ+ community, physicians, health systems and practices, and EHR vendors. Medical documentation that appropriately supports this patient population while upholding the highest privacy standards to protect these patients and the physicians that care for them, would be a vital step toward a more equitable and responsive health care delivery system.

AMA POLICY

The AMA has adopted several policies to support gender-diverse individuals in health care, foster care, and legal protections.

The AMA (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, preferred gender pronoun(s), preferred name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians (Policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation")

The AMA will also advocate: (1) for the inclusion of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries; including but not limited to the Current Population Survey, United States Census, National Survey of Older Americans Act Participants, all-payer claims databases; and (2) against the removal of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries without plans for updating measures of such demographic data (Policy H-440.817, "Protecting the Integrity of Public Health Data Collection").

Additionally—given the medical spectrum of gender identity and sex—the AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual's genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth (Policy D-295.312, "Medical Spectrum of Gender").

The AMA opposes mandated reporting or disclosure of patient information related to sexual orientation, gender identity, gender dysphoria, intersex identity, and any information related to gender transition for all individuals, including minors (Policy H-65.959, "Opposing Mandated Reporting of People Who Question Their Gender Identity").

Further, the AMA continues to (1) support the dignity of the individual, human rights and the sanctity of human life; (2) reaffirm its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age; (3) oppose any discrimination based on an individual's sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; and recognize that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States (Policy H-65.965, "Support of Human Rights and Freedom (H-65.965)

The AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement (Policy H-65.976, "Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations").

Additionally, AMA affirms that it has not been its policy now or in the past to discriminate with regard to sexual orientation or gender identity (Policy H-65.983, "Nondiscrimination Policy") Regarding LGBTQ+ older adults, AMA will disseminate educational content to increase awareness and understanding of LGBTQ++ health aging issues among the general public, health care professionals, and policy makers; promote cultural competency training for clinicians in caring for LGBTQ++ older adults; promote policies and practices for implementation within all health care settings that are inclusive and affirming for LGBTQ++ older adults; and advocate for increased funding and resources for research into health issues of LGBTQ++ older adults (Policy D-65.979, "LGBTQ+ Older Adults")

Moreover, our AMA:

1. Believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all

physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
3. Will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people (Policy H-160.991, "Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations").

Further, AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth (Policy H-60.927, "Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations").

AMA will also develop and implement a plan with input from the Advisory Committee on LGBTQ Issues and appropriate medical and community based organizations to distribute and promote the adoption of the recommendations pertaining to medical documentation and related forms in AMA policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation," to our membership (Policy D-315.974, "Promotion of LGBTQ+ Friendly and Gender-Neutral Intake Forms").

Regarding research and the LGBTQ+ communities, AMA will work with appropriate stakeholders to support the creation of model training for Institutional Review Boards to use and/or modify for their unique institutional needs as it relates to research collecting data on Lesbian, Gay, Bi-sexual, Transgender and Queer populations (Policy D-460.966, "Endorsing LGBTQ+ Research IRB Training").

In addition, AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths; (2) advocate for federal, state, and local law enforcement agencies to consistently

collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience (Policy H-65.957, "Preventing Anti-Transgender Violence").

Further, AMA:

1. Recognizes child, youth and young adult suicide as a serious health concern in the US.
2. Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter child, youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources.
3. Supports collaboration with federal agencies, relevant state and specialty societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in child, youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for children, youth and young adults at risk of suicide.
4. Encourages (a) efforts to provide children, youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk; as well as (b) continued research to better understand suicide risk and effective prevention efforts in children, youth and young adults, especially in higher risk sub-populations such as those with a history of childhood trauma and adversity, Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and children in the welfare system.
5. Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in children, youth and young adults; and research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools.
6. Will publicly call attention to the escalating crisis in children, youth and young adult mental health in this country in the wake of the Covid-19 pandemic.
7. Will advocate at the state and national level for policies to prioritize children's, youth's, and young adult's mental, emotional, and behavioral health.
8. Will advocate for comprehensive system of care including prevention, management, and crisis care to address mental and behavioral health needs for children, youth, and young adults

9. Will advocate for a comprehensive approach to the youth, and young adult mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy (Policy H-60.937, "Youth and Young Adult Suicide Prevention").

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 004-I-24 and the remainder of the report be filed:

1. Our AMA reaffirm Policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation." (Reaffirm HOD Policy)

2. Our AMA support the use of the term "chosen name" over "preferred name," recognizing its importance to transgender and gender-diverse patients. (New HOD Policy)

3. Our AMA acknowledge the evolving nature of language and engage appropriate stakeholders to ensure the continued relevance and accuracy of terminology used across AMA resources and advocacy. (New HOD Policy)

4. Our AMA continue to support efforts by EHR vendors, health systems, and physician practices, and work with relevant stakeholders (e.g., the ASTP/ONC, LGBTQIA+ advocacy groups, and minors' privacy experts), to improve EHR usability for transgender and gender-diverse patients, with attention to strong privacy protections, and report back on this progress by I-26. (New HOD Policy)

Fiscal Note: Moderate

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-I-25

Subject: AMA Efforts on Medicare Payment Reform and Increasing Transparency of AMA Medicare Payment Reform Strategy

Presented by: David H. Aizuss, MD, Chair

This report is submitted for the information of the House of Delegates (HOD). At the 2023 American Medical Association (AMA) Annual Meeting of the HOD, the HOD adopted Policy D-385.945, "Advocacy and Action for a Sustainable Medical Care System" and amended Policy D-390.922, "Physician Payment Reform and Equity." Together, they declare Medicare physician payment reform as an urgent advocacy and legislative priority, call on the AMA to implement a comprehensive advocacy campaign, and for the Board of Trustees (the Board) to report back to the HOD at each Annual and Interim meeting highlighting the progress of our AMA in achieving Medicare payment reform until a predictable, sustainable, fair physician payment system is achieved. In addition, the House adopted Policy 400.981, "Increasing Transparency of AMA Medicare Payment Reform Strategy," which calls on the AMA to:

1. Our American Medical Association provide a summary of findings and actionable recommendations from both internal and external advocacy consultants regarding Medicare payment reform. The report must primarily focus on barriers identified, gaps in the current strategy, and specific recommendations for improving and accelerating advocacy efforts.

2. Our AMA share with its members comprehensive reports on our Medicare payment reform advocacy efforts, including consultant findings on major barriers, strategy gaps, and recommendations for improvement, at both the Interim and Annual Meetings beginning at I-25, and more frequently as legislative dynamics dictate.

The Board has prepared the following report to provide an update on AMA activities for the year to date. (Note: This report was prepared in August based on approval deadlines, so more recent developments may not be reflected in it.)

AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM

The AMA's Medicare physician payment reform efforts were initiated early in 2022, following the development of a set of principles outlining the "Characteristics of a Rational Medicare Payment System" that was endorsed by 124 state medical associations and national medical specialty societies. These principles identified strategies and goals to: (1) ensure financial stability and predictability for physician practices; (2) promote value-based care; and (3) safeguard access to high quality care.

Subsequently, the AMA worked with Federation organizations to identify four general strategies to reform the Medicare payment system, including:

- Automatic annual payment updates based on the Medicare Economic Index (MEI);
- Updated policies governing when and how budget neutrality adjustments are made;
- Simplified and clinically relevant policies under the Merit-based Incentive Payment System (MIPS); and
- Greater opportunities for physician practices wanting to transition to advanced alternative payment models.

At the heart of the AMA's unwavering commitment to reforming the Medicare physician payment system lie four central pillars that underscore our strategic approach: legislative advocacy; regulatory advocacy; federation engagement; and grassroots, media, and outreach initiatives. Grounded in principles endorsed by a unified medical community, our legislative efforts drive the advancement of policies that foster payment stability and promote value-based care. We actively champion reform through regulatory channels, tirelessly engaging with crucial agencies such as the Centers for Medicare & Medicaid Services (CMS) and the White House to address impending challenges and ensure fair payment policies. Our federation engagement fosters unity and consensus within the broader medical community, pooling resources and strategies to amplify our collective voice. Lastly, our continued grassroots, media, and outreach efforts bridge the gap between policymakers and the public, ensuring our mission is well-understood and supported from all quarters. Together, these pillars fortify our endeavors to achieve a more rational Medicare physician payment system that truly benefits all.

Legislative Advocacy

The AMA shares its members' deep frustration over persistent Medicare payment cuts. While Congress mitigated approximately half of the 2024 cuts initially implemented in January 2024, physicians continue to sound the alarm that two decades of annual reductions are jeopardizing practice viability and limiting patient access to care. Unfortunately, the final 2025 Medicare Physician Fee Schedule imposed an additional 2.83 percent cut.

An early draft of a year-end legislative package in December 2024 included a proposal to address 2.5 percent of the scheduled cut. However, the larger draft proposal collapsed under political pressure largely resulting from an Elon Musk tweet, and the scaled-down spending package that ultimately passed, failed to address the payment cuts. As a result, physicians faced Medicare cuts for the fifth consecutive year, which went into effect on January 1, 2025. Meanwhile, the MEI increased by 3.5 percent in 2025, further widening the gap between what Medicare pays physicians and the actual cost of delivering quality care.

The financial stability of physician practices and the long-term sustainability of our nation's health care system are at serious risk. Medicare physician payment rates have effectively plummeted 33 percent from 2001 to 2025, when adjusted for inflation in practice costs. Addressing this widening gap is essential to ensure physicians can continue providing high-quality care to Medicare patients.

Fixing our unsustainable Medicare payment system remains an urgent advocacy and legislative priority for the AMA. The need to stop the annual cycle of pay cuts and patches and enact permanent Medicare payment reform could not be clearer. With Congress failing to reverse these cuts, millions of seniors will find it more difficult to access high-quality care, and physicians will be less able to accept new Medicare patients. The impact will be especially detrimental in rural and underserved areas and for small, independent physician practices that care for our nation's most vulnerable patients.

As a result of the continued advocacy by the AMA, Federation partners, and the broader physician community, common sense legislation has been introduced to reform the broken Medicare payment system. These bills reflect elements of the AMA-developed framework, "Characteristics of a Rational Medicare Physician Payment System."

Medicare Reform: Automatic Annual Inflation-Based Updates

The AMA and our Federation partners continue to press Congress to reverse the 2.83 percent cut that took effect on January 1, 2025. At the same time, we are urging lawmakers to enact automatic, annual inflation-based payment updates to ensure that Medicare payment keeps pace with rising practice costs.

Medicare Payment Reform: Budget Neutrality

In 2024, the GOP Doctors Caucus introduced H.R. 6371, a bill that would have addressed long-standing flaws in Medicare's budget neutrality policies. Strongly supported by the AMA, this legislation sought to compel CMS to correct inaccurate utilization projections and raise the budget neutrality threshold from $20 million to $53 million. While this bill did not pass, the AMA is now advocating for similar provisions in the 119th Congress to help mitigate the compounding impact of flawed budget adjustments on physician payment.

Medicare Payment Reform: Revising the MIPS Program

The AMA, working with Federation organizations, has also developed legislative language to reform MIPS. These reforms would target the program's disproportionate burden on small and rural practices, seek to provide physicians with more timely and actionable data from CMS, and streamline MIPS to make it more clinically relevant and less administratively complex.

119th Congress AMA Advocacy Highlights

In January 2025, Representatives Greg Murphy, MD (R-NC), and Jimmy Panetta (D-CA) introduced H.R. 879, the Medicare Patient Access and Practice Stabilization Act. Backed by more than 120 bipartisan cosponsors, the bill sought to reverse the 2.83 percent Medicare payment cut and replace it with a two percent increase. The following month, the AMA led a broad coalition of more than 80 organizations, including all 50 state medical associations and the Medical Society of the District of Columbia, in a sign-on letter urging Congress to pass the bill. In March, the AMA and its partners pressed for H.R. 879 to be included in the continuing resolution. That effort ultimately failed because the White House insisted on a "clean package" so neither H.R. 879 nor any related provisions made it into the final package. The cut remained in place, further destabilizing physician practices.

In April, Senator Roger Marshall (R-KS) introduced the Senate companion bill, S. 1640. AMA advocacy staff were highly involved in drafting this legislation, ensuring it was responsive to the real-time 2025 Medicare cuts.

National Advocacy Conference – February 2025

At the February 2025 National Advocacy Conference, the AMA launched its "Fix Medicare Now" campaign with a kickoff event at the Cannon House Office Building. Lawmakers including Representatives Murphy, Panetta, Schrier, Miller-Meeks, Joyce, Ruiz, Bera, and Kennedy joined to show their support. More than 350 physicians participated in Capitol Hill meetings, urging

lawmakers to pass H.R. 879 and take Senate action. The AMA amplified its message with a full-page ad in The Hill and distributed advocacy kits that emphasized the 33 percent drop in Medicare payments since 2001, adjusted for inflation. The event also featured remarks from other key Representatives, including Conaway, Onder, Krishnamoorthi, Dexter, Morrison, DeGette, and McCormick.

Grassroots, Media, and Outreach

The AMA has maintained a continuous drumbeat of grassroots contacts through its Physicians Grassroots Network, Patients Action Network, and its Very Influential Physicians program. Op-eds have been placed in various publications from AMA leaders, as well as from "grasstops" contacts in local newspapers. Digital advertisements are running targeted specifically to publications read on Capitol Hill, and media releases have been issued to highlight significant developments.

The AMA has a dedicated Medicare payment reform web site, www.FixMedicareNow.org, which includes a range of AMA-developed advocacy resource material, updated payment graphics and a new "Medicare basics" series of papers describing in plain language specific challenges presented by current Medicare payment policies and recommendations for reform.

To support the Medicare legislation cited above, the AMA has been engaged in a major grassroots campaign to engage patients and physicians in our lobbying efforts. The following statistics from January through the end of June 2025 result from the Fix Medicare Now campaign and engagement with the Physician Grassroots Network and Patients Action Network.

- 85+ million in earned media and ad impressions
- 2.2+ million media and ad engagements
- 670,000+ pageviews
- 633,000+ site users
- 68,000+ contacts to Congress
- 150+ third-party media placements and grass top contacts made in key Congressional districts

H.R. 1

H.R. 1, the One Big Beautiful Bill Act (OBBBA) initially included strong Medicare physician payment reform provisions, including a 75 percent MEI update for 2026 and a permanent annual update of 10 percent MEI thereafter. These provisions marked the first time since the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015 that physician payment updates would be permanently built into baseline Medicare rates.

The AMA advocacy team was instrumental in the development and inclusion of these House-passed Medicare provisions. Section 44304, which linked the update to inflation in practice costs using the MEI, reflected AMA policy and decades of advocacy, and was recently echoed in recommendations by the Medicare Payment Advisory Commission.

These provisions passed the House of Representatives. However, the Senate scaled the proposal back to a temporary 2.5 percent update for 2026.

The final version of H.R. 1, passed by the Senate, retained only the temporary one-year 2.5 percent conversion factor update—with no permanent, inflation-adjusted fix. Still, the inclusion of any update represented forward movement and provides important momentum for continued advocacy in the 119th Congress.

Advocacy with MedPAC and Looking Forward

The AMA has continued to engage directly with the Medicare Payment Advisory Commission (MedPAC) to push for reforms aligned with physician needs. Earlier in 2025, MedPAC signaled a notable shift by recommending an MEI minus 1 percent update for 2026, a departure from its longstanding reluctance to support any inflation-based adjustments. By June, MedPAC went further, voting to recommend permanent annual payment updates tied to MEI growth. This marked a major policy milestone and a clear acknowledgment of the financial pressures facing physicians under the current system.

Call to Action

Congress must urgently address a broken Medicare payment system that places enormous financial pressure on physicians and threatens access to care. The AMA continues to urge lawmakers to:

- Reverse the 2.83 percent payment cut;
- Enact a positive update to keep up with inflation; and
- Implement a long-term fix that ensures payment adequacy and stability.

Physician practices have lost 33 percent to inflation since 2001. Physician ownership of practices has also collapsed, dropping from 61 percent in 2001 to under 50 percent in 2016. This erosion threatens the viability of community-based care.

Fixing this system will remove a major financial stressor for physicians, protect patient access, and stabilize our health care infrastructure. The House-passed provisions of H.R. 1 will serve as a critical foundation for comprehensive reform in the 119th Congress. Ensuring regular, adequate payment updates is vital to practice sustainability, advancing value-based care models, and safeguarding access to care for Medicare beneficiaries—especially in rural and underserved communities, where practices treat four times as many Medicare patients as those in metropolitan areas.

As physicians across the country continue to share their stories and advocate for reform, there is hope that our united efforts will eventually break through the political and financial barriers that have hindered progress. The AMA will continue to fight tirelessly until a sustainable, fair, and effective Medicare physician payment system is achieved.

STRATEGIC REVIEW OF MEDICARE PAYMENT REFORM ADVOCACY

In response to Resolution 233-A-25, the AMA is actively in the process of implementing a comprehensive review of its Medicare payment reform strategy. This includes identifying options for engaging external advocacy consultants and refining internal processes to identify barriers, uncover strategy gaps, and generate targeted recommendations. While the execution plan is still in the early stages at the time this report was drafted, the AMA remains committed to advancing this work and will provide further updates at I-25.

CONCLUSION

The AMA will continue pressing Congress to fix the broken Medicare physician payment system and protect patient access to care. Despite ongoing challenges, sustained engagement from physicians remains critical. We urge all physicians to stay informed, follow Advocacy Update, participate in grassroots advocacy, and use resources such as FixMedicareNow.org to make their voices heard.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-I-25

Subject:	Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research Report
Presented by:	David H. Aizuss, MD, Chair
Referred to:	Reference Committee B

At the 2025 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-440.905, "Protecting Evidence-based Medicine, Public Health Infrastructure and Biomedical Research," that asks our AMA:

> To affirm that protecting science, clinical integrity, and the patient-physician relationship is central to the organization's mission.
>
> To assertively and publicly lead the House of Medicine in collective, sustained advocacy for federal and state policies, proposals, and actions that safeguard public health infrastructure, advance biomedical research, improve vaccine confidence, and maintain the integrity of evidence-based medicine and decision-making processes.
>
> To report back at the 2025 Interim Meeting of the AMA House of Delegates on the actions taken to implement this policy.

Reference Committee B heard extensive and strong testimony in support of Policy D-440.905 and this report is being submitted to the HOD as information as directed in the policy. (Note: Because of approval deadlines, this report was prepared in September of 2025.)

Since the January 2025 inauguration, the Trump Administration has taken a number of unprecedented actions to reduce funding for biomedical research, eliminate programs promoting public health and health equity, and shift policies regarding the regulation of vaccines. In addition to actions already taken by the Administration, they have proposed a significant reorganization of the Department of Health and Human Services (HHS) which, if approved by Congress, would reduce the Department's total discretionary funding by over $31 billion in Fiscal Year (FY) 2026 compared to FY 2025 and result in the elimination of several HHS programs. The Administration has already engaged in an unprecedented reduction in force of HHS employees across all agencies, resulting in the termination or incentivized retirement of tens of thousands of federal employees as of the drafting of this report. The proposed changes seek to redirect HHS to focus on Trump Administration priorities, such as chronic disease reduction efforts and eliminating work on diversity, equity, and inclusion programs and gender-focused research and care.

Biomedical Research

Reductions in support for biomedical research at the National Institutes of Health (NIH) have been a significant focus of the Trump Administration, with the Administration terminating $1.8 billion in grants within its first 40 days. The Administration has focused on eliminating funding for grants which it deems to not align with the Administration's priorities. About 30 percent of NIH funding for the National Institute on Minority Health and Health Disparities (NIMHD) was terminated, as were a number of previously awarded grants for gender-focused research.

In another unprecedented early move, the Administration moved forward with a new policy to cap indirect research expenses at 15 percent of the total grant award. This cap is expected to have a dramatic impact on medical research (especially higher-cost medical research), as it constrains resources necessary to carry out research projects. The indirect expenses cap has the potential to impact the number of research institutions that are able to carry out research projects, leaving only large, well-funded institutions capable of funding research.

The Trump Administration has also proposed a significant reorganization of the NIH that would reduce the number of institutes and centers that comprise the NIH from 27 to eight by eliminating some institutes and centers (including NIMHD) and consolidating others. The Administration is also proposing to cut $18 billion from NIH's appropriated funds—a 44 percent reduction in funding from FY 2025 levels. However, the ultimate decision regarding NIH funding levels and programmatic reorganization lies with Congressional appropriators, who, as of the date of this report, are just beginning the Congressional appropriations process. There are some early signals that Congress will reject significant funding cuts for scientific research, but the final status of NIH appropriations and potential reorganization will remain unknown until the conclusion of the FY 2026 appropriations process.

Evidence-Based Medicine

The Trump Administration has taken a number of actions that call into question the current evidence base underlying the practice of medicine. Other Administration actions directly contradict the current evidence base. To date, this has been most evident with HHS Secretary Robert F. Kennedy, Jr.'s approach to vaccine review and recommendations. At the onset of the current measles outbreak, Secretary Kennedy appeared to suggest alternative options to the measles vaccine, including treatment with Vitamin A supplementation, which lacks evidence demonstrating its utility as a treatment for measles. Shortly after his installation as Commissioner of the U.S. Food and Drug Administration (FDA), Dr. Marty Makary, along with FDA Chief Medical and Scientific Officer and Director of the Center for Biologics Evaluation and Research Dr. Vinay Prasad, announced a significant policy change regarding FDA's approach to review of COVID-19 vaccines. Announced in the New England Journal of Medicine (NEJM), the policy change would require any new COVID-19 vaccine for those under 65 or without additional risk factors to undergo a placebo-controlled randomized clinical trial. This policy change was made without the traditional opportunity for public review and comment and raised significant concern among the scientific and medical communities. Soon after this change in approach to reviewing COVID-19 vaccines was announced, Secretary Kennedy announced that COVID-19 vaccines were being removed from the Centers for Disease Control and Prevention's (CDC) recommended immunization schedule for healthy children and pregnant women, leading several top CDC officials to resign.

Outside of FDA, the Administration has taken further actions that have raised concern about its impact on vaccine hesitancy, including the abrupt removal of the full membership of the CDC's

Advisory Committee on Immunization Practices (ACIP) prior to their scheduled June 2025 meeting. In defense of the removal, the Secretary claimed that the ACIP members had significant conflicts of interest with pharmaceutical companies and were therefore biased in their assessments and recommendations. The members were quickly replaced by Secretary Kennedy without the traditional process of public nomination, and the new ACIP members include several individuals who have been the subject of some controversy over their positions on vaccination and who bring their own conflicts of interest to the panel. Historically, anyone joining ACIP must disclose any possible conflicts of interest and is subject to strict rules about their relationships with industry during their time on the committee. In an effort to further increase transparency, HHS launched a public tool sharing conflicts reported by ACIP members—however, as of the drafting of this report, the tool has yet to be updated with all of new members' disclosures. While the scheduled ACIP meetings proceeded as planned, the agenda ultimately included controversial topics previously thought to be settled science, such as the inclusion of thimerosal in influenza vaccination and mRNA vaccine technologies. In addition, meetings of ACIP Vaccine Work Groups have been paused and, on July 31, 2025, Secretary Kennedy notified several representatives of ACIP liaison organizations (such as the AMA, the American Academy of Pediatrics, the Infectious Diseases Society of America, the American Academy of Family Physicians, the American Nurses Association, and the Association of Immunization Managers) that they would no longer be permitted to serve on ACIP's Work Groups. The liaisons play a crucial role in ensuring that evidence-based science is applied as work group recommendations are developed and presented to ACIP voting members. On August 5, 2025, Secretary Kennedy cancelled $500 million in HHS contracts for mRNA vaccine development and announced the beginning of a coordinated wind-down of mRNA vaccine development activities under the Biomedical Advanced Research and Development Authority.

ACIP convened on September 18 and 19, 2025, and took several noteworthy votes. The committee declined to recommend the COVID-19 vaccine for any category of individuals. Instead, ACIP recommended that vaccination for COVID-19 be determined by "individual-based- decision-making" for those 65 and older, which the committee vote said was also known as "shared clinical decision making." For those aged six months to 64 years, COVID-19 vaccination should be "based on individual-based-decision making—with an emphasis that the risk-benefit of the vaccination is most favorable for individuals who are at an increased risk for severe COVID-19 disease and lowest for individuals who are not at an increased risk, according to the CDC list of COVID-19 risk factors." ACIP did not take a vote on whether the updated COVID-19 vaccines should be made available under the Vaccines for Children (VFC) program. In the same meeting, ACIP recommended that children aged 12-47 months be immunized for varicella by standalone vaccination, rather than by the combination measles, mumps, rubella, and varicella (MMRV) vaccine. Multiple organizations, including the AMA, issued statements expressing concern with both the data used by ACIP in support of these recommendations and the recommendations themselves.

Regarding the evidence base at large, the "Make Our Children Healthy Again Assessment" (also known as the "MAHA report") issued on May 22, 2025, by Secretary Kennedy's MAHA Commission stated that the current evidence base for medical practice has been too strongly influenced by pharmaceutical companies and therefore is not clinically valid. This criticism was focused strongly on several well-respected, peer-reviewed medical journals, as well as specialty practice guidelines. While not accusatory of physicians directly, the report suggests that physicians can ultimately harm patients by relying on a faulty and biased evidence base.

Finally, in an act that has implications for all of HHS and its sub-agencies, on March 3, 2025, Secretary Kennedy rescinded longstanding agency policy (commonly known as the

"Richardson Waiver") regarding voluntary adherence to Administrative Procedure Act (APA) rulemaking processes. The APA exempts certain agency actions—those relating to "agency management or personnel or to public property, loans, grants, benefits, or contracts"—from standard notice and comment rulemaking requirements, but under the Richardson Waiver (which had been HHS policy since 1971) HHS followed notice and comment processes when taking those actions anyway. The repeal of the Richardson Waiver will not impact processes for actions that are subject to the APA's rulemaking requirements under the terms of the statute, but it may change the processes HHS follows for actions such as grantmaking decisions and methodologies, changing eligibility standards for benefit programs administered by HHS (subject to statutory limitations), and awarding contracts.

Public Health Infrastructure

Immediately following his inauguration, President Trump moved quickly to begin dismantling many programs, communications efforts, and research projects within the CDC, raising the alarm within the public health, scientific, and medical communities. As part of its significant reduction in force efforts, the Administration has terminated approximately 2,400 employees at CDC alone, along with several thousand employees across other HHS agencies impacting public health. Adding to the disruption, Susan Monarez was fired from her post as Director of the CDC on August 27, 2025—less than a month after the United States Senate voted to confirm her appointment on July 29, 2025.

As with many other health care agencies, the Administration has proposed a significant reorganization to CDC, including additional funding reductions and program eliminations. This reorganization proposal includes the creation of a new agency, the Administration for a Healthy America (AHA). The Administration is proposing to combine several functions of the CDC, Health Resources and Services Administration, Agency for Healthcare Quality and Research (AHRQ), and other agencies into the new AHA, with a focus on primary care and chronic disease reduction. The new AHA would also incorporate health workforce, environmental health, mental health, and maternal health programs, among others. However, this proposal also recommends eliminating a significant number of programs within each of these agencies, raising concerns about adequate resources and staffing for a significant number of federal health care efforts.

The Administration has also taken actions, or proposed actions, relating to funding for HIV/AIDS initiatives. The Administration initially included $400 million in cuts to the President's Emergency Plan for AIDS Relief (PEPFAR), a global HIV/AIDS relief program, as part of a $9 billion rescissions package under consideration by Congress. However, the PEPFAR cuts were dropped from the bill before final passage by Congress. On the domestic front, the Administration's proposed budget for FY 2026 would largely maintain funding at FY 2025 levels for HIV care, treatment, and pre-exposure prophylaxis programs, but would eliminate HIV prevention and surveillance efforts at the CDC. As with the proposals relating to funding and structural reorganization at the NIH, the final decision on whether to adopt the Administration's proposals with respect to CDC's HIV/AIDS prevention and surveillance efforts lies with Congress. There are indications that Congress will ultimately preserve CDC prevention and surveillance funding—on July 31, 2025, the Senate Committee on Appropriations, in a broadly bipartisan vote, approved an FY 2026 HHS funding bill that essentially maintains funding for the CDC's National Center for HIV, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Prevention at FY 2025 levels.

AMA Advocacy Actions through September 2025

The AMA has been engaged in advocacy to affirm our commitment to biomedical research, evidence-based medicine, and public health since President Trump's inauguration in January 2025. Advocacy has been aimed at both the Administration directly and at Congress. An outline of specific advocacy actions as of October 1, 2025, is provided below. The AMA will continue to strongly advocate as a leader of the Federation of Medicine throughout the duration of this Administration.

- March 5, 2025 Letter to NIH on Indirect Expense Cap: The AMA joined numerous other physician and health care organizations in opposing the 15 percent cap on indirect research costs imposed by NIH on grantees. The letter highlighted the severe detrimental impact this cap would have on biomedical research and the United States' standing as a global leader in biomedical innovation.
- May 29, 2025 Letter to Secretary Kennedy on COVID-19 Vaccine Review: The AMA wrote to Secretary Kennedy expressing serious concern with the announced policy changes regarding review of COVID-19 vaccines and requirement for placebo-controlled randomized clinical trials (RCT) for new vaccines. The AMA noted that the announcement lacked transparency and opportunity for public input, while also highlighting the ethical concerns regarding RCTs when existing vaccines are available. Additionally, we highlighted the concerns about maintaining access to vaccines for those who want them—an early promise of Secretary Kennedy.
- June 12, 2025 Statement on ACIP: The AMA issued a statement on new members of the ACIP selected without transparency and proper vetting.
- June 13, 2025 Letter to Senator Cassidy on ACIP: The AMA wrote to Senator Cassidy requesting the Senator inquire as to the circumstance of the termination of the sitting members of ACIP.
- June 18, 2025 Letter to Secretary Kennedy on ACIP: The AMA led a Federation sign-on letter to Secretary Kennedy opposing his removal of all sitting members of ACIP. The letter called for the previously appointed members to be reinstated and for the appointment process to follow its long-standing tradition of a transparent public nomination process.
- June 25, 2025 Open Letter to the Public on Fall Respiratory Season: The AMA joined over 70 medical specialty groups in an open letter to the public urging the public to vaccinate for the fall respiratory season. The letter also highlighted concerns about the Administration's approach to vaccine recommendations.
- July 9, 2025 Friends of ARHQ Sign-On Letter in Support of USPSTF: The AMA joined Friends of ARHQ in writing to Congress to support the work of the United States Preventive Services Task Force (USPSTF) and urging Congress to protect USPSTF from political interference.
- July 27, 2025 Letter to Secretary Kennedy on USPSTF: The AMA wrote to Secretary Kennedy expressing deep concern regarding recent reporting that the Secretary intends to remove all of the members of the USPSTF. The letter highlights the essential role of the USPSTF in making evidence-based recommendations for clinical prevention of disease and the role these recommendations play in terms of health insurance coverage of preventive services.
- August 1, 2025 Joint Statement on ACIP Workgroups: ACIP Medical Association Liaisons, of which AMA is a part, issued a joint statement regarding ouster from ACIP vaccine workgroups.
- August 28, 2025 Statement on CDC: The AMA issued a statement on turmoil and leadership changes at the CDC.

- September 3, 2025 Statement on Florida Vaccine Mandates: The AMA issued a statement opposing Florida's plan to end vaccine mandates.
- September 19, 2025 Statement on MMRV Vaccine: The AMA issued a statement on Advisory Committee on Immunization Practice (ACIP) meeting on new MMRV vaccine recommendations.

Beyond the formal letters listed above, the AMA spoke out against reported changes Secretary Kennedy is considering making to the USPSTF. The AMA's media statement and interviews have emphasized the critical role this organization has in developing best practices for physicians to provide evidence-based care. National media including Reuters, NPR, CBS News, PBS News, and other outlets featured the AMA's concerns. Additional coverage is likely if further actions are taken by government. Media coverage of the USPSTF statement generated 285 media stories, 986 million media impressions and an estimated $9.1 million in publicity value (estimated traditional and online media across print publications, radio, television, news services, news websites, and blogs).

Since June, the AMA's leadership on vaccine advocacy has drawn widespread media attention. National coverage surged following Secretary Kennedy's controversial dismissal of CDC vaccine experts, prompting calls from senators and medical organizations for a formal review of ACIP. AMA's concerns and expertise are featured prominently in major outlets like CNN and USA Today. The AMA's letter to the American people on the importance of vaccines to battle influenza, respiratory syncytial virus, and COVID-19 was picked up by outlets like Medscape. Following Secretary Kennedy's July 31 exclusion of liaison organizations from ACIP Working Groups the AMA joined seven other medical association in a joint statement protesting the move. Media coverage of AMA's ACIP statements generated 2,551 media stories, 7.9 billion media impressions, and an estimated $72 million in publicity value.

AMA social media supported the AMA's advocacy responses by quickly producing text-based images featuring key quotes from official releases and amplifying related content across channels. For the July 27, 2025, USPSTF announcement, the AMA published a text image alongside the release, then amplified a video on July 28 and an AMA News story on July 29. In response to ACIP developments, the AMA supported the June 9 announcement of changes with a text image and release. For the ACIP liaison announcement, the AMA shared a text image and statement on August 1, followed by amplifying the AMA News story on August 2 and a video on August 3. In response to H.R. 1 (the "One Big Beautiful Bill Act"), the AMA posted a sounding-the-alarm carousel and video on July 2, and followed up with a text image and statement on July 3. Given the significant influence Congress will have over protecting the funding to, and structure of, federal research and public health agencies, the AMA has engaged in substantial advocacy with Congress to ensure federal agencies, advisory committees, and task forces remain independent, non-partisan, and protected from political interference to the most significant extent possible. The AMA is also advocating to protect critical programs from elimination and to ensure continued bipartisan support for biomedical research functions at NIH.

Over the past five years, the AMA has partnered with CDC on an annual flu campaign to encourage the American public to get vaccinated against the flu, with a focus on Black and Hispanic populations. However, with the CDC unable to participate this year, the AMA will be the sole sponsor of the campaign. The campaign has been very successful. Over the past five years, the campaign has had over 350 million digital and broadcast impressions, $50 million in donated media, and 1.27 million site sessions on GetMyFlushot.org. Those aware of the campaign are significantly more likely to agree that getting vaccinated helps protect their loved ones and is the most effective way of preventing the flu. They were also significantly more likely (58 percent

versus 45 percent) to receive a flu vaccine compared to those who did not see any of the campaign's public service announcements. Furthermore, a recent study published in JAMA Network Open found an increase in vaccination rates among Black and Hispanic older adults from 2019 to 2022. The annual flu campaign is tangible evidence of AMA support for, and effectiveness in promoting, flu vaccination.

State Activity

Over the past several years, states have increasingly considered legislation that undermines evidence-based medicine, weakens public health infrastructure, and interferes with the patient-physician relationship. These measures have included efforts to curtail the authority of public health authorities, discourage vaccinations, and restrict access to abortion care and gender-affirming care for minors.

State legislative activity slowed during the period between adoption of Policy D-440.905 in June and the writing of this report. At the time of writing, 42 of the 50 state legislatures had adjourned for the year, and, of the eight state legislatures still in session, six had finalized their FY2026 state budgets and two had passed deadlines for introducing new legislation. Nevertheless, significant legislation impacting public health and medical practice was enacted earlier in 2025. States including Idaho, Kansas, North Dakota, and Tennessee enacted laws restricting the authority of public health departments and numerous states passed laws governing vaccines, including legislation to establish liability of vaccine manufacturers in Texas; to expand nonmedical exemptions for mandated vaccines in North Dakota, Texas, Utah, and West Virginia; and to prohibit adolescents from consenting to vaccines in Alabama. However, positive legislation improving vaccine access was enacted in Colorado, Maine, Maryland, and Louisiana. On September 3, 2025, the governor and surgeon general of Florida announced a plan to end *all* vaccine and immunization requirements in Florida, pending approval by both the state Department of Health and the state legislature.

Notably, this year the United States experienced its largest measles outbreak in 30 years, with three deaths and 1,319 confirmed cases across 40 jurisdictions, due in part to declining vaccination rates. Measles has been officially "eliminated" from the United States since 2000 but this status may be at risk if the current outbreak is not contained. CDC data show national kindergarten immunization rates have dropped from roughly 95 percent pre-pandemic to just under 93 percent in 2023-24, while non-medical exemptions rates reached all-time highs. In Texas, for example, exemption requests surged sharply, with 153,000 requests in the 2023-2024 school year, nearly double the number in 2019. Relaxation of vaccine mandates and promotion efforts—such as the Louisiana Department of Health's decision to scale back vaccine campaigns—poses significant risks for preventable disease resurgence.

Meanwhile, in the area of reproductive health, Arkansas and Wyoming enacted laws restricting access to abortion medication, while Colorado, New York, Vermont, and Washington passed legislation protecting such access. In addition, bills amending exceptions for medical emergencies were enacted in Tennessee and Texas, insurance coverage of abortion care was expanded in Colorado and the District of Columbia, and shield law protections were strengthened in Colorado, the District of Columbia, Maine, North Carolina, Vermont, and Washington. On gender-affirming care, Kansas enacted the "Help Not Harm Act," banning care for minors effective July 1, 2025, while New Hampshire expanded the scope of its existing restriction.

The AMA, through the Advocacy Resource Center (ARC), continues to prioritize state advocacy to defend the patient-physician relationship and public health. The AMA works in close partnership

with state medical associations, national medical specialty associations, and public health coalitions to safeguard access to vaccines, abortion, and gender-affirming care. The ARC provides direct advocacy support to Federation members through letters and written testimony, legislative analysis, and strategy support. Often this work is conducted behind-the-scenes with Federation staff. The ARC also facilitates collaboration through regular coalition calls, webinars, and in-person convenings that bring together Federation members, subject matter experts, and allied organizations to share information and collaborate on strategy. For example, to address troubling vaccine legislation introduced in several states earlier this year, the ARC convened over 60 staff members from state and specialty medical associations for a virtual strategy session to share information and collaborate on strategies. Such strategy calls are held on a weekly basis during legislative sessions on a wide range of topics. Additionally, AMA initiatives stemming from the work of the Task Force to Protect the Patient-Physician Relationship—public opinion research to refine messaging on abortion laws, research on workforce impact of criminalizing medical care, and more—has been disseminated to Federation organizations to inform state advocacy efforts. The AMA's sustained engagement with state partners ensures that the AMA remains at the forefront of defending science-based public health policy at the state level, even amid heightened challenges to vaccine confidence, misinformation, and the erosion of public health infrastructure.

CONCLUSION

Through the efforts described in this report, the AMA continues to assertively and publicly advance the goals of Policy D-440.905 by supporting the integrity of evidence-based medicine and resisting encroachments that threaten biomedical research and public health infrastructure. Due to the amount of time between the drafting of this report and the interim HOD meeting, this report is not representative of the full breadth of federal and state activity, or the AMA's advocacy efforts, with respect to evidence-based medicine, biomedical research, and public health infrastructure. In particular, additional congressional action on appropriations is expected, which could significantly impact funding levels and program eliminations.

RECOMMENDATION

The Board of Trustees recommends the following and the remainder of the report be filed.

1. The third item of Policy D-440.905 be rescinded as having been accomplished by this report.

Fiscal note: Less than $500.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 21-I-25

Subject:	Specialty Society Representation in the House of Delegates - Five-Year Review
Presented by:	David H. Aizuss, MD, Chair
Referred to:	Reference Committee on Ethics and Bylaws

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) required to submit information and materials for the 2025 American Medical Association (AMA) Interim Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic Review Process."

Organizations are required to demonstrate continuing compliance with the guidelines established for representation in the HOD. Compliance with the five responsibilities of professional interest medical associations and national medical specialty organizations is also required as set out in AMA Bylaw 8.2, "Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations."

The following organizations were reviewed for the 2025 Interim Meeting:

American College of Occupational and Environmental Medicine
American Gastroenterological Association
American Geriatrics Society
American Orthopaedic Association
American Psychiatric Association
American Roentgen Ray Society
American Society of Nuclear Cardiology
Society of Cardiovascular Computed Tomography
The Triological Society

The Society of Hospital Medicine was also reviewed at this time because it failed to meet the requirements in June of 2025 and was granted a one-year grace period.

Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group's membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

The materials submitted indicate that: American College of Occupational and Environmental Medicine, American Gastroenterological Association, American Geriatrics Society, American Orthopaedic Association, American Psychiatric Association, American Roentgen Ray Society, American Society of Nuclear Cardiology, and Society of Cardiovascular Computed Tomography meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that the Society of Hospital Medicine met all guidelines and is in compliance with the five-year review requirements of specialty organizations represented in the HOD.

The materials submitted also indicate that The Triological Society did not meet all guidelines and is not in compliance with the five-year review requirements of specialty organizations represented in the AMA HOD.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:

1. The American College of Occupational and Environmental Medicine, American Gastroenterological Association, American Geriatrics Society, American Orthopaedic Association, American Psychiatric Association, American Roentgen Ray Society, American Society of Nuclear Cardiology, Society of Cardiovascular Computed Tomography, and Society of Hospital Medicine retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in the AMA Bylaw B-8.5.2 The Triological Society be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)

Fiscal Note: Less than $500

APPENDIX

Exhibit A - Summary Membership Information

Organization	**AMA Membership of Organization's Total Eligible Membership**
American College of Occupational and Environmental Medicine*	568 of 2,242 (25%)
American Gastroenterological Association*	1,604 of 7,804 (20%)
American Geriatrics Society*	578 of 2,579 (22%)
American Orthopaedic Association*	331 of 1,702 (20%)
American Psychiatric Association*	7,646 of 27,920 (27%)
American Roentgen Ray Society*	2,214 of 11,681 (19%)
American Society of Nuclear Cardiology	1,308 of 3,949 (33%)
Society of Cardiovascular Computed Tomography	473 of 1,947 (24%)
Society of Hospital Medicine	2,169 of 11,881 (18%)
The Triological Society*	108 of 574 (19%)

* *Represented in the House of Delegates at the 1990 Annual Meeting*

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.

2. The organization must:

   (a) represent a field of medicine that has recognized scientific validity;
   (b) not have board certification as its primary focus; and
   (c) not require membership in the specialty organization as a requisite for board certification.

3. The organization must meet one of the following criteria:

   (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
   (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.

4. The organization must be established and stable; therefore, it must have been in existence for at least five years prior to submitting its application.

5. Physicians should comprise the majority of the voting membership of the organization.

6. The organization must have a voluntary membership and must report as members only those physician members who are current in payment of applicable dues, and eligible to serve on committees or the governing body.

7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.

8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.

9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.

10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C

8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

8.2.1 To cooperate with the AMA in increasing its AMA membership.

8.2.2 To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.

8.2.3 To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.

8.2.4 To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.

8.2.5 To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.5 **Periodic Review Process.** Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society, or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

8.5.1 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting or may take such other action as it deems appropriate.

8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

REPORT 22 OF THE BOARD OF TRUSTEES (I-25)
Physician Assistant and Nurse Practitioner Movement Between Specialties
(Reference Committee B)

EXECUTIVE SUMMARY

At the 2024 Annual Meeting, Board of Trustees Report 14 was adopted as amended creating Policy H-35.960, "Physician Assistant and Nurse Practitioner Movement Between Specialties."

Two additional recommendations were referred for further study:

1. That the American Medical Association (AMA) support workforce research, including surveys by state medical and nursing boards, that specifically focus on gathering information on nurse practitioners and physician assistants practicing in specialty care, their certification(s), alignment of their certification to their specialty, and whether they have switched specialties during their career. (New HOD Policy)
2. That the AMA support research that evaluates the impact of specialty switching by nurse practitioners and physician assistants on the cost and quality of patient care. (New HOD Policy)

Board of Trustees Informational Report 15-A-25 provided an overview of existing data on the topic and this Board Report provides findings from qualitative and quantitative research conducted on specialty switching by nurse practitioners and physician assistants, which was conducted to fill in gaps in existing publicly available data.

Specifically, the AMA engaged in both qualitative and quantitative research of nurse practitioners and physician assistants to better understand the extent of specialty switching. Data from the quantitative portion of the research, which consisted of a survey of nurse practitioners and survey of physician assistants, confirms that 35 percent of nurse practitioners and 42 percent of physician assistants have switched specialties at least once during their career. This occurs across age groups and at every career stage. The data also confirmed that specialty switching was generally considered easy and common among these respective professions. Finally, the surveys uncovered that of those nurse practitioners and physician assistants that switched specialties, it was rare for the individual to have completed a certification or formal training in that specialty. Rather both nurse practitioners and physician assistants relied on physicians for on-the-job training to practice in their current specialty.

This research adds to the body of existing workforce research, specifically filling in gaps in research on specialty switching. These findings reinforce existing AMA policy on the importance of physician led care and AMA policy related to specialty switching, including the need to continue educating lawmakers on the education and training of nurse practitioners and physician assistants and the concept of specialty switching.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 22-I-25

Subject: Physician Assistant and Nurse Practitioner Movement Between Specialties

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee B

At the 2024 Annual Meeting, Board of Trustees Report 14 was adopted as amended creating Policy H-35.960, "Physician Assistant and Nurse Practitioner Movement Between Specialties" and the remainder of the report was filed:

1. Our American Medical Association encourages hospitals and other health care entities employing nurse practitioners and physician assistants to ensure that the practitioner's certification aligns with the specialty in which they will practice.
2. Our AMA will continue educating policymakers and lawmakers on the education, training, and certification of nurse practitioners and physician assistants, including the concept of specialty switching.
3. Our AMA will continue to support research into the cost and quality of primary care delivered by nurse practitioners and physician assistants.
4. Our AMA will continue to support research into the distribution and impact of nurse practitioners and physician assistants on primary care in underserved areas.
5. Our AMA will continue to support the expansion of access to physicians in under-resourced areas.

Two additional recommendations from this report were referred for further study:

1. That the American Medical Association (AMA) support workforce research, including surveys by state medical and nursing boards, that specifically focus on gathering information on nurse practitioners and physician assistants practicing in specialty care, their certification(s), alignment of their certification to their specialty, and whether they have switched specialties during their career. (New HOD Policy)
2. That the AMA support research that evaluates the impact of specialty switching by nurse practitioners and physician assistants on the cost and quality of patient care. (New HOD Policy)

Board of Trustees Informational Report 15-A-25 provided an overview of existing data on the topic and discussed the AMA's research on the subject which was in progress at the time of the Informational Report. This report, in response to the two items referred for further study, shares the findings from this research, and makes specific recommendations.

BACKGROUND

This is the third Board of Trustees report on this topic at issue. At the 2024 AMA Annual Meeting, Board of Trustees Report 14-A-24 examined the educational preparation of nurse practitioners and physician assistants, provided an overview of initial certifications and optional certifications for each profession, and summarized existing workforce studies and data on specialties and practice settings of each profession along with the alignment of such to the certification of the respective nurse practitioner or physician assistant. Testimony on Board of Trustees Report 14 called on the AMA to engage in further workforce research, particularly as related to specialty switching by nurse practitioners and physician assistants. This testimony prompted referral of these recommendations to the Board of Trustees for study.

Together Board of Trustees Informational Report 15-A-25 and this report share findings from this additional research, including new data that adds to this body of research. Board of Trustees Informational Report 15-A-25 provided a detailed summary of existing data on nurse practitioners and physician assistants, including information on their areas of practice by specialty, specialty certifications, and alignment of their certification to their specialty, as well as data on specialty switching by physician assistants. In preparation for this report, and to fill in gaps in existing data on specialty switching, the AMA engaged with a trusted vendor to conduct further workforce research on these topics. Findings from this research are described in this report.

The research project conducted by the AMA included both qualitative and quantitative research of nurse practitioners and physician assistants. The qualitative research was conducted through two national online bulletin board discussion groups consisting of 25 physician assistants and 24 nurse practitioners, respectively. The discussion groups were conducted over a four-day period from April 8-11, 2025, and were intended to explore general attitudes on relevant topics related to specialty switching and provide direction for the subsequent quantitative research. The quantitative research consisted of two national surveys (Surveys), one of 502 nurse practitioners (Nurse Practitioner Survey) and one of 500 physician assistants (Physician Assistant Survey) and was conducted July 16-August 4, 2025.

Findings from this research both confirm information from existing data and provide new data that were not otherwise available.

Specialty Switching

Findings from the Surveys filled significant gaps in data on specialty switching by nurse practitioners and physician assistants. While baseline data on specialty switching by physician assistants is available in the National Commission on Certification of Physician Assistants (NCCPA) *Statistical Profile of Board-Certified Physician Assistants by Specialty*, there is no publicly available data on specialty switching by nurse practitioners. These surveys, therefore, provided new information on specialty switching by nurse practitioners and expanded existing data from NCCPA on specialty switching by physician assistants which were discussed in BOT Report 15-A-25.

<u>Nurse Practitioner Survey Results</u>

Based on the Nurse Practitioner Survey, 35 percent of nurse practitioners have switched specialties at least once during their career with 13 percent switching more than once – seven percent switched twice and six percent switched three or more times.

	All NPs	Among 35% who switched
Switched Once	22%	61%
Switched Twice	7%	19%
Switched 3+	6%	20%

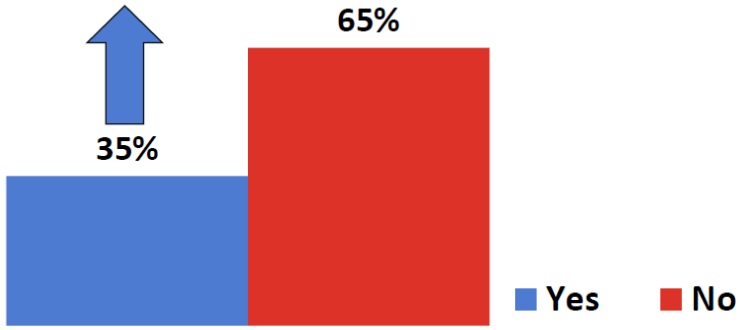

Figure 2. *Prior to practicing in your current medical specialty, did you practice as an NP in a different medical specialty?*

When it comes to nurse practitioners, switching specialties occurred relatively evenly across age groups, with those ages 50 or older slightly more likely to have switched specialties at some point in their career: under 40 (34 percent), ages 40-49 (33 percent), ages 50 and older (39 percent). The data also show that specialty switching occurs evenly across years in practice with nurse practitioners in practice 16 years or longer slightly more likely to change specialties than early career nurse practitioners. When looking at specialty switching by the number of years the nurse practitioner had been practicing in a specialty, the Nurse Practitioner Survey found that those new to a specialty were more likely to switch specialties compared to those who had been practicing in that specialty for 11 years or longer. Finally, of nurse practitioners with a family or adult population certification, 38 percent have switched specialties at least once, compared to 29 percent of nurse practitioners with another population certification. The table below provides more details on these and other demographics.

	All (100%)	Men (15%)	Women (85%)	Under 40 (31%)	Ages 40-49 (33%)	Ages 50+ (36%)	Non-Hispanic White (79%)	Persons of Color (20%)
% Yes NPs	35%	37%	35%	34%	33%	39%	35%	38%

	Years in Practice 5 or Less (20%)	Years in Practice 6-10 (32%)	Year in Practice 11-15 (19%)	Years in Practice 16+ (29%)	Years in Specialty 5 or Less (27%)	Years in Specialty 6-10 (30%)	Year in Specialty 11-15 (18%)	Years in Specialty 16+ (25%)
% Yes NPs	32%	35%	34%	39%	48%	39%	23%	27%

Figure 3. Demographics of nurse practitioners who have switched specialties. *Prior to practicing in your current medical specialty, did you practice as an NP in a different medical specialty?*

Nurse practitioners who switched specialties, on average, report practicing in their prior specialty for four years before switching. This was true for nurse practitioners practicing in both primary care specialties and other specialties. In addition, the Nurse Practitioner Survey found that a total of 45 percent of nurse practitioners switched out of primary care – 29 percent switched out of primary care and currently work in a specialty, and the remaining 16 percent remain in primary care but

switched to a different primary care specialty or switched to a different specialty and then switched back to primary care.

The Nurse Practitioner Survey also inquired among those respondents who switched specialties to share reasons for their decision to switch. Common reasons for switching specialties included more work/life balance (38 percent), a new professional challenge (35 percent), felt burnt out in previous specialty (29 percent), and better pay (22 percent).

The Nurse Practitioner Survey also sought to understand nurse practitioner sentiment on whether switching specialties was common, perceived as easy, and whether nurse practitioners who have not switched specialties in their career were likely to consider changing or switching from their current specialty. Overall, 78 percent of nurse practitioners said it was common for nurse practitioners to switch specialties, and 65 percent said it was easy to do so. However, among the 65 percent of nurse practitioners who have not switched specialties, 72 percent indicated that they were not likely to consider changing or switching from their current specialty over the course of their career.

Finally, the Nurse Practitioner Survey examined nurse practitioner perceptions and experiences around additional training and certifications to practice in a specialty. Interestingly, 66 percent of nurse practitioner respondents indicated “yes” when asked whether nurse practitioners should be required to complete additional certifications or training in their new specialty. However, a majority of these nurse practitioners indicated that additional training could be acquired on the job (65 percent) as opposed to before they start practicing in their medical specialty (35 percent). When asked whether they would obtain additional training or certifications to practice in a new specialty, 50 percent of all surveyed nurse practitioners said they were only interested in learning on the job and not interested in additional formal education, while 47 percent said they would be willing to go back to school to complete additional training, and three percent said they did not feel any additional training was necessary to practice in a new specialty.

A majority of nurse practitioners (59 percent of all nurse practitioners surveyed) also indicated that they received additional training from a physician to practice in their current specialty, including for the following: assess, evaluate, and diagnose patients (38 percent); interpret diagnostic tests (37 percent); develop patient treatment plans (30 percent); order diagnostic tests and screenings (30 percent); prescribe medications (29 percent); perform in-office diagnostic procedures (26 percent); and perform in-office surgical procedures (23 percent). Regarding whether specialty switching impacted the cost of care, over half of nurse practitioners (56 percent) said that specialty switching had no impact on the cost of care.

Other than your initial education, training, and coursework to become a (NP/PA), have you received any additional training from a physician in order for you to practice in your current medical specialty?

	Nurse Practitioners	Physician Assistants
Yes	59%	66%
No	41%	34%

Among Those Who Said Yes

From the following list, which of the following best describes the additional training you received?

Ranked by Nurse Practitioners	Nurse Practitioners	Physician Assistants
Assess, evaluate, and diagnose patients	38%	44%
Interpret diagnostic tests	37%	39%
Develop patient treatment plans	30%	43%
Order diagnostic tests and screenings	30%	34%
Prescribe medications	29%	32%
Perform in-office diagnostic procedures	26%	33%
Perform in-office surgical procedures	23%	35%
Other	3%	4%

Figure 4.

Physician Assistant Survey Results

Similarly, the Physician Assistant Survey found that 42 percent of surveyed physician assistants report having switched a specialty at least once during their career with 19 percent switching more than once – eight percent switched twice, and ten percent switched three or more times.

	All PAs	Among 42% who switched
Switched Once	24%	56%
Switched Twice	8%	18%
Switched 3+	10%	26%

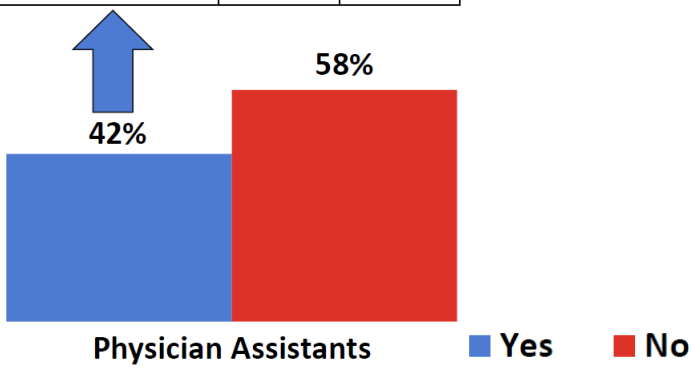

Figure 2. Prior to practicing in your current medical specialty, did you practice as a PA in a different medical specialty

Physician assistants older than 40 were more likely to switch specialties at some point during their career than those under 40 years of age. Similarly, early career physician assistants were less likely to have switched specialties compared to mid-career or late career physician assistants.

Interestingly, this is inconsistent with American Academy of Physician Assistant (AAPA) data finding that physician assistants with less than five years of experience were most likely to change specialties.[1] Generally speaking, when looking at years of practice in a specialty, there was consistency across groups. The table below provides more details on these and other demographics.

	All (100%)	Men (30%)	Women (70%)	Under 40 (58%)	Ages 40-49 (23%)	Ages 50+ (19%)	Non-Hispanic White (79%)	Persons of Color (20%)
% Yes PAs	42%	33%	46%	35%	53%	54%	40%	50%

	Years in Practice 5 or Less (32%)	Years in Practice 6-10 (22%)	Year in Practice 11-15 (17%)	Years in Practice 16+ (29%)	Years in Specialty 5 or Less (41%)	Years in Specialty 6-10 (22%)	Year in Specialty 11-15 (16%)	Years in Specialty 16+ (21%)	Primary Care (28%)	Other Specs (72%)
% Yes PAs	29%	40%	38%	61%	44%	41%	35%	47%	43%	42%

Figure 6. Demographics of physician assistants who have switched specialties. *Prior to practicing in your current medical specialty, did you practice as a PA in a different medical specialty?*

Physician assistants who switched specialties, on average, report practicing in their prior specialty for three to four years before switching. In addition, the Physician Assistant Survey found that a total of 46 percent of physician assistants switched out of primary care – 29 percent switched out of primary care and currently work in a specialty, and the remaining 17 percent remain in primary care but switched to a different primary care specialty or switched to a different specialty and then switched back to primary care.

The Physician Assistant Survey also inquired among those respondents who switched specialties to share reasons for their decision to switch. Common reasons identified by physician assistants for switching specialties included more work/life balance (54 percent), felt burnt out in previous specialty (41 percent), and better pay (29 percent).

The Physician Assistant Survey also sought to understand physician assistant sentiment on whether switching specialties was common, perceived as easy, and whether physician assistants who have not switched specialties in their career were likely to consider changing or switching from their current specialty. Overall, 91 percent of physician assistants said it was common for physician assistants to switch specialties, and 82 percent said it was easy to do so. However, among the 58 percent of physician assistants who have not switched specialties in their career, 57 percent indicated that they were not likely to consider changing or switching from their current specialty over the course of their career.

Finally, the Physician Assistant Survey examined physician assistant perceptions and experiences around additional training and certifications to practice in a specialty. When asked whether physician assistants should be required to complete additional certifications or training to practice in a new specialty, 68 percent said “no.” This sentiment was stronger among younger physician assistants and those in practice 10 years or less.

	All (100%)	Men (30%)	Women (70%)	Under 40 (58%)	Ages 40-49 (23%)	Ages 50+ (19%)	Non-Hispanic White (79%)	Persons of Color (20%)
% Yes PAs	32%	30%	34%	35%	28%	30%	31%	37%

	Years in Practice 5 or Less (32%)	Years in Practice 6-10 (22%)	Year in Practice 11-15 (17%)	Years in Practice 16+ (29%)	PA Switch Specs: Yes (42%)	PA Switch Specs: No (58%)	Specialty: Prim Care (28%)	Specialty: Other (72%)
% Yes PAs	36%	37%	27%	28%	25%	38%	28%	34%

Figure 7. *Do you think when a PA switches specialties they should be required to complete additional certifications or training in their new specialty in order to practice in it?*

Of those physician assistants who indicated that additional certifications or training should be required (32 percent), 89 percent indicated that it could be acquired on the job, whereas only 11 percent thought it should be done before they start practicing in the new specialty.

When it comes to additional training to practice in a new specialty, among all the physician assistants surveyed, 75 percent said they were only interested in learning on the job and not interested in additional formal education, 17 percent said they would be willing to go back to school to complete additional training, and eight percent said they did not feel like any additional training was necessary to practice in a new specialty.

A majority of all surveyed physician assistants (66 percent) also indicated that they received additional training from a physician to practice in their current specialty, including the following: assess, evaluate, and diagnose patients (44 percent); develop patient treatment plans (43 percent); interpret diagnostic tests (39 percent); perform in-office surgical procedures (35 percent); order diagnostic tests and screenings (34 percent); perform in-office diagnostic procedures (33 percent); and prescribe medications (32 percent) (see Figure 4). Regarding whether specialty switching impacted the cost of care, 60 percent of physician assistants said that specialty switching had no impact on the cost of care.

Nurse Practitioner and Physician Assistant Certifications

AMA research also sought to better understand the population certifications acquired by nurse practitioners and whether their population certification had an impact on specialty switching. The findings from the Nurse Practitioner Survey are generally consistent with existing data on nurse practitioners around population certification, which shows that a majority of nurse practitioners attain a Family Nurse Practitioner (FNP) certification upon graduation. Data from the Nurse Practitioner Survey provides more details by age, showing a shift among younger nurse practitioners away from certifications as a FNP toward other certifications, including Adult-Gerontology Acute Care and Psychiatric/Mental Health. The data also show a clear difference by gender with women more likely to have a certification as a FNP (72 percent) compared to men (57 percent). As discussed in earlier reports on this topic, all nurse practitioners must obtain certification in a specific population focus for licensure. While a majority of nurse practitioners obtain FNP certification, data from other workforce research shows a growing shift of nurse practitioners away from primary care toward specialties. For example, after examining state licensing renewal forms, the Oregon Center for Nursing found that only 25 percent of nurse practitioners practice in primary care.[2] While other workforce studies have found that newly

graduated nurse practitioners are more likely to enter specialty or subspecialty care rather than primary care.[3]

Table 1. Nurse practitioners by top three population certifications (age and gender)						
Population Certification	Total	Ages 26-39	Ages 40-49	Ages 50+	Women	Men
Family (FNP)	70%	64%	71%	74%	72%	57%
Adult-Gerontology Acute Care (AGACNP-BC	6%	11%	5%	3%	6%	8%
Psychiatric/Mental Health (PMHNP)	5%	8%	4%	3%	4%	10%

While workforce research exists on post graduate training completed by physician assistants, there is limited data on Certificates of Added Qualifications (CAQs), which are optional certificates that physician assistants can earn after completing a certain number of hours working in a specialty and passing an examination. The Physician Assistant Survey found that most physician assistants do not have CAQs, with 83 percent of respondents indicating they did not have a current or active CAQ. Younger physician assistants were less likely to have a CAQ compared to their older counterparts, with only 13 percent of those ages 26-39 reporting having a CAQ compared to 27 percent of those 50 years or older. Of note, CAQs are separate from the PA-C certification, which is the single, general certification offered to physician assistants who have graduated from an accredited program and passed the Physician Assistant National Certifying Examination. CAQs are also distinct from the optional post-graduate training that 5.7 percent of physician assistants complete after graduating from their initial physician assistant program.

Ranked by All Physician Assistants	Physician Assistants	Years in Practice: 5 or Less	Years in Practice: 6-10	Years in Practice: 11-15	Years in Practice: 16+
Emergency Medicine	4%	2%	1%	9%	7%
Orthopedic Surgery	3%	1%	1%	6%	5%
Dermatology	2%	1%	3%	4%	3%
Pediatrics	2%	1%	0%	1%	5%
Psychiatry	2%	2%	3%	1%	3%
Other	2%	3%	3%	3%	1%
Cardiovascular and Thoracic Surgery (CVTS)	1%	0%	0%	3%	2%
Hospital Medicine	1%	0%	2%	2%	2%
Obstetrics and Gynecology (OBGYN)	1%	1%	0%	1%	2%
Occupational Medicine	1%	1%	1%	1%	2%
Palliative Medicine and Hospice Care	1%	0%	0%	1%	1%
Nephrology	0%	0%	1%	1%	1%
Do not have any current/active CAQ's	83%	91%	86%	80%	76%

Figure 1. *Which, if any, of the following Certificates of Added Qualifications (CAQ's) do you have that are active/current? (Physician assistants were provided with a list of all CAQs offered by NCCPA and an "other" category. Respondents could select more than one.)*

This table depicts the total number of surveyed physician assistants with CAQs by specialty and by years in practice. For example, 4 percent of all physician assistants reported having a CAQ in emergency medicine, and 2 percent of physician assistants who have been in practice for five years or less reported having a CAQ in emergency medicine. Additionally, 83 percent of surveyed physician assistants do not have any current/active CAQs and 91 percent of surveyed physician assistants in practice for five years or less do not have any current/active CAQs.

DISCUSSION

Nurse practitioners and physician assistants commonly argue that scope expansions for their respective professions are necessary to overcome workforce shortages in primary care. Contrary to their advocacy argument, however, existing data show that an increasing number of nurse practitioners and physician assistants are moving away from primary care to specialties like dermatology, cardiology, psychiatry, and emergency medicine. Moreover, this is often done without any additional training or certification in these specialties. The Surveys provide new workforce data on specialty switching by nurse practitioners and physician assistants that were not previously available.

The data confirms that nurse practitioners and physician assistants are indeed switching specialties during their career; this occurs at all ages and at all career stages. Moreover, with few exceptions, this occurs without the nurse practitioner or physician assistant completing any additional formal education, training, or certifications in the specialty. Research also shows that nurse practitioner population certification may not always align with their current specialty. Likewise, physician assistants, who complete a generalist education with a single certification available upon graduation, rarely complete post-graduate training or optional CAQs in a specialty in which they are practicing. Rather, data from this survey confirm that nurse practitioners and physician assistants rely almost exclusively on physicians providing on-the-job training to practice in their current specialty. The data further show that nurse practitioners and physician assistants prefer this arrangement over completing additional formal training in a specialty.

This reliance on physicians to train nurse practitioners and physician assistants when they enter a new specialty speaks directly to the importance of physician supervision and collaboration of nurse practitioners and physician assistants to ensure patient safety and high-quality care. The data contributes to AMA's existing body of research on the distribution and impact of nurse practitioners and physician assistants on primary care in rural areas. Finally, this research confirms the need to continue educating policymakers and lawmakers on the education and training of nurse practitioners, including the concept of specialty switching and provides valuable data to support this work. Indeed, this data contributes to our expanding resources on scope of practice and will be instrumental in our advocacy efforts supporting physician led care, including strong physician supervision and collaboration of nurse practitioners and physician assistants.

CONCLUSION

The data described in this report adds to the existing research described in Board of Trustees Report 14-A-24 and Board of Trustees Informational Report 15-A-25. Altogether these reports provide a summary of the educational preparation of nurse practitioners and physician assistants, including initial certifications and optional certifications for each profession, as well as rich data on nurse practitioners and physician assistants in terms of their areas of practice by specialty, specialty certifications, alignment of their certification to their specialty, and specialty switching. Overall, the findings from this research support our policy on physician-led care, including the need for physician supervision or collaboration of nurse practitioners and physician assistants. The findings also support the need to continue educating lawmakers on the education, training, and certification of nurse practitioners and physician assistants, including the concept of specialty switching,

RECOMMENDATION

The Board of Trustees recommends that Policy H-35.960, "Physician Assistant and Nurse Practitioner Movement Between Specialties," be amended by addition and the remainder of the report be filed.

Policy H-35.960 "Physician Assistant and Nurse Practitioner Movement Between Specialties"

1. Our American Medical Association encourages hospitals and other health care entities employing nurse practitioners and physician assistants to ensure that the practitioner's certification aligns with the specialty in which they will practice.
2. Our AMA will continue educating policymakers and lawmakers on the education, training, and certification of nurse practitioners and physician assistants, including the concept of specialty switching.
3. Our AMA will continue to support research into the cost and quality of primary care delivered by nurse practitioners and physician assistants.
4. Our AMA will continue to support research into the distribution and impact of nurse practitioners and physician assistants on primary care in underserved areas.
5. Our AMA will continue to support the expansion of access to physicians in under-resourced areas.
6. Our AMA will continue to support workforce research, including surveys by state medical and nursing boards, that specifically focus on gathering information on nurse practitioners and physician assistants practicing in specialty care, their certification(s), alignment of their certification to their specialty, and whether they have switched specialties during their career. (Modify HOD Policy)
7. Our AMA will continue to support research that evaluates the impact of specialty switching by nurse practitioners and physician assistants on the cost and quality of patient care. (Modify HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] American Academy of Physician Assistants. *PAs and Specialty Change: Preparation, Motivation, and Scope,* 2024, at 5.

[2] Oregon Center for Nursing (2020). Primary Care Workforce Crisis Looming in Oregon: Nurse Practitioners Vital to Filling the Gap, But Not Enough to Go Around. Portland, OR, Oregon Center for Nursing, pg. 16.

[3] Martiniano R, Wang S, Moore J. A Profile of New York State Nurse Practitioners, 2017. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; October 2017

REPORT OF THE BOARD OF TRUSTEES

B of T Report 23-I-25

Subject:	Accreditation Council for Continuing Medical Education Observer Status in the House of Delegates
Presented by:	David H. Aizuss, MD, Chair
Referred to:	Reference Committee F

The Board of Trustees has received a request from the Accreditation Council for Continuing Medical Education (ACCME) to be considered for Official Observer status in the House of Delegates (HOD) of the American Medical Association (AMA). The ACCME's request has been considered using the criteria below (Policy G-600.025, "Official Observers in Our AMA House"):

1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both;
2. The organization should be national in scope and have similar goals and concerns about health care issues;
3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD; and
4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

DISCUSSION

As part of its request, ACCME submitted information on how it has met the criteria for Official Observer status, which is summarized below.

Criterion 1. The organization and the AMA should already have established an informal relationship and have worked together for the mutual benefit of both.

The AMA and ACCME collaborate to support physician lifelong learning through the CME system. The AMA owns and administers the AMA PRA Category 1 Credit™, while the ACCME accredits educational providers that deliver CME activities eligible for that credit. Together, our organizations align standards and policies to ensure that CME remains independent, evidence-based, and free from commercial influence. In addition, the AMA is one of seven ACCME Member Organizations that nominate individuals to serve on the ACCME Board of Directors.

Criterion 2. The organization should be national in scope and have similar goals and concerns about health care issues.

The ACCME ecosystem of accredited education providers spans all 50 states, 3 U.S. territories, and the District of Columbia, as well as 18 countries. The partnership between the AMA and

ACCME helps maintain a trusted, high-quality system that supports continuous physician education and improved patient care.

Criterion 3. The organization is expected to add a unique perspective or bring expertise to the deliberations of the HOD.

The ACCME would bring a valuable viewpoint to the HOD by offering expertise in physician lifelong learning, professional development, and competency-based education. Moreover, ACCME can provide real-world insight into how education influences clinical practice, quality improvement, and patient safety.

Criterion 4. The organization does not represent narrow religious, social, cultural, economic, or regional interests so that formal ties with the AMA would be welcomed universally by AMA members.

The ACCME mission is to assure and advance quality learning for healthcare professionals that drives improvements in patient care, and does not represent narrow religious, social, cultural, economic, or regional interests.

CONCLUSION

The Board of Trustees appreciates the long-standing relationship with ACCME. The AMA's core mission to promote the art and science of medicine and the betterment of public health is complementary to the ACCME vision of a community of education providers that support healthcare professionals in delivering optimal healthcare for all. Further, ACCME is working to drive transformation in the learning environment, support educators across the CME ecosystem, and simplify and align regulatory systems.

RECOMMENDATION

The Board of Trustees recommends that the Accreditation Council for Continuing Medical Education be admitted as an Official Observer in the House of Delegates, and that the remainder of this report be filed.

Fiscal Note: Minimal

Appendix - Official Observers to the House of Delegates

Organization	Year Admitted
Accreditation Association for Ambulatory Health Care	1993
Alliance for Continuing Medical Education	1999
Alliance for Regenerative Medicine	2014
Ambulatory Surgery Center Association	2005
American Academy of Physician Assistants	1994
American Association of Medical Assistants	1994
American Board of Medical Specialties	2014
American Dental Association	1982
American Health Quality Association	1987
American Hospital Association	1992
American Nurses Association	1998
American Public Health Association	1990
American Podiatric Medical Association	2019
Association of periOperative Registered Nurses	2000
Association of State and Territorial Health Officials	1990
Commission on Graduates of Foreign Nursing Schools	1999
Council of Medical Specialty Societies	2008
Federation of State Medical Boards	2000
Federation of State Physician Health Programs	2006
Intealth (ECFMG)	2011
Medical Group Management Association	1988
National Association of County and City Health Officials	1990
National Commission on Correctional Health Care	2000
National Council of State Boards of Nursing	2000
National Indian Health Board	2013
PIAA	2013
Society for Academic Continuing Medical Education	2003
United States Professional Association for Transgender Health	2024
US Pharmacopeia	1998
World Medical Association	2024

REPORT OF THE BOARD OF TRUSTEES

B of T Report 24-I-25

Subject: Amending Vaccine-related Policies

Presented by: David H. Aizuss, MD, Chair

Referred to: Reference Committee K

American Medical Association (AMA) Policy allows for the Board of Trustees to exercise its authority to take appropriate action and make decisions that are necessary to best represent the interests of patients and physicians and to advocate for science and public health.

At the September 2025 AMA Board of Trustees meeting, the Board voted to support the Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices (ACIP) recommendations as of May 1, 2025, as well as national medical specialty society recommendations on vaccines. While there are numerous AMA policies adopted by the House of Delegates (HOD) that support ACIP vaccine recommendations, the reality is that ACIP has changed dramatically, both in their composition and in the way that they function, since these policies were adopted. The Board's decision was necessary to ensure that the AMA can continue to communicate evidence-based vaccine recommendations to our members and their patients.

In keeping with policy G-600.071, the Board is bringing forth this report outlining the affected policies, which reference ACIP, with recommendations for amendment where appropriate for action by the HOD.

RECOMMENDATION

The Board of Trustees recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: $1,000.

Appendix

Policy Number	Title	Text	Recommendation
H-440.860	Financing of Adult Vaccines: Recommendations for Action	1. Our American Medical Association supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing. 2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States: Provider-related a. Develop a data-driven rationale for improved vaccine administration fees. b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs. c. Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc. d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given. Federal-related a. Increase federal resources for adult immunization to:	Amend. Insurance-related 1. Provide assistance to providers in creating efficiencies in vaccine management by: v. Providing model vaccine coverage contracts for purchasers of health insurance. vi. Creating simplified rules for eligibility verification, billing, and reimbursement. vii. Providing vouchers to patients to clarify eligibility and coverage for patients and providers. viii. Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP) recommended vaccines <u>as of May 1, 2025, and national medical specialty society recommended vaccines</u>. a. Increase resources for funding vaccines by providing first-dollar coverage for immunizations. b. Improve accountability by adopting performance measurements. c. Work with businesses that purchase private insurance to include all ACIP recommended immunizations <u>as of May 1, 2025, and national medical specialty society recommended vaccines</u> as part of the health plan. d. Provide incentives to encourage providers to begin immunizing by, for example: i. Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for

		i. Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations. ii. Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered. iii. Fund an adequate universal reimbursement rate for all federal and state immunization programs. b. Optimize use of existing federal resources by, for example: i. Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding. ii. Capitalizing on public health preparedness funding. c. Ease federally imposed immunization burdens by, for example: i. Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B. ii. Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient. iii. Simplifying the reimbursement process to eliminate payment-related barriers to immunization. d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations. State-related a. State Medicaid programs should increase state resources for funding vaccines by, for example: i. Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees. ii. Establishing and requiring payment of a minimum	reimbursing the provision of immunizations. ii. Simplifying payment to and encouraging immunization by nontraditional providers. iii. Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility). Manufacturer-related Market stability for adult vaccines is essential. Thus: v. Solutions to the adult vaccine financing problem should not deter research and development of new vaccines. vi. Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets. vii. Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP <u>recommend adult vaccines as of May 1, 2025, and national medical specialty society</u> recommended adult vaccines. viii. Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.

		reimbursement rate for administration fees. iii. Increasing state contributions to vaccination costs. iv. Exploring the possibility of mandating immunization coverage by third party payers. b. Strengthen support for adult vaccination and appropriate budgets accordingly. Insurance-related 1. Provide assistance to providers in creating efficiencies in vaccine management by: i. Providing model vaccine coverage contracts for purchasers of health insurance. ii. Creating simplified rules for eligibility verification, billing, and reimbursement. iii. Providing vouchers to patients to clarify eligibility and coverage for patients and providers. iv. Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines. a. Increase resources for funding vaccines by providing first-dollar coverage for immunizations. b. Improve accountability by adopting performance measurements. c. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as part of the health plan. d. Provide incentives to encourage providers to begin immunizing by, for example: i. Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for	

		reimbursing the provision of immunizations. ii. Simplifying payment to and encouraging immunization by nontraditional providers. iii. Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility). Manufacturer-related Market stability for adult vaccines is essential. Thus: i. Solutions to the adult vaccine financing problem should not deter research and development of new vaccines. ii. Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets. iii. Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP-recommended adult vaccines. iv. Educational outreach to both providers and the public is needed to improve acceptance of adult immunization. 3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.	
H-60.969	Childhood Immunizations	1. Our American Medical Association will lobby Congress to provide both the resources and the programs necessary, using the recommendations of the National Vaccine Advisory Committee and in accordance with the provision set forth in the National	Amend. 1. Our American Medical Association will lobby Congress to provide both the resources and the programs necessary, using the recommendations of the

		Vaccine Injury Compensation Act, to ensure that children nationwide are immunized on schedule, thus representing progress in preventive medicine. 2. Our AMA endorses the recommendations on adolescent immunizations developed by the Advisory Committee for Immunization Practices and approved by both the American Academy of Family Physicians and the American Academy of Pediatrics. 3. Our AMA will develop model state legislation to require that students entering middle or junior high school be adequately immunized according to current national standards. 4. Our AMA encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation. 5. Our AMA will continue to work with managed care groups and state and specialty medical societies to support a dedicated preventive health care visit at 11-12 years of age. 6. Our AMA will work with the American Academy of Family Physicians and the American Academy of Pediatrics to strongly encourage the Centers for Medicare & Medicaid Services to deactivate coding edits that cause a decrease in immunization rates for children, and to make these edit deactivations retroactive to January 1, 2013. 7. Our AMA recognizes that immunization requirements, including those for school attendance, serve as a strong motivator for parents and families to immunize their children according to the schedule recommended by the Centers for Disease Control and Prevention.	National Vaccine Advisory Committee and in accordance with the provision set forth in the National Vaccine Injury Compensation Act, to ensure that children nationwide are immunized on schedule, thus representing progress in preventive medicine. 2. Our AMA ~~endorses~~ supports the recommendations on adolescent immunizations developed by the Advisory Committee for Immunization Practices as of May 1, 2025, and ~~approved~~ recommended by ~~both~~ the American Academy of Family Physicians and the American Academy of Pediatrics. 3. Our AMA will develop model state legislation to require that students entering middle or junior high school be adequately immunized according to current national standards. 4. Our AMA encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation. 5. Our AMA will continue to work with managed care groups and state and specialty medical societies to support a dedicated preventive health care visit at 11-12 years of age. 6. Our AMA will work with the American Academy of Family Physicians and the American Academy of Pediatrics to strongly encourage the Centers for Medicare & Medicaid Services to deactivate coding edits that cause a decrease in immunization rates for children, and to make these edit deactivations retroactive to January 1, 2013. 7. Our AMA recognizes that immunization requirements, including those for school attendance, serve as a strong motivator for parents and families to immunize their children according to the schedule recommended by the Centers for Disease Control and Prevention.
H-440.877	Distribution and Administration of Vaccines	1. It is optimal for patients to receive vaccinations in their medical home to ensure coordination of care. This is particularly true for pediatric patients and for adult patients with chronic	Amend. 1. It is optimal for patients to receive vaccinations in their medical home to ensure coordination of care. This is

		disease and co-morbidities. If a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted back to the patient's primary care physician and entered into an immunization registry when one exists to provide a complete vaccination record. 2. All physicians and other qualified health care providers who administer vaccines should have fair and equitable access to all ACIP recommended vaccines. However, when there is a vaccine shortage, those physicians and other health care providers immunizing patients who are prioritized to receive the vaccine based upon medical risks/needs according to ACIP recommendations must be ensured timely access to adequate vaccine supply. 3. Physicians and other qualified health care providers should: a. Incorporate immunization needs into clinical encounters, as appropriate. b. Strongly recommend needed vaccines to their patients in accordance with ACIP recommendations and consistent with professional guidelines. c. Either administer vaccines directly or refer patients to another qualified health care provider who can administer vaccines safely and effectively, in accordance with ACIP recommendations and professional guidelines and consistent with state laws. d. Ensure that vaccination administration is documented in the patient medical record and an immunization registry when one exists e. Maintain professional competencies in immunization practices, as appropriate. 4. All vaccines should be administered by a licensed physician, or by a qualified health care provider pursuant to a prescription, order, or protocol	particularly true for pediatric patients and for adult patients with chronic disease and co-morbidities. If a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted back to the patient's primary care physician and entered into an immunization registry when one exists to provide a complete vaccination record. 2. All physicians and other qualified health care providers who administer vaccines should have fair and equitable access to all ACIP <u>and national medical specialty society</u> recommended vaccines. However, when there is a vaccine shortage, those physicians and other health care providers immunizing patients who are prioritized to receive the vaccine based upon medical risks/needs according to ACIP <u>and national medical specialty society</u> recommendations must be ensured timely access to adequate vaccine supply. 3. Physicians and other qualified health care providers should: a. Incorporate immunization needs into clinical encounters, as appropriate. b. Strongly recommend needed vaccines to their patients in accordance with ACIP recommendations and consistent with professional guidelines. c. Either administer vaccines directly or refer patients to another qualified health care provider who can administer vaccines safely and effectively, in accordance with ACIP recommendations <u>as of May 1, 2025, or</u> <u>national medical specialty society</u> ~~professional~~ guidelines and consistent with state laws. d. Ensure that vaccination administration is documented in the patient medical record and an immunization registry when one exists e. Maintain professional competencies in immunization practices, as appropriate.

		agreement from a physician licensed to practice medicine in the state where the vaccine is to be administered or in a manner otherwise consistent with state law. 5. Patients should be provided with documentation of all vaccinations for inclusion in their medical record, particularly when the vaccination is provided by someone other than the patient's primary care physician. 6. Physicians and other qualified health care providers who administer vaccines should seek to use integrated and interoperable systems, including electronic health records and immunization registries, to facilitate access to accurate and complete immunization data and to improve information-sharing among all vaccine providers. 7. Vaccine manufacturers, medical specialty societies, electronic medical record vendors, and immunization information systems should apply uniform bar-coding on vaccines based on standards promulgated by the medical community. 8. Our American Medical Association encourages vaccine manufacturers to make small quantities of vaccines available for purchase by physician practices without financial penalty.	4. All vaccines should be administered by a licensed physician, or by a qualified health care provider pursuant to a prescription, order, or protocol agreement from a physician licensed to practice medicine in the state where the vaccine is to be administered or in a manner otherwise consistent with state law. 5. Patients should be provided with documentation of all vaccinations for inclusion in their medical record, particularly when the vaccination is provided by someone other than the patient's primary care physician. 6. Physicians and other qualified health care providers who administer vaccines should seek to use integrated and interoperable systems, including electronic health records and immunization registries, to facilitate access to accurate and complete immunization data and to improve information-sharing among all vaccine providers. 7. Vaccine manufacturers, medical specialty societies, electronic medical record vendors, and immunization information systems should apply uniform bar-coding on vaccines based on standards promulgated by the medical community. 8. Our American Medical Association encourages vaccine manufacturers to make small quantities of vaccines available for purchase by physician practices without financial penalty.
H-440.970	Nonmedical Exemptions from Immunizations	1. Our American Medical Association believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in their group and the community at large. 2. Therefore, our AMA: a. Supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications.	1. Our American Medical Association believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in their group and the community at large. 2. Therefore, our AMA: a. Supports the immunization recommendations of national medical specialty societies as well as those of the Advisory Committee on Immunization Practices (ACIP) as of May 1, 2025, for all individuals

		b. Supports legislation eliminating nonmedical exemptions from immunization. c. Encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance. d. Encourages physicians to grant vaccine exemption requests only when medical contraindications are present. e. Encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common. f. Recommends that states have in place: i. an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP). ii. policies that permit immunization exemptions for medical reasons only. 3. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to: a. Eliminate non-medical exemptions from mandated immunizations.	without medical contraindications. b. Supports legislation eliminating nonmedical exemptions from immunization. c. Encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance. d. Encourages physicians to grant vaccine exemption requests only when medical contraindications are present. e. Encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common. f. Recommends that states have in place: i. an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP <u>as of May 1, 2025, or national medical specialty society guidelines</u>). ii. policies that permit immunization exemptions for medical reasons only. 3. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to:

		b. Limit medical vaccine exemption authority to only licensed physicians.	a. Eliminate non-medical exemptions from mandated immunizations. b. Limit medical vaccine exemption authority to only licensed physicians.
H-440.836	Role of Pharmacists in Improving Immunization Rates	1. Our American Medical Association believes that physicians and medical professional organizations should support state and federal efforts to engage pharmacists in vaccinating target populations that have difficulty accessing immunizations in a medical home. Before administration of a vaccine, pharmacists should assess the immunization status of the patient, which includes checking an immunization registry when one exists. Pharmacists should ensure that a record of vaccine administration is transmitted to the patient's primary care physician and documented in the immunization registry, and that written or electronic documentation is provided to the patient. 2. Our AMA believes that vaccination programs in pharmacies should promote the importance of having a medical home to ensure appropriate and comprehensive preventive care, early diagnosis, and optimal therapy. Physicians and pharmacists should work together in the community to: a. establish referral systems to facilitate appropriate medical care if the patient's conditions or symptoms are beyond the scope of services provided by the pharmacies; and b. encourage patients to contact a primary care physician to ensure continuity of care. 3. Our AMA believes that state educational requirements for pharmacists who administer vaccines should be based on ACIP recommendations and recognized standards and guidelines derived with input from physicians and pharmacists with demonstrated expertise in immunization practices.	Amend. 1. Our American Medical Association believes that physicians and medical professional organizations should support state and federal efforts to engage pharmacists in vaccinating target populations that have difficulty accessing immunizations in a medical home. Before administration of a vaccine, pharmacists should assess the immunization status of the patient, which includes checking an immunization registry when one exists. Pharmacists should ensure that a record of vaccine administration is transmitted to the patient's primary care physician and documented in the immunization registry, and that written or electronic documentation is provided to the patient. 2. Our AMA believes that vaccination programs in pharmacies should promote the importance of having a medical home to ensure appropriate and comprehensive preventive care, early diagnosis, and optimal therapy. Physicians and pharmacists should work together in the community to: a. establish referral systems to facilitate appropriate medical care if the patient's conditions or symptoms are beyond the scope of services provided by the pharmacies; and b. encourage patients to contact a primary care physician to ensure continuity of care. 3. Our AMA believes that state educational requirements for pharmacists who administer vaccines should be based on ACIP recommendations as of May 1, 2025, and recognized standards and guidelines derived with input from physicians and pharmacists with demonstrated expertise in immunization practices,

			such as national medical specialty society guidelines.
	Education and Public Awareness on Vaccine Safety and Efficacy	1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; (f) supports state policies allowing minors to override their parent's refusal for vaccinations; and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths. 2. Our AMA: (a) supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (b) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (c) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.	Amend. 1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; (f) supports state policies allowing minors to override their parent's refusal for vaccinations; and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths. 2. Our AMA: (a) ~~supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (b)~~ recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (~~c~~b) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.
H-440.958	Universal Immunization for	Our AMA: (1) supports the recommendations of Advisory Committee on Immunization Practice for the prevention of Hepatitis B; (2)	Amend.

	Hepatitis B Virus	encourages the immunization of all students entering medical school. The costs for the immunizations should be included in the school tuition; (3) supports the proposed regulation of OSHA requiring the vaccination of all healthcare workers at risk of hepatitis B virus infection; (4) encourages further professional and public education on hepatitis B disease, its transmission, and prevention. Such education should include state and federal legislators and emphasize the need for funding for immunization programs. In addition, education concerning hepatitis B should be a part of every sex and AIDS education course in the nation; and (5) encourages the U.S. Public Health Service and the World Health Organization to develop strategies for the elimination of hepatitis B both nationally and globally.	Our AMA: (1) supports the recommendations of Advisory Committee on Immunization Practice through May 1, 2025, and national medical specialty society guidelines for the prevention of Hepatitis B; (2) encourages the immunization of all students entering medical school. The costs for the immunizations should be included in the school tuition; (3) supports the proposed regulation of OSHA requiring the vaccination of all healthcare workers at risk of hepatitis B virus infection; (4) encourages further professional and public education on hepatitis B disease, its transmission, and prevention. Such education should include state and federal legislators and emphasize the need for funding for immunization programs. In addition, education concerning hepatitis B should be a part of every sex and AIDS education course in the nation; and (5) encourages the U.S. Public Health Service and the World Health Organization to develop strategies for the elimination of hepatitis B both nationally and globally.
H-440.851	Influenza Vaccine Availability and Distribution	Our AMA will: (1) continue efforts to communicate strongly to its partners involved in influenza vaccine production and distribution that physicians must receive influenza vaccines in a timely and equitable manner in order to help immunize all patients =6 months of age as recommended by the Center for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP); (2) urge manufacturers and distributors of influenza vaccine to provide a dedicated ordering system for small- and medium-size medical practices to pre-order vaccine up to an appropriate volume threshold; (3) support federal actions to allow physicians (MDs and DOs) to form purchasing alliances to allow for competitive purchasing of influenza vaccine comparable to large purchasers currently supplying pharmacy and grocery chain stores with influenza vaccine; (4) communicate current ACIP recommendations on the influenza vaccine to physicians and assist the CDC in disseminating its informational letters and bulletins to physicians and other providers of the influenza vaccine when they become available in order to ensure compliance with the ACIP recommendations with respect to immunization of patients with influenza vaccine; (5) work with the CDC and other immunization partners to explore options to provide for timely influenza immunization of indigent or underserved populations, including exploring options to provide for the timely redistribution of state and federally funded	Amend. Our AMA will: (1) continue efforts to communicate strongly to its partners involved in influenza vaccine production and distribution that physicians must receive influenza vaccines in a timely and equitable manner in order to help immunize all patients =6 months of age as recommended by the Center for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) and national medical specialty societies; (2) urge manufacturers and distributors of influenza vaccine to provide a dedicated ordering system for small- and medium-size medical practices to pre-order vaccine up to an appropriate volume threshold; (3) support federal actions to allow physicians (MDs and DOs) to form purchasing alliances to allow for competitive purchasing of influenza vaccine comparable to large purchasers currently supplying pharmacy and grocery chain stores with influenza vaccine; (4) communicate ~~current~~ ACIP recommendations as of May 1, 2025, or national medical specialty society recommendations on the influenza vaccine to physicians and assist the CDC in disseminating its informational letters and bulletins to physicians and other providers of the influenza vaccine when they become available in order to ensure compliance with the ~~ACIP~~ recommendations with respect to immunization of patients with influenza vaccine; (5) work with the CDC and other immunization partners to explore options to provide for timely influenza

		influenza vaccines to facilities or groups within the state willing to appropriately manage, distribute, and administer the vaccine to indigent or underserved populations; (6) continue its collaboration with the CDC and other stakeholders in influenza vaccination to work to achieve the influenza immunization goals of Healthy People 2020, with particular attention to improving demand for vaccine and achieving stability in the vaccine supply; (7) work with local public health officers through the Federation to respond to community flu vaccine shortages and possible influenza outbreaks to protect the public health; and, (8) urge the federal government to support, as a national priority, the development of safe and effective influenza vaccines employing new technologies and to continue to support adequate distribution to ensure that there will be an affordable, available and safe supply of influenza vaccine on an annual basis.	immunization of indigent or underserved populations, including exploring options to provide for the timely redistribution of state and federally funded influenza vaccines to facilities or groups within the state willing to appropriately manage, distribute, and administer the vaccine to indigent or underserved populations; (6) continue its collaboration with the CDC and other stakeholders in influenza vaccination to work to achieve the influenza immunization goals of Healthy People 2020, with particular attention to improving demand for vaccine and achieving stability in the vaccine supply; (7) work with local public health officers through the Federation to respond to community flu vaccine shortages and possible influenza outbreaks to protect the public health; and, (8) urge the federal government to support, as a national priority, the development of safe and effective influenza vaccines employing new technologies and to continue to support adequate distribution to ensure that there will be an affordable, available and safe supply of influenza vaccine on an annual basis.
H-185.969	Insurance Coverage for Immunizations	Our American Medical Association endorses laws requiring insurance companies to provide coverage for immunization schedules endorsed by the Advisory Committee on Immunization Practices, American Academy of Family Physicians, and American Academy of Pediatrics, with no co-pays or deductibles.	Amend. Our American Medical Association ~~endorses~~ supports laws requiring insurance companies to provide coverage for immunization schedules ~~endorsed~~ developed by the Advisory Committee on Immunization Practices through May 1, 2025, and subsequent vaccine recommendations developed by national medical specialty societies ~~American Academy of Family Physicians, and American Academy of Pediatrics~~, with no co-pays or deductibles.
D-440.981	Appropriate Reimbursements and Carve-outs for Vaccines	1. Our American Medical Association will continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services. 2. Our AMA will continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers, including federal funds to reimburse for administration of the COVID-19 vaccine to uninsured patients. 3. Our AMA will encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average	Amend. 1. Our American Medical Association will continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services. 2. Our AMA will continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers, including federal funds to reimburse for administration of the COVID-19 vaccine to uninsured patients. 3. Our AMA will encourage health plans to recognize that physicians incur costs associated with the procurement, storage

		wholesale price of any one particular vaccine. 4. Our AMA will seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices, or clearly state in large bold font in their notices to patients and businesses that they do not follow the federal advisory body on vaccine recommendations, the Advisory Committee on Immunization Practices. 5. Our AMA will advocate that a physician's office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care.	and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine. 4. Our AMA will seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices through May 1, 2025, and subsequent vaccine recommendations developed by national medical specialty societies, or clearly state in large bold font in their notices to patients and businesses that they do not follow ~~the federal advisory body on~~ evidence-based vaccine recommendations ~~the Advisory Committee on Immunization Practices~~. 5. Our AMA will advocate that a physician's office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care.
H-440.881	Liability Protection for Adult Vaccines	Our American Medical Association supports the expansion of the Vaccine Injury Compensation Fund to include any vaccine encouraged or recommended by the Advisory Committee on Immunization Practices for routine use in the adult population.	Amend. Our American Medical Association supports the expansion of the Vaccine Injury Compensation Fund to include any vaccine encouraged or recommended by the Advisory Committee on Immunization Practices as of May 1, 2025, or national medical specialty societies for routine use in the adult population.
H-440.889	Smallpox: A Scientific Update	Our American Medical Association strongly supports the Advisory Committee on Immunization Practices (ACIP) recommendations on the use of vaccinia (smallpox) vaccine in light of the available science and data.	Amend. Our American Medical Association recognizes that routine vaccination for smallpox is not recommended for the general public but people at high risk of occupational exposure to orthopoxviruses are recommended to receive routine vaccination. ~~strongly supports the Advisory Committee on Immunization Practices (ACIP) recommendations on the use of vaccinia (smallpox) vaccine, in light of the available science and data~~.
D-440.955	Insurance Coverage for HPV Vaccine	Our AMA: (1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices; (2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy	Our AMA: (1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices as of May 1, 2025 or as supported by national medical specialty society guidelines; (2) encourages insurance carriers and other

		benefit for medically eligible patients; and (3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations.	payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and (3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations.
H-440.921	Pneumococcal Vaccination	Our American Medical Association encourages physicians to expand their use of pneumococcal vaccine per current Advisory Committee on Immunization Practices recommendations.	Amend. Our American Medical Association encourages physicians to expand their use of pneumococcal vaccine per ~~current~~ Advisory Committee on Immunization Practices as of May 1, 2025, or national medical specialty society recommendations.
H-440.875	Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines	1. It is our American Medical Policy that all persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as soon as possible following publication of these recommendations in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR). 2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine. 3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines. 4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ACIP-recommended	Amend. 1. ~~It is our American Medical Policy that~~ Aall persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as of May 1, 2025, or national medical specialty society recommended vaccines as soon as possible following publication of these recommendations ~~in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR).~~ 2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine. 3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines. 4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery

		vaccines, and the timely distribution of ACIP-recommended vaccines to providers). 5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ACIP-recommended vaccines. 6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices. 7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines. 8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis. 9. Until compliance of our AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or	infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ~~ACIP~~ recommended vaccines, and the timely distribution of ~~ACIP~~ recommended vaccines to providers). 5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ~~ACIP~~ recommended vaccines. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines, including those from national medical specialty societies.

		based on prevailing preventive clinical health guidelines.	
H-60.923	Meningococcal Vaccination for School Children	Our American Medical Association supports efforts to require that school children receive meningococcal vaccine as recommended by the Advisory Committee on Immunization Practices guidelines.	Amend. Our American Medical Association supports efforts to require that school children receive meningococcal vaccine as recommended by the Advisory Committee on Immunization Practices as of May 1, 2025, or as supported by national medical specialty society guidelines.
D-330.896	Covering Vaccinations Through Medicare	Our American Medical Association will advocate that Medicare cover the full cost of all vaccinations administered to Medicare patients that are recommended by the Advisory Committee on Immunization Practices (ACIP) at the point of care and outside of budget neutrality requirements.	Amend. Our American Medical Association will advocate that Medicare cover the full cost of all vaccinations administered to Medicare patients at the point of care and outside of budget neutrality requirements, that are recommended by the Advisory Committee on Immunization Practices (ACIP) as of May 1, 2025, and subsequent vaccine recommendations developed by national medical specialty societies~~, at the point of care and outside of budget neutrality requirements~~.
D-40.991	Acceptance of TRICARE Health Insurance	Our AMA: 1. Encourages state medical associations and national medical specialty societies to educate their members regarding TRICARE, including changes and improvements made to its operation, contracting processes and mechanisms for dispute resolution. 2. Encourages the TRICARE Management Activity to improve its physician education programs, including those focused on non-network physicians, to facilitate increased civilian physician participation and improved coordination of care and transfer of clinical information in the program. 3. Encourages the TRICARE Management Activity and its contractors to continue and strengthen their efforts to recruit and retain mental health and addiction service providers in TRICARE networks, which should include providing adequate reimbursement for mental health and addiction services. 4. Strongly urges the TRICARE Management Activity to implement significant increases in physician payment rates to ensure all TRICARE beneficiaries, including service members and their families, have adequate access to and choice of physicians.	Amend. 1. Encourages state medical associations and national medical specialty societies to educate their members regarding TRICARE, including changes and improvements made to its operation, contracting processes and mechanisms for dispute resolution. 2. Encourages the TRICARE Management Activity to improve its physician education programs, including those focused on non-network physicians, to facilitate increased civilian physician participation and improved coordination of care and transfer of clinical information in the program. 3. Encourages the TRICARE Management Activity and its contractors to continue and strengthen their efforts to recruit and retain mental health and addiction service providers in TRICARE networks, which should include providing adequate reimbursement for mental health and addiction services. 4. Strongly urges the TRICARE Management Activity to implement significant increases in physician payment rates to ensure all TRICARE beneficiaries, including service members and their families, have adequate access to and choice of physicians.

		5. Strongly urges the TRICARE Management Activity to alter its payment formula for vaccines for routine childhood immunizations, so that payments for vaccines reflect the published CDC retail list price for vaccines. 6. Continues to encourage state medical associations and national medical specialty societies to respond to requests for information regarding potential TRICARE access issues so that this information can be shared with TRICARE representatives as they develop their annual access survey. 7. Continues to advocate for changes in TRICARE payment policies that will remove barriers to physician participation and support new, more effective care delivery models, including: (a) establishing a process to allow midlevel providers to receive 100 percent of the TRICARE allowable cost for services rendered while practicing as part of a physician-led health care team, consistent with state law; and (b) paying for transitional care management services, including payment of copays for services provided to TRICARE for Life beneficiaries receiving primary coverage through Medicare. 8. Continues to advocate for improvements in the communication and implementation of TRICARE coverage policies to ensure continued patient access to necessary services, including: (a) consistently approving full payment for services rendered for the diagnosis and treatment of common mental health conditions, regardless of the specialty of the treating physician; and (b) clarifying policies with respect to coverage for age appropriate doses of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices.	5. Strongly urges the TRICARE Management Activity to alter its payment formula for vaccines for routine childhood immunizations, so that payments for vaccines reflect the published CDC retail list price for vaccines. 6. Continues to encourage state medical associations and national medical specialty societies to respond to requests for information regarding potential TRICARE access issues so that this information can be shared with TRICARE representatives as they develop their annual access survey. 7. Continues to advocate for changes in TRICARE payment policies that will remove barriers to physician participation and support new, more effective care delivery models, including: (a) establishing a process to allow midlevel providers to receive 100 percent of the TRICARE allowable cost for services rendered while practicing as part of a physician-led health care team, consistent with state law; and (b) paying for transitional care management services, including payment of copays for services provided to TRICARE for Life beneficiaries receiving primary coverage through Medicare. 8. Continues to advocate for improvements in the communication and implementation of TRICARE coverage policies to ensure continued patient access to necessary services, including: (a) consistently approving full payment for services rendered for the diagnosis and treatment of common mental health conditions, regardless of the specialty of the treating physician; and (b) clarifying policies with respect to coverage for age appropriate doses of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices <u>as of May 1, 2025, and subsequent vaccine recommendations developed by national medical specialty societies</u>.
H-430.979	Support Public Health Approaches for the Prevention and Management of Contagious	1. Our American Medical Association, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.	Retain.

	Diseases in Correctional and Detention Facilities	2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities. 3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens. 4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities. 5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation. 6. Our AMA will advocate: a. for all employees working in a correctional facility or detention center to be up to date with vaccinations against COVID-19, unless there is a valid medical contraindication. b. for all employees working in a correctional facility or detention center, not up to date with vaccination for COVID-19 to be COVID rapid tested each time they enter a correctional facility or detention center, as consistent with Centers for Disease Control and Prevention (CDC) or local public health guidelines. c. for correctional facility or detention center policies that require non-employed, non-residents (e.g. visitors,	

		contractors, etc.) to either show evidence of being up to date for COVID-19 vaccines or show proof of a negative COVID test when they enter a correctional facility or detention center as consistent with CDC or local public health guidelines, at no cost to the visitor. d. that all people inside a correctional facility or detention center wear an appropriate mask at all times, except while eating or drinking or at a 6 ft. distance from anyone else if local transmission rate is above low risk as determined by the CDC. e. that correctional facilities or detention centers be able to request and receive all necessary funding for COVID-19 vaccination and testing, according to CDC or local public health guidelines.	
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,	Amend. 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

		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.	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 <u>national medical specialty societies or</u> 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 <u>as of May 1, 2025, and subsequent vaccine recommendations developed by national medical specialty societies</u>, 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

		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.	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.
H-440.852	Smallpox: A Scientific Update	Our American Medical Association will remain engaged with the CDC, the Advisory Committee on Immunization Practices (ACIP), and the Federation on smallpox vaccination and support a commitment to monitor the current status of smallpox and smallpox vaccination in the world and in the United States and develop appropriate recommendations as necessary.	Retain.
H-440.993	Smallpox Vaccination Policy	Our AMA supports the recommendations of the Public Health Service Advisory Committee on Immunization Practices that systematic programs of routine vaccination for smallpox for hospital and health personnel no longer be required.	Amend. Our AMA supports the recommendations ~~of the Public Health Service Advisory Committee on Immunization Practices~~ that systematic programs of routine vaccination for smallpox for hospital and health personnel no longer be required.

H-440.808	Digital Vaccine Credential Systems and Vaccine Mandates in COVID-19	COVID-19 and COVID-19 vaccines raise unique challenges. To meet these challenges, our American Medical Association: 1. Encourages the development of clear, strong, universal, and enforceable federal guidelines for the design and deployment of digital vaccination credentialing services (DVCS), and that before decisions are taken to implement use of vaccine credentials: a. Vaccine is widely accessible. b. Equity-centered privacy protections are in place to safeguard data collected from individuals. c. Provisions are in place to ensure that vaccine credentials do not exacerbate inequities. d. Credentials address the situation of individuals for whom vaccine is medically contraindicated. 2. Recommends that decisions to mandate COVID-19 vaccination, including, but not limited to for school attendance for children and college/university students, be made only: a. After a vaccine has received full approval from the U.S. Food and Drug Administration through a Biological Licenses Application. b. In keeping with recommendations of the Advisory Committee on Immunization Practices for use in the population subject to the mandate as approved by the Director of the Centers for Disease Control and Prevention. c. When individuals subject to the mandate have been given meaningful opportunity to voluntarily accept vaccination. d. Implementation of the mandate minimizes the potential to exacerbate	Retain

		inequities or adversely affect already marginalized or minoritized populations. 3. Encourages the use of well-designed education and outreach efforts to promote vaccination to protect both public health and public trust. 4. Recommends that vaccination credentials not be provided on the basis of natural immunity or prior SARS-CoV-2 infection. 5. Encourages U.S. government entities to offer vaccines, including COVID-19 vaccines, to all individuals seeking to enter the United States; encourage equitable access to vaccines developed for this and future pandemics; apply immigration requirements for COVID-19 vaccines in the same manner as other vaccines; and require adherence to CDC's evidence-based travel guidelines and public health mitigation measures.	

REVISED

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

Revised CCB Report 3-I-25

Subject: Credentialing and Temporary Delegates and Alternate Delegates

Presented by: Jerry P. Abraham, MD, MPH, Chair

Referred to: Reference Committee on Ethics and Bylaws

Over the years, there has been confusion around several existing Bylaws that focus on credentialing a delegate or alternate delegate when the original credentialed delegate or alternate is unable to attend a meeting in whole or in part. Specifically, the Speakers recently noted that they as well as delegations experienced difficulties at A-25 trying to follow existing Bylaws 2.10.4 and 2.10.4.1 and expressed strong support for a single designation to identify those delegates and alternate delegates who were taking the place of a previously credentialed delegate or alternate delegate for all or the remainder of the meeting.

The Council looked at the Bylaws and agreed that the word temporary delegate or alternate delegate was a better term to characterize an individual who was taking the place of another individual who had been credentialed by their society at least 45 days before the meeting. For credentialing purposes, all individuals whose names are submitted by the 45-day deadline in advance of a meeting, even those delegates or alternate delegates who are filling vacancies for their societies, are not designated as a substitute delegate or alternate delegate and thus receive the privileges of their position.

The Council, however, in looking at provisions that govern the credentialing of delegates found several outmoded provisions. The language related to certification is outmoded when specifying how delegates and alternate delegates are credentialed. Certification refers to the outdated process of having each group represented in the House of Delegates fill out a form and certify its accuracy. The Council understands that the term certification may have varying implications or significance for different purposes and delegations. Credentialing more appropriately reflects the current process.

As noted in prior testimony, the Medical Student Section (MSS) and the Resident and Fellow Section (RFS) requested retention of language specifying that constituent associations may have medical student and/or resident and fellow delegation members. Additionally, they requested that similar language be applied to specialty societies. Therefore, the Council added language to that effect.

The AMA does not hold outside entities to any further requirements than the need for their delegates and alternate delegates to be members of the AMA and their association, and therefore the Council initially deleted proscriptive language regarding terms and the filling of vacancies. However, several delegations requested that the original bylaw language be reinstated.

Language regarding some vacancies was similarly problematic. Additionally, earlier this year, the Speakers, the Council and the Resident and Fellow Section (RFS) noted a discrepancy with respect to the RFS sectional delegates and alternate delegates. Existing Bylaw 2.4.6 provided that a

delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of the term, yet Bylaw 2.4.3 stated that delegates and alternate delegates shall be elected (not selected) by the RFS in accordance with procedures adopted by the Section.

A vacancy is when a departure results in an open position where the person vacating the position does not return. AMA Bylaws allow for a selected "delegate" to immediately fill the open position. The use of the word "delegate" is important here – it implies that the position may only be filled by someone who is already a delegate (or alternate delegate) and has satisfied the applicable eligibility and credentialing requirements. This is important because the person filling that vacancy will take on the privileges previously enjoyed by the delegate.

While a temporary alternate delegate is temporary, the role of a temporary alternate delegate is similar to that of an alternate delegate, in that the temporary alternate delegate shall have all the rights and privileges similar to an alternate delegate (e.g., the temporary alternate delegate may vote but is not eligible for nomination or election as a Speaker or Vice Speaker of the HOD). Unlike a delegate that fills a vacancy, a temporary alternate delegate fills an open position for a single meeting. Like a delegate that fills a vacancy, a temporary alternate delegate is subject to eligibility and credentialing requirements of the seat to be filled.

To be consistent with the plain meaning of a substitute, a substitute taking the seat of a properly credentialed delegate (or alternate delegate), should meet the requirements of the original seat to be substituted, especially since a temporary alternate delegate would enjoy voting rights. A contrary position (e.g., dismiss the election requirement of an original seat) could be viewed as elevating a position that serves as a temporary accommodation to one that circumvents the original seat's established requirements.

With acknowledgement of extenuating circumstances that may warrant the need for a temporary alternate delegate, proposed language is offered to allow a special election to satisfy Bylaw requirements for an election for medical student regional delegates and alternate delegates (Bylaw 2.3.3) and resident and fellow sectional delegates and alternate delegates (Bylaw 2.4.3). As the medical student regional delegates and resident and fellow sectional delegates were established by the House to provide enhanced representation of these two sections, the House adopted some very specific guardrails to ensure that these individuals are elected, not appointed, by their peers.

Also, in keeping with the criteria by which AMA's Emergency Assistance Program funds are allocated, it is essential that the Bylaws are accurate when referencing the process by which duly credentialed members of the House are identified for each meeting as well as the process by which an opening is filled.

The revised Council report proposes additional bylaw amendments to provide further clarification and accuracy.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following Bylaws amendments and deletions (highlighted in RED) be adopted, and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

2—House of Delegates

2.0.1 Composition and Representation….

2.0.1.1 Qualification of Members of the House of Delegates. Members of the House of Delegates must be active members of the AMA and of the entity they represent.

2.0.1.2 Rights and Privileges. Delegates have the privilege of the floor of the House of Delegates which includes the ability to submit resolutions, discuss and make motions on items of business and vote in elections.

[subsequent section will be renumbered accordingly]

2.1 Constituent Associations….

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2.1.3 ~~Certification~~ Credentialing. The president or chief executive officer of each constituent association, or ~~the president's~~ their designee, shall provide ~~certify to~~ the AMA Office of House of Delegates Affairs with the names and contact information of their delegates and alternate delegates ~~from their respective associations. Certification must occur~~ at least 45 days prior to each ~~the Annual or Interim M~~meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

2.1.4 Term. Delegates from constituent associations shall be selected for two~~2~~-year terms and assume office on the date set by the constituent association, provided that such seats are authorized pursuant to these Bylaws. Constituent associations entitled to more than one delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.

2.1.5 Vacancies. The delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of that term.

2.1.~~5~~6 Resident/Fellow Physician and Medical Student Delegates. A constituent association may designate one or more of its delegate and alternate delegate seats to be filled by a resident/fellow physician member or a medical student member.

2.1.6.1 Term. Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term ~~beginning as of the date of certification of the delegate or alternate delegate by the constituent association to the AMA.~~

2.1.6.2 No Restriction on Selection. Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full 2-year term as a delegate or alternate delegate from a constituent association as provided in Bylaw 2.1.~~3~~4.

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2.2 National Medical Specialty Societies….

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2.2.3 ~~**Certification**~~ **Credentialing.** The president or chief executive officer of each specialty society, or ~~the president's~~ their designee, shall provide ~~certify to~~ the AMA Office of House of Delegates Affairs with the names and contact information of their delegates and alternate delegates ~~from their respective societies~~. ~~Certification must occur~~ at least 45 days prior to each ~~the Annual or Interim M~~meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

2.2.4 **Term.** Delegates from specialty societies shall be selected for two~~2~~-year terms, and shall assume office on the date set by the specialty society provided that such seats are authorized pursuant to these Bylaws. Specialty societies entitled to more than one delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.

2.2.5 Resident/Fellow Physician and Medical Student Delegates. A specialty association may designate one or more of its delegate and alternate delegate seats to be filled by a resident/fellow physician member or a medical student member.

2.2.5.1 **Term.** Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year.

2.2.5.2 **No Restriction on Selection.** Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full 2-year term as a delegate or alternate delegate from a specialty association as provided in Bylaw 2.2.3.

2.2.~~5~~6 **Vacancies.** The delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of that term.

2.3 **Medical Student Regional Delegates and Alternate Delegates.** In addition to the delegate and alternate delegate representing the Medical Student Section, medical student regional delegates and regional alternate delegates shall be apportioned and elected as provided in this bylaw.

2.3.1 **Qualifications.** Medical student regional delegates and alternate delegates must be active medical student members of the AMA. In addition, medical student regional delegates and alternate delegates must be members of and have received written endorsement from the~~ir endorsing~~ constituent association where their educational program is located. The region in which the endorsing society is located determines the student's region, and a medical student may only serve as a regional delegate, alternate delegate or a~~ny~~ temporary delegate or alternate delegate ~~form of substitute~~ (pursuant to Bylaws 2.8.3~~5~~ and 2.10.42) ~~only~~ for that region.

2.3.2 **Apportionment.** The total number of ~~M~~medical ~~S~~student r~~R~~egional delegates and alternate delegates is based on one delegate and one alternate delegate for each 2,000 active medical student members of the AMA, as recorded by the AMA on

December 31 of each year. Each Medical Student Region, as ~~defined by~~ delineated in the rules of the Medical Student Section, is entitled to one delegate and one alternate delegate for each 2,000 active medical student members of the AMA in an educational program located within the jurisdiction of the Medical Student Region. Any remaining ~~M~~medical ~~S~~student ~~Section~~ r~~R~~egional delegates and alternate delegates shall be apportioned one delegate and one alternate delegate per region(s) with the greatest number of active AMA medical student members in excess of a multiple of 2,000. If two regions have the same number of active AMA medical student members, ties will be broken by lottery by the ~~MSS~~ Medical Student Section Governing Council.

2.3.2.1 Effective Date. In January of each year the AMA shall notify the chair of the Medical Student Section Governing Council of the number of seats in the House of Delegates to which each Medical Student Region is entitled. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.3.3 Election. Medical student regional delegates and alternates shall be elected by the Medical Student Section in accordance with procedures adopted by the Medical Student Section and approved by the Board of Trustees. ~~Each elected delegate and alternate delegate must receive written endorsement from their constituent association in accordance with procedures adopted by the Medical Student Section and approved by the Board of Trustees.~~ Regional d~~D~~elegates and alternate delegates shall be elected in conjunction with ~~at~~ the Business Meeting of the Medical Student Section associated with ~~prior to~~ the Interim Meeting of the House of Delegates. Regional d~~D~~elegates and alternate delegates shall assume their office ~~be seated~~ at the next Annual Meeting of the House of Delegates.

2.3.4 ~~Certification~~ Credentialing. The ~~C~~chair of the Medical Student Section Governing Council, or the ~~C~~chair's designee, shall provide ~~certify to~~ the AMA Office of House of Delegates Affairs with the names and contact information of the delegates and alternate delegates for each Medical Student Region elected in accordance with 2.3.3 by December 31 of each year. These appropriately identified individuals shall be duly credentialed for each House of Delegates meeting occurring within their term as defined in 2.3.5. ~~Certification of delegates and alternate delegates must occur at least 45 days prior to the Annual Meeting of the House of Delegates.~~

2.3.5 Term. Medical s~~S~~tudent r~~R~~egional delegates and alternate delegates shall be elected for one-year terms ~~and shall assume office on the date set by the Medical Student Section Governing Council~~.

2.3.6 Vacancies. A medical student who fills a vacancy for a medical student regional delegate or alternate delegate must have been elected from the same medical student region as the vacating student. The delegate or alternate delegate ~~s~~elected to fill a vacancy shall assume office immediately after ~~s~~election and serve for the remainder of that term.

2.4 ~~Delegates from the~~ Resident and Fellow Sectional Delegates and Alternate Delegates. In addition to the delegate and alternate delegate representing the Resident and Fellow

Section, resident and fellow ~~physician~~ sectional delegates and alternate delegates shall be apportioned and elected in a manner as provided in this bylaw.

2.4.1 Qualifications. Resident and fellow sectional ~~D~~delegates and alternate delegates ~~from the Resident and Fellow Section~~ must be active members of the Resident and Fellow Section of the AMA. In addition, resident and fellow sectional ~~physician~~ delegates and alternate delegates must be members of and have written endorsement from a ~~their endorsing~~ society or organization currently seated in the HOD, in a capacity appropriate to their level of training.

2.4.2 Apportionment. The apportionment of resident and fellow sectional delegates ~~from the Resident and Fellow Section~~ is one delegate for each 2,000 active resident and fellow physician members of the AMA, as recorded by the AMA on December 31 of each year.

2.4.2.1 Effective Date. In January of each year, the AMA shall notify the chair of the Resident and Fellow Section Governing Council of the number of seats in the House of Delegates to which the Resident and Fellow Section is entitled. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.4.3 Election. Resident and fellow sectional ~~D~~delegates and alternate delegates shall be elected by the Resident and Fellow Section in accordance with procedures adopted by the Section and approved by the Board of Trustees. Resident and fellow sectional delegates and alternate delegates shall be elected at the Business Meeting of the Resident and Fellow Section prior to the Interim Meeting of the House of Delegates. Elected resident and fellow sectional delegates and alternate delegates shall assume their office at the next Annual Meeting of the House of Delegates. ~~Each delegate and alternate delegate must receive written endorsement from a society or organization currently seated in the House of Delegates and in accordance with procedures adopted by the Resident and Fellow Section and approved by the Board of Trustees.~~

2.4.4 ~~Certification~~ Credentialing. The ~~C~~chair of the Resident and Fellow Section Governing Council, or the ~~C~~chair's designee, shall provide ~~certify to~~ the AMA Office of House of Delegates Affairs the names and contact information of the resident and fellow sectional delegates and alternate delegates elected in accordance with 2.4.3 by December 31 of each year ~~for the Resident and Fellow Section~~. These appropriately identified individuals shall be duly credentialed for each House of Delegates meeting within their term as defined in 2.4.5. ~~Certification of delegates and alternate delegates must occur at least 45 days prior to the Annual Meeting of the House of Delegates.~~

2.4.5 Term. Resident and fellow sectional ~~D~~delegates and alternate delegates ~~from the Resident and Fellow Section~~ shall be elected for one-year terms ~~and shall assume office on the date set by the Resident and Fellow Section Governing Council~~.

2.4.6 Vacancies. A resident or fellow who fills a vacancy for a resident and fellow sectional delegate or alternate delegate must have been elected by the Resident and Fellow Section. The delegate or alternate delegate ~~s~~elected to fill a vacancy shall assume office immediately after ~~s~~election and serve for the remainder of the term.

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2.6 Other Delegates. Each of the following is entitled to a delegate: AMA Sections; the Surgeons General of the United States Army, United States Navy, United States Air Force, and United States Public Health Service; the Chief Medical Director of the Department of Veterans Affairs; the National Medical Association; the American Medical Women's Association; the American Osteopathic Association; and professional interest medical associations granted representation in the House of Delegates.

2.6.1 ~~Certification~~ Credentialing. The president, chief executive officer, chair, or other authorized individual of each entity described above shall provide ~~certify to~~ the AMA Office of House of Delegates Affairs with the names and contact information of their respective delegate and alternate delegate at least 45 days prior to each ~~the Annual or Interim M~~meeting of the House of Delegates.

2.6.2 Term. Delegates from these entities shall be selected for 2-year terms, and shall assume office on the date set by the entity. ~~Certification~~ Credentialing of delegates and alternate delegates must occur at least 45 days prior to the Annual or Interim Meeting of the House of Delegates.

2.6.3 Vacancies. The delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of that term.

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2.8 Alternate Delegates. Each organization represented in the House of Delegates may select an alternate delegate for each of its delegates entitled to be seated in the House of Delegates.

2.8.1 Qualifications. Alternate delegates must be active members of the AMA and of the entity they represent.

2.8.2 ~~Certification~~ Credentialing. Alternate delegates, with the exception of medical student regional and resident and fellow sectional alternate delegates, shall be ~~certified~~ credentialed ~~to the AMA~~ in the same manner as delegates at least 45 days prior to each meeting of the House of Delegates.

2.8.3 Term. Alternate delegates shall be selected for a 2-year term, and shall assume office on the date set by the organization, unless otherwise provided in these Bylaws.

2.8.4 Vacancies. Alternate delegates selected to fill a vacancy shall assume office immediately after selection and shall serve for the remainder of that term.

2.8.5 Rights and Privileges. At the request of their corresponding delegate, a~~A~~n alternate delegate may temporarily be seated for them ~~substitute for a delegate,~~ on the floor of the House of Delegates~~, at the request of the delegate by complying with the procedures established by the Committee on Rules and Credentials~~. The alternate delegate must display their corresponding delegate's temporary credential and may then assume their privilege of the floor. ~~While substituting for a delegate, the alternate delegate may speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, and vote.~~

2.8.6 Status. The alternate delegate is not a "member of the House of Delegates" as that term is used in these Bylaws. Accordingly, an alternate delegate may not introduce resolutions into the House of Delegates~~, n~~or vote in any election conducted by the House of Delegates. An alternate delegate is not eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates. The alternate delegate must immediately relinquish their position on the floor of the House of Delegates upon the request of their corresponding delegate for whom they are ~~alternate delegate is substituting~~ temporarily seated.

2.10 Registration and Seating of Delegates.

2.10.1 Notification. In January of each year, the AMA shall notify each organization of the number of seats in the House of Delegates to which it is entitled during the current year.

~~**2.10.2 Credentials.** A delegate or alternate delegate may only be seated if there is certification on file stating that the delegate or alternate delegate has been properly selected to serve in the House of Delegates.~~

~~**2.10.3 Lack of Credentials.** A delegate or alternate delegate may be seated without the certificate defined in Bylaw 2.10.2 provided proper identification as the delegate or alternate delegate selected by the respective entity is established, and so certified to the AMA.~~

2.10.2

~~**2.10.4 Substitute**~~ **Temporary Delegate.** When a credentialed delegate or alternate delegate is unable to attend a meeting of the House of Delegates, or a portion thereof, the president~~, the president's designee~~ or the chief executive officer, or chair ~~other authorized individual~~ of the entity the vacating delegate represents, or their designee, may ~~appoint~~ credential a temporary ~~substitute~~ delegate or temporary ~~substitute~~ alternate delegate, who shall be eligible to serve as ~~such~~ a temporary delegate or temporary alternate delegate in the House of Delegates at that meeting only.

2.10.2.1 Temporary Delegates or Alternate Delegates for the AMA Sections. When a delegate from an AMA Section, other than the medical student regional and resident and fellow sectional delegates, is unable to attend a meeting of the House of Delegates, or a portion thereof, the alternate delegate from that section may be credentialed as the temporary delegate. When an alternate delegate, other than the medical student regional and resident and fellow sectional alternate delegates, from an AMA Section is unable to attend a meeting of the House of Delegates, or a portion thereof, a temporary alternate delegate may be selected and subsequently credentialed from among the members of the section governing council.

2.10.2.2 Temporary Medical Student Regional Alternate Delegate. A medical student meeting the requirements in Bylaw 2.3.1 who fills a temporary unfilled seat for a medical student regional alternate delegate must have been elected at a special election with an endorsement from a

constituent association within the same medical student region as the absent medical student. Temporary medical student regional alternate delegates may only serve at the meeting for which they were credentialed.

2.10.2.3 Temporary Resident and Fellow Sectional Alternate Delegates. A resident or fellow meeting the requirements in Bylaw 2.4.1 who fills a temporary unfilled seat for a resident and fellow sectional alternate delegate must be elected in a special election. Temporary resident and fellow sectional alternate delegates may only serve at the meeting for which they were credentialed.

~~**2.10.4.1 Temporary Substitute Delegate.** A delegate whose credentials have been accepted by the Committee on Rules and Credentials and whose name has been placed on the roll of the House of Delegates shall remain a delegate until final adjournment of that meeting of the House of Delegates. However, if the delegate is not able to remain in attendance, that delegate's place may be taken during the period of absence by an alternate delegate, or a substitute alternate delegate selected in accordance with Bylaw 2.10.4 if an alternate delegate is not available. The person who takes the place of the delegate must have certification on file and shall be known as a temporary substitute delegate. Such temporary substitute delegate shall have all of the rights and privileges of a delegate while serving as a temporary substitute delegate, including the right to vote in the House of Delegates and to vote in any election conducted by the House of Delegates. The temporary substitute delegate shall not be eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates.~~

[Subsequent bylaw provisions 2.10.5, 2.10.6 and 2.10.7 will be renumbered as 2.10.3, 2.10.4 and 2.10.5]

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2.10.6
~~**2.10.8**~~ **Medical Student Seating.** Each medical student regional delegate shall be seated with the student's endorsing constituent association. Alternate delegates or temporary ~~substitute~~ medical student regional delegates or alternate delegates shall be assigned to the original regional delegate's seat location during the time they are seated for the original delegate.

2.10.7
~~**2.10.9**~~ **Resident and Fellow Seating.** Each ~~delegate from the~~ ~~R~~resident and ~~F~~fellow ~~Section~~ sectional delegate shall be seated with ~~the physician's~~ their endorsing society or organization. ~~In the case where a delegate has been endorsed by multiple entities, the delegate must choose, prior to the election, with which delegation the delegate wishes to be seated.~~ Alternate delegates or temporary ~~substitute~~ resident and fellow sectional delegates and alternate delegates shall be assigned to the original delegate's seat location during the time they are seated for the original delegate.

(Modify Bylaws)

Appendix to Revised CCB Report 3

CLEAN BYLAW LANGUAGE WITH ALL CHANGES ACCEPTED

2—House of Delegates

2.0.1 Composition and Representation….

2.0.1.1 Qualification of Members of the House of Delegates. Members of the House of Delegates must be active members of the AMA and of the entity they represent.

2.0.1.2 Rights and Privileges. Delegates have the privilege of the floor of the House of Delegates which includes the ability to submit resolutions, discuss and make motions on items of business and vote in elections.

[subsequent section will be renumbered accordingly]

2.1 Constituent Associations….

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2.1.3 Credentialing. The president or chief executive officer of each constituent association, or their designee, shall provide the AMA Office of House of Delegates Affairs with the names and contact information of their delegates and alternate delegates at least 45 days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

2.1.4 Term. Delegates from constituent associations shall be selected for two-year terms and assume office on the date set by the constituent association, provided that such seats are authorized pursuant to these Bylaws. Constituent associations entitled to more than one delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.

2.1.5 Vacancies. The delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of that term.

2.1.6 Resident/Fellow Physician and Medical Student Delegates. A constituent association may designate one or more of its delegate and alternate delegate seats to be filled by a resident/fellow physician member or a medical student member.

2.1.6.1 Term. Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term beginning as of the date of certification of the delegate or alternate delegate by the constituent association to the AMA.

2.1.6.2 No Restriction on Selection. Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full 2-year term as a delegate or alternate delegate from a constituent association as provided in Bylaw 2.1.3.

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2.2 National Medical Specialty Societies….

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2.2.3 Credentialing. The president or chief executive officer of each specialty society, or their designee, shall provide ~~certify to~~ the AMA Office of House of Delegates Affairs with the names and contact information of their delegates and alternate delegates at least 45 days prior to each meeting of the House of Delegates. These appropriately identified individuals shall be duly credentialed for that meeting only.

2.2.4 Term. Delegates from specialty societies shall be selected for two-year terms, and shall assume office on the date set by the specialty society provided that such seats are authorized pursuant to these Bylaws. Specialty societies entitled to more than one delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.

2.2.5 Resident/Fellow Physician and Medical Student Delegates. A specialty association may designate one or more of its delegate and alternate delegate seats to be filled by a resident/fellow physician member or a medical student member.

2.2.5.1 Term. Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year.

2.2.5.2 No Restriction on Selection. Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full 2-year term as a delegate or alternate delegate from a specialty association as provided in Bylaw 2.2.3.

2.2.6 Vacancies. The delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of that term.

2.3 Medical Student Regional Delegates and Alternate Delegates. In addition to the delegate and alternate delegate representing the Medical Student Section, medical student regional delegates and regional alternate delegates shall be apportioned and elected as provided in this bylaw.

2.3.1 Qualifications. Medical student regional delegates and alternate delegates must be active medical student members of the AMA. In addition, medical student regional delegates and alternate delegates must be members of and have received written endorsement from the~~ir~~ constituent association where their educational program is located. The region in which the endorsing society is located determines the student's region, and a medical student may only serve as a regional delegate, alternate delegate or a temporary delegate or alternate delegate (pursuant to Bylaws 2.8.2 and 2.10.2) for that region.

2.3.2 Apportionment. The total number of medical student regional delegates and alternate delegates is based on one delegate and one alternate delegate for each 2,000 active medical student members of the AMA, as recorded by the AMA on December 31 of each year. Each Medical Student Region, as delineated in the rules of the Medical Student Section, is entitled to one delegate and one alternate delegate for each 2,000 active

medical student members of the AMA in an educational program located within the jurisdiction of the Medical Student Region. Any remaining medical student regional delegates and alternate delegates shall be apportioned one delegate and one alternate delegate per region(s) with the greatest number of active AMA medical student members in excess of a multiple of 2,000. If two regions have the same number of active AMA medical student members, ties will be broken by lottery by the Medical Student Section Governing Council.

2.3.2.1 Effective Date. In January of each year the AMA shall notify the chair of the Medical Student Section Governing Council of the number of seats in the House of Delegates to which each Medical Student Region is entitled. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.3.3 Election. Medical student regional delegates and alternates shall be elected by the Medical Student Section in accordance with procedures adopted by the Medical Student Section and approved by the Board of Trustees. Regional delegates and alternate delegates shall be elected in conjunction with ~~at~~ the Business Meeting of the Medical Student Section associated with the Interim Meeting of the House of Delegates. Regional delegates and alternate delegates shall assume their office at the next Annual Meeting of the House of Delegates.

2.3.4 Credentialing. The chair of the Medical Student Section Governing Council, or the chair's designee, shall provide the AMA Office of House of Delegates Affairs with the names and contact information of the delegates and alternate delegates for each Medical Student Region elected in accordance with 2.3.3 by December 31 of each year. These appropriately identified individuals shall be duly credentialed for each House of Delegates meeting occurring within their term as defined in 2.3.5.

2.3.5 Term. Medical student regional delegates and alternate delegates shall be elected for one-year terms.

2.3.6 Vacancies. A medical student who fills a vacancy for a medical student regional delegate or alternate delegate must have been elected from the same medical student region as the vacating student. The delegate or alternate delegate elected to fill a vacancy shall assume office immediately after election and serve for the remainder of that term.

2.4 Resident and Fellow Sectional Delegates. In addition to the delegate and alternate delegate representing the Resident and Fellow Section, resident and fellow sectional delegates and alternate delegates shall be apportioned and elected in a manner as provided in this bylaw.

2.4.1 Qualifications. Resident and fellow sectional delegates and alternate delegates must be active members of the Resident and Fellow Section of the AMA. In addition, resident and fellow sectional delegates and alternate delegates must be members of and have written endorsement from a society or organization currently seated in the HOD, in a capacity appropriate to their level of training.

2.4.2 Apportionment. The apportionment of resident and fellow sectional delegates is one delegate for each 2,000 active resident and fellow physician members of the AMA, as recorded by the AMA on December 31 of each year.

2.4.2.1 Effective Date. In January of each year, the AMA shall notify the chair of the Resident and Fellow Section Governing Council of the number of seats in the House of Delegates to which the Resident and Fellow Section is entitled. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.4.3 Election. Resident and fellow sectional delegates and alternate delegates shall be elected by the Resident and Fellow Section in accordance with procedures adopted by the Section and approved by the Board of Trustees. Resident and fellow sectional delegates and alternate delegates shall be elected at the Business Meeting of the Resident and Fellow Section prior to the Interim Meeting of the House of Delegates. Elected resident and fellow sectional delegates and alternate delegates shall assume their office at the next Annual Meeting of the House of Delegates.

2.4.4 Credentialing. The chair of the Resident and Fellow Section Governing Council, or the chair's designee, shall provide the AMA Office of House of Delegates Affairs the names and contact information of the resident and fellow sectional delegates and alternate delegates elected in accordance with 2.4.3 by December 31 of each year. These appropriately identified individuals shall be duly credentialed for each House of Delegates meeting within their term as defined in 2.4.5.

2.4.5 Term. Resident and fellow sectional delegates and alternate delegates shall be elected for one-year terms.

2.4.6 Vacancies. A resident or fellow who fills a vacancy for a resident and fellow sectional delegate or alternate delegate must have been elected by the Resident and Fellow Section. The delegate or alternate delegate elected to fill a vacancy shall assume office immediately after election and serve for the remainder of that term.

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2.6 Other Delegates. Each of the following is entitled to a delegate: AMA Sections; the Surgeons General of the United States Army, United States Navy, United States Air Force, and United States Public Health Service; the Chief Medical Director of the Department of Veterans Affairs; the National Medical Association; the American Medical Women's Association; the American Osteopathic Association; and professional interest medical associations granted representation in the House of Delegates.

2.6.1 Credentialing. The president, chief executive officer, chair, or other authorized individual of each entity described above shall provide the AMA Office of House of Delegates Affairs with the names and contact information of their respective delegate and alternate delegate at least 45 days prior to each meeting of the House of Delegates.

2.6.2 Term. Delegates from these entities shall be selected for 2-year terms, and shall assume office on the date set by the entity. Credentialing of delegates and alternate delegates must occur at least 45 days prior to the Annual or Interim Meeting of the House of Delegates.

2.6.3 Vacancies. The delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of that term.

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2.8 Alternate Delegates. Each organization represented in the House of Delegates may select an alternate delegate for each of its delegates entitled to be seated in the House of Delegates.

2.8.1 Qualifications. Alternate delegates must be active members of the AMA and of the entity they represent.

2.8.2 Credentialing. Alternate delegates, with the exception of medical student regional and resident and fellow sectional alternate delegates, shall be credentialed in the same manner as delegates at least 45 days prior to each meeting of the House of Delegates.

2.8.3 Term. Alternate delegates shall be selected for a 2-year term, and shall assume office on the date set by the organization, unless otherwise provided in these Bylaws.

2.8.4 Vacancies. Alternate delegates selected to fill a vacancy shall assume office immediately after selection and shall serve for the remainder of that term.

2.8.5 Rights and Privileges. At the request of their corresponding delegate, an alternate delegate may temporarily be seated for them~~,~~ on the floor of the House of Delegates. The alternate delegate must display their corresponding delegate's temporary credential and may then assume their privilege of the floor.

2.8.6 Status. The alternate delegate is not a "member of the House of Delegates" as that term is used in these Bylaws. Accordingly, an alternate delegate may not introduce resolutions into the House of Delegates or vote in any election conducted by the House of Delegates. An alternate delegate is not eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates. The alternate delegate must immediately relinquish their position on the floor of the House of Delegates upon the request of their corresponding delegate for whom they are-temporarily seated.

2.10 Registration and Seating of Delegates.

2.10.1 Notification. In January of each year, the AMA shall notify each organization of the number of seats in the House of Delegates to which it is entitled during the current year.

2.10.2 Temporary Delegate. When a credentialed delegate or alternate delegate is unable to attend a meeting of the House of Delegates, or a portion thereof, the president or the chief executive officer, or chair of the entity the vacating delegate represents, or their designee, may credential a temporary delegate or temporary alternate delegate, who shall be eligible to serve as a temporary delegate or temporary alternate delegate in the House of Delegates at that meeting only.

2.10.2.1 Temporary Delegates or Alternate Delegates for the AMA Sections. When a delegate from an AMA Section, other than the medical student regional and resident and fellow sectional delegates, is unable to attend a meeting of the House of Delegates, or a portion thereof, the alternate delegate from that section may be credentialed as the temporary delegate. When an alternate delegate, other than the medical student regional and resident and fellow sectional alternate delegates, from an AMA Section is unable to attend a meeting of the House of Delegates, or a portion thereof, a temporary alternate

delegate may be selected and subsequently credentialed from among the members of the section governing council.

2.10.2.2 Temporary Medical Student Regional Alternate Delegate. A medical student meeting the requirements in Bylaw 2.3.1 who fills a temporary unfilled seat for a medical student regional alternate delegate must have been elected at a special election with an endorsement from a constituent association within the same medical student region as the absent medical student. Temporary medical student regional alternate delegates may only serve at the meeting for which they were credentialed.

2.10.2.3 Temporary Resident and Fellow Sectional Alternate Delegates. A resident or fellow meeting the requirements in Bylaw 2.4.1 who fills a temporary unfilled seat for a resident and fellow sectional alternate delegate must be elected in a special election. Temporary resident and fellow sectional alternate delegates may only serve at the meeting for which they were credentialed.

[Subsequent bylaw provisions 2.10.5, 2.10.6 and 2.10.7 will be renumbered as 2.10.3, 2.10.4 and 2.10.5]

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2.10.6 Medical Student Seating. Each medical student regional delegate shall be seated with the student's endorsing constituent association. Alternate delegates or temporary medical student regional delegates or alternate delegates shall be assigned to the original regional delegate's seat location during the time they are seated for the original delegate.

2.10.7 Resident and Fellow Seating. Each resident and fellow sectional delegate shall be seated with their endorsing society or organization. Alternate delegates or temporary resident and fellow sectional delegates and alternate delegates shall be assigned to the original delegate's seat location during the time they are seated for the original delegate.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(I-25)

Introduced by: Resident and Fellow Section, Medical Student Section

Subject: Clarifying the Medical Student Section's and Resident and Fellow Section's Abilities to Fill Temporary Vacancies in Accordance with the AMA Bylaws

Referred to: Reference Committee on Ethics and Bylaws

Whereas, Section 2.10.4 of the AMA Bylaws provides that "When a delegate or alternate delegate is unable to attend a meeting of the House of Delegates, the president, the president's designee or other authorized individual of the entity may appoint a substitute delegate or substitute alternate delegate, who shall be eligible to serve as such delegate or alternate delegate in the House of Delegates at that meeting;" (B-2.10.4); and

Whereas, in September and October 2025, the Medical Student Section (MSS) and Resident and Fellow Section (RFS) Governing Councils received a series of memoranda from the AMA Speakers that ultimately informed them that AMA Bylaws 2.10 and its subsections do not apply to the MSS and RFS; and

Whereas, this was observed to be a novel interpretation of the AMA Bylaws and a departure from historical precedent under extant bylaws; and

Whereas, this notice created a distinct change in how the MSS and RFS had historically operated, as previous interpretation of the bylaws had allowed the MSS and RFS to appoint substitute delegates and alternate delegates as well as temporary substitute delegates and temporary substitute alternate delegates under section 2.10.4 which affords this capability to every other delegation in the House of Delegates; and

Whereas, the MSS and RFS submitted formal requests to the AMA Council on Ethical and Judicial Affairs (CEJA) to clarify the new interpretations of the bylaws; and

Whereas, until a final CEJA ruling is provided, the MSS and RFS have been instructed to operate in accordance with the bylaws interpretation that preceded the disputed reinterpretation; and

Whereas, in light of the lack of clarity surrounding the interpretation of the bylaws, a more explicit codification of the intent of the bylaws and past precedent would be beneficial so as to avoid ambiguity in interpretation in the future; therefore be it

RESOLVED, that our American Medical Association Bylaws be amended to explicitly affirm the ability of the Resident and Fellow Section to appoint substitute resident and fellow sectional delegates and alternate delegates as well as temporary substitute resident and fellow sectional delegates in accordance with procedures adopted by the Section as all other delegations to the House of Delegates are able to and without being held to a higher threshold of election (Modify Bylaws); and be it further

RESOLVED, that our AMA Bylaws be amended to explicitly affirm the ability of the Medical Student Section to appoint substitute medical student regional delegates and alternate delegates as well as temporary substitute medical student regional delegates in accordance with procedures adopted by the Section as all other delegations to the House of Delegates are able to and without being held to a higher threshold of election. (Modify Bylaws)

Fiscal Note: Minimal – less than $1,000

Received: 11/14/25

RELEVANT AMA POLICY

Registration and Seating of Delegates. B-2.10
2.10.1 Notification. In January of each year, our American Medical Association shall notify each organization of the number of seats in the House of Delegates to which it is entitled during the current year.
2.10.2 Credentials. A delegate or alternate delegate may only be seated if there is certification on file stating that the delegate or alternate delegate has been properly selected to serve in the House of Delegates.
2.10.3 Lack of Credentials. A delegate or alternate delegate may be seated without the certificate defined in Bylaw 2.10.2 provided proper identification as the delegate or alternate delegate selected by the respective entity is established, and so certified to the AMA.
2.10.4 Substitute. When a delegate or alternate delegate is unable to attend a meeting of the House of Delegates, the president, the president's designee or other authorized individual of the entity may appoint a substitute delegate or substitute alternate delegate, who shall be eligible to serve as such delegate or alternate delegate in the House of Delegates at that meeting.
2.10.4.1 Temporary Substitute Delegate. A delegate whose credentials have been accepted by the Committee on Rules and Credentials and whose name has been placed on the roll of the House of Delegates shall remain a delegate until final adjournment of that meeting of the House of Delegates. However, if the delegate is not able to remain in attendance, that place of that delegate may be taken during the period of absence by an alternate delegate, or a substitute alternate delegate selected in accordance with Bylaw 2.10.4 if an alternate delegate is not available. The person who takes the place of the delegate must have certification on file and shall be known as a temporary substitute delegate. Such temporary substitute delegate shall have all of the rights and privileges of a delegate while serving as a temporary substitute delegate, including the right to vote in the House of Delegates and to vote in any election conducted by the House of Delegates. The temporary substitute delegate shall not be eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates.
2.10.5 Constituent Association President. The current president of a constituent association may also be certified as an additional alternate delegate at the discretion of each constituent association.
2.10.6 National Medical Specialty Society or Professional Interest Medical Association President. The current president of a national medical specialty society or a professional interest medical association may also be certified as an additional alternate delegate at the discretion of each national medical specialty society or professional interest medical association.
2.10.7 Representation. No delegate or alternate delegate may be credentialed or seated at any meeting to represent more than one organization in the House of Delegates.
2.10.8 Medical Student Seating. Each medical student regional delegate shall be seated with the student's endorsing constituent association. Alternate or substitute delegates shall be assigned to the original regional delegate's seat location during the time they are seated for the original delegate.
2.10.9 Resident and Fellow Seating. Each delegate from the Resident and Fellow Section shall be seated with the physician's endorsing society or organization. In the case where a delegate has been endorsed by multiple entities, the delegate must choose, prior to the election, with which delegation the delegate wishes to be seated. Alternate or substitute delegates shall be assigned to the original delegate's seat location during the time they are seated for the original delegate.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(I-25)

Introduced by: Resident and Fellow Section

Subject: Hardship for International Medical Graduates from Palestine

Referred to: Reference Committee C

Whereas, Palestinians are experiencing a severe humanitarian and medical crisis due to the Israel-Palestine conflict[1]; and

Whereas, Gaza's only two medical schools have been destroyed during this conflict, leaving Palestinian physicians without the ability to obtain primary-source verification of their medical education[2]; and

Whereas, many U.S. states require additional verification for international medical graduates (IMGs) beyond the Federation Credentials Verification Service (FCVS) profile in order to issue state medical licenses; and

Whereas, the nationwide physician shortage highlighted during the COVID-19 pandemic underscores the importance of enabling physicians to hold multiple state licenses to serve underserved areas; and

Whereas, the U.S. government has targeted Palestinian passport holders, creating additional barriers for Palestinian physicians who wish to train in the United States, which is in direct opposition to AMA policy D-255.980 Impact of Immigration Barriers on the Nation's Health[4]; and

Whereas, our AMA has current policy D-255.974 Hardship for International Medical Graduates from Ukraine, which states that our AMA will advocate for a hardship waiver for primary source verification of medical education for all licensing requirements for Ukraine medical school graduates until the humanitarian crisis is resolved; therefore be it

RESOLVED, that our American Medical Association advocate with relevant stakeholders that advise state medical boards to develop alternative pathways such as a hardship waiver for primary source verification of medical education for all licensing requirements for physicians who graduated from medical schools in Palestine until the current humanitarian crisis in Palestine is resolved (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate with relevant stakeholders to consider waiving the requirement that the Statement of Need for visa application come directly from a federal/central Ministry of Health office for Palestinian physicians who matched to the residency or fellowship in the U.S. until the resolution of the current humanitarian crisis in Palestine. (Directive to Take Action)

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

Received: 11/14/25

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RELEVANT AMA POLICY

Hardship for International Medical Graduates from Ukraine D-255.974
Our American Medical Association will advocate with relevant stakeholders that advise state medical boards to grant hardship waiver for primary source verification of medical education for all licensing requirements for physicians who graduated from medical schools in Ukraine until the current humanitarian crisis in Ukraine is resolved. [Res. 019, A-22]

International Medical Graduate Employment H-255.965
Our American Medical Association will support federal legislation that reduces the administrative burden and streamlines the process of hiring International Medical Graduates. [Res. 203, I-22]

Expedited H-1B Pathways for International Medical Graduate Physicians in the USA H-255.961
Our American Medical Association supports the continuance of premium processing and other mechanisms that expedite H-1B visa applications and renewals for International Medical Graduate physicians. [Res. 222, A-25]

Impact of Immigration Barriers on the Nation's Health D-255.980
1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine. 2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion. 3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion. 4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care. 5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice. 6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S. [Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 210, A-23]

Support for International Medical Graduates from Countries Facing Major Humanitarian Crises H255.962
1. Our American Medical Association affirms its support and will advocate for immigrant physicians and trainees working in the United States when their country of origin faces major humanitarian crises, regardless of their country's political alignment, to promote an understanding of the challenges specific to immigrant physicians. 2. Our AMA will support the development and implementation of channels of communication for immigrant physicians to share their personal and professional journey when facing severe destruction, humanitarian crises, or personal losses in their country of origin, contributing therefore to improving the understanding of the difficulties faced by immigrant physicians. [Res. 314, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(I-25)

Introduced by: Medical Student Section

Subject: Upholding Professional Integrity and Ethical Leadership through Continued Publication of the AMA Journal of Ethics

Referred to: Reference Committee F

Whereas, the *AMA Journal of Ethics* is the only major open-access, peer-reviewed ethics journal published by a national medical association and for over 25 years has served as a core educational and professional resource to guide medical students, physicians, and other health care professionals in making sound ethical decisions in service to patients and society[1]; and

Whereas, in early November 2025, the editor in chief of the *AMA Journal of Ethics* announced that it would cease publishing new content after December 2025[2]; and

Whereas, the *AMA Journal of Ethics* serves as a bridge between clinical practice and health law, providing commentaries and expert analyses that inform legislative and regulatory debates on topics ranging from the corporate practice of medicine to the integration of artificial intelligence technologies to the challenges of end-of-life care[3-6]; and

Whereas, as an exclusively digital, open-access publication, the journal achieves broad dissemination and citations, including over 3.1 million website visits and 37,000 podcast downloads in 2024 alone, which promotes reputational value and educational benefits[7-10]; and

Whereas, the *AMA Journal of Ethics* advances the AMA's core mission "to promote the art and science of medicine and the betterment of public health" by disseminating key educational resources, including case-based reflections from students and physicians that cover the full spectrum of learning objectives fundamental to ethics education in medical school[11,12]; and

Whereas, of the 247 editorial fellows credited for issues in the *AMA Journal of Ethics* since December 2003, 133 (53.8%) were students pursuing medical or other advanced degrees and 77 (31.2%) were residents or fellows[13]; and

Whereas, the discontinuation of the AMA Journal of Ethics has eliminated editorial fellowship and publication opportunities that previously empowered medical students, residents, and early-career physicians to investigate and drive timely conversations on ethics and professionalism[14-16]; and

Whereas, the AMA was in part founded to establish the world's first national code of ethics for physicians, emphasizing ethics as a foundational pillar for the AMA, and ceasing publication of the *AMA Journal of Ethics* may be seen as the AMA deprioritizing ethics at a time when public trust in health care is at an all-time low[17-19]; and

Whereas, amidst increasing commercial, technological, and governmental pressures on medicine, the *AMA Journal of Ethics* is a necessary expression of the AMA's commitment to its own Code of Ethics, simultaneously reinforcing its reputation as a leader in medicine and

education and strengthening its relationships with current and future members as well as the public; therefore be it

RESOLVED, that our American Medical Association reaffirm its commitment to sustaining accessible, physician-led education and discourse on the ethical challenges in medicine (New HOD Policy); and be it further

RESOLVED, that our AMA maintain current funding and operations of the *AMA Journal of Ethics* through at least the end of fiscal year 2027 (Directive to Take Action); and be it further

RESOLVED, that our AMA study and report back with recommendations on how our organization can maintain leadership in medical ethics education, including an investigation of more sustainable or alternative publishing models for the *AMA Journal of Ethics* (Directive to Take Action); and be it further

RESOLVED, that our AMA support the continued work, dissemination, and publication of the *AMA Journal of Ethics.* (New HOD Policy)

Fiscal Note: Major - $1.5 to $2 million annually

Received: 11/14/2025

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RELEVANT AMA POLICY

H-300.982 Maintaining Competence of Health Professionals
(1) Health professionals are individually responsible for maintaining their competence and for participating in continuing education; all health professionals should be engaged in self-selected programs of continuing education. In the absence of other financial support, individual health professionals should be responsible for the cost of their own continuing education. (2) Professional schools and health professions organizations should develop additional continuing education self-assessment programs, should prepare guides to continuing education programs to be taken by practitioners throughout their careers, and should make efforts to ensure that acceptable programs of continuing education are available to practitioners. (3) Health professions organizations and faculty of programs of health professions education should develop standards of competence. Such standards should be reviewed and revised periodically. (4) When reliable and cost-effective means of assessing continuing competence are developed, they should be required for continued practice. (5) Patient relations and ethics are appropriate subjects for continuing education; educational providers should increase the offering in these fields.
[BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: BOT Rep. 17, A-04; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: BOT Rep. 13, A-19]

H-295.961 Medicolegal, Political, Ethical, and Economic Medical School Course
(1) The AMA urge every medical school and residency program to teach the legal, political, ethical and economic issues which will affect physicians. (2) The AMA will work with state and county medical societies to identify and provide speakers, information sources, etc., to assist with the courses. (3) An assessment of professional and ethical behavior, such as exemplified in the AMA Principles of Medical Ethics, should be included in internal evaluations during medical school and residency training, and also in evaluations utilized for licensure and certification. (4) The Speaker of the HOD shall determine the most appropriate way for assembled physicians at the opening sessions of the AMA House of Delegates Annual and Interim Meetings to renew their commitment to the standards of conduct which define the essentials of honorable behavior for the physician, by reaffirming or reciting the seven Principles of Medical Ethics which constitute current AMA policy. (5) There should be attention to subject matter related to ethics and to the doctor-patient relationship at all levels of medical education: undergraduate, graduate, and continuing. Role modeling should be a key element in helping medical students and resident physicians to develop and maintain professionalism and high ethical standards. (6) There should be exploration of the feasibility of improving an assessment of ethical qualities in the admissions process to medical school. (7) Our AMA pledges support to the concept that professional attitudes, values, and behaviors should form an integral part of medical education across the continuum of undergraduate, graduate, and continuing medical education.
[Res. 189, A-90; Modified by CME Rep. 1, I-95; Appended: Res. 318, I-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed in lieu of Res. 902, I-13; Reaffirmation I-15; Reaffirmed: CEJA Rep. 11, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(I-25)

Introduced by: Resident and Fellow Section

Subject: Sustaining Ethical Leadership Through Continued Support of the *AMA Journal of Ethics*

Referred to: Reference Committee F

Whereas, medical ethics help provide a framework to “prioritize patients’ well-being, dignity, and trust,” as well as to safeguard the integrity of the physician-patient relationship[1]; and

Whereas, the American Medical Association was in part founded to establish the national code of ethics for physicians[2], emphasizing ethics as a foundational pillar for the AMA; and

Whereas, the AMA has a longstanding policy underscoring the importance of developing, educating on, and enforcing ethical standards in medicine, including, but not limited to, H-140.951 and H-140.964; and

Whereas, the AMA Journal of Ethics is an editorially independent, peer-reviewed journal dedicated to helping students, trainees, and clinicians navigate ethical decisions and nuanced challenges in patient care, health care leadership, education, research, and policy[3,4]; and

Whereas, the AMA Journal of Ethics is widely accessible and disseminates information to the broader public, exploring emerging ethical issues for physicians and trainees, facilitating engagement among the broader public, and cultivating physician ethical scholars through its editorial fellowships[3,4]; and

Whereas, the AMA Journal of Ethics functions without a subscription charge, making possible over 3.1 million website visits and 37,000 podcast downloads in 2024 alone[4]; and

Whereas, the H-index and SJR metric assess a journal's productivity and citation impact, and the AMA Journal of Ethics ranked 16th out of 50 based on the H-index and ranked 19th out of 50 based on the SJR metric when compared to other journals included in the “Issues, Ethics, and Legal Aspects” category[5]; and

Whereas, in the current dawn of augmented intelligence (AI), ethical AMA leadership is more crucial than ever to protect the standards of clinical practice, professional integrity, patient privacy, data security, informed consent, patient autonomy, health equity, and social responsibility, including the just and conscientious use of AI and emerging technologies, guided by moral reasoning, responsibility, and fairness[6]; and

Whereas, the JAMA Summit Report on Artificial Intelligence explicitly recognizes that "important ethical and legal issues will affect adoption of health and health care AI" including data rights, privacy, ownership, and the deployment of AI[7]; and

Whereas, the AMA Journal of Ethics, after more than 25 years of monthly open-access publication, stated that it “will cease publishing new content after December 2025,” though

previously published content will remain available[4]; and

Whereas, the cessation of new content in the AMA Journal of Ethics comes amid the rapid adoption of AI and automation in healthcare, risking a void in accessible, peer-reviewed ethics, and the journal upholds empathy, equity, justice, and self-reflection, which are values critically necessary and readily endangered during this time; therefore be it

RESOLVED, that our American Medical Association support the continued work, dissemination, and publication of the AMA Journal of Ethics to address ethical challenges in healthcare (New HOD Policy); and be it further

RESOLVED, that our AMA reaffirm its commitment to sustaining accessible, physician-led ethics education and discourse. (New HOD Policy)

Fiscal Note: Major – $1.5 to $2 million annually

Received: 11/14/25

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RELEVANT AMA POLICY

Enforcement of Code of Ethics H-140.964

1. It is the policy of our American Medical Association to make appropriate education and enforcement of its ethical guidelines a priority.
2. It is the policy of our AMA with the input and consent of the Federation, to begin a process to coordinate the Federation, including specialty societies and hospital medical staffs, in joint efforts to better communicate and enforce ethical standards.

[BOT Rep. BBB, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11;Reaffirmed: CEJA Rep. 1, A-21]

Professionalism in Medicine H-140.951

Our American Medical Association believes that the primary mission of the physician is to use best efforts and skill in the care of patients and to be mindful of those forces in society that would erode fundamental ethical medical practice. The AMA affirms that the medical profession is solely responsible for establishing and maintaining standards of professional medical ethics and that the state neither legislate ethical standards nor excuse physicians from their ethical obligations. The AMA House of Delegates, Board of Trustees, staff, and membership rededicate themselves to professionalism such that it permeates all activities and is the defining characteristic of the AMA's identity.

[Res. 4, A-95; Reaffirmed: CEJA Rep. 2, A-05; Reaffirmation I-09; Consolidated: CEJA Rep. 03, A-19; Modified: Speakers Rep. 02, I-24]

The AMA Code of Medical Ethics Evolving to Provide Health Care Systems Ethics Guidance H-140.818
Our AMA supports the continued evolution of the Code of Medical Ethics in addressing how health care organizations and physicians can work together in meeting their mutual obligations to serve patients and the public. [CEJA Rep. 01, A-25]

11.2.1 Professionalism in Health Care Systems

1. Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.
2. Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.
3. Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.
4. Formularies, clinical practice guidelines, decision support tools that rely on augmented intelligence, and other mechanisms intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.
5. Physicians in leadership positions within health care organizations and the profession should:

(a) Ensure that decisions to implement practices or tools for organizing the delivery of care are transparent and reflect input from key stakeholders, including physicians and patients.
(b) Recognize that over reliance on financial incentives or other tools to influence clinical decision making may undermine physician professionalism.
(c) Ensure that all such tools:
(i) are designed in keeping with sound principles and solid scientific evidence.
a. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles.
b. Practice guidelines, formularies, and similar tools should be based on best available evidence and developed in keeping with ethics guidance.
c. Clinical prediction models, decision support tools, and similar tools such as those that rely on AI technology must rest on the highest-quality data and be independently validated in relevantly similar populations of patients and care settings.

(ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;
(iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;
(iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.
(d) Encourage, rather than discourage, physicians (and others) to:
(i) provide care for patients with difficult to manage medical conditions;
(ii) practice at their full capacity, but not beyond.
(e) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.
(f) Ensure that the use of financial incentives and other tools is routinely monitored to:
(i) identify and address adverse consequences;
(ii) identify and encourage dissemination of positive outcomes.

6. All physicians should:
   (g) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.
   (h) Advocate for changes in how the delivery of care is organized to promote access to high-quality care for all patients.

AMA Principles of Medical Ethics: I,II III,V
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Resolutions not for Consideration

Resolutions

235	Ensuring Medical Liability Insurance Transparency and Continuity
302	Increasing the Use of Retired Physicians in Teaching Students and Residents
303	Expanding Graduate Medical Education to Address Rural Primary Care Shortage
309	Reasonable Workplace Accommodations for Residents and Fellows During Pregnancy
310	Remedying the Harms of AMA's Role in the Flexner Report
312*	Promoting the Equitable Evaluation of Non-Research Domains in Trainee Selection
801	Excessive Cost of Multi-State DEA Licensure
803	Ensuring Physician Input in the Development of Alternative Payment Models (APMs)
810	Opposing Unilateral Downcoding of Physician Services by Insurance Companies
820	Establishing an AMA "First Responder Team" for Real-Time Physician Advocacy Against Adverse Insurance Company Actions
902	Advocating for Improvements in Systems of Care for Autism
910	Increasing Funding for Gynecological Cancer Research
913	Establish AMA Policy and Project to Compile and Distribute JAMA Patient Pages to Enhance Public Medical Literacy
914	Develop Climate-Conscious Resources for Physicians
915	Reduce Environmental Impact of Medical Journals
916	Studying the Environmental Impact of Ambient Clinical Intelligence Use
928	AMA's Continued Support for COVID-19 Vaccination in Pregnant Individuals
934*	Partnership with the Administration to Reduce Harmful Chemicals in Food and Align with European Safety Standards

**Contained in Meeting Tote*

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(I-25)

Introduced by: Medical Student Section

Subject: Promoting the Equitable Evaluation of Non-Research Domains in Trainee Selection

Referred to: Reference Committee C

Whereas, the AAMC has developed a Holistic Review Model that encourages residency programs to "select/rank a cohort of learners encompassing the complementary experiences, qualities, and characteristics needed to achieve their institutional and program mission and goals"[1]; and

Whereas, the Accreditation Council for Graduate Medical Education (ACGME) has already specified the need for advocacy to be taught in residency curricula, while no such requirements exist for medical school accreditation by the Liaison Committee on Medical Education (LCME)[2,3]; and

Whereas, service, teaching, and advocacy (including participation in organized medicine) are critical for developing a diverse and talented pool of physicians and trainees who can advance the art and science of medicine and the betterment of public health amid extensive systemic issues[1,4]; and

Whereas, program directors desire applicants with research experiences because they demonstrate transferable skills like critical thinking and curiosity that can be similarly developed through significant advocacy and leadership activities[5]; and

Whereas, a disproportionate focus on research and publications by residency programs may discount applicants who do not have access to research opportunities or have demonstrated their passion and talent in other equally valuable domains, including service, teaching, advocacy, volunteer work, clinical experiences, or leadership roles[6]; and

Whereas, the current sections of the ERAS application place a greater emphasis on research compared to other domains of interest in that ERAS lists "Research" as one of eight Experience Types while combining "Volunteer/service/advocacy" into one category; and

Whereas, the average number of publications reported by applicants for competitive specialties continues to rise despite limited evidence that these research experiences are associated with clinical performance in residency[7,8,9]; and

Whereas, on October 22, 2025, the AAMC announced that the ERAS Publications Section would be converted into a Scholarly Works section for the 2027 cycle and beyond, which would remove the ability to list publications that are not peer-reviewed[10]; and

Whereas, this would further disproportionately bias the evaluation of residency/fellowship applications towards peer-reviewed scientific research while actively limiting the consideration of

other works (including resolutions and Op-Eds) that may demonstrate a candidate's strengths and suitability for a given program; and

Whereas, the loss of structured opportunities to list these key experiences actively harms the ability of programs to fairly and holistically review applicants and would result in highly inequitable consideration of candidates for these programs; and

Whereas, helping applicants showcase these accomplishments on residency/fellowship applications has been a key priority of our AMA[11-13]; therefore be it

RESOLVED, that our American Medical Association support efforts and work with relevant parties to:

a) Improve the holistic and equitable consideration of research, advocacy, service, teaching, mentorship, and other non-research domains in medical school and residency/fellowship selection; and
b) Reduce the emphasis on research expectations for applicants; and
c) Improve medical school and residency/fellowship application services to allow applicants to comprehensively showcase the non-research domains that best align with their experiences and career goals. (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

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RELEVANT AMA POLICY

D-200.985 Strategies for Enhancing Diversity in the Physician Workforce

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

H-460.930 Importance of Clinical Research
(1) Given the profound importance of clinical research as the transition between basic science discoveries and standard medical practice of the future, the AMA will a) be an advocate for clinical research; and b) promote the importance of this science and of well-trained researchers to conduct it.
(2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense.
(3) The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the research bench to medical practice. The AMA strongly encourages these groups to make significant financial contributions to support such research.
(4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research.
(5) Our AMA encourages and supports development of community and practice-based clinical research networks.
[CSA Rep. 2, I-96; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: CME Rep. 4, I-08; Modified: CSAPH Rep. 01, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 934
(I-25)

Introduced by: Organized Medical Staff Section

Subject: Partnership with the Administration to Reduce Harmful Chemicals in Food and Align with European Safety Standards

Referred to: Reference Committee K

Whereas, the American Medical Association recognizes that food safety and the reduction of harmful chemical additives in the food supply represents a critical public health priority affecting millions of Americans; and

Whereas, the European Union has implemented more stringent regulations regarding food additives, artificial colors, preservatives, and other chemical substances, resulting in significantly lower exposure rates to potentially harmful compounds compared to the United States; and

Whereas, numerous peer-reviewed studies have linked certain food additives commonly used in the United States—including artificial food dyes, certain preservatives, and flavor enhancers—to adverse health outcomes including hyperactivity in children, allergic reactions, and potential carcinogenic effects; and

Whereas, the current U.S. food regulatory framework allows the use of over 3,000 food additives, many of which are prohibited or restricted in European markets due to safety concerns; and

Whereas, American families deserve access to food products that meet the same safety standards enjoyed by consumers in Europe and other developed nations; and

Whereas, the Trump Administration has expressed commitment to improving American health outcomes and reducing regulatory barriers that may impede food safety improvements; and

Whereas, collaboration between medical professionals and government agencies is essential to develop evidence-based policies that protect public health while supporting American food producers and manufacturers; therefore be it

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

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

(Directive to Take Action); and be it further

RESOLVED, that our AMA will monitor the implementation of any resulting food additive regulation policies and provide ongoing medical and scientific guidance to ensure reforms achieve meaningful public health improvements. (Directive to Take Action)

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

Received: 11/14/25

RELEVANT AMA POLICY

Food Safety - Federal Inspection Programs H-150.967

Our American Medical Association encourages the FDA and the U.S. Department of Agriculture to continue their efforts to assure the safety of the food supply. Inspection of meat, poultry, and seafood should be viewed as one component of an overall program for improving food safety.
Citation: CSA Rep. L, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21

FDA Drug Safety Policies D-100.978

Our American Medical Association will monitor and respond, as appropriate, to the implementation of the drug safety provisions of the Food and Drug Administration Amendments Act of 2007 (FDAAA; P.L. 110-85) so that the Food and Drug Administration can more effectively ensure the safety of drug products for our patients. Citation: Sub. Res. 505, A-08; Reaffirmed: CSAPH Rep. 1, A-21

Addressing the Health Impacts of Ultraprocessed Foods H-150.914

1. Our AMA supports and promotes public awareness and education about the differences between healthful foods and unhealthful ultraprocessed foods (UPF) and the benefits of minimally processed and unprocessed foods.
2. Our AMA supports federal, state, and local policies that promote and incentivize the production and distribution of healthier, affordable, minimally-processed and unprocessed foods.
3. Our AMA encourages the integration of nutrition education into all levels of medical education to empower clinicians to best counsel patients efficiently and effectively on reducing unhealthful UPF consumption.
4. Our AMA supports increased funding to the FDA for research into the health impacts of ultraprocessed foods and strategies to mitigate their risks.

Citation: Res. 430, A-25

Reform the US Farm Bill to Improve US Public Health and Food Sustainability H-150.932

Reform the US Farm Bill to Improve US Public Health and Food Sustainability: Our American Medical Association supports the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders.
Citation: Res. 215, A-13; Reaffirmed: BOT Rep. 09, A-23

Strategies to Reduce the Consumption of Food and Beverages with Added Sweeteners H-150.927

1. Our American Medical Association acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption and food products with added sugars, and support evidence-based strategies to reduce the consumption of SSBs and food products with added sugars, including but not limited to, excise taxes on SSBs and food products with added sugars, removing options to purchase SSBs and food products with added sugars in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption and food products with added sugars, and the use of plain packaging.
2. Our AMA encourages continued research into strategies that may be effective in limiting SSB consumption and food products with added sugars, such as controlling portion sizes; limiting options to purchase or access SSBs and food products with added sugars in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs and food products with added sugars to children; and changes to the agricultural subsidies system.
3. Our AMA encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price.
4. Our AMA encourages physicians to
    a. counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with healthier beverage and food choices, as recommended by professional society clinical guidelines.
    b. work with local school districts to promote healthy beverage and food choices for students.
5. Our AMA recommends that taxes on food and beverage products with added sugars be enacted in such a way that the economic burden is borne by companies and not by individuals and families with limited access to food alternatives.
6. Our AMA supports that any excise taxes are reinvested in community programs promoting health.
7. Our AMA will advocate for the end of tax subsidies for advertisements that promote among children the consumption of food and drink of poor nutritional quality, as defined by appropriate nutritional guiding principles.

Citation: CSAPH Rep. 03, A-17; Modified: Res. 429, A-22

Fast Food H-150.979

The AMA encourages fast food restaurants to reduce the saturated fat content of their foods, as well as to offer low fat alternatives to highly saturated fat foods.
Citation: Sub. Res. 123, A-86; Amended by Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16

Increasing Awareness of Nutrition Information and Ingredient Lists H-150.948

Our American Medical Association supports legislation or rules requiring restaurants, retail food establishments, and vending machine operators that have menu items common to multiple locations, as well as all school and workplace cafeterias, especially those located in health care facilities, to have available for public viewing ingredient lists, nutritional information, and standard nutrition labels for all menu items.
Citation: Sub. Res. 411, A-04; Reaffirmed: A-07; Reaffirmed in lieu of Res. 413, A-09 and Res. 418, A-09; Modified: BOT Rep. 1, A-14; Modified: CSAPH Rep. 01, A-24

The Health Effects of High Fructose Syrup H-150.919

1. Our American Medical Association recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS.
2. Our AMA encourages independent research (including epidemiological studies) on the health effects of HFCS and other added sugars, and evaluation of the mechanism of action and relationship between fructose dose and response.
3. Our AMA in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added sugars in their diet.

Citation: CSAPH Rep. 8, A-23

Food Additives H-150.998

Our American Medical Association supports the passage of legislation that would amend the Food Additive Act to require evidence based upon scientifically reproducible studies of the association of food additives with an increased incidence of cancer in animals or humans at dosage levels related to the amounts calculated as normal daily consumption for humans before removal of an additive from the market.
Citation: Sub. Res. 4, A-776; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 6, A-10; Reaffirmed; BOT Rep. 7, A-21

Summary of Fiscal Notes I-25

Report(s) of the Board of Trustees

01	Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis	Minimal
02	Laser Surgery	Minimal
03	Stark Law Self-Referral Ban	Minimal
04	Addressing and Reducing Patient Boarding in Emergency Departments (EDs)	Minimal
05	Addressing the Unregulated Body Brokerage Industry	Moderate
06	Information Blocking Rule	Minimal
07	Codification of the Chevron Deference Doctrine	Minimal
08	On the Ethics of Human Lifespan Prolongation	Minimal
09	2025 AMA Advocacy Efforts	Info. Report
10	Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients	Moderate
11	Supporting Diversity in Research	Minimal
12	Support For Doula Care Programs	Minimal
13	Antidiscrimination Protections for LGBTQ+ Youth in Foster Care	Minimal
14	AMA Efforts on Medicare Payment Reform and Increasing Transparency of AMA Medicare Payment Reform Strategy	Info. Report
15	Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research Report	Minimal
16	Preservation of Medicaid	Minimal
17	Establishing an Advisory Committee on AI/AN Affairs	
18	Published Metrics for Hospitals and Hospital Systems	Minimal
19	Addressing the Historical Injustices of Anatomical Specimen Use	Minimal
20	AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates	Info. Report
21	Specialty Society Representation in the House of Delegates - Five-Year Review	Minimal
22	Physician Assistant and Nurse Practitioner Movement Between Specialties	Minimal
23	Accreditation Council for Continuing Medical Education Observer Status in the House of Delegates	Minimal
24	Amending Vaccine-related Policies	Minimal

Report(s) of the Council on Constitution and Bylaws

01	Bylaws Review Report	Minimal
02	Bylaws Clarifications Subsequent to A-25 House of Delegates Meeting	Minimal
03	Credentialing of Temporary Delegates and Alternate Delegates	

Report(s) of the Council on Ethical and Judicial Affairs

01	Amendment to Opinion 1.1.1 “Patient-Physician Relationships”	Minimal
02	Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	Minimal
03	Ethical Impetus for Research in Pregnant and Lactating Individuals	Minimal

Summary of Fiscal Notes I-25

Opinion(s) of the Council on Ethical and Judicial Affairs

01	Contracts to Deliver Health Care Services	Info. Report
02	Organ Transplantation Allocation Decisions	Info. Report

Report(s) of the Council on Long Range Planning and Development

01	Private Practice Physicians Section Five-Year Review	Minimal
02	Evaluation of the Structure of the AMA House of Delegates	Minimal

Report(s) of the Council on Medical Education

01	Additional Pathways for International Medical Graduates	Minimal

Report(s) of the Council on Medical Service

01	Health Savings Account Reform	Minimal
02	Telehealth Licensure	Minimal
03	Payment Models to Sustain Rural Hospitals	Minimal
04	Payment for Biosimilars	Minimal

Report(s) of the Council on Science and Public Health

01	Drug Shortages: 2025 Update	Info. Report
02	Regulation of Ionizing Radiation Exposure for Health Care Professionals	Minimal
03	Plastic Pollution Reduction	Minimal

Report(s) of the HOD Committee on Compensation of the Officers

01	Report of the House of Delegates Committee on the Compensation of the Officers	

Report(s) of the Speakers

01	Online Reference Committees	Minimal
02	Election Committee Review of Election Rules for Clarification	Minimal
03	Speaker Recorded Interviews for AMA Elections	Info. Report

Resolutions

001	Clarifying Conscientious Objection	Modest
002	Ensuring Ethical Use of Wearable Recording Devices in Clinical Encounters	Modest
003	Report on Gender-Based Pay Equity in Medicine	Modest
004	Patient Options to Restrict Secondary Use of Their Healthcare Data	Minimal
005	Preserving Autonomy in the Patient-Physician Relationship	Modest
006	Amendment to AMA Bylaws to Enable Continuity of Leadership	Minimal
007	Improving Protection for Reproductive Health Information	Minimal
008	Health Plan In-Network Steering of Pathology/Laboratory Services	Modest
009	Gender Equity in Disability Insurance for Physicians	Minimal
010	Clarifying the Medical Student Section's and Resident and Fellow Section's Abilities to Fill Temporary Vacancies in Accordance with the AMA Bylaws	Minimal
201	Model State Legislation incorporating Medical Malpractice Tort Reform Based on Utah H.B. 503 (2025)	Modest
202	Deepfake Technology and Harm to Physicians and Patients	Moderate
203	Restore and Enhance Federal Loan Programs for Medical Education	Modest

Summary of Fiscal Notes I-25

204	Addressing Anti-Physician Contractual Provisions	Moderate
205	Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care	Moderate
206	Restore Funding to USAID	Moderate
207	Support for a Federal Tax Incentive for Volunteer Community Preceptors	Modest
208	Centralization of Medicare Provider Data Sources	Moderate
209	Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians	Moderate
210	PBM Divestiture and Transparency	Moderate
211	Access to, and Retention of, Electronic Medical Records	Modest
212	Acknowledging Flexibility on Buprenorphine Mono-product Use for Opioid Use Disorder	Modest
213	Pathways to U. S. Permanent Residency for H-1B Physicians	Moderate
214	Physician Visa Protection and Pathway to Serve Underserved Communities	Modest
215	Extending the Medicaid Work Requirement Exemption up to 12 Months Postpartum	Minimal
216	Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs	Moderate
217	Protecting Access to Public Service Loan Forgiveness (PSLF), Income-Driven Repayment (IDR), and Direct Plus Loans for Graduate or Professional Students (Grad PLUS Loans)	Modest
218	Amend AMA Policy D-160.921 on Sensitive Locations to Protected Areas	Minimal
219	Addressing the Harms and Misleading Nature of Medicare Advantage Plans	Modest
220	Medicare Should not Unfairly Penalize Physicians	Modest
221	Not-for-Profit Status	Modest
222	Tackling Administrative Waste—Let Us Be Part of the Solution to Putting Our Health System on a Sustainable Path	Moderate
223	Halt the Rollout of New Payment Models by the Center for Medicare & Medicaid Innovation (CMMI)—A New Administration Offers an Opportunity	Modest
224	Recoupment by CMS Recovery and Audit Contractors (RAC)—Due Process	Modest
225	Federal Legislation to Prohibit the Corporate Practice of Medicine	Modest
226	Transparency with the Term “Emergency Department”	Modest
227	Call for Immediate and Aggressive Action by the AMA to Reverse Medicaid Cuts Impacting Seniors	$88,442 - create and compile report
228	Support Permanent Funding and Expansion of Native Hawaiian Healthcare	Minimal
229	Protection of Medicaid Beneficiaries’ Private Health Information from Immigration Enforcement	Modest
230	Banning Non-compete Agreements in States	Modest
231	Ensuring Equitable and Timely Medical Licensure for Physicians Providing Abortion and Gender-Affirming Care	Moderate
232	Safeguarding Access to IVF Amid Restorative Reproductive Medicine Legislation	Modest
233	Renewing Mental Health Infrastructure in the School System	Moderate
234	Study on Impact of Inflation Reduction Act on Oncology, Other Physician Practices	Moderate
236	Deceptive Advertising in Accredited Allied Health Professional, Non-Physician Graduate Programs	Modest

237	Protecting and Improving Rural Health	Moderate
301	Preventing Sleep Deprivation and Supporting Medical Student Wellness	Minimal
304	Systemic Exclusion of IMGs from Residency Programs	Minimal
305	Paid Sick Leave and Flexible Work Arrangements for Caregivers of Individuals with Special Needs, Chronic Illness, or Elderly Parents	Minimal
306	Support for Paid Prenatal Leave	Minimal
307	Integrating Artificial Intelligence (AI) Literacy Into UME, GME, and CME	Moderate
308	Enhancing the Pathway for Black Male Medical Students	Modest
311	Gender and URiM Disparities in Surgical Training Volumes	Minimal
313	Hardship for International Medical Graduates from Palestine	Moderate
601	Reimagining and Modernizing the U.S. Healthcare Delivery System	$240,365 - convene task force (similar expected for subsequent years)
602	Standardizing the Appointment Process for AMA Councils	Moderate
603	Upholding Professional Integrity and Ethical Leadership through Continued Publication of the AMA Journal of Ethics	$1.5 to $2 million annually
604	Sustaining Ethical Leadership Through Continued Support of the AMA Journal of Ethics	$1.5 to $2 million annually
802	Patient Choice of Physician	Minimal
804	Medicare Advantage Filing Limit	Modest
805	Shared Medical Appointments	Moderate
806	Insurance Coverage for Colonoscopy Preparation Cost	Modest
807	Protecting Hospitals and Patients from Inappropriate Denials of Inpatient Admissions	Minimal
808	No Prior Authorization for Inexpensive Medications	Modest
809	Ensuring Patient Safety and Physician Oversight in the Integration of Hospital Inpatient Virtual Nursing	Moderate
811	Non-Medical Switching	Modest
812	Discontinue Review Choice Demonstration Project for Inpatient Rehabilitation Hospital Admissions	Modest
813	Increased Regulation of For-Profit Healthcare Insurance	Moderate
814	Mandate for Insurance Companies to Assist in the Transition of Patients to Alternative Participating Physicians Upon Contract Termination	Modest
815	Mandating Health Insurers to Provide a Real-Time Online Tool for Coverage and Payment Policies, Integrated into Electronic Health Records (EHRs)	Moderate
816	Prohibit Arbitrary Time Limits on Preauthorizations	Modest
817	Prohibiting Insurers from Denying Payment for Procedures Based on Site of Service	Moderate
818	Universal Out-of-Network Benefits	Modest
819	Update the status of Virtual Credit card policy, EFT fees, and lack of Enforcement of Administrative Simplification Requirements by CMS	Modest
821	Improving Access to Emergency Ophthalmologic Surgical Care	Modest
822	Improving Home or Community-Based Services Waiver Waiting List Management	Minimal
823	Accountability in the Use of Augmented Intelligence for Prior Authorization	Modest

Summary of Fiscal Notes I-25

824	Equitable Payment and Increased Access for In-Office Pediatric Lead Screening and Testing	Modest
825	Ensuring Coverage for In-Office Point-of-Care (POC) Testing in Outpatient Medical Practices	Modest
826	Increase National Immunization Rates by Advocating for Equitable Vaccine Payments	Minimal
827	Opposition to Prior Authorization in Medicare Fee-for-Service, Burdensome Administrative Requirements	Modest
828	Creating a Public Scorecard on Insurer Delays in Care and Payment Caused by Prior Authorization	Moderate
829	Publicize Insurer Financial Gains from Delayed Care and Payment Caused by Prior Authorization	Minimal
901	Distinction Between Healthful and Unhealthful "Ultraprocessed" Foods	Minimal
903	Nitrous Oxide Inhalant Abuse	Minimal
904	Supporting Certification of the Public Health Workforce	Minimal
905	Standardizing Brain Death Policies	Modest
906	Rethink the Medicare Annual Wellness Visit	Modest
907	In-Office Dispensing of Generic Medications	Modest
908	Support of Access to Insulin-Detemir	Moderate
909	Clinical Significance of Sleepiness	Minimal
911	Safeguarding NIH-Funded and Other Women's Health Research in Peer-Reviewed Publishing	Modest
912	Increasing Access through Federated Healthcare Data Architecture	Moderate
917	Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup	Modest
918	Remove Outdated Barriers to Genetic Testing	Modest
919	Strengthening Trust through AMA-Based Leadership for Evidence-Based Vaccines (STABLE Vaccines)	$3.1 million annually -research and develop public facing materials
920	Alcohol and Aging: Educating Physicians and Advocating for Safer Warnings	Modest
921	Prioritizing Deprescribing in Seniors	Modest
922	Addressing Health Impacts of Indian Boarding Schools	Minimal
923	Enhancing Disaster Preparedness Mechanisms for People with Disabilities	Modest
924	Preserving Access to Gamete Donation and Gestational Carriers and Protecting Parental Rights	Modest
925	Evidence-Based Vaccine and Preventive Services Recommendations	Modest
926	Establishment of Federal and State Offices of Men's Health	Minimal
927	Battlefield Acupuncture – An Educational Call to Arms	Minimal
929	Protecting Access to Evidence-based Psychotropic Medication for the Treatment of Pediatric Mental Illness	Modest
930	Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing	Moderate
931	Preserving Evidence-Based, Equitable Grooming Standards in Military Service	Modest
932	Shared Decision-Making and Low Dose CT Lung Cancer Screening in Clinical Practice	Moderate
933	Addressing Gaps in National Healthcare Safety Network (NHSN) Data Quality	Modest