2025 AMA Medical Student Section (MSS) Interim Meeting
National Harbor, MD
November 13-14

Policy Materials

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 003
(I-25)

Introduced by: Alexia Childress[1], Paige Hinman[1], Nikita Schroll-McLaughlin[2], Thomas Hansen[3], Madison Calloway[4], Zhuochen Yuan[5], Manith Humchad[6]

Affiliations: [1]University of Virginia School of Medicine, Region 6
[2]Virginia Tech Carilion School of Medicine, Region 6
[3]Medical College of Wisconsin-Milwaukee, Region 2
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Subject: Ethical Guidance on Postmortem Sample Collection for Genetic Testing

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, postmortem genetic testing (PMGT), or molecular autopsy, of blood and/or fresh tissue is an increasingly recognized tool for identifying genetic causes in cases of sudden unexplained death (SUD)[1,2,7,14]; and

Whereas, PMGT is clinically useful in identifying pathogenic mutations and determining familial risk for conditions such as thoracic aortic aneurysm and dissection, inherited arrhythmogenic syndromes (such as cardiomyopathies and channelopathies), and sudden infant death syndrome or sudden unexplained death in childhood[2,12,13]; and

Whereas, PMGT allows for targeted cascade testing of relatives to identify potential carriers, implement preventative measures and surveillance (such as lifestyle modifications and regular imaging), and provide families with psychological benefits and closure following SUD[1,3-6]; and

Whereas, leading specialty societies including the American College of Medical Genetics and Genomics, the Asia Pacific Heart Rhythm Society, Heart Rhythm Society, European Heart Rhythm Society, Latin American Heart Rhythm Society, the American Heart Association, and the National Association of Medical Examiners, recommend postmortem collection and storage of blood and/or tissue for PMGT in cases of SUD, but provide little ethical guidance on informed consent, privacy, and storage[4,7,11,15,16]; and

Whereas, no nationally standardized ethical guidance exists in the United States to address informed consent, privacy, disclosure of results, long-term storage, or disposition of postmortem biological samples for PMGT, leading to variability and uncertainty for family members, clinicians, and genetic counselors[8,9,11,16]; and

Whereas, our American Medical Association (AMA) Code of Ethics has established Opinion 4.1.1 (“Genetic Testing & Counseling”), Opinion 3.2.2 (“Confidentiality Postmortem”), and

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Opinion 4.1.4 ("Forensic Genetics"), which collectively emphasize physicians' ethical responsibilities to protect the genetic information of patients and their biological relatives while utilizing genetic testing to help diagnose and predict future health risks, principles that extend to PMGT and communication with surviving biological relatives, but there is no clear statement on the ethics of collecting, storing, and sharing genetic information after death[10]; therefore be it

RESOLVED, that our American Medical Association supports the development of ethical guidance on the collection and storage of postmortem biological samples for genetic testing when clinically indicated, in accordance with existing recommendations from specialty societies.

Fiscal Note: TBD

Date Received: 09/21/2025

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RELEVANT AMA POLICY

4.1.1 Genetic Testing & Counseling

Genetic testing can provide valuable information to support informed decision making about personal health risks and care options as well as reproductive choices. The fact that genetic information carries implications for others to whom the individual is biologically related raises ethical challenges of balancing confidentiality against the well-being of others.

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Because genetic contribution to disease can be complex and highly variable, interpreting findings and helping patients understand the implications for their health and health care requires special skill and attention. Genetic testing is most appropriate when the results of testing will have meaningful impact on the patient's care. Physicians should not encourage testing unless there is effective therapy available to prevent or ameliorate the condition tested for. Whether a genetic test is performed to help diagnose an existing health condition, or to predict future health risks, or to provide information for managing a disease, it is important that the patient receives appropriate counseling. Physicians who order genetic tests (individually or as part of a multi-test panel or large-scale sequencing) or who offer clinical genetic services should: (a) Have appropriate knowledge and expertise to counsel patients about heritable conditions, risks for disease, and implications for health management, and to interpret findings of individual genetic tests or collaborate with other health care professionals who can provide these services, such as licensed genetic counselors. (b) Adhere to standards of nondirective counseling and avoid imposing their personal moral values or judgment on the patient. (c) Discuss with the patient: (i) what can and cannot be learned from the proposed genetic test(s) and reasons for and against testing, including the possibility of incidental findings. Physicians should ascertain whether the patient wishes to be informed about findings unrelated to the goal of testing; (ii) medical and psychological implications for the individual's biological relatives; (iii) circumstances under which the physician will expect the patient to notify biological relatives of test findings; and (iv) that the physician will be available to assist in communicating with relatives. (d) Obtain the individual's informed consent for the specific test or tests to be performed. (e) Ensure that appropriate measures are taken to protect the confidentiality of the patient's and their biological relatives' genetic information. [Issued: 2016]

H-480.944 Improving Genetic Testing and Counseling Services
Our AMA supports: (1) appropriate utilization of genetic testing, pre- and post-test counseling for patients undergoing genetic testing, and physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) the development and dissemination of guidelines for best practice standards concerning pre- and post-test genetic counseling; and (3) research and open discourse concerning issues in medical genetics, including genetic specialist workforce levels, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic testing and counseling on patient care and outcomes. [Res. 913, I-16]

H-185.919 Payment and Coverage for Genetic/Genomic Precision Medicine
Our AMA encourages public and private payers to adopt processes and methodologies for determining coverage and payment for genetic/genomic precision medicine that: (a) Promote transparency and clarity; (b) Involve multidisciplinary stakeholders, including genetic/genomic medicine experts and relevant national medical specialty societies; (c) Describe the evidence being considered and methods for updating the evidence; (d) Provide opportunities for comment and review as well as meaningful reconsiderations; and (e) Incorporate value assessments that consider the value of genetic/genomic tests and therapeutics to patients, families and society as a whole, including the impact on quality of life and survival. Our AMA encourages coverage and payment policies for genetic/genomic precision medicine that are evidence-based and take into account the unique challenges of traditional evidence development through randomized controlled trials, and work with test developers and appropriate clinical experts to establish clear thresholds for acceptable evidence for coverage. Our AMA will work with interested national medical specialty societies and other stakeholders to encourage the development of a comprehensive payment strategy that facilitates more consistent coverage of genetic/genomic tests and therapeutics that have clinical impact. Our AMA encourages national medical specialty societies to develop clinical practice guidelines incorporating precision medicine approaches that support adoption of appropriate, evidence-based services. Our AMA supports continued research and evidence generation demonstrating the validity, meaningfulness, short-term and long-term cost-effectiveness and value of precision medicine. [Joint CMS / CSAPH Rep. 01, I-17 Reaffirmed: CMS Rep. 06, A-18 Reaffirmed: CMS Rep. 06, A-19]

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H-85.954 Importance of Autopsies
Our AMA: (b) promotes the use of updated autopsy protocols for medical research, particularly in the areas of cancer, cardiovascular, occupational, and infectious diseases; (e) requests The Joint Commission to consider amending the Accreditation Manual for Hospitals to require that the complete autopsy report be made part of the medical record within 30 days after the postmortem; (f) supports the formalization of methods of reimbursement for autopsy in order to identify postmortem examinations as medical prerogatives and necessary medical procedures; (h) promotes the incorporation of updated postmortem examinations into risk management and quality assurance programs in hospitals. [CCB/CLRPD Rep. 3, A-14; Reaffirmed: CCB/CLRPD Rep. 01, A-24]

4.1.2 Genetic Testing for Reproductive Decision Making
Genetic testing can provide information to help prospective parents make informed decisions about childbearing.Genetic testing to inform reproductive decisions was once recommended only for women/couples whose family history or medical record indicated elevated risk for a limited set of genetically mediated conditions. As procreation among individuals of diverse ancestries becomes more common and tests for more conditions become more accurate and less costly, the relevance of broad preconception, pre-implantation, or prenatal genetic screening grows stronger. Physicians may ethically provide genetic testing to inform reproductive decision making when the patient requests, but may also wish to offer broad screening to all persons who are considering having a child. Physicians who provide reproductive health care that includes genetic testing should:(c) Obtain the individual's informed consent to the specific test or tests to be performed. Physicians should ascertain whether the person wishes to be informed about incidental findings.(d) Inform the individual about any abnormal findings for the tests ordered and discuss the severity of the associated health condition, likelihood of clinical manifestation (penetrance), age at onset, and other factors relevant to a decision about childbearing.(e) Respect an individual's decision to terminate or continue a pregnancy when testing reveals a genetic abnormality in the fetus, in accordance with applicable law. [Issued 2016]

D-460.996 Medical Genetics
Our AMA will join with the American College of Medical Genetics and other professional and lay organizations to: (1) Publicize the resources and services offered by medical genetics professionals to other medical specialties; and (2) advocate for federal funding specifically targeted to the development and stable support of a clinical genetics infrastructure commensurate with the application of new genetic knowledge to the prevention and treatment of human disease. [Res. 527, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep 01, A-19]

RELEVANT MSS POSITIONS

200.019MSS Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems
Our AMA-MSS will ask (1) That our AMA support efforts to assess the usage of genetic testing and need for counseling services, physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) , That our AMA encourage efforts to create and disseminate guidelines for best practice standards concerning counseling and data security for genetic test results in medical settings and in direct-to-consumer contexts; and (3) That our AMA support further research into and open discourse concerning issues in medical genetics, including the genetic specialist workforce shortage, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic test results and counseling on patient satisfaction. [MSS Res 11, A-16; Appended: MSS Res. 57, I-19]

165.010MSS Development and Support of Prospective Personalized Health Planning

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AMA-MSS will ask the AMA to: (1) continue to recognize the need for possible adaptation of the United States' health care system to prospectively prevent the development of disease by ethically using genomics, proteomics, metabolomics, imaging and other advanced diagnostics, along with standardized informatics tools to develop individual risk assessments and personal health plans; (2) support studies aimed at determining the viability of prospective care models, and measures that will assist in creating a stronger focus on prospective care in the United States' health care system; and (3) support research and discussion regarding the multidimensional ethical issues related to prospective care models, such as genetic testing. [MSS Rep F, A-04; AMA Res 422, A-05 Referred]

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 004
(I-25)

Introduced by: Eli Schantz[1], Joel Dumonsau[2], Andrew Norton[3], Hailey Greenstone[4]

Affiliations:
[1] Indiana University School of Medicine
[2] Creighton University School of Medicine
[3] University of Wisconsin School of Medicine and Public Health
[4] Tufts University School of Medicine

Subject: Clarifying Conscientious Objection

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, recent high-profile cases of conscientious objection have involved physicians refusing care to patients based upon their identity characteristics, including a child who was refused care because of their parents' sexuality and a mother who was refused prenatal care because they were unmarried[1-2]; and

Whereas, present AMA policy, by limiting conscientious objection only where it constitutes discrimination or creates an undue burden on patients, tacitly permits the use of conscientious objection in the aforementioned cases; and

Whereas, in spite of AMA policy asking physicians to "take care that their actions do not discriminate against…individual patients," conscientious objection has long been invoked to refuse care to patients based upon protected characteristics, including gender identity and sexuality[3-5]; and

Whereas, in spite of the fact that AMA policy places clear limits on conscientious objection, such limits are frequently not reflected in state or federal law or policy[6-8]; and

Whereas, the limits of conscience objection outlined in AMA Code of Ethics Opinion 1.1.7 are dependent on the legal definition of discrimination, and a change in the legal definition of discrimination would thereby change our guidance for when conscientious objection is permissible; and

Whereas, the revocation of federal protections for LGBTQ+, gender-diverse, or disabled populations would thereby render it permissible for physicians to conscientiously object to providing care to patients in these populations; and

Whereas, the ethical principles which underlie medical practice are beholden to no law; and

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Whereas, the use of conscientious objection to refuse care to patients based upon their membership in particular groups, rather than an ethical objection to providing a particular type of care, is widely regarded as unethical by philosophers of medicine[9-11]; therefore be it

RESOLVED, that our AMA-MSS, in order to ensure that a physician's right to choose their patients is appropriately limited by their duty to provide equitable access to care, (1) supports further study of the practice of conscientious objection and (2) reform to relevant AMA policies aligning with this goal.

Fiscal Note: TBD

Received: 09/21/2025

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RELEVANT AMA POLICY

- Code of Medical Ethics 1.1.2 Prospective Patients
  - "Physicians must uphold ethical responsibilities not to discriminate against prospective patients on the basis of race, gender, sexual orientation, or gender identity or other person or social characteristics…"
- Code of Medical Ethics 1.1.5 Terminating a Patient-Physician Relationship
  - Physicians' fiduciary responsibility to patients entails an obligation to support continuity of care for their patients, alerting the patient to any foreseeable impediments to continuity of care, and facilitating transfer of care when appropriate
- Code of Medical Ethics 1.1.7 Physician Exercise of Conscience
  - Physicians are expected to provide care in emergencies and to respect basic civil liberties and not discriminate against individuals
- Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias, and Microaggressions H-65.991
  - Health care organizations and systems should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias, and microaggressions in their workplaces

RELEVANT MSS POSITIONS

- 65.002MSS Nondiscrimination Based on Sexual Orientation
- 65.011MSS Physician Objection to Treatment and Individual Patient Discrimination

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 007
(I-25)

Introduced by: Samantha Shuster[1]

Affiliations: [1]Kansas City University College of Osteopathic Medicine

Subject: Improving Access to Phenotype-Matched Blood for Transfusion-Dependent Patients

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, Sickle cell disease (SCD) affects an estimated 100,000 individuals in the United States and disproportionately impacts Black and African American communities nationwide, while other transfusion-dependent conditions such as thalassemia and bone marrow failure syndromes also require frequent transfusion support[1]; and

Whereas, Patients requiring chronic transfusion therapy are at significant risk of red blood cell alloimmunization when transfusions are not phenotype-matched, which can complicate future transfusion management and lead to life-threatening hemolytic reactions[2]; and

Whereas, Phenotype-matched blood, ideally sourced from racially and ethnically diverse donors, has been shown to substantially reduce alloimmunization, but access remains limited due to the underrepresentation of minority blood donors in the U.S. blood supply[3]; and

Whereas, The American Society of Hematology's 2020 guidelines recommend extended red cell antigen profiling by genotype or serology for all patients with sickle cell disease at the earliest opportunity, yet lack of insurance coverage and reimbursement often serves as a barrier to implementation, limiting equitable access to this standard of care[4]; therefore be it

RESOLVED**,** that our AMA amend Policy H-50.977 by addition to read as follows:

> Our AMA supports national efforts to recruit and retain blood donors to ensure a safe and sufficient blood supply, and supports initiatives to expand recruitment and retention of racially and ethnically diverse blood donors, particularly from underrepresented communities, to improve access to phenotype-matched blood for patients with high transfusion requirements, including those with sickle cell disease. Our AMA supports scientifically-based policies that ensures the safety of the nation's blood supply; and be it further

RESOLVED**,** that our AMA advocates for insurance coverage and reimbursement of extended red blood cell phenotyping and genotype matching for patients with sickle cell disease and other transfusion-dependent conditions.

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Fiscal Note: TBD

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RELEVANT AMA Policy

Sickle Cell Disease H-350.973
Our AMA recognizes sickle cell disease as a chronic illness; encourages educational efforts directed to health care providers and the public regarding the treatment and prevention of sickle cell disease; and supports the inclusion of sickle cell disease in newborn screening programs and encourages genetic counseling for affected individuals or those at risk. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Modified: BOT Rep. 12, A-11; Appended: Res. 906, I-19; Modified: Res. 910, I-23]

H-50.977 — Blood Donor Recruitment
Our AMA supports national efforts to recruit and retain blood donors to ensure a safe and sufficient blood supply.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 101
(I-25)

Introduced by: [1]Micah Char, [2]Buddy Kalanikumupa'a Seto-Myers, [1]Misty Kahale

Affiliations: [1]Kirk Kerkorian School of Medicine at UNLV
[2]University of Washington School of Medicine

Subject: Support Permanent Funding and Expansion of Native Hawaiian Healthcare

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, Native Hawaiians (or Kānaka Maoli) are the Indigenous peoples of Hawai‘i who trace their ancestry to the Hawai‘ian islands since time immemorial and/or since pre-Western Pacific navigation[1,2]; and

Whereas, the Kingdom of Hawai‘i was a sovereign Indigenous nation from 1795-1893 serving Native Hawaiians and other Hawaiian citizens in the Hawai‘ian Islands and which obtained international treaties recognizing its existence, including with the United States[2]; and

Whereas, the illegal 1893 overthrow and 1898 annexation of the Hawaiian Kingdom by the United States directly harmed the Native Hawaiian people and their political sovereignty[2]; and

Whereas, after Western contact and American occupation, Native Hawaiians sustained intergenerational biopsychosocial wounds manifesting in socioeconomic disparity, community discord, and disparate rates of metabolic disorders, cancers, infectious disease, and mental health distress at higher rates than other populations in the United States[1,3-13]; and

Whereas, Native Hawaiian and Pacific Islander youth experience disproportionately high rates of suicide, with suicide being the leading cause of death for ages 15–24, while Native Hawaiians overall are less likely to receive mental health treatment compared with non-Hispanic whites[9]; and

Whereas, culturally grounded identity and traditional healing practices serve as protective factors against stress and poor health outcomes among Native Hawaiians, with studies showing that stronger engagement in Native Hawaiian culture is associated with reduced stress and improved well-being among young adults[14,15]; and

Whereas, in recognition of its wrongful termination of Native Hawaiian sovereignty and the adversity experienced by Native Hawaiians, the United States Congress codified a political trust relationship with Native Hawaiians as an Indigenous community and has since repeatedly reaffirmed this relationship through subsequent acts, in parallel with legislation concerning American Indian and Alaska Native tribes[2]; and

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Whereas, this trust relationship obligates the United States to provide funding and policy support to Native Hawaiians to better their conditions[2,16,17]; and

Whereas, on this trust principle and with precedent from the 1976 Indian Health Care Improvement Act (IHCIA), the federal government enacted the Native Hawaiian Health Care Improvement Act (NHHCIA), codified under 42 U.S. Code Chapter 122 and initially enacted as the Native Hawaiian Health Care Act of 1988, to improve health outcomes for Native Hawaiians by funding disease prevention, health promotion, and culturally relevant services,[2,16,17,18]; and

Whereas, the NHHCIA funds the Native Hawaiian Health Care Systems (NHHCS) which deliver essential subsidized primary care services to Native Hawaiians with system sites on the Hawaiian islands of Oʻahu, Kauaʻi, Molokaʻi, Maui, and Hawaiʻi[2,16,17]; and

Whereas, the NHHCIA established Papa Ola Lōkahi, a public health and NHHCS oversight body with the responsibility of advancing the public health and wellbeing of Native Hawaiians through community-based initiatives, research, and public policy[2,16,17]; and

Whereas, the NHHCS and Papa Ola Lōkahi are uniquely designed to improve the condition of Native Hawaiian health by delivering health care that is attuned to Native Hawaiian values, language, culture, history, intergenerational traumas, and traditional medicines[2,16,17]; and

Whereas, the NHHCIA is funded through HRSA Health Center Program appropriation[2,8,19,20]; and

Whereas, unlike the Indian Health Care Improvement Act which established the Indian Health Service for American Indians and Alaska Natives, the NHHCIA is subject to periodic reauthorization and limited discretionary funding, meaning Native Hawaiians are the only Indigenous population with a federal trust relationship who do not have a permanently authorized and funded health care system[2,8,18,19,21,22]; and

Whereas, Native Hawaiian physician workforce shortages, insufficient funding, and limited system locations are impeding the effectiveness of the the NHHCIA, with experts recognizing a need for permanent funding to implement wider access and increased workforce development[23-26]; therefore be it

RESOLVED, that our AMA-MSS supports the expansion of federally funded Native Hawaiian healthcare systems, including traditional Indigenous medicine programs, and culturally grounded healthcare services.

Fiscal Note: TBD

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RELEVANT AMA Policy

Improving Health Care of American Indians and Alaska Natives H-350.976
Our AMA… (2) Our AMA recommends that the federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives… (13) strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

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[CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09, A-23; Modified: CMS Rep. 03, A-24; Reaffirmed: Res. 244, A-24]

Improving Healthcare of Minority Communities in Rural Areas H-350.937
Our AMA… (2) Our AMA encourages enhanced understanding by federal, state and local governments of the unique health and health-related needs, including mental health, of minority communities in rural areas in an effort to improve their quality of life. [Res. 433, A-24; Modified: CSAPH Rep. 07, A-25]

Health Care Access for American Indians and Alaska Natives H-350.939
Our American Medical Association supports (a) the federal government continuing to enhance and develop alternative pathways for American Indian and Alaska Native patients to access the full spectrum of health care, including within and outside of the established Indian Health Service (IHS) system; (b) collaborative research efforts to better understand the limitations of IHS health care, including barriers to access, disparities in treatment outcomes, and areas for improvement; (c) studies between the IHS and the CDC to better evaluate regional health outcomes, and potential treatment deficiencies among American Indian and Alaska Native populations, including with respect to cancer care; and (d) federal and other efforts to increase funding for and provide technical assistance to develop and expand accessible specialty care services at IHS, Tribal, and Urban Indian Health Programs and associated facilities, including by contracting with other physician practices. [Res. 242, A-24]

Indian Health Service H-350.977
The policy of the American Medical Association is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. Our AMA specifically recommends… (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; (d) Improvement in transportation to make access to existing private care easier for the American Indian population; (e) that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation; and (f) the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Appended: Res. 305, A-23; Reaffirmed: BOT Rep. 09, A-23; Reaffirmed: CMS Rep. 03, A-24; Reaffirmed: Res. 244, A-24; Reaffirmed: BOT Rep. 31, A-24; Modified: CMS Res. 305, A-24]

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 102
(I-25)

Introduced by: Micah Char[1], Jennifer Ritchie[2]

Affiliations: [1] Kirk Kerkorian School of Medicine at UNLV
[2] Indiana University School of Medicine

Subject: Support the Development of Federal Analytic Capacity to Forecast Patient Access Impacts of Medicare, Medicaid, and CHIP Policy Changes

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, health insurance coverage has been consistently associated with improved access to care and health outcomes, as demonstrated by the Oregon Medicaid experiment, which showed reduced financial strain and increased utilization of preventive services[1]; and

Whereas, research published in the New England Journal of Medicine confirms that Medicaid expansions reduce all-cause mortality and increase access to both primary and specialty care for low-income populations[2]; and

Whereas, the Institute of Medicine has concluded that health insurance is strongly correlated with better health outcomes and reduced mortality, underscoring the importance of evaluating the impact of changes in coverage policies[3]; and

Whereas, the U.S. Government Accountability Office has reported that rural hospital closures increase patient travel distances by more than 20 miles on average, limiting timely access to emergency, primary, and specialty services[4]; and

Whereas, analyses by Families USA project that proposed federal Medicaid cuts could eliminate up to 56% of the net income of independent rural hospitals, threatening the survival of safety-net providers and thereby limiting patient access[5]; and

Whereas, public testimony by patients and health advocates has been shown to increase policymaker awareness and influence decisions, as seen in both Affordable Care Act deliberations and recent debates over H.R. 1, where patient stories were cited in floor speeches opposing Medicaid cuts[6-8]; and

Whereas, federal policymaking has precedent for requiring structured impact analyses, such as the National Environmental Policy Act (NEPA) of 1970, which mandates Environmental Impact Statements and allows for public input and transparency[9,10]; and

Whereas, fiscal policy proposals are routinely analyzed by the Congressional Budget Office (CBO), which provides prospective assessments of budgetary effects, but these analyses do not

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systematically account for how proposed changes affect patient access, physician participation, wait times, or equity[11]; and

Whereas, several states, including California, have used Health Impact Assessments (HIAs) to evaluate major public health and environmental decisions, demonstrating that structured health consequence forecasting is both feasible and effective at informing policy[12,13]; and

Whereas, despite the scale of federal healthcare programs such as Medicare and Medicaid, there is currently no standardized capacity at the federal level to project the likely effects of major program changes on patient access, leaving patients vulnerable to unintended harms[4,14]; and

Whereas, the Congressional Budget Office has acknowledged limitations in its ability to forecast non-budgetary outcomes, underscoring the importance of supplementing fiscal scoring with access-focused projections[11]; and

Whereas, developing analytic capacity to forecast patient access impacts would help policymakers evaluate trade-offs between cost-containment strategies and equitable access to care, aligning with AMA's commitment to both fiscal responsibility and patient-centered care[15]; therefore be it

RESOLVED, that our American Medical Association support the development of federal analytic capacity within agencies such as the Congressional Budget Office (CBO), Government Accountability Office (GAO), or Medicare Payment Advisory Commission (MedPAC) to forecast the effects of proposed changes to Medicare, Medicaid, or CHIP on patient access, including physician participation, appointment availability, geographic workforce distribution, and health equity; and be it further

RESOLVED, that our AMA encourage pilot programs and state-level initiatives to evaluate the feasibility of structured patient access impact assessments, building an evidence base to inform national models; and be it further

RESOLVED, that our AMA advocates that Congress and relevant federal agencies invest in research and modeling tools that enable policymakers to better assess the real-world consequences of major healthcare financing changes beyond budgetary effects, ensuring that patient access and equity remain central considerations in reform.

Fiscal Note: TBD

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RELEVANT AMA Policy

Sequestration Budget Cuts D-165.941
Our AMA will take all necessary legislative and administrative steps to prevent extended or deeper sequester cuts in Medicare payments. [Res. 215, I-12; Appended: Res. 222, A-15; Reaffirmed: Res. 212, I-21]

Cuts in Medicare and Medicaid Reimbursement H-330.932
Our AMA continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients. [Sub. Res. 101, A-97; Reaffirmation A-99 and Reaffirmed: Res. 127, A-99; Reffirmation A-00; Reaffirmation I-00; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00; Reaffirmation A-01; Reaffirmation and Appended: Res. 113, A-02; Reaffirmation A-05; Reaffirmed in lieu of Res. 207, A-13; Reaffirmed: Res. 212, I-21; Reaffirmed in lieu of: Res. 225, A-25]

Health System Reform Legislation H-165.838
(9) Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation: (a) Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services. (b) Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system. (c) Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted. (d) Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate. (e) Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another. (f) Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest. [Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15;

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Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 02, I-23; Appended: CMS Rep. 02, I-24; Appended: CMS Rep. 02, I-24; Reaffirmed: CMS Rep. 02, I-24; Reaffirmed: Res. 826, I-24]

RELEVANT MSS POSITIONS

Opposing Legislation to Cut Funding to the HRSA Health Careers Opportunity Program and the HRSA Centers of Excellence Program 350.012MSS

AMA-MSS will ask the AMA to: (1) publicly oppose any reduction or elimination of funding for the Health Careers Opportunity Program and the Centers of Excellence Program; and (2) work with other interested organizations to seek increased public and private sector funding for the Health Careers Opportunity Program and the Centers of Excellence Program. (MSS Res Late 2, I-06; Reaffirmed: MSS GC Rep D, I-11; Reaffirmed: MSS GC Report A, I-16; Reaffirmed: MSS GC Report A, I-21)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 103
(I-25)

Introduced by: Layla Ahmadi[1], Viha Bynagari[2], Lauren Zaylskie[1], Samir Reddy[4], Parisa Jahangirizadeh[3], Mitchell Nelson[5], Mallika Desai[6]

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Subject: Advocacy and Legal Action on Tariffs Affecting Medical Products and Healthcare Supply Chains

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, cycles of U.S. tariff policy and court-driven reversals have introduced uncertainty into health care supply chains, with evidence that tariff costs are largely passed on through higher import prices and firm expenses, raising system costs[1-3]; and

Whereas, the United States depends heavily on global markets for personal protective equipment (PPE), pharmaceuticals, and device inputs leaving it acutely vulnerable to trade barriers and export controls[4-6]; and

Whereas, shortages of essential medical products as seen with tariff-driven price increases, trade barriers, and supply chain disruptions, pose significant patient safety risks, as illustrated by the 2022 iodinated contrast media shortage during the COVID-19 pandemic, which forced conservation protocols, delayed imaging, and required reprioritization of care[7-10]; and

Whereas, drug shortages, especially sterile injectables, IV fluids, and essential generics, have reached historic highs in recent years, with downstream delays and cancellations of care, persisting despite mitigation efforts[11-14]; and

Whereas, foundational analyses demonstrate that U.S. healthcare spending is primarily price-driven rather than utilization-driven, so tariff-related price increases predictably worsen affordability and access[15]; and

Whereas, federal authorities maintain mechanisms to exclude medical products from tariffs and have repeatedly extended such exclusions for dozens of medical products through 2025[16-19]; and

Whereas, health insurers have begun attributing higher 2026 premium rates to anticipated increases in pharmaceutical and medical supply costs from new tariffs, with some carriers requesting 2 to 3.6 percentage point increases in their rate filings with state regulators[20-21]; and

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Whereas, organizations including the American Hospital Association (AHA), Association of American Medical Colleges (AAMC), and AdvaMed**,** have publicly advocated for exemptions for medications, devices, and essential inputs from tariff regimes due to risks to availability, equity, and costs[22-25]; and

Whereas, multiple lawsuits, including *V.O.S. Selections, Inc. v. United States*, are underway in the U.S. Court of International Trade challenging the legality of tariffs imposed under the International Emergency Economic Powers Act (IEEPA) and invoking the major questions doctrine, which limits executive authority on issues of "vast economic or political significance" absent clear congressional authorization[26-28]; and

Whereas, while numerous amici, including constitutional scholars, former officials, economists, and advocacy groups, have filed briefs in these cases, none have explicitly framed the impact of tariffs through the lens of health care system disruption, patient access, rising insurance premiums, or supply chain resilience[29-32]; and

Whereas, given the current administration's trade policy priorities, additional tariffs or reversals of existing medical product exclusions are highly likely, and the persistence of global geopolitical and economic instability is projected to further destabilize medical supply chains[33]; and

Whereas, our AMA-MSS authorship team has initiated an MSS Action Item requesting the AMA Litigation Center to evaluate participation in tariff-related litigation, but given the Federal Circuit's August 29, 2025 decision in V.O.S. Selections v. United States, the September 3, 2025 petition for certiorari, and the Supreme Court's expedited briefing schedule this fall, the timeline for merits briefs limits the feasibility of Litigation Center action in the current case; and

Whereas, existing AMA policy directs our AMA to monitor tariff impacts and support legislative mitigation, but does not advocate for exemptions or direct legal advocacy efforts such as amicus briefs; therefore be it

RESOLVED, that our American Medical Association evaluate and, where appropriate, consider submitting amicus curiae briefs in ongoing or future litigation concerning tariffs that affect the affordability, accessibility, or supply of medical products, as well as their secondary impacts, including increased insurance premiums, reduced coverage, and other tariff-driven cost burdens on patients and health systems, with particular emphasis on patient safety, equity, and healthcare delivery.

Fiscal Note: TBD

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RELEVANT AMA Policy

Impact of Tariffs on Healthcare Access and Costs D-110.981
(1) Our American Medical Association will actively monitor and assess the impact of current and proposed tariffs on healthcare costs and patient access to medical services; and (2) Our AMA supports legislative efforts aimed at mitigating the negative effects of tariffs on the healthcare system, ensuring that patient care, medical supplies, and pharmaceuticals remains accessible and affordable. [Res. 210, A-25]

Availability of Personal Protective Equipment (PPE) H-440.810

Our AMA: …(6) Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies. [Res. 412, I-20; Appended: Res. 414, A-21; Modified: Res. 410, I-2]

Pandemic Preparedness H-440.847

Our American Medical Association…(2) urges Congress and the Administration to work to ensure adequate funding and other resources to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to a pandemic or other serious public health emergency…[CSAPH Rep. 5, I-12; Reaffirmation A-15; Modified: Res. 415, A-21; Reaffirmed: CSAPH Rep. 1, I-22; Appended: Res. 924, I-22]

Controlling Cost of Medical Care H-155.966

Our American Medical Association urges the American Hospital Association and all hospitals to encourage the administrators and medical directors to provide to the members of the medical staffs, housestaff and medical students the charges for tests, procedures, medications and durable medical equipment in such a fashion as to emphasize cost and quality consciousness. [Sub. Res. 75, I-81; Reaffirmed: CLRPD Rep. F, I-9; Res. 801, A-93; CMS Rep. 12, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 5, A-12; Reaffirmed: CMS Rep. 1, A-22; Reaffirmation A-23]

International Trade Agreements D-505.998

Our AMA will…(2) in collaboration with interested members of the Federation and other professional organizations, advise the US Trade Representative on trade issues that could affect physicians or the provision of medical services, and advocate applicable AMA policy…[BOT Rep. 18, A-04; Reaffirmation A-07; Reaffirmation A-15]

RELEVANT MSS POSITIONS

135.028 MSS: Protecting the Healthcare Supply Chain from the Impacts of Climate Change
AMA-MSS will ask the AMA to support the development of strategies and technologies to strengthen supply chain networks, including building climate resiliency into new or updated facilities, increasing emergency stockpiles of key products, and incentivizing the innovation and adoption of reusable medical products to resist the impact of supply chain disturbances. [MSS Res. 422, A-24; AMA Res. 914, I-24, Adopted as Amended]

440.088MSS: Amending D-440.847, to Call for National Government and States to Maintain Personal Protective Equipment and Medical Supply Stockpiles
“In order to prepare for a pandemic, our AMA: Urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile, and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce … medical supplies, and personal protective equipment, and to continue the development of the nation’s capacity to rapidly manufacture the necessary supplies needed …; and (b) to bolster the infrastructure and capacity of state and local health

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departments to effectively prepare for and respond to, and protect the population from illness and death in an influenza a pandemic or other serious public health emergency; Encourages states to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency;" [MSS Res. 004, Nov. 2020; HOD Res. 415, A-21; I-20 (N-20); HOD Res. 415, A-21]

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 104
(I-25)

Introduced by: Paige Hinman[1], Alexia Childress[1], Maya Livni[2]

Affiliations: [1]University of Virginia School of Medicine, Region 6
[2]Medical College of Wisconsin, Region 2

Subject: Health Insurance Coverage of Hearing Devices and Related Services

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, of the approximately 28.8 million adults in the United States who could benefit from hearing devices, fewer than 20% use them, demonstrating a significant gap in utilization[1]; and

Whereas, research has shown that working-age adults (18-64 years) with untreated hearing loss experience adverse outcomes compared to those with normal hearing, including a 40% higher risk of death even after adjusting for confounding factors, greater social-situational limitations, higher rates of psychological distress, and an increased risk of dementia[2-5]; and

Whereas, the use of hearing aids has been shown to decrease difficulties in communication and social interaction among individuals after initiating use, and compared to adults with untreated hearing loss, adults who use hearing aids have decreased mortality, psychological distress, and risk of dementia[2,4,6,7]; and

Whereas untreated hearing loss among working-age adults has been associated with an estimated $193.8 billion in lost population income and $28.6 billion in unrealized federal tax revenue annually, while the use of hearing aids has been estimated to mitigate individual income loss of up to $22,000 per year[8]; and

Whereas, hearing devices and related audiological services, including diagnostic testing, fitting, and regular replacements, are inconsistently covered across private insurance plans and are typically excluded under Medicaid, making them inaccessible to many low-income adults[9-11]; and

Whereas, the American Medical Association (AMA) supports public and private health insurance coverage of hearing services and devices for hearing-impaired infants and children, but not adults (H-195.929), and has supported private health insurance coverage in the past, as outlined in H-185.910, H-185.907, and H-425.966[12-15]; and

Whereas, out-of-pocket costs for hearing aids and related services are unaffordable for 77% of Americans with functional hearing loss, and consumer surveys demonstrate that willingness to adopt hearing aids would more than double if insurance contributed to or fully covered the cost, demonstrating that lack of affordability and coverage limits utilization[10]; and

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Whereas, adults with similar degrees of hearing loss and at least partial health insurance coverage for hearing aids are significantly more likely to acquire these devices than those without coverage, indicating that out-of-pocket cost is a barrier to adoption[16]; and

Whereas, adults with untreated hearing loss incur approximately $3,536 more in total healthcare spending over an 18-month span compared to those without hearing loss, while the average cost of hearing aids and related services is estimated to be $2,500, demonstrating that modest investments in coverage can yield meaningful healthcare savings[10,17]; therefore be it

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

Fiscal Note: TBD

Received: 09/21/2025

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RELEVANT AMA Policy

Hearing Aid Coverage H-185.929
Our AMA:...(5) supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly; (7) supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss; (8) supports physician and

patient education on the proper role of over the counter hearing aids, including the value of physician-led assessment of hearing loss, and when they are appropriate for patients and when there are possible cost-savings; (9) encourages the United States Preventive Services Task Force to re-evaluate its determination not to recommend preventive hearing services and screenings in asymptomatic adults over age 65 in consideration of new evidence connecting hearing loss to dementia; (10) works with interested state medical associations to support coverage of hearing exams, hearing aids, cochlear implants, and aural rehabilitative services by appropriate physician-led teams, in Medicaid and CHIP programs and any new public payers. [CMS Rep. 6, I-15 Appended: Res. 124, A-19 Appended: CMS Rep. 02, A-23 Reaffirmed: CMS Rep. 02, A-23 Reaffirmed: Res. 102, A-24]

RELEVANT MSS POSITIONS

Increased Affordability and Access to Hearing Aids and Related Care 25.003MSS

AMA-MSS asked the AMA to 1) support policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences to the elderly; 2) encourage increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids; and 3) support the availability of over-the-counter hearing aids for the treatment of age-related mild-to- moderate hearing loss. (MSS CEQM Rep I-18, Adopted) (AMA Res 124, A-19, Adopted [H-18.929])

Medicare Coverage of Dental, Vision, and Hearing Services 180.021MSS

AMA-MSS will ask the AMA to (1) support Medicare coverage of preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures and (2) support Medicare coverage of routine eye examinations and visual aids, including eyeglasses and contact lenses.
AMA-MSS will ask AMA to amend Policy H-185.929, Hearing Aid Coverage by addition as follows:
1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability, and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams, and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team, aural rehabilitative services, and hearing aids as part of Medicare’s Benefit.
5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. (MSS Res. 16, I-21) (AMA Res. 119, Alternate Resolution Adopted in Lieu [], A-22)

Medicaid Hearing Coverage 180.025MSS

MA-MSS will ask that the AMA amend H-185.929 by addition to read as follows:
Hearing Aid Coverage H-185.929
1. Our AMA supports public and private health
insurance coverage that provides all hearing- impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.

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5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the- counter hearing aids for the treatment of mild-to-moderate hearing loss.
8. Our AMA advocate that hearing exams, hearing aids, cochlear implants and aural rehabilitative services be covered in all Medicaid programs and any new public insurance programs. (MSS Res. 016, I-22)
Res. 415, A-21]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 105
(I-25)

Introduced by: Cindy Li[1], Pratik Thakur[2]

Affiliations: [1] University of Virginia School of Medicine
[2] Ohio State University College of Medicine

Subject: Opposing Alternative Funding Programs

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, Alternative Funding Programs (AFPs) are employer- or third-party vendor- benefit designs that exclude expensive medications from insurance formularies and instead require beneficiaries to enroll in manufacturer/charitable assistance programs or cover the costs themselves, thereby shifting liability outside the insurance benefit[1,10]; and

Whereas, AFPs divert limited manufacturer and charitable patient assistance funds away from uninsured and underinsured populations for whom they were intended, raising concerns about equity and sustainability[2]; and

Whereas, in *AbbVie v. Payer Matrix*, AbbVie alleges that AFP models are misrepresenting insured patients as uninsured in a "fraudulent and deceptive scheme" to access manufacturer assistance funds, demonstrating increasing legal and regulatory scrutiny over these programs[17]; and

Whereas, as AFP adoption has grown rapidly, many patients are unaware of enrollment until coverage is denied, unexpected medical bills arrive, or medications are suddenly switched, disrupting continuity of care and undermining the physician-patient relationship[5,7]; and

Whereas, patients routed through AFPs experience significant barriers to care, including average treatment delays of 68 days to therapy, with 88% reporting associated stress or anxiety and 24% reporting worsening of their condition[6]; and

Whereas, AFPs raised compliance risks under federal statutes, including the ACA, ERISA, HIPAA, and the Anti-Kickback Statute, due to benefit misclassification, unauthorized data-sharing, and misaligned financial incentives[8,9]; and

Whereas, AFPs often circumvent Affordable Care Act (ACA) regulations by reclassifying the medications as non-essential health benefits (non-EHB), which shifts full cost liability onto patients or undermine cost-sharing safeguards by preventing copay from counting toward deductibles/out-of-pocket limits[10]; and

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Whereas, copay adjustment programs, which seek to limit plan sponsor exposure to prescription drug costs by raising patient OOP costs, have been addressed by a growing number of state bans, so AFPs have emerged as a loophole achieving a similar effect, evading existing bans and regulations to continue affecting patient costs[3,4,16]; and

Whereas, national patient and provider organizations, including the CancerCare-led Alternative Funding Task Force, PAN Foundation, and Alliance for Patient Access, have publicly opposed AFPs and urged federal action to treat covered prescription drugs as essential health benefits across markets and to prohibit plan designs that require enrollment in third-party assistance as a condition of coverage[11,12,13,14]; and

Whereas, although AMA policy D-110.983 directs the AMA to educate on and address the negative impacts of AFPs, it does not state AMA's opposition to AFPs as a benefit design model, leaving a gap for a durable policy stance[15]; therefore be it

RESOLVED, that our American Medical Association oppose the use of Alternative Funding Programs (AFPs) and similarly functioning benefit designs and advocate for federal and state legislation and regulation prohibiting their use.

Fiscal Note: TBD

Received: 09/21/2025

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RELEVANT AMA Policy

Alternative Funding Programs D-110.983
Our American Medical Association will educate employers, benefits administrators, and patients on alternative funding programs (AFPs) and their negative impacts on patient access to treatment and will advocate for legislative and regulatory policies that would address negative impacts of AFPs. [Res. 707, A-24]

Adequacy of Health Insurance Coverage Options H-165.846
Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses. [CMS Rep. 7, A-07; Reaffirmation I-07, Reaffirmation A-09; Reaffirmed: Res. 103, A-09; Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res. 101, A-19]

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 109
(I-25)

Introduced by: [1]Bhoomi Shah, [2]Cindy Li, [3]Zain Ahmed, [4]Linwei Li, [5]Zhuochen Yuan

Affiliations: [1]University of Virginia School of Medicine
[2]University of Virginia School of Medicine
[3]University of Virginia School of Medicine
[4]University of Texas Rio Grande School of Medicine
[5]University of Miami School of Medicine

Subject: Support for Covering Genetic Surveillance for High-Risk Patients

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, screening refers to preventive testing offered to the general population, while surveillance involves repeated, long-term monitoring of individuals at high risk- defined as those with a lifetime cancer risk 3- to 4-fold greater than the general population, or an absolute lifetime risk exceeding 20–25% for a specific cancer [10-11]; and

Whereas, individuals with pathogenic germline mutations (e.g., BRCA1/2, TP53, CDKN2A) represent such high-risk populations, as they meet these criteria with markedly increased lifetime risks of multiple cancers, and therefore guidelines recommend early surveillance imaging such as breast magnetic resonance imaging (MRI) and whole-body MRI for timely detection[11-12]; and

Whereas, surveillance imaging enables cancers to be detected at earlier, more treatable stages, reducing morbidity, mortality, and long-term health system costs and early detection of cancer and subsequent intervention has shown substantial increase in 5-year survival rates in multiple cancer types[16-19]; and

Whereas, in hepatocellular carcinoma, meta-analysis data demonstrate that surveillance in patients with cirrhosis leads to a higher rate of early-stage detection (risk ratio [RR] 1.86), increased receipt of curative treatments (RR 1.83), and improved overall survival (hazard ratio 0.67), even after adjusting for lead-time bias[14]; and

Whereas, patients without coverage of screening exams present with screenable cancers in a more advanced state with elevated tumor markers [8]; and

Whereas, surveillance based on risk has demonstrated clinical value in patients with existing colorectal adenomas, stage IV colorectal cancer, and nasopharyngeal carcinoma, including improvements in survival and quality-adjusted life years gained [3,6,9,13]; and

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Whereas, with rising cost of chemotherapy, routine colorectal screening has the potential to be cost-saving by reducing the fee of multisystemic chemotherapy cost for advanced stage treatment ($1317 to $296 per patient), not to mention the avoided physical and emotional burden on patients and their families [21]; and

Whereas, population-based studies demonstrate that screening for colorectal cancer patients yields approximately $16,000 in healthcare savings per patient within the first two years after diagnosis, with lifetime savings projected to be higher [22]; and

Whereas, in a cohort with pathogenic *BRCA1/2* mutations undergoing recommended annual breast MRI surveillance, 11% experienced insurance denials, with Medicaid patients having the highest denial rates, highlighting persistent, system-level barriers to guideline-based preventive care [1,5]; and

Whereas, high-risk population in need of more routine surveillance measures face specific barriers such as prior authorization denials, which hinders early detection of cancer and therefore subsequent higher tumor burden [5]; and

Whereas, prior authorization requirements and insurance denials for surveillance imaging remain a major barrier to care, with patients often facing delays, inconsistent determinations of "medical necessity," and burdensome appeals processes that prevent timely access to evidence-based surveillance, with 69% of cancer patients experiencing care delays due to prior authorization [5,15]; and

Whereas, the Genetic Information Nondiscrimination Act (GINA) prohibits health insurance and employment discrimination on the basis of genetic information but does not mandate coverage of evidence-based surveillance or preventive interventions, leaving patients with hereditary cancer syndromes vulnerable to gaps in insurance protection and financial barriers to recommended care [7]; and

Whereas, existing AMA policy supports insurance coverage for multiple cancer screening services (including breast, lung, and colorectal cancer) but does not yet address the unique needs of patients who require ongoing cancer surveillance due to elevated genetic risk; therefore be it

RESOLVED, that our American Medical Association supports expanding insurance coverage of early surveillance and preventive interventions for patients at elevated risk of cancer.

Fiscal Note: TBD

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RELEVANT AMA Policy

H-55.977 Male Breast Cancer
Our AMA:
1. recognizes that breast cancer is a condition that affects males as well as females;

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2. recognizes that men who carry a known BRCA mutation, have a strong family history of cancer (especially male breast cancer), have a personal history of breast cancer, or have an altered estrogen-testosterone ratio are at increased risk of developing male breast cancer;
3. supports the utilization of heightened surveillance methods when indicated, and consideration of genetic testing when appropriate, in men who are at increased risk of developing breast cancer;
4. supports physician and patient education about the risks, signs, and symptoms of male breast cancer, and genetic consultation for males at increased risk and for their family members; and
5. supports Medicare and insurance coverage for male breast cancer surveillance and diagnostic methods, including clinical breast examination, mammography, genetic consultation, and genetic testing, when indicated.H-185.954 Coverage for Certain Types of Well Care Examinations by Health Insurers: urges health insurers to make available policies that provide coverage for a range of clinical preventative service

H-185.936 Lung Cancer Screening to be Considered Standard Care
Our American Medical Association recommends that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit.
Our AMA will empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States.
Our AMA will work with interested national medical specialty societies and state medical associations to urge the Centers for Medicare & Medicaid Services and state Medicaid programs to increase access to low-dose CT screening for Medicaid patients at high risk for lung cancer by including it as a covered benefit, without cost-sharing or prior authorization requirements, and increasing funding for research and education to improve awareness and utilization of the screening among eligible enrollees.

H-185.960 Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans
Our American Medical Association supports health plan coverage for the full range of colorectal cancer screening tests.
Our AMA will advocate through legislation and/or regulation, as appropriate for adequate payment and the elimination of cost-sharing in all health plans for the full range of colorectal cancer screening and all associated costs, including colonoscopy that includes a “diagnostic” intervention (i.e. the removal of a polyp or biopsy of a mass), as defined by Medicare. To further this goal, the AMA will develop a coding guide to promote common understanding among health care providers, payers, health care information technology vendors, and patients.
Our AMA will seek to eliminate cost-sharing in all health plans for “follow-on” colonoscopies performed for colorectal cancer screening and all associated costs, defined as when other alternative screening tests (i.e., stool- or blood-based tests) are found to be positive.
Our AMA will seek to classify follow-up, follow-on, or surveillance colonoscopy after an original screening colonoscopy that required polyp removal as a screening service under the Affordable Care Act preventive services benefit and will seek to eliminate patient cost sharing in all health plans under such circumstances.

H-525.993 Screening Mammography
Our AMA:
a. recognizes the mortality reduction benefit of screening mammography and supports its use as a tool to detect breast cancer.
b. recognizes that as with all medical screening procedures there are small, but not inconsequential associated risks including false positive and false negative results and overdiagnosis.
c. favors participation in and support of the efforts of professional, voluntary, and government organizations to educate physicians and the public regarding the value of screening mammography in reducing breast cancer mortality, as well as its limitations.

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d. advocates remaining alert to new epidemiological findings regarding screening mammography and encourages the periodic reconsideration of these recommendations as more epidemiological data become available.
e. believes that beginning at the age of 40 years, all women should be eligible for screening mammography.
f. encourages physicians to regularly discuss with their individual patients the benefits and risks of screening mammography, and whether screening is appropriate for each clinical situation given that the balance of benefits and risks will be viewed differently by each patient.
g. encourages physicians to inquire about and update each patient's family history to detect red flags for hereditary cancer and to consider other risk factors for breast cancer, so that recommendations for screening will be appropriate.
h. supports insurance coverage for screening mammography.
i. supports seeking common recommendations with other organizations, informed and respectful dialogue as guideline-making groups address the similarities and differences among their respective recommendations, and adherence to standards that ensure guidelines are unbiased, valid and trustworthy.
j. reiterates its longstanding position that all medical care decisions should occur only after thoughtful deliberation between patients and physicians.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 112
(I-25)

Introduced by: Jon Bernard[1], Alison Blodgett[2], Michael Youn[3], Khushbakht Shah[4], Anand Kathardekar[4], Suraj Joshi[5]

Affiliations:
[1] University of Cincinnati College of Medicine
[2] Indiana University School of Medicine
[3] California Northstate University College of Medicine
[4] Northeast Ohio Medical University
[5] Tufts University School of Medicine

Subject: Eliminating the Medicaid Institution for Mental Diseases Exclusion

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, in 1965, the law that created Medicaid also introduced the Institution for Mental Diseases (IMD) exclusion[1]; and

Whereas, the IMD exclusion prevents Medicaid from funding inpatient care rendered to Medicaid patients aged 21 to 64 in facilities with more than 16 beds that primarily provide psychiatric treatment[1]; and

Whereas, when the IMD exclusion was created, psychiatric care primarily took place in large state hospitals funded and operated by the states, and the exclusion was intended to keep states financially responsible for those institutions while simultaneously steering Medicaid funding toward general hospitals and community-based facilities and promoting deinstitutionalization[2]; and

Whereas, while deinstitutionalization has continued, community resources have not met growing mental health needs, leaving patients with serious mental illness dependent on emergency departments, jails, and shelters for care[3]; and

Whereas, patient outcomes, measured by decreased suicide risk, are improved when individualized care is given in psychiatric inpatient facilities rather than outside of these facilities[4, 5]; and

Whereas, the IMD exclusion has caused a shortage of accessible inpatient psychiatric beds, forcing patients to wait longer for care and increasing strain on emergency departments; and[6]
Whereas, removing the IMD exclusion would enable health systems to be eligible to receive Medicaid reimbursement for inpatient mental health services, improving the financial sustainability of these facilities and expanding patient access[1, 2]; and

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Whereas, current AMA policy supports improving access to psychiatric beds and maintaining state mental health services, but does not explicitly address federal policies that limit Medicaid coverage for inpatient mental health care[7]; and

Whereas, Medicaid funding in some states can currently support short-term substance use treatment, but not other mental health treatment, through Section 1115 waiver programs as a temporary opportunity to increase funding for this care[8]; and

Whereas, 16 states and the District of Columbia have received Section 1115 waivers allowing Medicaid to reimburse all mental health treatment beyond just substance use disorder, and an analysis from 2017 to 2021 showed that 12 of these states and the District of Columbia experienced decreases in mental health–related emergency department visits, underscoring the benefit of covering all serious mental health treatment, not just substance use disorder[9]; and

Whereas, the AMA has addressed the IMD exclusion in letters to states, the House, and the Senate (most recently in 2020), but the AMA has only advocated for continuation of and increased access to waivers as a temporary solution[10]; and

Whereas, bipartisan bills that would fully eliminate the IMD exclusion were introduced yearly in the U.S. House of Representatives from 2022-2025, but the AMA did not advocate for the passage of these bills[1, 10]; and

Whereas, explicit policy would allow AMA advocacy staff to support legislation that eliminates the IMD in its entirety instead of promoting waivers as a temporary solution, ensuring equitable access to mental health and substance use treatment, advancing parity in medical care, and strengthening behavioral healthcare systems[2]; and therefore be it

RESOLVED, that our American Medical Association support and advocate for the elimination of the Medicaid Institution for Mental Diseases (IMD) exclusion.

Fiscal Note: TBD

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RELEVANT AMA Policy

Support for Continuance of Section 1115 Medicaid Waivers and Demonstration Projects D-290.971: Our AMA supports the use of Medicaid Section 1115 waivers to address health-related social needs through evidence-based and medically appropriate interventions.

Access to Psychiatric Beds and Impact on Emergency Medicine H-345.978: Our AMA supports efforts to facilitate access to both inpatient and outpatient psychiatric services and the continuum of care for mental illness and substance use disorders, ameliorate the psychiatric workforce shortage, and provide adequate reimbursement for the care of patients with mental illness.

Medicaid Coverage of Adults in Psychiatric Hospitals H-345.976: Our American Medical Association will monitor the Medicaid Emergency Psychiatric Demonstration Project established by the Patient Protection and Affordable Care Act for consistency with AMA policy, especially the impact on access to psychiatric care and treatment of substance use disorders.

Maintaining Mental Health Services by States H-345.975: Our American Medical Association supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 211
(I-25)

Introduced by: Rachel Westphal[1]* and Cecilia Li[1]*

Affiliations: [1] Michigan State University College of Human Medicine
*Both authors contributed equally to this resolution.

Subject: Recognition of Intersex Individuals and their Human Rights

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, intersex individuals, also known as individuals with Differences of Sex Development or "DSD" or Variations in Sex Characteristics or "VSC,"[1] are those born with naturally occurring variations in chromosomal, gonadal, or anatomical sex characteristics; and

Whereas, intersex individuals represent up to 1.7% of the population and often face stigma, discrimination, and inadequate or harmful non-consensual medical treatment[2]; and

Whereas, intersex infants and children have historically been subjected to irreversible and non-consensual genital surgeries or gonadectomies to conform to binary sex norms[3], despite a lack of evidence for medical necessity and substantial risk of long-term psychological and physical harm[4]; and

Whereas, in 2025, the president of the United States issued an executive order, Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, which erased the recognition of intersex individuals by asserting a sexual binary defined by medically inaccurate terms[5]; and

Whereas, this erasure of the intersex identity increases the disparities[6,7] experienced by intersex people in all aspects of life, including healthcare[8,9], and violates their human rights; and

Whereas, the AMA should adopt an analogous position to the 2023 position of the United Nations[10] and the 2024 position of the World Health Organization[11] to support the validation of intersex as a sex category to be assigned at birth; and

Whereas, "intersex" refers to naturally occurring variations in sex characteristics, making it a distinct classification that is not defined by gender identity alone; and

Whereas, intersex is not necessarily synonymous with "undesignated" or "nonbinary," as the latter terms refer to a broader category of individuals who self-determine their gender identity to be outside of the male-female binary; and

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Whereas, while intersex individuals may choose to self-determine their gender identity, they should have the right to choose to identify as intersex as a distinct legal sex category; and

Whereas, requiring intersex individuals to choose only between nonbinary, undesignated, male, and female for legal sex is restrictive, inaccurate, and erases the existence of intersex as a distinct biological reality; and

Whereas, current AMA policy H-65.967 supports the inclusion of an undesignated or nonbinary gender option in addition to "male" and female" on government records and identification, however, this language does not explicitly recognize intersex individuals as a distinct category for sex or gender designation; therefore, be it

RESOLVED, that our American Medical Association support the right of intersex individuals, individuals with Differences of Sex Development (DSD) and variations in sexual characteristics (VSC) to have "intersex" or other alternatives including "X" as a sex category assigned at birth or selected later in medical and legal documentation on the federal and state levels.

Fiscal Note: TBD

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RELEVANT AMA Policy

Conforming Sex and Gender Designation on Government IDs and Other Documents H-65.967

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1. Our American Medical Association supports every individual's right to determine their gender identity and sex designation on government documents and other forms of government identification.
2. Our AMA supports policies that allow for a sex designation or change of designation on all government IDs to reflect an individual's gender identity, as reported by the individual and without need for verification by a medical professional.
3. Our AMA supports policies that include an undesignated or nonbinary gender option for government records and forms of government-issued identification, which would be in addition to "male" and "female."
4. Our AMA supports efforts to ensure that the sex designation on an individual's government-issued documents and identification does not hinder access to medically appropriate care or other social services in accordance with that individual's needs.
5. Our AMA will advocate for the removal of sex as a legal designation on the public portion of the birth certificate, recognizing that information on an individual's sex designation at birth will still be submitted through the U.S. Standard Certificate of Live Birth for medical, public health, and statistical use only.
   [Res. 4, A-13; Appended: BOT Rep. 26, A-14; Modified: Res. 3, A-19; Appended: BOT Rep. 15, A-21]

Medical Spectrum of Gender D-295.312
Given the medical spectrum of gender identity and sex, our 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. [Res. 003, A-17; Modified: Res. 005, I-18]

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967
Our 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… [Res. 212, I-16; Reaffirmed in lieu of: Res. 008, A-17; Modified: Res. 16, A-19; Appended: Res. 242, A-19; Modified: Res. 04, I-19]

RELEVANT MSS POSITIONS

Supporting Autonomy for Intersex Patients and Patients with Differences of Sex Development 245.020MSS
AMA-MSS will ask that our AMA affirm that medically unnecessary surgeries in intersex patients and individuals born with differences of sex development are unethical and should be avoided until the patient can actively participate in decision-making. (MSS Res 17, I-15) (AMA Res 003, A-16 Referred) (Reaffirmed: MSS Res. 086, Nov. 2020) (Reaffirmed: MSS GC Rep B, A-21)

Conforming Sex and Gender Designation on Government IDs and Other Documents 65.035MSS
AMA-MSS (1) formally supports HOD policy H-65.967, Conforming Sex and Gender Designation on Government IDs and Other Documents; and (2) rescinds policy 65.019MSS, Conforming Birth Certificate Policies to Evolving Medical Standards for Transgender Patients. (MSS Res. 31, I-19) (Reaffirmed: MSS GC Report A, A-24)

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation 315.005MSS

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AMA-MSS will ask (1) that our AMA support the inclusion of a patient's biological sex, gender identity, sexual orientation, pronoun(s), and (if applicable) surrogate identifications in medical documentation and related forms in a culturally-sensitive manner; and (2) that our AMA advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health. (MSS Res 09, A-16) (Amended: LGBTQ+ Affairs Report A, A-21)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 212
(I-25)

Introduced by: Vlada Stark[1], Madison Kurth[2], Rachel Rezabek[3], Jillian Luthy[1], Sarah Al-shimary[1], Muhammad Shamim[1], Marianne Estrada[1], Zhuochen Yuan[4], Eileen Enriquez[1], Ryan Jannoud[1], Conan Ng[1], Mira Dani[1]

Affiliations: [1]University of Nevada, Las Vegas Kirk Kerkorian School of Medicine
[2]University of Wisconsin School of Medicine and Public Health
[3]University of Virginia School of Medicine
[4]University of Miami Miller School of Medicine

Subject: Ensuring Multilingual Pediatric Access Points for Undocumented Patients

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, the expansion of U.S. Immigration and Customs Enforcement (ICE) and its aggressive enforcement actions has increased barriers to education and healthcare access for undocumented immigrants and their children, including exclusion from federal health programs and fear of family separation or deportation, creating confusion on how to safely access resources[1-7]; and

Whereas, delays in preventive care for pediatric patients increase the risks of infectious disease outbreaks, missed identification of developmental delays, and untreated mental and behavioral health concerns[8,9]; and

Whereas, many undocumented immigrants face language barriers that create a need for multilingual resources across education, healthcare, and employment opportunities[10,11]; and

Whereas, language access is a critical determinant of health and effective communication is essential to equitable pediatric care, yet nearly one in four children in the United States belongs to an immigrant family, and approximately 60% of these children have at least one parent with limited English proficiency, creating challenges to understanding medical information, confidentiality protections, and available services[12-14]; and

Whereas, language barriers and unclear communication in pediatric healthcare settings hinder immigrant families' understanding of diagnoses and treatment plans, contributing to disparities in preventive care (63% vs 74% in English-speaking households), lower rates of medical home use (18% vs 33%), and increased likelihood of reporting poor health outcomes (43% vs 12%)[15]; and

Whereas, school districts such as Chicago Public Schools and Los Angeles Unified School District have created publicly accessible platforms offering immigrant families resources on legal rights, workshops, financial aid, and health support, delivered in multiple languages (including Spanish, English, Tagalog, and Russian) and formats (websites, videos, factsheets, and cards),

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thereby demonstrating that multilingual and multimodal outreach can reduce barriers and expand access to essential services[16,17]; and

Whereas, the implementation of multilingual resources and health records has been shown to improve doctor–patient relationships, reduce anxiety, increase adherence to treatment plans, and give families more control over health decisions[18,19]; and

Whereas, school nurses remain the most frequently utilized health service in schools, with 65.8% of referrals for screenings and substantial visits for acute and chronic conditions, underscoring schools as critical access points for trauma-informed pediatric care, where the utilization of multilingual resources helps eliminate barriers to accessibility[19,20]; and

Whereas, federally qualified health centers (FQHCs) and School-Based Health Centers (SBHCs) serve as critical sites for families seeking free or low-cost healthcare, with more than 3,900 SBHCs—most located in low-income Title I schools—providing primary, preventive, and mental health services to 6.3 million students annually, including uninsured, underinsured, and undocumented children[21-23]; and

Whereas, Telehealth Access Points (TAPs) are dedicated public spaces for attending telehealth appointments that help undocumented pediatric patients overcome technological limitations, lack of digital literacy, and transportation challenges, enhancing trauma-informed care and healthcare outcomes[24]; and

Whereas, broadband internet deserts limit patient portal use and provider communication, disproportionately impacting low-income, minority, and uninsured populations, underscoring the essential role of SBHCs as equitable, in-person access points for care when digital health technologies fall short[25]; and

Whereas, the American Academy of Pediatrics has established guidelines, including immigrant child health advocacy initiatives and the Council on Immigrant Child and Family Health, which promote access to healthcare for children in immigrant families[26]; therefore be it

RESOLVED, that our American Medical Association support the creation and dissemination of multilingual educational resources in pediatric access points, including schools, School-Based Health Centers, and Telehealth Access Points, to ensure immigrant families clearly understand confidentiality protections, patient rights, diagnoses, and available services.

Fiscal Note: TBD

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RELEVANT MSS POLICY

60.026MSS Support for Children of Incarcerated Parents
AMA-MSS asked the AMA to support legislation and initiatives that provide resources and support for children of incarcerated parents.

60.045MSS Expanding Adverse Childhood Experiences Categories
That our AMA-MSS support (1) collaboration with the CDC and other relevant parties to advocate for the addition of witnessing violence, experiencing discrimination, living in an unsafe neighborhood, experiencing bullying, placement in foster care, migration-related trauma, living in poverty, and any additional categories as needed and justified by scientific evidence to the currently existing Adverse Childhood Experiences (ACEs) categories for the purposes of continuing to improve research into the health impacts of ACEs and how to mitigate them; (2) working with the CDC and other relevant parties to

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advocate for resources to expand research into ACEs and efforts to operationalize those findings into effective and evidence-based clinical and public health interventions; and (3) the establishment of a national ACEs response team grant to dedicate federal resources to supporting prevention and early intervention efforts aimed at diminishing the impacts ACEs have on the developing child.

270.041MSS Supporting External Accountability for ICE and CBP
AMA-MSS promotes the health and well-being of immigrants and their families who are affected by immigration raids and/or held in detention by U.S. Immigration and Customs Enforcement or U.S. Customs and Border Protection.

RELEVANT AMA POLICY
Adverse Childhood Experiences and Trauma-Informed Care H-515.952
Our American Medical Association recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization

Care of Women and Children in Family Immigration Detention H-350.955
(1) Our AMA recognizes the negative health consequences of the detention of families seeking safe haven. (2) Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States. (3) Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.(4) Our AMA will advocate for access to health care for women and children in immigration detention.(5) Our AMA will advocate for the preferential use of alternatives to detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies.(6) Our AMA advocates for the implementation of evidence-based, child-centered, and trauma-informed policies across all detention centers, ensuring detained minors have access to developmentally appropriate socioemotional care, including physical contact, and for all detained people, free, unfettered communication access including regular in-person communication, phone calls, and letters.(7) Our AMA supports efforts to address and mitigate concerns and accusations of child abuse and neglect in detention centers.

Providing Medical Services through School-Based Health Programs H-60.991
Our American Medical Association supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 301
(I-25)

Introduced by: Amandine Roure[1]

Affiliations: [1] Kirk Kerkorian School of Medicine at UNLV

Subject: Protecting Physicians-in-Training from Data Broker Exploitation

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, physicians-in-training increasingly rely on online platforms for student loans, educational resources, credentialing, and mental health services, creating unique exposure to third-party data broker collection, aggregation, and resale of personal information[1]; and

Whereas, commercial data brokers collect, aggregate, and sell location and behavioral data that can reveal visits to sensitive sites and health-related usage patterns, placing individuals at risk of stigma, harassment, discrimination, and other harms as documented by enforcement actions such as *FTC v. Kochava, Inc.* and subsequent FTC actions restricting sales of sensitive location data[2,3]; and

Whereas, public-interest research and policy analyses have demonstrated that data brokers and downstream actors buy and exchange information about mental-health conditions and other sensitive indicators, and that popular mental-health apps often share user data with third parties—creating an identifiable risk vector for people seeking care, including medical trainees[4,5]; and

Whereas, while HIPAA protects patient health information, it does not extend to the personal data that trainees generate through non-clinical platforms, leaving a gap in protections for medical students, residents, and early-career physicians[6]; and

Whereas, current AMA policies (H-406.991[7], H-406.997[8], and D-406.995[9]) principally address physician data in clinical or professional contexts rather than commercial resale of trainee personal data; and

Whereas, some states such as California[10], Vermont[11], Texas[12], and Oregon[13] have enacted data broker regulations requiring registration, audits, or opt-out mechanisms, but these state laws vary in scope and implementation, producing an uneven patchwork of protections that leaves trainees in many jurisdictions without consistent safeguards; and

Whereas, a uniform national standard for personal data protections would ensure consistent safeguards across all states, reducing inconsistencies in data privacy protections[14]; and

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Whereas, physicians-in-training face heightened risk because access to loan, credentialing, and mental health platforms is often a condition of professional advancement, making them structurally more vulnerable to data exploitation than the general public[1]; therefore be it

RESOLVED, that our American Medical Association support federal and state legislative and regulatory efforts to restrict the collection and resale of personally identifiable information from medical students, residents, and early-career physicians by commercial data brokers; and be it further

RESOLVED, that our AMA advocate for transparent disclosure of data collection practices by licensing boards, educational platforms, and online credentialing services used by physicians-in-training; and be it further

RESOLVED, that our AMA support the development of accessible opt-out mechanisms for medical students, residents, early-career physicians, and practicing physicians from nonessential data collection and aggregation by commercial platforms.

Fiscal Note: TBD

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RELEVANT MSS POLICY

Work of the Task Force on the Release of Physician Data H-406.991
Principles for the Public Release and Accurate Use of Physician Data

The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data when it is used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care for all patients and is used to provide accurate physician performance assessments in concert with the following Principles: 1. Patient Privacy Safeguards, 2. Data Accuracy and Security Safeguards, 3. Transparency Requirements, 4. Review and Appeal Requirements, 5. Physician Profiling Requirements, 6. Quality Measurement Requirements, 7. Patient Satisfaction Measurement Requirements

Collection and Analysis of Physician-Specific Health Care Data H-406.997
1. Our AMA advocates that third party payers, government entities, and others that collect and analyze physician-specific health care data adhere to the following principles: (a) The methods for collecting and analyzing physician-specific health care data shall be disclosed to physicians under review and the public. (b) Physician-specific health care data shall be valid, accurate, objective and used primarily for the education of both consumers and physicians. (c) Data elements used in the collection of physician-specific health care data, including severity adjustment factors, shall be determined by advisory committees which include actively practicing, and where relevant, specialty-specific, physicians from the region where the data are being collected. (d) Statistically valid data collection, analysis, and reporting methodologies, including establishment of a statistically significant minimum number of cases, shall be developed and appropriately implemented prior to the release of physician-specific health care data. (e) The quality and accuracy of the physician-specific health care data shall be evaluated by conducting periodic medical record audits.

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2. Our AMA believes that health care coalitions which include physicians as full voting members are an appropriate forum for undertaking health care data collection and analysis activities; in consideration of the potential for misinterpretation, violation of privacy rights, and antitrust concerns, it is recommended that charge or utilization data provided to such entities by government, third party payers, and self-insureds companies be in the form of ranges or averages and not be physician-specific.

D-406.995 – Safeguard NPI and Physician Privacy
Our AMA will advocate for an approach that restricts NPI access to those with a legitimate need for these numbers and pursue a strategy that minimizes the amount of information released in association with each NPI number.

RELEVANT MSS POSITIONS

Healthcare Provider Data Privacy Protection 480.036MSS
AMA-MSS (1) supports physicians and healthcare providers who experience doxxing, and support nondiscrimination and privacy protection for employees, and the availability of resources on doxxing; (2) supports data privacy and anti-doxxing laws to prevent harassment, threats, and non-consensual publishing of information; and (3) supports institutions, employers, and state medical societies in providing legal resources and support to individuals affected by doxxing and prophylactically prevent doxxing through training and education on the issue.

Increased Health Privacy on Mobile Apps in Light of Roe v. Wade 480.030MSS
AMA-MSS will ask the AMA to amend policy D-315.968 by addition as follows:

Supporting Improvement to Patient Data Privacy D-315.968
Our AMA will (1) strengthen patient and physician data privacy protections by advocating for legislation that reflects the AMA's Privacy Principles with particular focus on mobile health apps and other digital health tools, <u>in addition to non-health apps and software capable of generating patient data and (2) will work with appropriate stakeholders to oppose using any personally identifiable data to identify patients, potential patients who have yet to seek care, physicians, and any other healthcare providers who are providing or receiving healthcare that may be criminalized in a given jurisdiction.</u>

Privacy of Student Electronic Medical Records at Medical School Affiliated Hospitals 315.002MSS
AMA-MSS supports added safeguards, such as audits or "break the glass" access, for medical student records when those records are placed in the same system used for patients at the school's affiliated hospitals.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 311
(I-25)

Introduced by: Vignesh Senthilkumar[1], Samir Reddy[2], Druv Bhagavan[3]

Affiliations: [1] University of Virginia School of Medicine
[2] UT Southwestern Medical School
[3] Washington University School of Medicine

Subject: Evaluation of Situational Judgement Tests in Medical School Admissions

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, medical school applicants face substantial barriers, and the application process itself is becoming increasingly inaccessible to students, being both monetarily and mentally taxing[1-2, 18-19]; and

Whereas, situational judgment tests are video- and text-based examinations that evaluate an applicant's judgment and decision-making skills, interpersonal competencies, professionalism, ethics, and empathy[3]; and

Whereas, 64 medical schools require or recommend, two common SJTs in medical school admissions[4-5]; and

Whereas, despite medical students and applicants overwhelmingly calling for greater transparency in admissions processes, medical schools rarely elaborate on how these examinations are used in admissions[6]; and

Whereas, while SJTs may play a role in a holistic admissions process, they do not replace existing, more personal methods of interpersonal evaluations, such as multiple mini-interviews[7]; and

Whereas, holistic evaluation of a candidate is impossible to successfully conduct in a timed SJT[8]; and

Whereas, there is little to no correlation between performance on SJTs and both academic success and likelihood of disciplinary action[9,10]; and

Whereas, SJT scores show significant group differences by race, ethnicity, and gender, and provide only modest predictive value beyond traditional metrics such as MCAT and GPA, raising equity concerns[11-16]; and

Whereas, the AMA itself has encouraged caution when utilizing novel online personality assessments for admission and/or selection for residency and fellowship programs[17]; and

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Whereas, despite seeing increasing use, SJTs have not yet been universally adopted, leaving a key window for our AMA to act; therefore be it

RESOLVED, that our American Medical Association work with the Association of American Medical Colleges and other relevant stakeholders to evaluate the utilization of situational judgment tests, and other similar online decision-making assessments in the medical school admissions process and determine whether or not this style of examination meets the AMA's stated goal of holistic applicant review, unbiased by non-modifiable factors; and be it further

RESOLVED, that our AMA advocate for greater transparency in how situational judgement tests are scored, and in their current utilization in medical school admissions.

Fiscal Note: TBD

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RELEVANT MSS POLICY

Medical Student Involvement and Validation of the Standardized Video Interview Implementation D-310.949
Our AMA: (1) will work with the Association of American Medical Colleges and its partners to advocate for medical students and residents to be recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process; (2) will advocate for delaying expansion of the Standardized Video Interview until data demonstrates the Association of American Medical Colleges' stated goal of predicting resident performance, and make timely recommendations regarding the efficacy and implications of the Standardized Video Interview as a mandatory residency application requirement; and (3) will, in collaboration with the Association of American Medical Colleges, study the potential implications and repercussions of expanding the Standardized Video Interview to all residency applicants.
Res. 960, I-17

Increasing Medical School Class Sizes D-295.938
Our AMA supports increasing the number of medical students, provided that such expansion would not jeopardize the quality of medical education.
Res. 309, A-08 Reaffirmed: CME Rep. 01, A-18

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our American Medical Association, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following:
    a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school.
    b. Diversity or minority affairs offices at medical schools.
    c. Financial aid programs for students from groups that are underrepresented in medicine.
    d. Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities.

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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

Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process D-310.945

1. Our AMA will encourage medical schools, medical honor societies, and residency/fellowship programs to work toward ethical, equitable, and transparent recruiting processes, which are made available to all applicants.
2. Our AMA will advocate for residency and fellowship programs to avoid using objective criteria available in the Electronic Residency Application Service (ERAS) application process as the sole determinant for deciding which applicants to offer interviews.
3. Our AMA will advocate to remove membership in medical honor societies as a mandated field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting its use as an automated screening mechanism—and encourage applicants to share this information within other aspects of the ERAS application.
4. Our AMA will advocate for and support innovation in the undergraduate medical education to graduate medical education transition, especially focusing on the efforts of the Accelerating Change in Medical Education initiative, to include pilot efforts to optimize the residency/fellowship application and matching process and encourage the study of the impact of using filters in the Electronic Residency Application Service (ERAS) by program directors on the diversity of entrants into residency.
5. Our AMA will encourage caution among medical schools and residency/fellowship programs when utilizing novel online assessments for sampling personal characteristics for the purpose of admissions or selection and monitor use and validity of these tools.

CME Rep. 02, I-22 Reaffirmed: CME Rep. 05, A-25

Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education H-295.844

1. Our American Medical Association will encourage interested parties to study the impact of different interview formats on applicants, programs, and institutions.
2. Our AMA will continue to monitor the impact of different interview formats for medical school and graduate medical education programs and their effect upon equity, access, monetary cost, and time burden along with the potential downstream effects upon on applicants, programs, and institutions.
3. Our AMA recommends that individual medical schools use the same interview format for all applicants to the same class at their institution to promote equity and fairness while allowing for accommodations for individuals with disabilities.
4. Our AMA recommends that individual graduate medical education programs use the same interview format for all applicants to the same program to promote equity and fairness while allowing for accommodations for individuals with disabilities.

CME Rep. 03, I-23

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Educating Competent and Caring Health Professionals H-295.975
(1) Programs of health professions education should foster educational strategies that encourage students to be independent learners and problem-solvers. Faculty of programs of education for the health professions should ensure that the mission statements of the institutions in which they teach include as an objective the education of practitioners who are both competent and compassionate.
(2) Admission to a program of health professions education should be based on more than grade point average and performance on admissions tests. Interviews, applicant essays, and references should continue to be part of the application process in spite of difficulties inherent in evaluating them. Admissions committees should review applicants' extra-curricular activities and employment records for indications of suitability for health professions education. Admissions committees should be carefully prepared for their responsibilities, and efforts should be made to standardize interview procedures and to evaluate the information gathered during interviews. Research should continue to focus on improving admissions procedures. Particular attention should be paid to improving evaluations of subjective personal qualities.
(3) Faculty of programs of education for the health professions must continue to emphasis than they have in the past on educating practitioners who are skilled in communications, interviewing and listening techniques, and who are compassionate and technically competent. Faculty of health professions education should be attentive to the environment in which education is provided; students should learn in a setting where respect and concern are demonstrated. The faculty and administration of programs of health professions education must ensure that students are provided with appropriate role models; whether a faculty member serves as an appropriate role model should be considered when review for promotion or tenure occurs. Efforts should be made by the faculty to evaluate the attitudes of students toward patients. Where these attitudes are found lacking, students should be counseled. Provisions for dismissing students who clearly indicate personality characteristics inappropriate to practice should be enforced.
(4) In spite of the high degree of specialization in health care, faculty of programs of education for the health professions must prepare students to provide integrated patient care; programs of education should promote an interdisciplinary experience for their students.
BOT Rep. NN, A-87 Modified: Sunset Report, I-97 Reaffirmed: CME Rep. 2, A-07 Reaffirmed: CME Rep. 01, A-17

RELEVANT MSS POSITIONS

295.250MSS Support for Innovative Medical School Pathways
AMA-MSS will ask that our AMA collaborate with AMA's ChangeMedEd Initiative to study the following topics and report back with recommendations on ways to innovate the structure, content, and timing of medical education:
a) Expansion of three-year pathways and pathways prioritizing residency seats for students entering primary care, OBGYN, psychiatry, and practice in under-resourced, rural, and IHS areas;
b) Re-evaluation of premedical prerequisites for clinical readiness (including organic chemistry, calculus, and calculus-based physics versus high-school physics) and expectation of a bachelor's degree for medical school;
c) Medical school acceptance of prerequisite credit earned in high school or community college or via placement/test-out examinations, to prevent pressure to repeat coursework;
d) Options to shorten preclinical education to better reflect clinical readiness and emphasize clinical exposure, including external asynchronous study aids, placement/test-out examinations, and completion of preclinical education prior to medical school;
e) Possibility of merging the MCAT and USMLE Step 1/COMLEX Level 1;
f) Changes to standardized exams to better reflect clinical readiness, including adjusting frequency of questions based on their proportional relevance to clinical knowledge expected for a general medical degree, while still including content on less common concepts.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 401
(I-25)

Introduced by: Micah Char[1], Galileo Dumont[2], Shane Jung[1], Eileen Enriquez[1]

Affiliations: [1] Kirk Kerkorian School of Medicine at UNLV
[2] University of Colorado Anschutz School of Medicine

Subject: Support Heavy Metal and Toxic Exposure Testing for Residents Affected by Wildfires

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, wildfires in the United States are increasing in frequency and intensity, driven in part by climate change, with the annual acreage burned doubling in recent decades[1]; and

Whereas, urban and suburban wildfires increasingly burn homes, vehicles, electronics, and industrial facilities, producing hazardous air, soil, and water contamination distinct from forest-only fires[2]; and

Whereas, toxic substances released by burning urban infrastructure include heavy metals such as lead, arsenic, mercury, and cadmium, as well as polycyclic aromatic hydrocarbons (PAHs), dioxins, and volatile organic compounds (VOCs)[3]; and

Whereas, wildfire smoke can travel hundreds of miles, exposing populations far beyond the burn zone to toxic pollutants, with documented effects on air quality across entire regions[4]; and

Whereas, wildfire smoke exposure is associated with increased hospital admissions for respiratory disease, cardiovascular events, and premature mortality, as well as with increased risk of some types of cancer[5-7]; and

Whereas, wildfire byproduct exposure is estimated to cause tens of thousands of hospitalizations and premature deaths each year, resulting in billions of dollars in health care costs and lost productivity nationwide[8-11]; and

Whereas, fire suppressants used to combat wildfires often themselves contain heavy metals contributing to environmental contamination[12]; and

Whereas, toxic heavy metals such as lead and cadmium persist in the environment long after fires are extinguished, contaminating soil, groundwater, and household dust[13,14]; and

Whereas, the CDC lowered the blood lead reference value for children in 2021, monitoring for mild or moderate environmental exposures[15], and chronic exposure is associated with irreversible neurocognitive deficits in children, as well as hypertension, renal dysfunction, and adverse pregnancy outcomes[16,17]; and

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Whereas, first responders, cleanup workers, utility crews, and residents can become exposed to harmful smoke during and after fires, and this exposure can be detected and quantified with post-incident urine testing for smoke byproducts (PAHs)[18]; and

Whereas, current AMA policy *Hazardous Pollutants and Heavy Metals* (D-135.962) addresses chronic environmental toxins in food, water, and soil, but does not address the acute, mixed toxic exposures unique to wildfire events[19]; and

Whereas, current AMA policies *Reducing Lead Poisoning* (H-60.924) and *Global Climate Change and Human Health* **(**H-135.938) emphasize environmental history-taking and exposure assessment, but do not establish standardized post-wildfire community screening or medical follow-up[20,21]; and

Whereas, current AMA policies *AMA Advocacy for Environmental Sustainability and Climate (* (H-135.923) and *Stewardship of the Environment* (H-135.973) broadly support climate change adaptation, but do not provide wildfire-specific mechanisms for toxicant screening or equitable access to care[22,23]; and

Whereas, current AMA policy *AMA Public Health Strategy* (D-440.912) supports public health infrastructure broadly, but does not specifically call for post-wildfire toxic exposure testing, mobile health services, or follow-up care for impacted communities[24]; and

Whereas some state public health agencies, in coordination with national agencies, have tested residents for heavy metal toxicity following wildfire, yet such testing is not standardized nor implemented after all wildfires[25,26]; therefore be it

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

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

Fiscal Note: TBD

Received: 09/21/2025

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RELEVANT MSS POLICY

Global Climate Change and Human Health H-135.938

1. Our AMA: …(3b) Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability. (5)Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment. [CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22]

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Hazardous Pollutants and Heavy Metals D-135.962
Our AMA (1) urges governmental agencies to establish and enforce limits for identified hazardous pollutants and heavy metals in our food, water, soil, and air. (2a) monitor the chronic effects of exposure to hazardous pollutants and heavy metals including at levels below regulation limits; (2b) monitor the burden of toxicity in communities, especially near urban, Superfund, military bases, and industrial sites; and (2c) educate individuals on the chronic effects of those exposures. [Res. 409, A-24]

Reducing Lead Poisoning H-60.924
Our AMA (3) will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: (b) identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed; (c) continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services; (e) provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead. [CCB/CLRPD Rep. 3, A-14Appended: Res. 926, I-16Appended: Res. 412, A-17Modified: Res. 432, A-24Modified: Speakers Rep. 02, I-24]

Mercury Pollution D-135.992
(1) Our American Medical Association recognizes that the trading of air pollutants is potentially harmful for vulnerable populations. (2) Our AMA encourages state governments to be proactive in protecting citizens from harmful mercury emissions. (3) Our AMA encourages reduction in mercury use in manufacturing wherever possible, and recognize that more must be done using available and emerging technology to reduce mercury emissions. (4) Our AMA recommends increased vigilance, monitoring and tracking of mercury use and emissions in chlor-alkali facilities that use mercury in manufacturing processes. (5) Our AMA encourages the US government to assume a leadership role in reducing the global mercury burden and work toward promoting binding, health-protective international standards. (6) Our AMA supports the Environmental Protection Agency's national mercury emissions standards for cement kilns at limits based on the latest pollution control technology. (7) Our AMA supports modern and strict source monitoring of mercury emissions from cement plants.

Federal Programs H-135.999
The AMA believes that the problem of air pollution is best minimized through the cooperative and coordinated efforts of government, industry and the public. Current progress in the control of air pollution can be attributed primarily to such cooperative undertakings. The Association further believes that the federal government should play a significant role in these continuing efforts. This may be done by federal grants for (1) the development of research activity and (2) the encouragement of local programs for the prevention and control of air pollutants.

AMA Advocacy for Environmental Sustainability and Climate H-135.923
(1) Our AMA encourages health care organizations to develop climate resilience plans, for the continuity of operations in an emergency, that take into account the needs of groups in their community that experience disproportionate risk of climate-related harm and ensure the necessary collaboration between different types of healthcare facilities. (2) Our AMA recognizes that climate resilience and mitigation efforts will be community-specific and supports physician engagement at the local level to promote community alliances for environmental justice and equity. (3) Our AMA supports the Joint Commission’s Sustainable Healthcare Certification, which supports health systems in pursuing decarbonization by establishing greenhouse gas (GHG) baseline emissions as well as measuring and documenting GHG reductions. (4) Our AMA supports the development of strategies and technologies to strengthen supply chain networks, including economic incentives for building climate and disaster resiliency and redundancy into new or updated facilities, increasing emergency stockpiles of key products, and incentivizing the innovation and adoption of reusable medical products to resist the impact of supply chain disturbances.

Stewardship of the Environment H-135.973

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Our AMA encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.

AMA Public Health Strategy D-440.912
Our AMA will continue to support increased funding for public health infrastructure and workforce, which should include funding for preventative medicinerelated residency programs, to increase public health leadership in this country.

RELEVANT MSS POSITIONS

MSS Toward Environmental Responsibility 135.012
The AMA-MSS will ask the AMA to recognize the negative impact of climate change on global human health, particularly in the areas of infectious disease, the direct effects of heat, severe storms, food and water availability, and biodiversity. [MSS Amended Rep A, I-07;cAMA Res 607, A-08 Referred ; Modified: MSS GC Report A, I-16; Reaffirmed: MSS GC Report A, I-21]

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 405
(I-25)

Introduced by: Hannah Lynch[1], Mackenzie Johnson[1], Rose Zach[1], Anusha Vasudevan[1], Famesh Zafar Patel[1], Mathew Kyrillos Hanna[1], Gabe Zdrale[1]

Affiliations: [1]University of Arizona College of Medicine Phoenix

Subject: Food Allergy Management in Hospitals

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, food allergies affect about 6.2% of American adults and 5.8-8% of children[1]; and

Whereas, The Joint Commission requires that a patient's medical record document any food allergies, but it offers no detailed instructions on how to ensure the right diet is delivered to the right patient each time, creating a gap in the policy and practice in the hospital[2]; and

Whereas, patients assigned special diets to accommodate food sensitivities consumed on average <70% of their nutritional needs in the hospital[3]; and

Whereas, Pennsylvania Safety Authority analysts identified 285 events involving dietary errors between January 2009 and June 2014 at one hospital, where the most frequently reported events were meals delivered to patients who were allergic to a food item on the tray[4]; and

Whereas, a recent study at Mayo from 2018-2019 showed that the top 8 allergens accounted for only 47.8% of patients' allergens, demonstrating that about half of allergies are to less common or atypical allergens, suggesting the need for better education for staff surrounding atypical allergies and their management[5]; and

Whereas, patients with multiple different food allergies remain at high risk for allergic reactions due to occult ingredients in different foods, beverages, medications, vaccines, and personal care products[6]; and

Whereas, packaged foods are required by the Food Allergen Labeling and Consumer Protection Act to label the major 9 allergens, but there is no universal equivalent or law regarding declaration of allergens in hospital cafeteria-prepared foods[7]; and

Whereas, half of people with food allergies report at least one adverse allergic reaction per year, with 82.1% of these being unintentional and due to cross-contamination[8]; and

Whereas, there is a large known mental burden on patients with food allergies and their parents, and increased stress is known to lead to adverse patient outcomes during and after hospital visits[9,10]; and

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Whereas, patients generally prefer staff to be over-informed regarding their food allergies and welcomed visual alerts[11]; and

Whereas, restaurant ingredient lists for all menu items must be available and accessible to staff per CDC recommendation[12]; and

Whereas, restaurant staff education programs must include training on label reading, cross-contact prevention, and recognition of major allergens per the American Academy of Allergy, Asthma, and Immunology[13]; and

Whereas, during the implementation of food service plans, staff training, and improvement of policy and protocols related to food allergies, a recent study showed zero reported cases of allergy exposure over 2 years during their intervention period[14]; and

Whereas, multidisciplinary interventions including menu modifications, new food service systems, protected mealtimes, and staff education led to significant improvements in patient food intake, nutritional status, satisfaction, safety outcomes, and quality of life[15,16]; therefore be it

RESOLVED, that our American Medical Association support federal and state policies for comprehensive food allergy training for nonmedical staff in hospital cafeterias and food service delivery regarding cross contamination, specific allergy language, and hidden ingredients; and be it further

RESOLVED, that our AMA support efforts regarding displaying food allergens and ingredients for all foods available in the hospital cafeteria and on patient food delivery menus; and be it further

RESOLVED, that our AMA support the integration between food allergy documentation in EMRs and diet orders to the cafeteria to prevent unintended allergen exposure; and be it further

RESOLVED, that our AMA supports efforts to display specific and accurate patient food allergies in hospital rooms in clear sight prior to food delivery to prevent unintended allergen exposure.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Preventing Allergic Reactions in Food Service Establishments D-440.932
Pursue federal legislation requiring restaurants and food establishments to include a menu notice reminding to let staff know of food allergies, educate staff, identify menu items containing major allergens identified by FDA [Res. 416, A-15; Rescinded/Converted to H Poligy: CSAPH Rep. 01, A-25]

Food Insecurity Among Patients with Celiac Disease, Food Allergies, and Food Intolerance H-425.963
(1) Our American Medical Association supports federal and state efforts to increase the affordability and quality of food alternatives for
people with celiac disease, food allergies, and food intolerance.
(2) Our AMA supports federal and state efforts to extend requirements for mandatory nutrient fortification to food alternatives for people with celiac disease, food allergies, and food intolerance.
(3) Our AMA supports efforts to expand nutrition assistance eligibility and benefits to equitably meet the needs of households affected by celiac disease, food allergies, and food intolerance and increase access to food alternatives for people with celiac disease, food allergies, and food intolerance, including, but not limited to, efforts by food banks and pantries, food delivery systems, and prescription produce programs. [Res. 910, I-24]

Healthful Food Options in Health Care Facilities H-150.949
Our AMA…(1) encourages healthful food options be available, at reasonable prices and easily accessible, on the premises of health care facilities. (2) hereby calls on all health care facilities to improve the health of patients, staff, and visitors by: (a) Providing a variety of healthy food, including plant-based meals, and meals that are low in saturated and trans fat, sodium, and added sugars. (b) Eliminating processed meats from menus. (c) Providing and promoting healthy beverages. (3) Our AMA hereby calls for health care facility cafeterias and inpatient meal menus to publish nutrition information (4) and will work with relevant stakeholders to define "access to food" for medical trainees to include overnight access to fresh food and healthy meal options within all training hospitals. [Res. 410, A-04; Reaffirmed

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Rep. 1, A-14; Appended Res. 406, A-17; Modified Res. 425, A-18; Modified Res. 904, I-19; Appended Res. 304, A-21; Modified Res. 416, A-25]

RELEVANT MSS POSITIONS

Allergic Reactions in Schools and Airplanes 150.012MSS
(1) Recommend: increasing student education in schools on food allergies and that emergency food allergy guidelines and emergency kits be available in schools and on commercial airlines with trained staff (MSS Res 33, A-03)

Healthy Food Options in Hospitals 150.014MSS
(1) AMA-MSS asked the AMA to encourage that healthy food options be available, at reasonable prices and easily accessible, on hospital premises. (MSS Res 21, I-03)

Equity in Celiac Disease and Food Allergies Research and Resources 150.049MSS
(1) Support: for people with celiac disease, food allergies, and food intolerance, support federal/state increasing affordability and quality of food available to, extending requirements for mandatory nutrient fortification, and expanding nutrition assistance eligibility and benefits. (MSS Res 419, A-24)

Allergen Labeling for Spices and Herbs 150.050MSS
(1) AMA-MSS will ask that our AMA support requirements for transparent disclosure of individual ingredients in aggregate categories, such as “spices and herbs,” and regular FDA evaluation of labeling exemptions. (MSS Res 416, I-24)

Culturally and Religiously Inclusive Food Options 150.051MSS
(1) AMA-MSS supports access to culturally and religiously inclusive food options in health care facilities. (MSS Res 409, A-25)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 408
(I-25)

Introduced by: Lauren Zaylskie[1], Laura Clarke[1], Wade Catt[1]

Affiliations: [1]Indiana University School of Medicine

Subject: Oppose AI Data Center Pollution Impact on Community Health

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, as artificial intelligence (AI) grows exponentially in popularity and demand, concerns over its negative impact on the environment and air quality become more pressing, raising concern for the physical health of the public near AI data center hubs[13]; and

Whereas, training new AI models is particularly worrying, as it produces the air pollution equivalent of 10,000 round trips by car and consumes the energy of hundreds of households, often drawing electricity from power plants that burn fossil fuels[5,7,8]; and

Whereas, AI data centers release numerous neurotoxic chemicals, including mercury and lead, as well as increase multiple greenhouse gases by up to 48%, where these gases impact more than the local level through drift to other cities and erosion of the atmosphere[4,9,10]; and

Whereas, AI data centers are being built at rapid rates, with powerful companies making deals worth up to $100 billion dedicated to expanding AI data centers in the United States and reopening nuclear power plants to do so[14,15]; and

Whereas, additional concerns have arisen over the chosen locations of AI, with many residing in historically disadvantaged or low-income communities, where AI data centers have been built over Black homes, in communities with already low public health scores, and that the wealth gap between white and black households could widen by $43 billion[16-18]; and

Whereas, in Memphis, Tennessee, community leaders and organizations like the NAACP have spoken out to raise awareness about the growing public health crisis in their city from methane gas turbines, calling it a “human rights violation”[6]; and

Whereas, in San Antonio, Texas, AI data centers used over 463 million gallons of water in just two years, with the state shifting the burden onto its residents who were not involved in or compensated by its construction, and who are now being asked by city officials to take shorter showers[2,3]; and

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Whereas, local politicians have signed nondisclosure agreements and formed partnerships with AI companies, undermining their ability to provide unbiased information about AI data center impacts on the health and wellness of communities they are built in[11-13]; and

Whereas, to protect public health, it is critical to establish transparent frameworks, compliance requirements, and reporting standards for AI data centers, enabling the assessment of inhalable particulate matter, sulfur dioxide, nitrogen oxide, and other harmful air pollutants, as well as their short- and long-term community health impacts[1]; and

Whereas, these preventative measures would also equip local and state government officials to make transparent and informed decisions about where to site AI data center facilities, balancing technological progress with the protection of nationwide community health[1]; and

Whereas, without transparency and community engagement, low-income communities housing AI data center facilities are left with little influence or say over developments that may negatively impact their health[1]; therefore be it

RESOLVED, that our American Medical Association support transparency by state and local officials, including the disclosure of partnerships or agreements, on how locations for AI data centers are chosen and the potential impact on historically disadvantaged communities; and be it further

RESOLVED, that our AMA encourage the provision of preventative and regular care for the residents of communities who currently are or will be affected by AI data center pollution.

Fiscal Note: TBD

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RELEVANT AMA POLICY

H-135.998 AMA Position on Air Pollution

1. Our AMA urges that:
    a. Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties.
    b. Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community.
    c. Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends.
    d. Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control. [BOT Rep. L, A-65; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-11Reaffirmation A-12; Reaffirmation A-14; Reaffirmation A-16; Reaffirmed: BOT Rep. 29, A-19]

H-135.941 Air Pollution and Public Health

1. Our AMA supports increased physician participation in regional and state decision-making regarding air pollution across the United States. [Res. 408, A-08; Reaffirmed in lieu of Res. 509, A-09; Reaffirmed: CSAPH Rep. 01, A-19]

H-135.979 Clean Air

1. Our AMA supports cooperative efforts with the Administration, Congress, national, state and local medical societies, and other organizations to achieve a comprehensive national policy and program to address the adverse health effects from environmental pollution factors, including air and water pollution, toxic substances, the "greenhouse effect," stratospheric ozone depletion and other contaminants. [Sub. Res. 43, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmed in lieu of Res. 509, A-09; Reaffirmed: CSAPH Rep. 01, A-19]

H-135.949 Support of Clean Air and Reduction in Power Plant Emissions

1. Our American Medical Association supports:
    a. federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide.
    b. efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.

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2. Our AMA will:
    a. support the Environmental Protection Agency's proposal, under the Clean Air Act, to regulate air quality for heavy metals and other air toxins emitted from smokestacks. The risk of dispersion through air and soil should be considered, particularly for people living downwind of smokestacks.
    b. urge the EPA to finalize updated mercury, cadmium, and air toxic regulations for monitoring air quality emitted from power plants and other industrial sources, ensuring that recommendations to protect the public's health are enforceable. [Res. 429, A-03; Reaffirmation I-07; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Modified: Res. 506, A-15Modified: Res. 908, I-17; Appended: Res. 401, A-22]

RELEVANT MSS POSITIONS

Resolution 508 Ensuring Environmental Sustainability in AI Applications

1. RESOLVED, that our AMA-MSS study mechanisms / create guidelines for the responsible use of AI that mitigates the environmental impacts of AI infrastructure and use, including the consideration of:

a. moratoria on the construction of new data centers without comprehensive assessments of their long-term environmental and socioeconomic impacts.

b. opposition to tax incentives for technology companies engaged in these practices that shift infrastructure costs onto consumers and taxpayers.

c. supporting the development of environmental regulations on AI infrastructure (including data centers), including independent assessments of energy sources, to limit excessive energy consumption, water use, noise pollution, and emissions. (MSS Res. 508, I-25)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 411
(I-25)

Introduced by: Christopher Martinez [1], Joel Dumonsau [2], Andrew Norton [3], Patrick Noone [1], Amber Akhter [1], Niles Babin [1], Sophie De Fries [1]

Affiliations: [1] University of Illinois College of Medicine Chicago
[2] Creighton University School of Medicine
[3] University of Wisconsin School of Medicine and Public Health

Subject: National Database for Civilian Injuries by Law Enforcement

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas tear gas, kinetic impact projectiles, and other law-enforcement crowd-control methods are associated with significant morbidity and mortality, including permanent disability and death [1]; and

Whereas current AMA policy H-145.969 opposes the use of chemical irritants and kinetic impact projectiles against peaceful crowds, but there is no national surveillance system to track law-enforcement–incited injuries [2]; and

Whereas the AMA has supported narrowly focused public health surveillance efforts, including sports-related injuries, which demonstrates feasibility and precedent [3]; and

Whereas a national, publicly accessible database would provide accountability, transparency, and evidence to guide policy and public health interventions[4]; therefore be it

RESOLVED, that our American Medical Association advocates for the creation of and federal funding for a national, publicly accessible database, modeled after existing public injury surveillance systems, to track and report injuries and deaths caused by law enforcement in the context of crowd-control practices.

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RELEVANT AMA POLICY

Less-Lethal Weapons and Crowd Control H-145.969

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Our AMA (1) supports prohibiting the use of rubber bullets, including rubber or plastic-coated metal bullets and those with composites of metal and plastic, by law enforcement for the purposes of crowd control and management in the United States. (2) Our AMA supports prohibiting the use of chemical irritants and kinetic impact projectiles to control crowds that do not pose an immediate threat. (3) Our AMA recommends that law enforcement agencies have in place specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries, for the use of kinetic impact projectiles and chemical irritants. (4) Our AMA encourages guidelines on the use of kinetic impact projectiles and chemical irritants to include considerations such as the proximity of non-violent individuals and bystanders; for kinetic impact projectiles, a safe shooting distance and avoidance of vital organs (head, neck, chest, and abdomen), and for all less-lethal weapons, the issuance of a warning followed by sufficient time for compliance with the order prior to discharge. [BOT Rep. 10, A-21Reaffirmed: BOT Rep. 2, I-21]

Chemical and Biologic Weapons H-520.992
Our AMA condemns the use of chemical and biologic weapons. [Res. 175, I-89Reaffirmed: Sunset Report, A-00Reaffirmed: CSAPH Rep. 1, A-10Reaffirmed: CSAPH Rep. 01, A-20]

Policing Reform H-65.954
Our AMA (2) will work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers.[Res. 410, I 20Reaffirmed: CSAPH Rep. 2, A-21Reaffirmed: BOT Rep. 2, I 21Appended: Res. 431, A-23]

RELEVANT MSS POSITIONS

Protestor Protections 440.091MSS
Our AMA-MSS will ask the AMA to: (1) advocate to ban the use of chemical irritants and kinetic impact projectiles for crowd-control in the United States and (2) encourage relevant stakeholders including but not limited to manufacturers and government agencies to develop, test, and use crowd-control techniques which pose no risk of physical harm. (MSS Res. 008, Nov. 2020) (AMA Res. 409, Nov. 2020, Referred for Study) (Adopted, BOT Rep. 10, A-21 [ ])

Increase Advocacy and Research into the Effects of Police Brutality on Public Health Outcomes 440.054MSS
AMA-MSS will ask the AMA to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly members of ethnic and racial minority communities. (MSS Res 32, A-15) (AMA Res 910, I-15 Not Considered) (AMA Res 406, A-16 Adopted as Amended [H-515.955])

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 412
(I-25)

Introduced by: Bettina Anil[1], Ramsha Saad[1], Jorell Borretto[1]

Affiliations: [1]William Carey University College of Osteopathic Medicine

Subject: Mental Health and Early Screening in Gastrointestinal Diseases

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, celiac disease and inflammatory bowel disease (IBD) are chronic gastrointestinal (GI) conditions that carry substantial psychosocial burden, with patients experiencing elevated rates of depression, anxiety, social isolation, and disordered eating compared to the general population;[1,2] and

Whereas, adolescents and young adults with celiac disease face heightened risks of mental health comorbidities due to dietary restrictions, social stigma, and the burden of lifelong gluten avoidance;[3] and

Whereas, pediatric populations with chronic medical conditions—including GI diseases such as constipation, celiac disease, and undernutrition—often first present symptoms in school settings, where school nurses and counselors may lack standardized screening or referral pathways;[4] and

Whereas, disparities in access to pediatric subspecialty care are more pronounced in Title I schools, rural communities, and communities of color, compounding inequities in both GI and mental health outcomes;[4] and

Whereas, the AMA has long-standing policy supporting school-based health services (H-60.991) and the identification and treatment of depression and other mental illnesses (H-345.984), but no policies specifically addressing the intersection of chronic GI disease and psychosocial needs, nor standardized approaches to pediatric symptom referral; and

Whereas, models of integrated care linking medical and mental health professionals are supported by emerging research on the gut-brain axis and have been recognized in other contexts (e.g., peripartum depression screening), yet there is limited awareness and dissemination for pediatric chronic disease populations;[5] and

Whereas, collaboration with specialty societies such as the American Gastroenterological Association (AGA), North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition (NASPGHAN), American Psychiatric Association (APA), and American Academy of

RESOLVED, That our AMA incorporate education on the psychosocial and mental health needs

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of individuals with chronic gastrointestinal diseases into existing AMA educational channels (e.g., podcasts, blogs, physician-facing education); and be it further

RESOLVED, that our American Medical Association encourage physicians caring for high-risk populations, including individuals with celiac disease and IBD, to utilize validated mental health screening tools (e.g., PHQ-9, GAD-7) in alignment with existing AMA and specialty society guidance; and be it further

RESOLVED, that our AMA encourage the development and dissemination of resources for school-based health personnel to improve early identification and referral of children with chronic medical conditions—including, but not limited to, gastrointestinal diseases—particularly in Title I and medically underserved districts; and be it further

RESOLVED, that our AMA explore collaboration with national pediatric, gastroenterology, and psychiatry organizations to study and promote integrated care models that address both the medical and psychosocial needs of children with chronic diseases.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Further Action to Respond to the Gun Violence Public Health Crisis D-145.992
Where school-based services exist, our AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council.

Preserving Access to Reproductive Health Services D-5.999

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Our AMA: will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings. encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model. will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 413
(I-25)

Introduced by: Evan Hawthorn[1]

Affiliations: [1] Kentucky College of Osteopathic Medicine

Subject: Evidence-Based COVID-19 Patient Education

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, COVID-19 continues to cause significant morbidity and mortality, with infections growing or likely growing in 40 states as of July 2025, demonstrating the ongoing public health threat[1]; and

Whereas, scientific evidence conclusively demonstrates that SARS-CoV-2 spreads primarily through airborne transmission via aerosolized particles[2]; and

Whereas, infectious particles can remain suspended in air for hours, fundamentally changing our understanding of transmission mechanisms from early pandemic assumptions[3,4]; and

Whereas, Long COVID affects an estimated 36% of individuals who contract COVID-19 globally, representing millions of Americans living with debilitating long-term health consequences[5]; and

Whereas, repeated COVID-19 infections increase the risk of developing Long COVID, making prevention of initial and subsequent infections critical for protecting public health[6,7]; and

Whereas, high-quality masks such as N95 respirators provide significantly superior protection compared to surgical or cloth masks[8]; and

Whereas, implementation of FFP2 respirators (equivalent to N95) results in a 13-fold reduction in viral dose, demonstrating the effectiveness of high-quality respiratory protection [9]; and

Whereas, the AMA's current COVID-19 educational resources, including the "COVID-19: Frequently Asked Questions" webpage, fail to mention airborne transmission at all, instead prioritizing handwashing and recommending the use of cloth masks[10]; and

Whereas, the AMA's patient education materials, including the "Known Your Risk," "When to Get Medical Care," and "Timing Is Everything" fact sheets, focus on post-infection treatment while omitting or downplaying prevention strategies beyond vaccination[11]; and

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Whereas, these educational resources have not been substantially updated since January 2023, failing to reflect current scientific consensus on airborne transmission and evidence-based prevention strategies; and

Whereas, this communication gap between established scientific evidence and public communication undermines effective prevention efforts and leaves patients without access to potentially life-saving information about transmission mechanisms and optimal protective measures; therefore be it

RESOLVED, that our American Medical Association update its public-facing COVID-19 educational resources to clearly state that SARS-CoV-2 spreads primarily through airborne transmission and that high-quality masks (N95 respirators or equivalent) provide the most effective personal prevention strategy.

Fiscal Note: TBD

Received: 09/21/2025

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RELEVANT AMA POLICY

Vector-Borne Diseases H-440.820
Our AMA supports and will advocate for (4) Education and training for health care professionals and the public about the risk of **vector-borne diseases** and prevention efforts as well as the dissemination of available information; [Res. 430, A-18]

Availability of Personal Protective Equipment (PPE) H-440.810
Our AMA: …(2) supports evidence-based standards and national guidelines for PPE use,reuse, and appropriate cleaning/decontamination during surge conditions; and (8) supports the rights **of** physicians and trainees to participate in public commentary addressing the adequacy **of** clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care **of** patients

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and physicians during a pandemic or natural disaster. Res. 412, I-20; Appended: Res. 414, A-21 Modified: Res. 410, I-21]

RELEVANT MSS POSITIONS
An Urgent Initiative to Support COVID-19 Information Programs D-440.921
(2) educating the public about up-to-date, evidence-based information regarding COVID- 19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, countering misinformation and building public confidence; (HOD Res. 421, A-21, Adopt as amended)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 415
(I-25)

Introduced by: Katherine Hofmann[1], Jessie Chen[1], Tim Madigan[1], Paaras Kumar[2], Ami Dave[1], Zhuchen Yuan[1]

Affiliations: [1]University of Miami Miller School of Medicine
[2]University of Toledo College of Medicine and Life Sciences

Subject: Adolescent Dating Violence Comprehensive Screening Tool Development

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, adolescent dating violence (ADV), also referred to as adolescent intimate partner violence, is a prevalent public health problem in the United States, with national surveys estimating that over 1 in 8 students reported experiencing physical violence, sexual violence, or both by someone they were dating or going out with in the past year, with trend analyses showing an overall increase in sexual dating violence between 2019 and 2021[1-3]; and

Whereas, psychological and emotional abuse is even more common, with over 60% of adolescent daters reporting such experiences in national surveys, and up to 75% reporting technology-assisted or cyber abuse from people they are dating[4,5]; and

Whereas, adverse childhood experiences (ACEs) increase vulnerability to, but are distinct from, adolescent dating violence (TDV), as ACEs typically precede TDV while TDV constitutes a separate form of interpersonal violence with unique risk factors and consequences[6-8]; and

Whereas, those who experience the intersectionality of identities being racial/ethnic backgrounds, sexual orientation and gender identity, and underserved community status are disproportionately affected by adolescent dating violence; and

Whereas, large-scale studies show that LGBTQ+ youth experience disproportionately higher rates of physical, sexual, psychological, and cyber dating violence than their cisgender, heterosexual, and White peers, with transgender and gender-expansive youth reporting 2–3 times higher victimization and all groups facing elevated risks of suicidality and adverse mental health symptoms[9-14]; and

Whereas adolescents who experience dating violence are at significantly increased risk for depression, anxiety, suicidality, substance use, high risk sexual behaviors, future intimate partner violence, and significantly higher odds of emergency department utilization, independent of other risk factors[15-18]; and

Whereas, failure to routinely screen adolescents for dating violence in clinical and school settings leads to missed opportunities for early intervention, support, and referral to evidence-

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based services, perpetuating a cycle of recurrent victimization, perpetration, and chronic mental health and substance use disorders into adulthood[15-18]; and

Whereas, despite these risks, there is a lack of comprehensive, validated, and routinely used screening tools for adolescent dating violence in the United States[19-21]; and

Whereas, existing adult intimate partner violence screening instruments (HARK, HITS, E-HITS, PVS, WAST) have not been validated for adolescents and are rarely used in pediatric or adolescent clinical practice—a gap specifically recognized by the U.S. Preventive Services Task Force, despite encouragement from the American Academy of Pediatrics[19-21]; and

Whereas, reviews highlight that very few screening measures have undergone psychometric evaluation in sexual minority samples, and none have been rigorously validated for intersectional groups or for the unique forms of abuse experienced by LGBTQ+ and gender-diverse youth[22,23]; and

Whereas, existing validated adolescent dating violence screening instruments such as the Conflict in Adolescent Dating Relationships Inventory (CADRI) and the Measure of Adolescent Relationship Harassment and Abuse (MARSHA) have limited clinical utility[24-28]; and

Whereas, while the MARSHA-C (Measure of Adolescent Relationship Harassment and Abuse – Compact) was developed with input from diverse youth and shows promising validity, its limited sample size, single online validation, lack of replication in clinical settings, and absence of cross-cultural or long-term outcome data mean it is not yet established for routine clinical use[29-32]; and

Whereas, a recent systematic review found a large degree of mistrust of available dating violence resources among African American and Latino youth, largely due to a lack of culturally sensitive interventions within these resources[32]; and

Whereas, current adult and adolescent dating violence prevention tools have been shown to reduce physical violence, but there has been a lack of statistically significant progress in reducing sexual violence, suggesting that new and more inclusive screening tools and interventions are needed[33]; and

Whereas, pediatricians and adolescent medicine physicians have expressed a clear need for validated, trauma-informed, and culturally sensitive tools that specifically address the needs of LGBTQ+ youth, gender-diverse adolescents, racial/ethnic minority groups, and underserved populations; the American Academy of Pediatrics explicitly recognizes that these populations experience disproportionately high rates of dating violence and that pediatricians must be equipped to provide inclusive, developmentally appropriate care, yet the current lack of validated tools remains a barrier to effective identification and intervention[34]; therefore be it

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

Fiscal Note: TBD

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RELEVANT AMA POLICY

Family and Intimate Partner Violence H-515.965
The AMA recognizes family and intimate partner violence as critical public health issues and calls on physicians to prevent violence, support survivors, and receive comprehensive training in diagnosis, intervention, and referral practices. It also urges collaboration across healthcare and community organizations, supports appropriate reporting laws, and emphasizes the need to address connections between substance use and violence through screening, education, and evidence-based interventions.

Education of Medical Students and Residents about Domestic Violence Screening H-295.912
The AMA advocates for medical education programs to train students and residents to sensitively screen for family abuse and connect patients with community resources.

Improving Screening and Treatment Guidelines for Intimate Partner Violence (IPV) Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (LGBTQ) D-515.980
Our AMA will: (1) promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ survivors of IPV; (2) encourage physicians to familiarize themselves with resources available in their communities for LGBTQ survivors of IPV; (3) advocate for federal funding to support programs and services for survivors of IPV that do not discriminate against underserved communities, including on the basis of sexual orientation and gender identity; (4) encourage research on intimate partner violence in the LGBTQ community to include studies on the prevalence, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening; and (5) encourage the dissemination of research to educate physicians and the community regarding the prevalence of IPV in the LGBTQ population, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening.

Adverse Childhood Experiences and Trauma-Informed Care H-515.952
The AMA supports integrating evidence-based trauma-informed care and Adverse Childhood Experiences (ACEs) screening into medical practice, education, and policy to prevent poor health outcomes, improve patient support, and avoid re-traumatization. It advocates for research, funding, and collaboration with public health agencies to expand ACEs categories, develop effective interventions, and strengthen prevention and early intervention efforts nationwide.

RELEVANT MSS POSITIONS

Teaching Domestic Violence Screening 295.078MSS

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AMA-MSS will ask the AMA to encourage editors and publishers of medical training literature to include (1) domestic violence screening questions in recommendations and guidelines for conducting a comprehensive medical history and (2) domestic violence intervention and documentation protocols.

Comprehensive Sexual Education 170.023MSS
To support the incorporation of information on adoption, sexual violence prevention, dental dams, and other barrier protection methods, and culturally competent materials that are language concordant for Limited English Proficiency (LEP) pupils into public school sex education or family planning curricula.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 417
(I-25)

Introduced by: Yasmine El-Hage[1], Karina Patel,[2] Lee Dason Lam[1], Sakar Gupta,[3] Kaya Adelzadeh[1]

Affiliations: [1]University of California, Davis School of Medicine
[2]University of Connecticut School of Medicine
University of Wisconsin - Madison School of Medicine[3]

Subject: Protecting Environmental Health Before, During, and After War

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, according to the World Health Organization (WHO), healthier environments could prevent almost one-quarter of the global burden of disease, as clean air, a stable climate, safe water, sanitation, and hygiene (WASH), safe use of chemicals, protection from radiation, healthy workplaces, sustainable agriculture, health-supportive cities, and preserved natural ecosystems are all prerequisites for good health;[1] and

Whereas, according to the UN Environment Programme (UNEP), heavy bombardment of populated areas contaminates soil, air, and groundwater from the munitions and the release of hazardous materials such as asbestos, industrial chemicals, and fuel, creating long-term environmental and health hazards;[2] and

Whereas, explosives use destroys water supplies and sanitation facilities, leading to pollution from sewage; in rural areas, bombing decreases soil quality and agricultural productivity by disrupting topography and altering drainage patterns; and unexploded remnants of war left behind continue to injure and kill civilians for years;[3] and

Whereas, in Gaza since 2023, 80% of WASH infrastructure has been disabled; raw sewage contaminates farmland, groundwater, and the Mediterranean; and 96% of households lack safe water, heightening risk of disease and death;[4] and

Whereas, according to the FAO and the Lebanese Ministry of Agriculture, conflict in Lebanon destroyed 47,000 olive trees covering nearly a quarter of agricultural land, as well as 340,000 farm animals, driving malnutrition and chronic disease;[5] and

Whereas, the war in Syria has wiped out nearly one-fifth of the nation's forest cover through bombardments and fuel harvesting, compounding humanitarian crises;[6] and

Whereas, in Ukraine, shelling of water facilities jeopardized the supply for 3.9 million people, with 750,000 children at risk of diarrheal illness;[7] and

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Whereas, the sinking of military vehicles during conflicts has caused long-term oil spills, including wrecks off of the Iraqi coast that release hydrocarbons into the Persian Gulf linked to cancer, anemia, organ damage, and neurological harm, contaminating Kuwaiti desalination plants that supply the majority of regional drinking water;[8] and

Whereas, military greenhouse gas emissions were excluded from the 1997 Kyoto Protocol, and military emissions reporting under the 2015 Paris Agreement was made voluntary, resulting in systematic underestimation of warfare's climate toll;[9] and

Whereas, the UN General Assembly states that areas of environmental importance should be designated as protected zones in armed conflict;[10] and

Whereas, international law, including the Rome Statute of the ICC and the Geneva Conventions, prohibits methods of warfare that cause widespread, long-term, and severe environmental damage, recognizing such acts as war crimes;[11] and

Whereas, the U.S. Department of Defense is the world's largest institutional consumer of oil and among the world's top greenhouse gas emitters, adding significantly to climate change;[3] and

Whereas, between 1961 and 1971, more than 91 million liters of Agent Orange, containing persistent environmental pollutants (POPs) that accumulate in food sources, were applied across 3.1 million hectares of Vietnam, exposing over 4 million people to toxic dioxins, leading to cancers, congenital disabilities, and intergenerational harm;[12,13] and

Whereas, more than 600 U.S. military sites have been designated as Superfund sites, reflecting widespread contamination of air, soil, and water by hazardous substances associated with defense activities;[14] and

Whereas, proximity to toxic waste and Superfund sites has been linked to increased risks of cancer, congenital anomalies, and other adverse health outcomes, with disproportionate impacts on low-income and minority communities;[15] and

Whereas, supporting evidence from the U.S. Environmental Protection Agency (EPA) Discharge Monitoring Reports documents releases of arsenic, cyanide, and lead by the Atlantic Fleet Weapons Training Facility on Vieques Island, Puerto Rico, into surrounding waters of the live impact area, demonstrating that environmental pollution can lead to adverse neonatal outcomes;[16] and

Whereas, a 2023 Department of Defense brief acknowledged over 245 military bases where polyfluoroalkyl substances (PFAS), known endocrine disruptors, may have contaminated groundwater aquifers that serve as sources of drinking water;[17,18] and

Whereas, uranium is a heavy metal with both chemical toxicity and radioactivity, capable of causing renal failure, DNA damage, hypertension, cancer, diminished bone growth, reduced fertility, and multigenerational effects as observed in Hiroshima survivors;[19] and

Whereas, the Vanadium Corporation's recruitment of Navajo lands to mine uranium for atomic bombs, without informing local community members of the purpose or health risks, led to the Church Rock incident, the largest accidental release of radioactive material in U.S. history into the Rio Puerco, as well as elevated radiation-induced disease in Navajo communities;[20] and

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Whereas, there is documented use of white phosphorus (WP) in Lebanon and Gaza by Israel, which has received significant military aid yearly and utilized weapons produced by the U.S. – including white phosphorus – from 2008-2009 and in October 2023;[21,22] and

Whereas, exposure to WP munitions contaminates agricultural land and damages crops and livestock through uncontrolled fires, and WP infiltration into soil and water fosters eutrophication and contaminates fisheries with enduring health consequences, such as central nervous system impairment, coma, organ failure, or myocardial injury;[23,24] and

Whereas, during and after conflicts, environmental governance, waste management, and ecosystem services often collapse, compounding exposure risks and intensifying future conflict risks;[25] and

Whereas, the American College of Occupation and Environmental Medicine has underscored that capacity building in environmental medicine, including training in taking exposure histories and reporting sentinel events (such as outbreaks of waterborne illness and clusters of toxic exposure), is necessary for clinicians seeing displaced and/or conflict-impacted populations;[26] and therefore be it

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

RESOLVED, that our AMA supports the research into, as well as the subsequent clean-up and restoration of, toxic exposures and environmental harm related to U.S. and U.S.-supported military activities that lead to adverse health outcomes; and

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

Fiscal Note: TBD

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RELEVANT AMA POLICY

Search Terms: environmental health; war; conflict; Superfund

- D-135.966 / Climate Change as a Public Health Crisis
  - Establishes the health linkage to environmental system degradation, providing a foundation for recognizing ecosystem disruption from conflict.
- H-135.938 / Global Climate Change and Human Health
  - Supports education and clinical integration of environmental determinants, which can be extended to conflict-associated exposures.
- H-135.991 / Clean Air / Environmental Health
  - Affirms protection of air quality and reduction of toxic exposures; conflict-related pollution (e.g., burn pits, infrastructure collapse) and legacy contaminants fall within this mandate.
- D-440.972 Safety from Nuclear Weapons and Medical Consequences of Nuclear War
  - Recognizes the catastrophic medical, environmental, and public health consequences of nuclear weapons use (or the threat thereof) and the need for prevention, preparedness, and mitigation. War's potential to escalate to nuclear exchange, as well as the long-term radiological contamination of ecosystems, water, soil, food, and human populations, represents an extreme amplification of environmental health harms that demand integration into armed conflict health policy.
- D-135.962 Hazardous Pollutants and Heavy Metals

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- Urges governmental agencies to establish and enforce limits for identified hazardous pollutants and heavy metals in food, water, soil, and air; supports efforts to monitor chronic effects of exposure (including at levels below regulatory limits); monitor community toxicity burdens - especially near urban, Superfund, military, and industrial sites; and educate individuals on chronic exposure consequences. This underscores the importance of tracking cumulative and legacy toxic exposures in conflict and post-conflict settings where war-related pollution layers on preexisting environmental burdens.

RELEVANT MSS POSITIONS

Search Terms: environmental health; war; conflict; Superfund

- 135.024MSS Environmental Health Equity in Federally Subsidized Housing

    - Acknowledges adverse health impacts from proximity to Superfund and polluted sites, supports mandated disclosure, surveillance, and limits on hazardous pollutants; this aligns with the need to treat legacy military testing/training sites (many of which are or become Superfund sites) as ongoing environmental health equity issues.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 420
(I-25)

Introduced by: Isabel Ball[1], Alison Blodgett[2], Rachel Rezabek[3]

Affiliations: [1] Tufts University School of Medicine
[2] Indiana University School of Medicine
[3]University of Virginia School of Medicine

Subject: Infant Feeding Options for HIV-Seropositive Individuals

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, human milk's composition of nutrients, along with its antimicrobial, anti-inflammatory, and immunoregulatory agents makes it uniquely ideal for human infants[1]; and

Whereas, the benefits of human milk for newborn infants are numerous, including but not limited to decreased incidence of lower respiratory infections, otitis media, SIDs, and overall neonatal and infant mortality[2–5]; and

Whereas, human milk also has proven decreased incidence of other later-onset diseases including but not limited to, obesity, Type 1 and Type 2 diabetes, and inflammatory bowel disease[6–9]; and

Whereas, breastfeeding has many health benefits for the lactating person, such as decreased incidence of several types of cancer, type 2 diabetes, and hypertension[10–12]; and

Whereas, despite its extensive proven benefits, there are extensive disparities in breastfeeding rates, particularly as the rates in non-Hispanic White and Hispanic populations are significantly higher than in non-Hispanic Black populations[13]; and

Whereas previous studies estimated, for parents not on antiretroviral therapy (ART), a transmission rate of HIV to breastfeeding infants of 5-6% with some estimates as high as 16%[14,15]; and

Whereas, newer evidence, including the multi-country PROMISE trial, places the transmission rate as less than 5%, and less than 1% for parents that have a suppressed viral load[16]; and

Whereas, due to the extensive benefits of breastfeeding for infants and the lactating parent, the newer evidence of, although not zero, low rates of transmission by parents adequately virally suppressed by ART has prompted greater discussion of infant feeding options; and

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Whereas, the National Institutes of Health (NIH) recommends clinicians support the choice of HIV seropositive individuals to breastfeed if they are virally suppressed, or to formula/replacement feed[17]; and

Whereas, the American Academy of Pediatrics (AAP) supports breastfeeding among HIV seropositive individuals who desire to do so if criteria are met, including early ART initiation, sustained viral suppression, adherence to ART and infant prophylaxis, and reliable ART access[18]; and

Whereas, our AMA has adopted multiple policies supporting breastfeeding, including H-245.982 ("AMA Support for Breastfeeding") and D-310.950 ("Protecting Trainee's Breastfeeding Rights"); and

Whereas, AMA Policy H-20.916 currently advises clinicians to unequivocally counsel HIV seropositive patients against breastfeeding where alternative nutrition is available, which is inconsistent with evidence and recommendations; therefore be it

Resolved, AMA-MSS will ask the AMA to amend Policy H-20.916, "Breastfeeding and HIV Seropositive People," by addition and deletion as follows:

Breastfeeding and HIV Seropositive People, H-20.916

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

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RELEVANT AMA POLICY

Breastfeeding and HIV Seropositive Individuals H-20.916
Our American Medical Association believes that, where safe and alternative nutrition is widely available, HIV seropositive people should be counseled not to breastfeed and not to donate breast milk. HIV testing of all human milk donors should be mandatory, and milk from HIV-infected donors should not be used for human consumption. [CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Reaffirmed: CSAPH Rep. 8, A-23]

Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission H-20.918

In view of the significance of the finding that treatment of HIV-infected pregnant people with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their infants, our AMA recommends the following statements:

((6) When HIV infection is documented in a pregnant person, proper post-test counseling should be provided. The patient should be given an appropriate medical evaluation of the stage of infection and full information about the recommended management plan for their own health. Information should be provided about the potential for reducing the risk of perinatal transmission of HIV infection to the infant through the use of antiretroviral therapy, and about the potential but unknown long-term risks to the patient and the infant from the treatment course. The final decision to accept or reject antiretroviral treatment recommended for the patient and their infant is the right and responsibility of the patient. When the serostatus is either unknown or known to be positive, appropriate counseling should also be given regarding the risks associated with breastfeeding for both her own disease progression and disease transmission to the infant.
[CSA Rep. 4, A-03; Reaffirmed: CEJA Rep. 3, A-10; Reaffirmed: CSAPH Rep. 01, A-20; Modified: Speakers Rep. 02, I-24]

AMA Support for Breastfeeding H-245.982
(1) Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages

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public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.
(2) Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.
(3) Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.
(4) Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).
(5) Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines. [CSA Rep. 2, A-05Res. 325, A-05Reaffirmation A-07Reaffirmation A-12Modified in lieu of Res. 409, A-12 and Res. 410, A-12Appended: Res. 410, A-16Appended: Res. 906, I-17Reaffirmation: I-18]

Protecting Trainees' Breastfeeding Rights D-310.950
(1) Our American Medical Association will work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME), to include language in housestaff manuals or similar policy references of all training programs regarding protected times and locations for milk expression and secure storage of breast milk.
(2)Our AMA will work with appropriate bodies, such as the LCME, ACGME, and Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for breastfeeding people in regular program reviews. [Res. 302, I-16Modified: Speakers Rep. 02, I-24]

RELEVANT MSS POSITIONS

AMA Support for Breastfeeding 245.022MSS
AMA-MSS asked the AMA to encourage (1) perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include: (a) education of parents about the medical benefits of breastfeeding and encouragement of its practice, and (b) education of parents about formula and bottle-feeding options.

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(2) strengthen the support for breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff;
(3) encourage hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice “rooming-in,” to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services
(4) support legislation encouraging and promoting breastfeeding, such as tax credits for businesses that provide facilities and equipment for employed breastfeeding mothers to breastfeed or express milk on business premises
and
(5) support the right to breastfeed and/or pump and store breast milk for incarcerated mothers.(AMA Amended Res 506, A-93 Adopted [H-245.982], Amended by MSS Res. 602, A-25)

Doctors Defending Breastfeeding 245.016MSS
AMA-MSS will ask the AMA to: (1) Discourage hospitals and health care professionals from distributing formula and bottles to women who are willing and able to breastfeed; (2) Oppose the marketing or distribution of infant formula in ways that may interfere with the protection and promotion of breastfeeding; and (3) Recognize the inherent conflict of interest present when infant formula manufacturers provide financial support for research into or professional meetings regarding infant and child feeding. (MSS Res 1, I-06)

Protecting a Mother’s Right to Breastfeed 245.011MSS
AMA-MSS supports state legislation that clarifies and enforces a mother’s right to breastfeed in a public place and will encourage all states to adopt breastfeeding legislation which clarifies and protects a mother’s right to breastfeed in a public place. (MSS Res 15, A-02)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 421
(I-25)

Introduced by: Sanya Dhama[1], Sirapa Vichaikul[2], Anand Kathardekar[3], Galileo Dumont[4]

Affiliations: [1] University of California, Riverside, School of Medicine
[2] Michigan State University College of Human Medicine
[3] Northeast Ohio Medical University
[4] University of Colorado School of Medicine

Subject: Increasing Lung Cancer Screening Through Electronic Health Records

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, lung cancer is the second most common cancer and the leading cause of cancer death in the United States[1]; and

Whereas, lung cancer is more likely to be treated successfully when found at earlier stages, with an overall 5-year survival rate of 20.5%, compared with a 67% 5-year relative survival rate for localized lung cancer before cancer spreads outside of the lung[1,2,3]; and

Whereas, low-dose computed tomography (LDCT) scans are the evidence-based method to screen individuals at high risk for lung cancer, and the U.S. Preventive Services Task Force (USPSTF) recommends annual screening in adults aged 50 to 80 years with a ≥20 pack-year smoking history who currently smoke or have quit within the past 15 years[2,4]; and

Whereas, insurance plans under the Affordable Care Act and Medicare are required to cover USPSTF grade B preventative services – such as lung cancer screening – without cost-sharing[5,6]; and

Whereas, only 16.0% of eligible people were screened for lung cancer across the United States in 2022, with only 27.4% of cases being diagnosed at an early stage and over 43% of cases not being caught until a late stage[7]; and

Whereas, 53% of surveyed primary care physicians (PCPs) in Los Angeles County were unaware of USPSTF recommendations for LDCT screening[8]; and

Whereas, a 2020 study found that 54.7% of PCPs reported the most common barrier to lung cancer screening was the failure of electronic health records (EHRs) to notify providers of eligible patients, and 29.2% of providers reported never ordering LDCT scans for eligible patients[9]; and

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Whereas, electronic health records (EHRs) have capabilities to provide decision support with automated and patient-centered alerts based on a patient's smoking history and clinical risk[10]; and

Whereas, a study conducted from 2017 to 2019 at Rutgers Robert Wood Johnson Medical Group implemented EHR tobacco history prompts and a single-click LDCT order prompt for eligible patients, increasing the percentage of LDCT orders from 14.6% to 36.6% of eligible patients[11]; and

Whereas, Bon Secours Mercy Health increased LDCT screening by 156% within two years and increased early diagnoses by 76% after implementing EHR tools, structured team workflows, and smoking history documentation[12]; and

Whereas, integrated EHR interventions have been associated with significantly higher closure of lung cancer screening care gaps and program-level gains in screening and early detection[15]; and

Whereas, American Medical Association (AMA) policy H-478.990 highlights the importance of collecting and streamlining the tobacco use history on EHRs; and

Whereas, AMA policy H-185.936 recognizes LDCT as an evidence-backed screening method able to reduce lung cancer mortality by about 20% and AMA policy H-315.969 supports physician use of EHRs for clinical decision support and education; and

Whereas, structured smoking-history fields linked to EHR prompts have been shown to improve identification of patients eligible for LDCT and increase screening orders in primary care, underscoring that tobacco use documentation, cessation counseling, and automated alerts can increase screening uptake[13,14]; therefore be it

RESOLVED, that our American Medical Association support efforts to develop and integrate standardized, guideline-based lung cancer screening (e.g. low-dose CT) toolkits within electronic health records (EHRs), featuring functions such as automated decision support and risk-based alerts to increase equitable access and early detection of lung cancer.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Lung Cancer Screening to be Considered Standard Care H-185.936
Our AMA: (1) recommends that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit; (2) will empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States; and (3) will work with interested national medical specialty societies and state medical associations to urge the Centers for Medicare & Medicaid Services and state Medicaid programs to increase access to low-dose CT screening for Medicaid patients at high risk for lung cancer by including it as a covered benefit, without cost-sharing or prior authorization requirements, and increasing funding for research and education to improve awareness and utilization of the screening among eligible enrollees.

Tobacco Control Content in Electronic Health Records H-478.990
Our AMA encourages: (a) physicians to capture information from all their patients on tobacco use, secondhand smoke exposure, cessation interest, and past quit attempts; and (b) the development of EHR systems that provide physicians with the ability to capture information on specific health behaviors deemed appropriate by the physician and that provide physicians the option to utilize automated reminders to benefit their patients.

Medical Records and Patient Privacy H-315.969
(8) encourages medical schools and residency programs to: (a) design clinical documentation and electronic health records (EHR) training that provides evaluative feedback regarding the value and effectiveness of the training, and, where necessary, make modifications to improve the training; ... and (c) provide EHR professional development resources for faculty to assure appropriate modeling of EHR use during physician/patient interactions.

Public Health Surveillance H-440.813
Our AMA will advocate for incentives for physicians to upgrade their EHR systems to support electronic case reporting as well as incentives to submit case reports that are timely and complete.

EHR Interoperability D-478.972
Our AMA will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce

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common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data.

RELEVANT MSS POSITIONS

Reducing Barriers to Preventive Health Care Delivery and Compensation 160.022MSS
AMA- MSS will ask the AMA to support both the reduction of financial barriers to the delivery of cost-effective preventive health care services, and the implementation of financial incentives for cost-effective preventive medical care.
a public place. (MSS Res 15, A-02)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 422
(I-25)

Introduced by: Eva Eleftheriadis[1] & Isabel Nguyen[2], Felicia Delgadillo[2], Sakar Gupta[3]

Affiliations: [1]Pennsylvania State College of Medicine
[2]Western University of Health Sciences, College of Osteopathic Medicine of the Pacific
[3]University of Wisconsin-Madison, School of Medicine and Public Health

Subject: Support for Vocal Hygiene Resources & Education

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, over a third of working individuals worldwide utilize their voice as a primary occupational tool[1]; and

Whereas, a "professional voice user" is an individual who uses their voice to perform a certain job: elite vocal performers (singers, actors), professional voice users (lecturers, clergy, air-traffic controllers), nonvocal professionals (teachers, lawyers, doctors, businessmen, etc.), and nonvocal nonprofessionals (clerks, laborers)[1-4]; and

Whereas, professional voice users whose obligations require suboptimal vocal load and vocal demand are at higher risk of developing preventable voice disorders that significantly impair communication, decrease income, and negatively impact quality of life[1,2,5]; and

Whereas, vocal hygiene is defined as "an indirect intervention tool in which the clinician provides strategies to improve vocal health by modifying the physical environment of voicing" via optimized efficiency of respiration, phonation, and resonance of muscle activity [3.6]; and

Whereas, vocal hygiene encompasses personalized daily regimens of beneficial habits to maintain vocal fold health, such as eliminating inappropriate vocal habits that place unnecessary wear on the voice, to optimize to voice production and overall vocal health[7-9]; and

Whereas, several conditions and health behaviors can lead to voice problems, including but not limited to upper respiratory infections, inflammation caused by gastroesophageal reflux, vocal misuse and overuse, vocal fold hemorrhage, vocal fold growths, laryngeal cancer, neurological diseases such as spasmodic dysphonia or vocal fold paralysis, or psychological trauma[10-11]; and

Whereas, surveys of professional and amateur singers showed high levels of interest in education of anatomy and physiology, voice care, and voice disorders, yet significant paucity of knowledge and anxiety about visiting health professionals for vocal checkups[12-13]; and

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Whereas, one survey answered by 81 respondents at music schools with graduate singing programs demonstrated that only 45% of respondents' programs employed medical professionals to deliver and clarify vocal health instruction[14]; and

Whereas, practicing vocal hygiene and receiving vocal health education can prevent the onset of irreversible long-term vocal pathology and decrease healthcare spending on expensive treatments such as surgical procedures[11,15,17]; and

Whereas, studies show that conservative treatment plans with vocal hygiene have successfully treated vocal fold polyps (up to 56.3% improvement, 37% disappearance of polyps) and nodules (elimination or reduction in up to 81.8% of patients), as well as prevented recurrence of vocal nodules in both pediatric and adult populations[15,17]; and

Whereas, there are abundant opportunities for interprofessional collaboration on vocal hygiene education amongst professional voice users, vocal educators, researchers, speech-language pathology, otolaryngology, occupational health, primary care, and behavioral health[2,4,16]; and

Whereas, World Voice Day, observed annually on April 16, is recognized internationally to raise awareness of the importance of voice health and prevention of voice disorders;[18] therefore, be it

RESOLVED, that our American Medical Association support efforts to increase awareness, education, and access to resources for vocal hygiene; and be it further

RESOLVED, that our AMA promote World Voice Day (April 16) as an annual day of observance to increase awareness of voice care and the prevention of voice disorders.

Fiscal Note: TBD

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RELEVANT AMA POLICY

None

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 426
(I-25)

Introduced by: Vlada Stark[1], Alexia Childress[2], Jillian Luthy[1], Alison Blodgett[3], Muhammad Shamim[1], Sarah Al-Shimary[1], Ryan Ng[1], Kaleb Cutter[1], Eileen Enriquez[1], Ryan Jannoud[1], Conan Ng[1], Mira Dani[1]

Affiliations: [1] University of Nevada, Las Vegas Kirk Kerkorian School of Medicine, Region 1
[2] University of Virginia School of Medicine, Region 6
[3]Indiana University School of Medicine, Region 5

Subject: Confidential Remote Reporting Systems for Domestic Violence Victims

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, intimate partner violence (IPV) affects over 10 million people in the U.S. each year, with nearly half of cases unreported, costing an estimated $12 billion annually and contributing long-term health effects, including anxiety, depression, PTSD, sleep disorders, and traumatic brain injury, [1-3]; and

Whereas, healthcare workers are mandatory reporters of child abuse under the federal Child Abuse Prevention and Treatment Act and state laws, but there are no federal mandatory reporter laws for domestic violence, although some states have full or partial laws in place[4-9]; and

Whereas, the current mandatory reporting laws may actually reduce help seeking behaviors, a study found that 40% of women facing domestic violence reported being less likely to seek shelter services if a report would be made, and these effects are amplified among minority and immigrant populations who often face added obstacles of institutional racism, immigration laws, fears of deportation, barriers receiving legal aid, limited culturally competent services, and restricted cultural or familial expectations[10-13]; and

Whereas, healthcare providers report barriers including lack of training, knowledge, time, and resources, which contribute to a lack of trust and disclosure from victims of IPV, resulting in only approximately 10-50% of IPV cases detected in healthcare settings[14,15]; and

Whereas, barriers can be reduced through the availability of confidential, culturally and linguistically appropriate support resources, as well as through improved healthcare training such as incorporating narrative practice and managing resistance to IPV screening within healthcare teams[16,17]; and

Whereas, effective interventions incorporate empowerment-focused approaches with comprehensive assessments, assistance in identifying safety threats, education on available resources, developing safety plans, and completing periodic safety check-ins[18]; and

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Whereas, intimate partner violence (IPV) screening and reporting are increasingly conducted through telehealth platforms such as videoconferencing and patient portals, often without IPV-specific safeguards, and implementing measures such as secured password protection, survivor- and provider-only access controls, and protections against unauthorized access to electronic protected health information (ePHI) can reduce barriers to reporting by alleviating survivor concerns of confidentiality and potential data breaches[19]; and

Whereas, the COVID-19 pandemic highlighted both the potential of telehealth platforms in helping isolated individuals access confidential support services and the increased reliance on domestic violence hotlines when police reports declined, underscoring the importance of developing non-law enforcement reporting options for survivor safety[20,21]; and

Whereas, IPV survivors face heightened risks of digital surveillance and interference by abusive partners during telehealth encounters, including monitoring, restricting access to technology, and attempts to access health records, underscoring the need for secure, survivor-controlled platforms for reporting[19]; and

Whereas, digital and app-based IPV screening tools such as myPlan, IRIS, and telehealth-integrated questionnaires have demonstrated feasibility, acceptability, and safety in clinical and home settings[22]; and

Whereas, app-based screening for IPV has shown feasibility in clinical settings, with a prenatal care app detecting IPV disclosures during COVID-19 shelter-in-place that were not documented in routine medical charts, demonstrating the potential of mobile health platforms to provide confidential, survivor-controlled reporting pathways[23]; and

Whereas, integrating secured, survivor-directed (and not mandatory) reporting mechanisms into existing telehealth platforms and patient portals these issues can be addressed by taking the following steps to reduce barriers to care by protecting ePHI, ensuring confidentiality, and connecting survivors safely to medical, legal, and social support services[19,22,23]; therefore be it

RESOLVED, that our American Medical Association support the development and integration of secure, home-based reporting options for survivors of domestic violence — remote electronic healthcare delivery services — that reduce barriers to reporting by protecting ePHI, ensure survivor-directed (and not mandatory) consent to reporting, and enable safe connection to medical, legal, and social support services; and be it further

RESOLVED, that our AMA advocate for healthcare facilities to link home-based reporting systems to trauma-informed follow-up protocols, including individualized safety planning, survivor-directed communication preferences, and connection to community resources.

Fiscal Note: TBD

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RELEVANT MSS POLICY

Support for Protecting Children from Harmful Custody Proceedings 60.050MSS
AMA-MSS supports efforts to strengthen child custody laws to prioritize child safety in cases such as family violence through the use of qualified expertise, evidence-based practices, trauma-informed training, and consideration of prior abuse. (MSS Res. 205, A-25)

Identifying Victims of Adult Domestic Violence 515.001MSS
AMA-MSS will ask the AMA to: (1) work with social services and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of adult domestic violence and to better serve all of the victim's needs including medical, legal and social aspects; and (2) ask the appropriate organizations to support the inclusion of curricula that address adult domestic violence (AMA Res 419, I-91 Adopted [D-515.985]).

RELEVANT AMA POLICY

Insurance Discrimination Against Victims of Domestic Violence H-185.976
Our AMA: (1) opposes the denial of insurance coverage to victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and

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appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence.

Education of Medical Students and Residents about Domestic Violence Screening H-295.912
Our American Medical Association will continue its support for the education of medical students and residents on domestic violence by advocating that medical schools and graduate medical education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient.

Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse D-515.982
Our American Medical Association will work with members of the Federation of Medicine and other appropriate organizations to educate physicians on (1) the relationship between domestic violence and child abuse and (2) the appropriate role of the physician in treating patients when domestic violence and/or child abuse are suspected.

Intimate Partner Violence Policy and Immigration D-515.979.
Our AMA: (1) encourages appropriate stakeholders to study the impact of mandated reporting of domestic violence policies on individuals with undocumented immigrant status and identify potential barriers for survivors seeking care; and (2) will work with community based organizations and related stakeholders to clarify circumstances that would trigger mandated reporting of intimate partner violence and provide education on the implications of mandatory reporting on individuals with undocumented immigrant status

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 428
(I-25)

Introduced by: Jasmina Davis[1], Annabell Davis[1], Lenna Gottschild[1], Priya Patel[2]

Affiliations: [1] Indiana University School of Medicine
[2] Texas Tech University Health Sciences Center School of Medicine

Subject: Supporting Transportation Infrastructure Reform for Public Health

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, the American Medical Association (AMA) recognizes robust transportation infrastructure as a fundamental social determinant of health that directly impacts patient access to medical facilities, pharmacies, and essential community services [1–4]; and

Whereas, in 2017, 5.8 million individuals in the United States delayed medical care due to a lack of transportation, with such barriers being responsible for 25% of all missed clinic appointments, representing a significant risk factor for long-term mortality among patients with chronic conditions [5–7]; and

Whereas, the first mile (origin to transit stop) and last mile (transit stop to destination) segments of transportation often have poor connectivity in the United States due to lack of suitable pedestrian infrastructure, with sidewalks having 45% less spatial access than roads, thus disproportionately disadvantaging individuals reliant on them, such as elderly, children, and disabled [8]; and

Whereas, since the 1980s, U.S. transportation infrastructure has prioritized automobile access, allocating approximately 80% of federal transportation funding to highways and less than 20% to public transit infrastructure, while active transport networks face an estimated $7 billion funding shortfall, resulting in consistently underfunded, unaffordable, and unreliable accessible transportation options [3,9]; and

Whereas, current federal transportation formulas and design standards (e.g. reliance on vehicle miles traveled and road throughput), prioritize automobile speed over safety, incentivizing road designs that endanger pedestrians, cyclists, and transit users [6]; and

Whereas, vulnerable road users (e.g. cyclists, pedestrians) comprise approximately 20% of all traffic fatalities with pedestrian deaths reaching a 40-year high, yet many states have raised the allowable numbers of deaths and serious injuries among these users, with a disproportionate burden in marginalized communities [3,6]; and

Whereas, “Complete Streets” is a transportation policy approach that requires streets to be designed for safe access for pedestrians, bicyclists, public transportation, as well as motorists

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for users of all ages and abilities, incorporating robust pedestrian and cycling infrastructure, traffic calming measures, and public transport accommodations [10]; and

Whereas, access to sidewalks, bike lanes, and other active mobility infrastructure has been shown to significantly improve physical activity levels and health outcomes, with systematic reviews highlighting that walkability interventions reduce chronic disease burden and enhance equity in urban environments [11]; and

Whereas, implementation of programs like Complete Streets improves equity by establishing sidewalk connections for bus stops, safety by averting 0.6 fatalities per 100,000 cyclist years while encouraging a 2.4% increase in cycling, and improves overall population health by reducing obesity rates [11–14]; and

Whereas the Federal Highway Administration released a report in March 2022 setting forth an initiative to adopt the Complete Streets design model in its approach to funding and designing most federally funded roads [15]; and

Whereas, the Complete Streets Act of 2025 has been introduced to Congress and the House of Representatives, requiring states to establish Complete Street programs and dedicating 5% of federal highway funding to providing technical assistance and incentives for their development, further promoting safer streets for all users [16,17]; therefore be it

RESOLVED, that our American Medical Association support federal adoption of Complete Streets policies or similar street design strategies that facilitate the construction of integrated, multimodal transportation infrastructure, ensuring safe and accessible travel for pedestrians, bicyclists, public transit users, and motorists of all ages and abilities with a special emphasis on addressing the needs of underserved communities including but not limited to rural areas, low-income neighborhoods, and communities of color; and be it further

RESOLVED, that our AMA support reform of federal transportation funding formulas, to explicitly prioritize pedestrian safety metrics, transit accessibility, and health outcomes rather than solely vehicle miles traveled and level-of-service when calculating success of roads; and be it further

RESOLVED, that our AMA works with federal agencies, including the Department of Transportation, to integrate health impact assessments into transportation planning processes, to ensure that public health considerations are central to infrastructure investment decisions.

Fiscal Note: TBD

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17. Complete Streets Act of 2025, No. H.R.3712 (2025). https://www.congress.gov/bill/119th-congress/house-bill/3712

RELEVANT AMA POLICY

Health Promotion and Disease Prevention H-425.993
The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; (5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and preferably clean-energy public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention.

Green Initiatives and the Health Care Community H-135.939
Our AMA supports building practices that help reduce resource utilization and contribute to a healthy environment.
Our AMA supports the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation.
Our AMA supports community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.
Our AMA encourages pilot studies on the feasibility of urban ambulance fleets being replaced with renewably powered vehicles when current petroleum-powered EMS ambulances become retired from service.

Government to Support Community Exercise Venues H-470.952
Our American Medical Association encourages towns, cities and counties across the country to make recreational exercise more available by utilizing existing or building walking paths, bicycle trails, swimming pools, beaches and community recreational fitness facilities.
Our AMA encourages governmental incentives such as tax breaks and grants for the development of community recreational fitness facilities.

Promotion of Exercise H-470.991
Our American Medical Association:

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supports the promotion of exercise, particularly exercise of significant cardiovascular benefit.
encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest.

Our AMA supports National Bike to Work Day and encourages active transportation whenever possible.

RELEVANT MSS POSITIONS

10.013MSS: Implementing Bike Lanes to Improve Overall Bicyclist Safety

160.037MSS: Mitigating the Transportation Barrier for Accessibility of Healthcare for the Medicaid Population

290.006MSS: Expanding Medicaid Transportation to Include Health Grocery Destinations

470.004MSS: AMA Endorsement of National Bike to Work Day

470.006MSS: Bicycle Sharing Programs

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 429
(I-25)

Introduced by: Ramsha Saad[1], Bettina Anil[1], Jorell Barretto[1]

Affiliations: [1]William Carey University College of Osteopathic Medicine

Subject: Ensuring Tattoo Ink Safety: Improving Oversight, Reporting, and Skin Health Awareness

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, tattooing is increasingly common in the U.S., with approximately 32% of adults having tattoos prevalence disproportionately higher among younger adults and certain demographic groups yet ink manufacturing and labeling practices vary widely[1], and periodic contamination events and product recalls have been reported[2], underscoring the need for improved oversight, labeling, and reporting with broad population impact; and

Whereas, current federal oversight of tattoo inks is largely post-market and reporting of adverse events related to tattoo inks and procedures is fragmented and underused by clinicians, patients, and non-clinical stakeholders[3-4]; and

Whereas, existing AMA policy addresses state regulation of tattoo facilities and encourages ingredient disclosure, but reviewers noted gaps in operational federal enforcement, reporting usability, and clinician education that remain unaddressed[4]; and

Whereas, tattoo-related complications documented in the literature include bacterial and atypical mycobacterial infections, allergic and granulomatous reactions, delayed healing, and diagnostic delays when tattoos obscure skin cancers[5]; and

Whereas, FDA surveillance and testing continue to identify contaminated inks, with 18 voluntary U.S. tattoo-ink recalls from 2003 to 2024 and additional 2025 safety alerts for inks contaminated with pathogens such as Pseudomonas aeruginosa, underscoring an ongoing preventable risk[6]; and

Whereas, better operational tools (clear recall notices, usable reporting pathways, clinician guidance) are feasible within FDA authority and are likely to produce near-term public health benefit without overreaching into state regulation of tattoo businesses[6]; now, therefore, be it

RESOLVED, that our American Medical Association urge the FDA to increase risk-based sampling and laboratory testing of tattoo inks, to publish clear plain-language notifications and recall details when safety issues are identified, and to take enforcement action against contaminated or misbranded products within its current statutory authorities; and be it further

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RESOLVED, that our AMA urge the FDA to simplify, promote, and publicize adverse-event reporting pathways relevant to tattoo inks and procedures (e.g., MedWatch), explicitly enable and encourage reporting by clinicians, patients, and tattoo professionals, and publish periodic de-identified summaries that inform clinicians and the public; and be it further

RESOLVED, that our AMA, working with dermatology and other relevant specialty associations and public health partners, develop and disseminate physician-facing guidance and patient education about recognition, documentation, and counseling for common tattoo-related complications (including infections, allergic/inflammatory reactions, and situations where tattoos may mask skin disease), with materials suitable for CME and inclusion in clinical workflows.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Regulation of Tattoo Artists and Facilities H-440.909
Our AMA: (1) encourages the state regulation of tattoo artists and tattoo facilities to ensure adequate procedures to protect the public health; and encourages tattoo artists, tattoo facilities, and physicians to report all adverse reactions associated with tattooing to the Food and Drug Administration MedWatch program; (2) encourages manufacturers of tattoo inks to provide a list of their ingredients to protect public health; (3) encourages tattoo artists and tattoo facilities to obtain informed consent from their clients, that includes potential risks, prior to performing a tattooing procedure; and (4) will, in consultation with relevant stakeholders, develop model state legislation for regulation of tattoo artists and tattoo facilities to ensure adequate procedures to protect the public health and safety. [Res. 506, A-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: Res. 911, I-18]

Adequacy of Sterilization in Commercial Enterprises H-440.934
Our American Medical Association requests that state health departments ensure the adequacy of sterilization of instruments used in commercial enterprises (tattoo parlors, beauty salons, barbers, manicurists, etc.) because of the danger of exchange of infected blood-contaminated fluids. [Sub. Res. 409, I-92Reaffirmed: CSA Rep. 8, A-03 Modified: CSAPH Rep. 1, A13 Reaffirmed: CSAPH Rep. 08, A-23]

Early Detection and Prevention of Skin Cancer H-55.972
Our AMA: (1) encourages all physicians to: (a) perform skin self-examinations and to examine themselves and their families on the first Monday of the month of May, which is designated by the American Academy of Dermatology as Melanoma Monday; (b) examine their patients' skins for the early detection of

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melanoma and nonmelanoma skin cancer; (c) urge their patients to perform regular self-examinations of their skin and assist their family members in examining areas that may be difficult to examine; (d) and educate their patients concerning the correct way to perform skin self-examination; (2) supports mechanisms for the education of lay professionals, such as hairdressers and barbers, on skin self-examination to encourage early skin cancer referrals to qualified health care professionals; (3) supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color; (4) will continue to work with the American Academy of Dermatology, National Medical Association and National Hispanic Medical Association and public health organizations to promote education on the importance of skin cancer screening and skin cancer screening in patients of color. [CCB/CLRPD Rep. 3, A-14 Reaffirmed: CSAPH Rep. 01, A-24]

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 431
(I-25)

Introduced by: Kathryn Riggs[1], Savanna King[2], Areesheh Khan[1], Zarah Shah[3]

Affiliations: [1] University of Virginia School of Medicine
[2] University of Toledo College of Medicine and Life Sciences
[3] Northeast Ohio Medical University

Subject: Promoting Sex- and Gender-Inclusive Diagnostic Practices, Language, and Patient Education

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, current medical literature demonstrates robust evidence of systemic disparities in diagnostic and treatment delays for female patients compared to their male counterparts across multiple areas of medicine; and

Whereas, in GI medicine, women with IBD have significantly longer diagnostic delays and higher rates of misdiagnosis compared to men despite similar clinical presentations[1]; and

Whereas, delay in diagnosis of IBD has been shown to be associated with further disease progression and worse patient outcomes[2]; and

Whereas, in rheumatology, women have higher rates of misdiagnosis and diagnostic delays when presenting with spondyloarthritis with recent evidence suggesting clinician expectations and documentation biases may contribute to this disparity[3]; and

Whereas, delay in diagnosis of spondyloarthritis has been shown to be associated with increased disease activity, greater functional impairment, higher rates of disability, and more advanced structural damage[4]; and

Whereas, in neurology, women hospitalized due to ischemic stroke were less likely to receive standard diagnostic testing/imaging and less likely to be evaluated by a stroke specialist[5]; and

Whereas, incomplete neurovascular imaging and diagnostic delay of ischemic stroke have been shown to be associated with worse patient outcomes and increased odds of subsequent stroke[6,7]; and

Whereas, cardiology is the field with the most notable differences in diagnostic timeline and treatment interventions for women compared to men[8]; and

Whereas, women are more likely to have a missed angina diagnosis despite presenting with similar symptoms as men[9]; and

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Whereas, women experiencing Acute coronary syndrome (ACS) are more likely to have delays in diagnosis after hospital presentation, are less likely to receive evidence based medication therapy, are less likely to be treated with cardiac catheterization and receive timely reperfusion, are more likely to experience prolonged "door-to-balloon" times, and have increased rates of in-hospital mortality, repeat MI, stroke, and major bleeding[10-14]; and

Whereas, despite coronary heart disease being a leading cause of morbidity and mortality amongst American women, common signs/symptoms that women present with are often described as 'atypical'[15,16]; and

Whereas, multiple studies have found that describing common female presentations as 'atypical' likely contributes to diagnostic and treatment delays, suggesting that this term should be retired from medical education and literature[17-20]; and

Whereas, in addition to in-hospital diagnostic and treatment delays, women experiencing ACS also have significantly increased delays in time from symptom onset to hospital presentation likely due to insufficient patient education on 'atypical' symptoms that women experience[10,12,21,22]; and

Whereas, despite current AMA policy supporting the use of decision supports tools and clinical guidelines to mitigate gender bias in discrimination, the representation of women in clinical research, and the inclusion of women's health in medical education curriculum, the evidence above provides strong rationale for continued efforts to improve gender bias in diagnosis and treatment through changing how we categorize symptoms as 'typical' vs 'atypical' and through improving patient education on the variety of clinical presentations[23]; and

Whereas, the AMA may work with professional societies to advocate for redefinition of an 'atypical' presentation to minimize implicit bias against common female presentations and improve patient awareness of gender differences in symptomatic presentation; and

Whereas, the AMA may additionally work with the Accreditation Council for Continuing Medical Education to provide training modules on gender- and sex-based diagnostic disparities and how to overcome them as future CME requirements; and

Whereas, the AMA may work with professional societies and major electronic health record vendors to integrate patient education materials on sex-based variations of clinical symptoms and the need for acute care/diagnostic workup; therefore be it

RESOLVED, that our American Medical Association supports efforts to improve gender and sex equity in diagnosis and treatment; and further be it

RESOLVED, that our AMA supports discontinuing use of the term 'atypical' to describe sex- and gender-based differences in symptomatic presentations in medical education curriculum and reference materials; and further be it

RESOLVED, that our AMA supports advocacy efforts for greater awareness on the variety of clinical presentations for disease processes with a focus on gender- and sex-based variation in medical education curriculum/materials, continuing medical education, and health policy efforts; and further be it

RESOLVED, that our AMA supports the production of patient education materials and the integration of regulated, validated screening tools into patient-facing electronic health record systems to better help female patients identify medical emergencies necessitating immediate care.

Fiscal Note: TBD

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23. Referenced AMA policies: H-410.946, H-295.890, H-525.988

RELEVANT AMA POLICY

Decreasing Sex and Gender Disparities in Health Outcomes H-410.946

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Our AMA: (1) supports the use of decision support tools that aim to mitigate gender bias in diagnosis and treatment; and (2) encourages the use of guidelines, treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes. [Res. 005, A-18]

Medical Education and Training in Women's Health H-295.890
Our AMA: …(1) encourages the coordination and synthesis of the knowledge, skills, and attitudinal objectives related to women's health/**gender**-based biology that have been developed for use in the medical school curriculum. Medical schools should include attention to women's health throughout the basic science and clinical phases of the curriculum; and (7) Our AMA encourages its representatives to the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education (ACGME), and the various ACGME Review Committees to promote attention to women's health in accreditation standards. [Jt. Rep. CME and CSA, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 01, A-19; Appended: CME Rep. 01, A-23]

Plan for Continued Progress Toward Health Equity H-180.944
Health equity, defined as optimal **health** for all, is a goal toward which our American Medical Association will work by advocating for **health** care access, research, and data collection; promoting **equity** in care; increasing **health** workforce diversity; influencing determinants of **health**; and voicing and modeling commitment to **health equity**. [BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, 1-21; Reaffirmed: CMS Rep. 1, 1-23; Reaffirmed: BOT Rep. 30, A-24]

Sex and Gender Differences in Medical Research, H-525.988
Our AMA: (1) reaffirms that gender exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;
(2) affirms the need to include both all genders in studies that involve the health of society at large and publicize its policies;
(3) supports increased funding into areas of women's health and sexual and gender minority health research;
(4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minorities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minorities from diverse cultural and ethnic groups, geographic locations, and socioeconomic status; and
(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative.
(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minorities
(7) encourages the FDA to internally develop criteria for identifying medication and medical devices seeking FDA approval that were developed based on research that did not include adequate participation of women, and sexual and gender minorities. (MSS Res. 016, A-22; AMA Res. 004, Adopt as Amended/Refer Subsection 7, A-23)

RELEVANT MSS POSITIONS

Decreasing Sex and Gender Disparities in Health Outcomes 525.007MSS
AMA-MSS will ask the AMA to (1) promote the use of health care guidelines, protocols, and decision support tools that identify existing sex and gender differences and disparities in health care; and (2) encourage the use of guidelines, and treatment protocols, and decision support tools specific to individual patient anatomy for conditions in which physiologic and pathophysiologic differences exist based on anatomical differences. (MSS Res. 62, I-17; Amended: MSS GC Report A, A-23)

Amending Policy H-525.988, "Sex and Gender Differences in Medical Research" 460.026MSS
AMA-MSS will ask that our AMA amend Policy H-525.988, "Sex and Gender Differences in Medical Research," by insertion as follows:

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 432
(I-25)

Introduced by: Isabel Nguyen[1], Alexia Childress[2], Vignesh Senthilkumar[2], Druv Bhagavan[3]

Affiliations: [1]Western University of Health Sciences, College of Osteopathic Medicine of the Pacific
[2]University of Virginia School of Medicine
[3]Washington University in St. Louis School of Medicine

Subject: Public Emergency Alert Reporting Requirements on Private Platforms

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, mass casualty events such as climate-fueled disasters and domestic terrorist attacks are becoming more commonplace, necessitating continual evaluation of existing public emergency alert systems and integration of mobile public alert and warning technology[1-3]; and

Whereas, the loss of experienced operators and federal funding has led to failures in the timely utilization of integrated emergency warning systems, including at least 15 federally declared major disasters since 2016, during which officials in the most-harmed communities failed to send alerts over FEMA's Integrated Public Alert & Warning System (IPAWS) and resulted in significant morbidity, mortality, and community losses[4-8]; and

Whereas, leading up to the catastrophic Texas floods that killed 78 people on July 4th, 2025, emergency alerts were delayed due to understaffing and federal funding cuts to the National Weather Service, or posted later to private social media platforms Facebook and Twitter/X and were inaccessible without a user account[9-12]; and

Whereas, during disasters and mass casualty incidents, victims, family members, and responders utilize social media platforms to communicate about issues including their status and location, disaster updates, the impacts of the disaster on surroundings, where and how to locate shelter and supplies, how to volunteer, and health and medical advice[13-14]; and

Whereas, emergency announcements, alerts, and warnings are increasingly being issued on private social media platforms, but people who lack social media presence risk missing posts that are only viewable by smart device owners and verified platform users[4,15-16]; and

Whereas, as of 2018, social network sites (e.g., X, Facebook, Instagram) cumulatively have around 3.2 billion users around the world, but a digital divide exists due to uneven access and presence on social media platforms[17-18]; and

Whereas, crises events worsen the digital divide between individuals and communities who do and do not have affordable access, skills, and support to effectively engage online, resulting in

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greater increased risk exposure and worsened health outcomes of vulnerable populations (e.g., elderly, low income, racial/ethnic minorities, rural)[19-22]; and

Whereas, emergency responders face several concerns regarding use of social media as an independent mechanism for emergency alerts due to increased content volume, alert delays, difficulty of locating relevant and actionable information, lack of geographic specificity, and potential for spread of misinformation[23-27]; and

Whereas, while there is currently no legal obligation in the U.S. for social media platforms to provide data transparency, social media platforms including X and Facebook have raised public outrage for blocking non-members from accessing posts with life-saving details or removing community members' alert posts deemed in violation of community guidelines[28-30]; and

Whereas, social media platforms that publish emergency alerts and utilize location-based safety notifications ultimately require residents to create accounts to view and upload crucial time-sensitive information, or be restricted from access in times of crisis[31-32]; therefore be it

RESOLVED, that our American Medical Association discourage the use of social media platforms as a standalone medium or replacement in lieu of more widely accessible public emergency alert systems at the federal, state, and local levels ; and be it further

RESOLVED, that our AMA advocate for data transparency on account-restricted social media platforms to ensure that any time-sensitive alerts from federal, state, or local emergency responder organizations are immediately publicly visible to all individuals, without requiring account creation, paywalls, or other additional verification steps.

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RELEVANT AMA POLICY

Development of a Federal Public Health Disaster Intervention Team H-130.942

1. Our AMA supports government efforts to:
    a. coordinate and integrate federal medical and public health disaster response entities such as the Medical Reserve Corps, National Disaster Medical System, Public Health Services Commissioned Corps (PHSCC), as well as state-to-state sponsored Emergency Management Compact Systems, to strengthen health system infrastructure and surge capacity for catastrophic disasters (Incidents of National Significance) as defined by the Department of Homeland Security's (DHS) National Response Plan (NRP); and

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   b. place all federal medical and public health disaster response assets (with the exception of the Department of Defense) under authority of the Secretary of the Department of Health and Human Services (DHHS) to prevent significant delays and ensure coordination during a catastrophic disaster (Incident of National Significance).
2. Our AMA will monitor progress in strengthening federal disaster medical and public health response capacity for deployment anywhere in the nation on short notice, and report back as appropriate. [BOT Rep. 3, A-07,Reaffirmed in lieu of Res. 218, I-15,Modified: CSAPH Rep. 01, A-25]

Emergency Preparedness D-130.974

1. Our American Medical Association encourages state and local public health jurisdictions to develop and periodically update, with public and professional input, a comprehensive Public Health Disaster Plan specific to their locations. The plan should:
   a. Provide for special populations such as children, the indigent, and the disabled.
   b. Provide for anticipated public health needs of the affected and stranded communities including disparate, hospitalized and institutionalized populations.
   c. Provide for appropriate coordination and assignment of volunteer physicians.
   d. Be deposited in a timely manner with the Department of Health and Human Services, the Department of Homeland Security and other appropriate federal agencies.
2. Encourages the Federation of State Medical Boards to implement a clearinghouse for volunteer physicians (MDs and DOs) that would:
   a. Validate licensure in any state, district or territory to provide medical services in another distressed jurisdiction where a federal emergency has been declared.
   b. Support national legislation that gives qualified physician volunteers (MDs and DOs), automatic medical liability immunity in the event of a declared national disaster or federal emergency. [Sub. Res. 803, I-05,Reaffirmation A-06,Reaffirmed: BOT Rep. 2, A-07,Reaffirmed in lieu of Res. 938, I-11,Modified: BOT action in response to referred for decision Res. 415, A-12,Modified: CSAPH Rep. 1, A-22]

Domestic Disaster Relief Funding D-130.966

1. Our American Medical Association lobby Congress to a) reassess its policy for expedited release of funding to disaster areas; b) define areas of disaster with disproportionate indirect and direct consequences of disaster as "public health emergencies"; and c) explore a separate, less bureaucratic process for providing funding and resources to these areas in an effort to reduce morbidity and mortality post-disaster.
2. Our AMA will lobby actively for the recommendations outlined in the AMA/APHA Linkages Leadership Summit including: a) appropriate funding and protection of public health and health care systems as critical infrastructures for responding to day-to-day emergencies and mass causality events; b) full integration and interoperable public health and health care disaster preparedness and response systems at all government levels; c) adequate legal protection in a disaster for public health and healthcare responders and d) incorporation of disaster preparedness and response competency-based education and training in undergraduate, graduate, post-graduate, and continuing education programs.
[Res. 421, A-11,Reaffirmation A-15,Rescinded/Converted to H policy: CSAPH Rep. 01, A-25]

All Hazards Disaster Preparedness and Response D-130.972

Our AMA will work with: (1) subject matter experts at the national level to quickly produce a provider manual on state licensure and medical liability coverage for physicians during disasters; (2) appropriate medical, public health, disaster response and relief organizations to improve plans, protocols, and policies regarding the provision of health care in mass evacuation shelters; and (3) appropriate state and local organizations to develop templates for private practice/office continuity plans in CD-ROM or web-based format that can be stored in state medical association offices on a server in the event of a disaster. [Res. 426, A-06,Reaffirmed in lieu of Res. 218, I-15,Rescinded / Converted to H Policy: CSAPH Rep. 01, A-25]

Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems D-440.942

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1. Our American Medical Association will champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes.
2. Our AMA will develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress.
3. Our AMA will work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials.
4. Our AMA will advocate for
    a. consistent, sustainable funding to support our public health infrastructure.
    b. incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff.
    c. public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health.
    d. efforts to ensure equitable access to public health funding and programs. [Res. 407, I-20,Modified: CSAPH Rep. 2, I-21,Reaffirmed: CMS Rep. 5, A-22]

Universal Access for Essential Public Health Services D-440.924

1. Our American Medical Association supports equitable access to the 10 Essential Public Health Services and the Foundational Public Health Services to protect and promote the health of all people in all communities.
2. Our AMA encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB).
3. Our AMA will work with appropriate stakeholders to develop a comprehensive list of minimum necessary programs and services to protect the public health of citizens in all state and local jurisdictions and ensure adequate provisions of public health, including, but not limited to clean water, functional sewage systems, access to vaccines, and other public health standards.
4. Our AMA will work with the National Association of City and County Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the Big Cities Health Coalition, the Centers for Disease Control and Prevention (CDC), and other related entities that are working to assess and assure appropriate funding levels, service capacity, and adequate infrastructure of the nation's public health system, including for rural jurisdictions. Res. 419, A-19,Modified: CSAPH Rep. 2, A-22]

RELEVANT MSS POSITIONS

Enhancing Disaster Preparedness Mechanisms for People with Disabilities 440.135MSS

AMA-MSS will ask our AMA, in coordination with relevant stakeholders, advocate for greater integration of inclusive emergency alert systems (e.g., visual, auditory, and haptic notifications) in emergency preparedness planning to ensure disaster response accessibility for people with disabilities; and be it further

AMA-MSS will ask our AMA support increased federal and state funding for disability-specific disaster preparedness measures such as assistive technologies, durable medical equipment, mobility devices, and education programs for individuals with disabilities in collaboration with relevant stakeholders. (MSS Res. 434, A-25)

Adverse Impacts of Delaying the Implementation of Public Health Regulations 440.081MSS

AMA-MSS asked the AMA to support updates to the EPA's Risk Management Program Rule, such as the Chemical Disaster Rule, that prioritize chemical disaster prevention, emergency preparedness, and accessibility of safety information to the public. (MSS CGPH Rep A, I-18)

(AMA Res 529, Adopted as Amended [D-440.925]) (Amended: MSS GC Report A, A-24)

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Longitudinal Capacity Building to Address Climate Action and Justice 440.112MSS
AMA-MSS will ask the AMA to: (1) Declare climate change an urgent public health emergency that threatens the health and well-being of all individuals; (2) Aggressively advocate for prompt passage of legislation and policies that limit global warming to no more than 1.5 degrees Celsius over pre-industrial levels and address the health and social impacts of climate change through rapid reduction in greenhouse gas emissions aimed at carbon neutrality by 2050, rapid implementation and incentivization of clean energy solutions, and significant investments in climate resilience through a climate justice lens; (3) Study opportunities for local, state, and federal policy interventions and advocacy to proactively respond to the emerging climate health crisis and advance climate justice with report back to the House of Delegates; and (4) Consider the establishment of a longitudinal task force or organizational unit within the AMA to coordinate and strengthen efforts toward advocacy for an equitable and inclusive transition to a net- zero carbon society by 2050, with report back to the House of Delegates. (MSS Res. 27, I-21) (AMA Res. 430, Adopted Alternate Resolution in Lieu of [], A-22)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 505
(I-25)

Introduced by: Nathan Goturi[1], Sumeet Kadian[2], Anshika Gupta[1], Luke Dotson[3]

Affiliations: [1]Boston University Chobanian and Avedisian School of Medicine, [2]University of Connecticut School of Medicine, [3]Baylor College of Medicine

Subject: Increasing Patient Autonomy Through Federated Data Architecture

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, large de-identified patient datasets are critical for studies of rare diseases, health disparities, and population-wide trends, and their availability enables augmented intelligence innovation, expands access to precision medicine, enhances interoperability, and advances equitable patient-centered healthcare[1-9]; and

Whereas, multi-center research collaborations present the opportunity for novel insights and are necessary for replicability and large-scale validation of findings, but institutions and groups with limited access to large datasets face barriers to participation, limiting their contributions[10-13]; and

Whereas, health data and protected health information (PHI) that are de-identified per the widely-used Department of Health and Homeland Security (HHS) guidelines are no longer protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and may be lawfully aggregated and shared for secondary use[14,15-24]; and

Whereas, both HHS and medical literature acknowledge that data de-identified via HHS guidelines retains a non-zero risk of re-identification, potentially allowing submission of fraudulent medical claims, leakage of PHI, and loss of trust in healthcare organizations[14,25-29].; and

Whereas, entities that control de-identified data may freely sell this data for-profit to external organizations without patient consent, a multi-billion dollar industry that places patients at risk of re-identification without allowing for autonomy over secondary use of their own data[30-32]; and

Whereas, data privacy practices acknowledging that all data collected on an individual can present risks, and thus ensure individuals control access to their health data have been implemented under the European Union's General Data Protection Regulation (GDPR)[33-35]; and

Whereas, these practices allow patients' right to control their data to coexist with large-scale research infrastructures that preserve privacy like the European Union's OpenSAFELY, which has supported numerous peer-reviewed studies using secure and auditable access to EHRs while allowing individuals to restrict secondary data use[33-38]; and

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Whereas, preserving patients' autonomy to restrict secondary use of their data from use in these efforts is an implementable solution that address the non-zero re-identification risk of de-identified data and advances patient-directed healthcare; and

Whereas, federated data refers to a model in which participating organizations keep their patient-level data locally, transform them to a common data model, and run standardized queries/algorithms locally that return only approved or aggregate results, thereby enabling multi-site analyses without centralizing PHI, enhancing both security and collaboration[39]; and

Whereas, federated data architecture's success is accepted in medical literature and underpins established networks such as the Food and Drug Administration's Sentinel Distributed Database and Patient-Centered Outcomes Research's Distributed Research Network[40-44]; and

Whereas, the U.S. government already has a federation-ready interoperability policy stack to facilitate multi-center research, enable cross-network exchange nationwide (with a majority of hospitals planning participation), and standardize electronic health information access[45-50]; and

Whereas, the U.S. government supports the technical resources necessary to achieve a federated data model and adopting one aligns with articulated goals for cross-organizational data exchange without consolidation, as reflected in federal initiatives such as "America's AI Action Plan" and the White House and CMS "Health Tech Ecosystem Initiative"[51-53]; and

Whereas, a non-federated data architecture allows for limitation of data access to historically prestigious institutions (e.g., Intelligent Research in Sight (IRIS) Registry) and allows entities that control de-identified datasets to profit by selling to external parties (e.g., Healthcare Cost and Utilization Project (HCUP)), reducing interoperability and equity in research[54,55.]; and

Whereas, given existing technical and legislative infrastructure, adopting a federated data architecture is possible, and doing so would expand equitable data access, reduce gatekeeping and profit-driven restrictions on de-identified data, and enhance interoperability[42]; and

Whereas, it is logically and ethically reasonable to argue for the continued use of appropriately de-identified data for research, as the potential benefits (robust research, equitable innovation, precision care) justify the privacy hazards; and

Whereas, adopting a federated data architecture would enhance data security while allowing patients to restrict secondary data use, strengthening patient autonomy and directly addressing many of the legal and privacy challenges of data sharing[42,56,57]; and therefore be it

RESOLVED, that our AMA-MSS support healthcare data privacy practices that provide patients with options to withdraw or restrict secondary uses of their data, including the ability to retroactively withdraw their data from de-identified data sets; and it be further

RESOLVED, that our AMA-MSS support the adoption of a federated data architecture to facilitate patients' control over secondary uses of their data, enhance multi-center collaboration and equity in research, accelerate responsible and open-weight open-source AI development, and augment data security by avoiding centralization of protected health information.

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RELEVANT AMA POLICY

Information Technology Standards and Costs (D-478.996)
Our AMA will (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems;...(e) continue its active

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involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

National Health Information Technology (D-478.995)
Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care; (4a) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; (b) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

Research Handling of De-Identified Patient Information (H-315.962)
Our AMA supports efforts to promote transparency in the use of de-identified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such information.

Assessing the Intersection Between AI and Health Care (H-480.931)
(1a) Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based

Medical Information and Its Uses (H-406.987)
Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete; Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter; Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used; Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement; Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility and reduce barriers that currently limit access to and use of the health care data.

Patient Privacy and Confidentiality (H-315.983)
Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:...(c) that patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled;...(4) Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review;...(10) Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB; (11) Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses

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are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures

Clinical Data Registries (H-450.933)
Our AMA encourages multi-stakeholder efforts to develop and fund clinical data registries for the purpose of facilitating quality improvements and research that result in better health care, improved population health, and lower costs.

Relevant MSS POLICY

Pure and Applied Research (460.001MSS)
AMA-MSS supports the following principles: (1) A commitment to stabilization of support for biomedical research and research training should be made by the government;...(4) In any system of regulation or incentive regarding private sponsorship of academic research, provisions should be made to actively encourage the role of training researchers as well as the role of conducting research; (5) Individuals and institutions must police themselves in order to combat overly restrictive regulation; (6) Greater decentralization of the decision-making authority from federal agencies to grantee institutions should occur, especially in the day-to-day management of grants and contracts.

Comparative Effectiveness Research (460.011MSS)
It is policy of the AMA-MSS to support the creation of an independent organization that: (1) Conducts and supports research into the comparative effectiveness and cost effectiveness of new and existing medical interventions to increase information available for clinical decision-making; (2) publicly disseminates findings to medical professionals and patients; (3) involves representatives of physicians and patients in its governance; (4) ensures that all studies maintain the highest standards of scientific credibility and investigator integrity, including submission of studies through a peer-review process and rules regarding conflicts of interest;...(6) recognizes that patients are unique individuals and while attempting to provide evidence for specific subgroups and circumstances, acknowledges that population-level research is not applicable to every clinical case.

Creation of National Registry for Healthy Subjects in Phase I Clinical Trials (460.014MSS)
AMA-MSS will ask the AMA to encourage the development and implementation of a national registry, with minimally identifiable information, for healthy subjects in phase I trials by the US Food and Drug Administration or other appropriate organizations to promote subject safety, research quality, and document previous trial participation.

Enabling a Contiguous, National Electronic Health Record Network (315.003MSS)
AMA-MSS supports efforts to require the interoperability of independent healthcare systems such that electronic health records data be entirely transferable

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 507
(I-25)

Introduced by: Thomas Hansen[1], Maya Livni[1], Samir Reddy[2]

Affiliations: [1] Medical College of Wisconsin
[2] University of Texas Southwestern Medical School

Subject: Supporting Ethical Allocation of Future Xenotransplant Organs

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, xenotransplantation is currently defined by the Food and Drug Administration (FDA) as any procedure involving transplantation or implantation into a human recipient of tissues or organs from a nonhuman animal source[1]; and

Whereas, the increasing application of human organ transplantation as a definitive treatment for end stage organ failure has resulted in disparity of supply and demand for such organs, making xenotransplantation an appealing solution to overcome this obstacle[2–4]; and

Whereas, the March 2025 porcine kidney transplant in a living human recipient at Massachusetts General Hospital, building on prior pig-to-human heart and kidney xenotransplants in both brain-dead and living recipients, demonstrated proof of concept for clinical xenotransplantation and established its feasibility in humans[5–8]; and

Whereas, sustained advances in donor pig genetic engineering, immunosuppressive regimens, and preclinical models have resulted in prolonged xenograft survival in nonhuman primates and functional porcine kidney xenografts in human recipients, confirming a clear trajectory toward clinical application[6–10]; and

Whereas, on February 3, 2025, the FDA approved the first human clinical trial using genetically edited porcine kidneys for patients with end-stage renal failure[11], signaling the growing clinical relevance of xenotransplantation[9,12,13]; and

Whereas, the FDA and Centers for Medicare and Medicaid Services (CMS) oversee xenotransplant research and clinical trials, with regulations emphasizing safety, informed consent, and xenozoonosis surveillance but lack allocation frameworks for clinical use of xenotransplant-derived organs[16,17]; and

Whereas, the Organ Procurement and Transplantation Network (OPTN) regulates organ allocation in the United States, setting national policies for donor-recipient matching and equitable distribution, yet current frameworks do not address the unique challenges of xenotransplant organ allocation[14,15]; and

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Whereas, the U.S. organ allocation system continues to face challenges in equity, cost-effectiveness, and transparency, with disparities tied to geography and referral practices that undermine fairness and disproportionately benefit patients with greater access to high-quality healthcare[18]; and

Whereas, socioeconomic and racial inequities further exacerbate barriers to transplantation, as patients with lower income, unstable housing, or non-private insurance remain less likely to be referred, listed, or successfully transplanted despite decades of policy reform[19–21]; and

Whereas, OPTN has adopted a *Continuous Distribution* allocation framework that simultaneously considers multiple factors to improve equity, using values prioritization exercises to create organ-specific composite scores adaptable across organ types[22]; and

Whereas, OPTN employs allocation algorithms based on geography, organ size, blood type, and organ-specific criteria to optimize graft survival, but neither these algorithms nor existing FDA and CMS frameworks address the unique considerations of xenotransplant organs[24,25]; and

Whereas, existing AMA policy on xenotransplantation supports FDA guidelines, continued research, and endorses clinical best practices, but does not address future, ethical, logistical, and equity related challenges regarding allocation; and

Whereas, on September 12, 2024, the OPTN policy oversight committee approved a project to examine how xenotransplantation will interface with human allograft allocation through ethical analysis, with findings expected for public comment in January 2026, signaling OPTN's openness to addressing ethical concerns and allocation frameworks for xenotransplant organs[26-28]; and therefore be it

RESOLVED**,** that our American Medical Association support the development of policies for xenotransplant-derived organ allocation that safeguard equity, ethical principles, patient access, and address existing disparities; and be it further

RESOLVED**,** that our AMA encourage the Organ Procurement and Transplantation Network to study attributes relevant to xenotransplant-derived organ allocation to inform the creation of fair and equitable policies.

Fiscal Note: TBD

Received: 09/21/2025

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RELEVANT AMA POLICY

Xenotransplantation: Scientific Implications H-370.972

Our AMA: (1) supports the general xenotransplantation guideline documents produced in 2000 by the Public Health Service, the 1999 Food and Drug Administration (FDA) guidelines relating to nonhuman primates and xenotransplantation, the 2002 FDA guidelines on measures to reduce the possible risk of transmission of zoonoses from xenotransplantation, and the Institute of Medicine xenotransplantation guideline document; and (2) encourages continuation of research on xenotransplantation to gather data to determine more accurate risk analysis.[CSA Rep. 8, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

6.3.1 Xenotransplantation

Physicians have an obligation to participate in efforts to increase the supply of organs available for transplantation. In fulfilling that obligation, they must also be mindful of their obligations to protect the interests of patients and the welfare of the public. Xenotransplantation, i.e., using organs or tissues from nonhuman animal species for transplantation into human patients, is a

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possible novel means of addressing the shortage of transplantable organs that can pose distinctive ethical challenges with respect to patient safety and public health… [Issued: 2016]

Tissue and Organ Donation H-370.983
Our American Medical Association will assist the United Network for Organ Sharing in the implementation of their recommendations through broad-based physician and patient education.[Res. 533, A-92; Reaffirmed: CSA Rep. 12, I-99; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12; Reaffirmed: CEJA Rep. 4, A-22]

The HRSA – Organ Procurement and Transplantation Network (OPTN) Modernization Initiative H-370.953
Our American Medical Association supports an Organ Procurement and Transplantation Network (OPTN) Board, per the National Organ Transplant Act (NOTA) regulations, that includes patients, living donors and donor families, transplant centers, organ procurement organizations (OPOs), patient and medical associations, and other transplant stakeholders to ensure experience, expertise, and knowledge from content experts; and should be elected by the membership rather than be appointed or elected by the government or its contractors which would result in politicizing medical care decisions.[Res. 025, A-24]

11.1.3 Allocating Limited Health Care Resources
Physicians' primary ethical obligation is to promote the well-being of their patients. Policies for allocating scarce health care resources can impede their ability to fulfill that obligation, whether those policies address situations of chronically limited resources, such as ICU (intensive care unit) beds, medications, or solid organs for transplantation, or "triage" situations in times of scarcity, such as access to ventilators during an influenza pandemic…[Issued: 2016]

RELEVANT MSS POSITIONS

Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation 370.024MSS
AMA-MSS will ask the AMA (1) support initiatives that decrease financial and institutional barriers for organ transplantation to uninsured or insurance-ineligible recipients, regardless of immigration status, excluding medical tourism as defined in the AMA code of ethics 1.2.13… (MSS CEQM MIC Report A, I-22; AMA Res. 003, Adopt as Amended, A-23)

RELEVANT AMA ACTIONS

Comment Letter to HHS -June 20, 2024: AMA comments on HRSA's plans for future organization of OPTN ensuring the organization is member-driven

Comment Letter to HHS - May 22, 2020: AMA comments on regulation regarding regulation of advance kidney transplantation

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 508
(I-25)

Introduced by: Clare Grossman[1], Charlie Dubach-Reinhold[1], Sharlene Shirali[1], Kelly Gocke[1]

Affiliations: [1] University of California San Francisco

Subject: FDA Medical Product Labeling

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, biological differences across demographic subgroups can lead to clinically meaningful variations in safety and efficacy profiles of medications and medical devices across subgroups, particularly sex and age[1–3]; and

Whereas, for example, a 2009 study found that implantable cardioverter defibrillators provided no mortality benefit for women and were associated with a 70% higher rate of adverse events compared to men, yet tens of thousands of women continue to receive ICDs annually,[4] and the sedative zolpidem exhibits slower clearance and higher plasma concentrations in women and the elderly, increasing the risk of adverse effects[5,6]; and

Whereas, race is a dynamic concept shaped by sociopolitical factors, and acts as a poor proxy for ancestry, which better accounts for shared genetic similarities and traits, and therefore reported subgroup differences between racial groups may be confounded by unmeasured social determinants of health and not reflect biological differences[7]; and

Whereas, despite recommendations from the Food and Drug Association (FDA),[8] the Society for Cardiovascular Angiography & Interventions,[9] and the American Society of Clinical Oncology and the Association of Community Cancer Centers,[10] clinical trial populations for medical products frequently underrepresent women, gender-diverse people, racial and ethnic minorities, and older adults[11–15]; and

Whereas, underrepresentation in clinical trials limits the statistical power to detect safety and efficacy differences across subgroups, undermining their generalizability[16]; and

Whereas, guidelines for statistical considerations for subgroup analyses in clinical trials have been well-researched and published by regulatory agencies and peer-reviewed journals,[17–19] and statistical models exist to overcome concerns of low power and data dredging[20]; and

Whereas, though the FDA has published guidance and action plans,[21,22] a 2021 study estimated that only approximately 23% to 33% of clinical trials for prescription drugs or medical devices report subgroup analyses at all,[23] indicating that non-enforceable FDA guidance alone is insufficient to increase clinical trial diversity and subgroup analysis reporting; and

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Whereas, although existing AMA policy H-460.911 advocates for the determination and free distribution of specific outcomes for all subgroups in all clinical trials,[24] the minimal reporting of subgroup analysis shows that 'free distribution' is not been an effective or enforceable strategy to ensure that subgroup-specific outcomes are accessible to patients or providers[23]; and

Whereas, labeling for prescription medicines is the FDA's primary tool for communicating drug information to healthcare professionals, patients, and their caregivers[25]; and

Whereas, FDA-approved labels for prescription medications include medication guides, patient package inserts, and instructions for use, therefore allowing adequate space for the printing of additional information[26]; and

Whereas, requiring the inclusion of subgroup analyses on FDA labels would both provide a centralized source of information about medical product safety and efficacy *and* increase compliance with well-recognized best practices for clinical trial representation and subgroup analyses; and

Whereas, providing patients with evidence-informed decision aids has been shown to improve risk perception accuracy and facilitate shared decision-making, not cause harm, thereby enhancing public health outcomes and patient empowerment[27]; therefore be it

RESOLVED, that our AMA advocates for the FDA to require that prescription drug and medical device labels include:

1. Subgroup analyses of safety and efficacy outcomes across the categories of age and sex, even if such comparisons are negative, and
2. An explicit disclaimer when representation is inadequate to assess these subgroup-specific effects.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Increasing Participation in Clinical Research of People Identifying with Minoritized and Marginalized Groups H-460.911
(3) Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist. [BOT Rep. 4, A-08; Reaffirmed: CSAPH Rep. 01, A-18; Modified: Res. 016, I-22; Modified: Res. 913, I-24]

Sex and Gender Differences in Medical Research H-525.988
Our AMA: (7) supports the FDA's requirement of actionable clinical trial diversity action plans from drug and device sponsors that include women and sexual and gender minority populations;
(8) supports the FDA's efforts in conditioning drug and device approvals on post-marketing studies which evaluate the efficacy and safety of those products in women and sexual and gender minority populations when those groups were not adequately represented in clinical trials; and

Prescription Product Labeling H-115.994

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(1) The official labeling should not be regarded as the sole standard of acceptable or accepted medical practice nor as a substitute for clinical judgment or experience nor as a limitation on usage of the drug in medical practice. The official labeling statements approved by the FDA establish the parameters governing advertising or promotion of the drug product. [Sub. Res. 30, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Modified: Res. 505, A-15; Reaffirmed: CSAPH Rep. 01, A-25]

Consumer Medication Information H-115.969
Our American Medical Association supports the following basic principles for supplying written prescription drug information to patients: (1) Our AMA supports the pursuit of a single document for the provision of written consumer medication information (CMI), replacing the current framework of patient package inserts, pharmacy generated prescription drug leaflets, and Medication Guides. (2) The FDA collaboratively develop, test, and implement a single-document CMI process based on rigorously defined, essential information needed by patients to safely and effectively use medications. (3) The FDA validate CMI prototypes in actual use studies. (4) CMI should be provided in electronic formats on a publicly accessible Web site so that prescribers have access to these tools for improving patient adherence. (5) CMI should stand on its own and not be an integral component of pharmacy marketing activities. [CSAPH Rep. 3, A-11Reaffirmed: CSAPH Rep. 1, A-21]

RELEVANT MSS POSITIONS

Advocacy for a System of Improved and Standardized Instructions for Drug Labels in order to Promote Health Literacy and Patient Well-Being 115.002MSS
“AMA-MSS will ask the AMA to (1) encourage the Food and Drug Administration and other appropriate third parties to consider the implementation of a system of written medication instructions with strongly correlating standardized pictorial representations that adequately represent the instructions in order to allow individuals of low literacy to clearly comprehend directions for and significance of medication use; and (2) encourage the Food and Drug Administration (FDA) and other appropriate third parties to include on all prescribed medication labels, if the patient so desires, the reason for which the medication was prescribed.” (MSS Res 24, A-12)

Amending Policy H-525.988, “Sex and Gender Differences in Medical Research” 460.026MSS
“AMA-MSS will ask the AMA to (1) encourage the Food and Drug Administration and other appropriate third parties to consider the implementation of a system of written medication instructions with strongly correlating standardized pictorial representations that adequately represent the instructions in order to allow individuals of low literacy to clearly comprehend directions for and significance of medication use; and (2) encourage the Food and Drug Administration (FDA) and other appropriate third parties to include on all prescribed medication labels, if the patient so desires, the reason for which the medication was prescribed.” (MSS Res. 016, A-22)

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 602
(I-25)

Introduced by: Natasha Topolski[1]

Affiliations: [1]McGovern Medical School

Subject: Development of Sustainable Guidelines for the MSS Strategic Plan and Reporting Process

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, the AMA MSS Governing Council (GC) develops a strategic plan each year to guide its priorities and initiatives; and

Whereas, this strategic planning process has historically lacked consistent transparency, visibility, and mechanisms for input from the broader MSS membership; and

Whereas, MSS policies 640.001MSS and 630.078MSS reference strategic planning and outcomes communication, the MSS Positions Compendium does not currently outline consistent procedures for strategic plan development, member input solicitation, reporting, or archiving; and

Whereas, AMA Policy G-625.020 outlines the process for the AMA Board of Trustees strategic planning process that emphasizes transparency, broad member participation, and regular communication about progress on strategic goals can serve as a model for an effective MSS position; and

Whereas, the AMA produces an Annual Report and Advocacy Efforts Report that provide structured updates on strategic priorities and progress, thereby ensuring transparency, accountability, and institutional memory for the larger AMA; and

Whereas, while the MSS GC can report on strategic plan outcomes without a formal position, the absence of such a position has led to inconsistent reporting, loss of institutional memory, and added strain on each GC as they must repeatedly decide how to approach reporting, if they remember to do so at all; and

Whereas, historical efforts like the MSS “Chair’s Report” and directives for “annual reports to the MSS Assembly” on the MSS Strategic Plan previously aimed to address these issues, they are not currently reflected in the MSS Positions Compendium and consequently have not been consistently implemented; and

Whereas, MSS members have a right to assurance that their leadership follows a clearly defined process for Strategic Plan development and reporting, akin to AMA Policy G-625.020;

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Whereas, while the MSS GC retains authority over the creation and content of the MSS Strategic Plan, the MSS Assembly has a right to establish an MSS Position that defines a clear process for Strategic Plan development and reporting that ensures leadership accountability, akin to the AMA Board of Trustees' strategic planning process outlined in Policy G-625.020; and

Whereas, establishing a formal MSS position on strategic planning and reporting would strengthen institutional memory, ensure accountability to current and future members, highlight behind-the-scenes leadership work, and provide opportunities for broader member input and engagement; and

Whereas, while 640.001MSS permits the Committee on Long Range Planning (COLRP) to study the strategic planning process without a directive from the MSS Assembly, this resolution provides a legitimate directive for a study that is within the Assembly's purview to ensure accountability and membership review by requiring timely completion and report back to the MSS; and

Whereas, this resolution calls only for a study to consider a formal position on MSS Strategic Planning, which would involve input from the MSS GC and staff, and may recommend for or against the proposed components, with final recommendations returning to the Assembly for consideration; therefore be it

RESOLVED, that the AMA-MSS study the MSS Strategic Planning Process and report back with recommendations for a formal MSS Strategic Planning Position that:

a. Defines a transparent and sustainable process and timeline for strategic plan development, implementation, progress reporting, and archiving;
b. Considers the possibility of identifying and updating advocacy priorities within the scope of the MSS and consistent with AMA policy;
c. Incorporates mechanisms to solicit and integrate input from the broader MSS membership; and
d. Is mindful of the MSS Governing Council's workload and resource capacity.

Fiscal Note: TBD

Received: 09/21/2025

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RELEVANT AMA POLICY

AMA Strategic Planning G-625.020

1. Our AMA annual strategic planning cycle shall include the following dimensions:
    a. Information: Our AMA strategic planning process shall be based on information about the environment in which medicine and our AMA must function. Drawing from a variety of sources including public and physician survey data, other types of research findings and data, and the work of our AMA councils, sections, and special groups, the Council on Long Range Planning and Development (CLRPD) shall provide strategic support to our AMA Board by identifying, analyzing, and interpreting environmental trends. The Board of Trustees and the CLRPD shall work collaboratively to distribute information on the

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environment and our AMA's vision, objectives, and strategies to all the participants in the strategic planning process.

b. Participation: Our AMA strategic planning process should provide for broad participation by the House of Delegates, Councils, Sections, Special Groups, staff, and other appropriate internal and external sources. The Board of Trustees shall provide opportunities for these entities to provide input into the development of our AMA's strategic plan.

2. Our AMA strategic planning process should generate:
    a. a multi-year plan that identifies the most critical strategic issues for the organization.
    b. the critical success factors for each issue.
    c. annual work plans with measurable performance objectives, tasks and timelines, assignments for implementation, and expected outcomes.

3. The Board must ensure that adequate resources - staff, funding, and material - are available for developing our AMA strategic plan.

4. The goals of our AMA strategic plan should become an overarching part of all Board and Council meetings. All ongoing initiatives and new undertakings must be regularly measured against the plan, and emerging issues that impact the plan should be identified.

5. Our AMA strategic plan will be presented to the HOD in a more visible, proactive, and interactive way.

6. Our AMA Board of Trustees will continue to:
    a. consider input from the House, CLRPD, and broad physician community when developing the Strategic Plan and making resource allocation decisions.
    b. exercise its fiduciary responsibilities with respect to allocating resources appropriately and consistent with the AMA's vision, goals and priorities.
    c. monitor the activity and results related to commitments established in the planning process.

7. Our AMA will continue to communicate activities, achievements, and opportunity for physician involvement through the Federation, Physician Grassroots Network, AMA publications (paper, email, and web-based), and other channels as appropriate.

Informational Reports. B-7.0.2
Each Section may submit at the Annual Meeting an informational report detailing the activities and programs of the Section during the previous year. The report(s) shall be submitted to the House of Delegates through the Board of Trustees. The Board of Trustees may make such non-binding recommendations regarding the report(s) to the Sections as it deems appropriate, prior to transmitting the report(s) to the House of Delegates without delay or modification by the Board. The Board may also submit written recommendations regarding the report(s) to the House of Delegates.

AMA Advocacy Analysis G-640.005
Our AMA Board of Trustees will provide a report to the House of Delegates at each Interim Meeting highlighting the prior year advocacy activities to include efforts, successes, challenges, and recommendations / actions to further optimize advocacy efforts.

RELEVANT MSS POSITIONS

MSS Committee on Long Range Planning 640.001MSS
It is the policy of the AMA-MSS that the Committee on Long Range Planning should be a Committee, appointed by the Chair, to study issues referred by the Chair as well as structure, function, and strategic planning issues relating to the future of the MSS.

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Standing Committee Task Force Report 640.015MSS
(5) every Standing Committee leadership team develop a detailed strategic plan at the beginning of their terms

Evaluating the Value of Region Restructuring (Follow Up) 665.014MSS
(3) Region bylaws will be reviewed and assessed by each Region annually during the leadership transitions and strategic planning process

Optimizing MSS Communications 630.078MSS
AMA-MSS will continue to support and explore strategies to optimize communications with general members, including at minimum:

1. Production of an electronic newsletter;
2. Maintenance of virtual platforms for direct communication with members (i.e. GroupMe) at the national and regional levels;
3. Maintenance of an easily accessible and regularly updated list of important events and deadlines for MSS and AMA activities;
4. Maintenance of an easily accessible list of items important to the MSS that will be coming before the AMA House of Delegates, updated before each HOD meeting;
5. Maintenance of an easily accessible list of outcomes of items important to the MSS considered at the AMA House of Delegates updated after each House of Delegates meeting;
6. Maintenance of an easily accessible list of implementation outcomes of items important to the MSS considered at the AMA House of Delegates upon publication of the annual House of Delegates Follow Up Implementation Report;
7. Regular dissemination of information about shared initiatives with other AMA entities;
8. Ensure MSS Regions maintain active and timely communication with MSS delegates and other general Region members regarding responsibilities and opportunities; and

Developing and maintaining a series of free online materials providing detailed information on MSS functions and engagement opportunities.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Late Resolution 001
(I-25)

Introduced by: Druv Bhagavan[1], Natasha Topolski[2], Khushbakht Shah[3], Carlene Kranjac[4], Mitch Hanson[5], Shalmali Bhadkamkar[6], Sara Kazyak[7], Sanjay Neerukonda[2]

Affiliations: [1]Washington University in St. Louis School of Medicine, [2]McGovern Medical School, [3]Northeast Ohio Medical University, [4]Medical College of Wisconsin, [5]Medical College of Georgia, [6]University of Toledo, [7]Wayne State University School of Medicine

Subject: Pending Transmittal Update: "Overemphasis on Research in Trainee Selection" (306-I-24-MSS)

Sponsored by:

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Whereas, resolution 306-I-24-MSS "Overemphasis on Research in Trainee Selection" was Adopted as Amended at the Interim 2024 MSS Assembly Meeting [1,2]; 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 [3]; and

Whereas, this update removes the ability to list publications that are not peer-reviewed [3]; and

Whereas, the elimination of the ability to list publications that are not peer-reviewed limits the ability of residency/fellowship applicants to showcase advocacy work, including resolutions, Op-Eds, and other published works; and

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

Whereas, this results in highly inequitable consideration of candidates for these programs, especially candidates who are applying from institutions without a significant research enterprise or who may not have had opportunities to conduct research; 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; and

Whereas, helping applicants showcase these accomplishments on residency/fellowship applications has been a key priority of our AMA and our MSS [4-8]; therefore be it

RESOLVED**,** that pending MSS transmittal "Overemphasis on Research in Trainee Selection" (306-I-24-MSS) be amended by addition and deletion to read as follows:

> 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;~~Improve residency/fellowship application services to allow applicants to differentiate between non-research domains of experience such as advocacy and service, as well as research experiences; and~~
> b) R~~r~~educe the emphasis on the quantity of 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.

and be it further

RESOLVED**,** that 310.063MSS "Overemphasis on Research in Trainee Selection" be amended by addition and deletion to read as follows:

> AMA-MSS will ask 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;~~Improve residency/fellowship application services to allow applicants to differentiate between non-research domains of experience such as advocacy and service, as well as research experiences; and~~
> b) R~~r~~educe the emphasis on the quantity of 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.

Fiscal Note: TBD

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RELEVANT AMA POLICY

D-200.985 Strategies for Enhancing Diversity in the Physician Workforce
“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.”

H-460.930 Importance of Clinical 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.”

Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process D-310.945
Our AMA will encourage medical schools, medical honor societies, and residency/fellowship programs to work toward ethical, equitable, and transparent recruiting processes, which are made available to all applicants.
Our AMA will advocate for residency and fellowship programs to avoid using objective criteria available in the Electronic Residency Application Service (ERAS) application process as the sole determinant for deciding which applicants to offer interviews.
Our AMA will advocate to remove membership in medical honor societies as a mandated field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting its use as an automated screening mechanism—and encourage applicants to share this information within other aspects of the ERAS application.
Our AMA will advocate for and support innovation in the undergraduate medical education to graduate medical education transition, especially focusing on the efforts of the Accelerating Change in Medical Education initiative, to include pilot efforts to optimize the residency/fellowship application and matching process and encourage the study of the impact of using filters in the Electronic Residency Application Service (ERAS) by program directors on the diversity of entrants into residency.
Our AMA will encourage caution among medical schools and residency/fellowship programs when utilizing novel online assessments for sampling personal characteristics for the purpose of admissions or selection and monitor use and validity of these tools.

RELEVANT MSS POSITIONS

295.044MSS Effective Education for the Future of Medicine:
The AMA-MSS Governing Council will continue to identify opportunities to present timely and relevant health policy information to medical students

295.153MSS Health Policy Education in Medical Schools:

AMA-MSS will monitor progress on the development of the Association of American Medical College's behavioral and social science core competencies and report back upon release of the competencies.

295.171MSS Health Policy Education in Medical Schools:
(1) AMA-MSS encourages medical schools to implement teaching strategies that promote outcome based development of behavioral and social science foundations for medical students; and (2) AMA-MSS encourages the AAMC to engage in appropriate follow-up research based on the implementation of its behavioral and socioeconomic report competencies.

295.173MSS Policy and Advocacy Rotations for Medical Students:
AMA-MSS will ask the AMA to (1) support the recognition and incorporation of elective advocacy and health policy rotations and fellowships for medical students within the US medical curriculum; and (2) work with state and specialty societies, the AAMC, AACOM, COCA, LCME, and other interested organizations to implement health advocacy rotations and fellowships, and develop a set of model guidelines and curricular goals to be used by state and specialty societies.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Late Resolution 002
(I-25)

Introduced by: Isaac Meng[1]; Eli Schantz[1]; Natasha Topolski[2]; Druv Bhagavan[3]; Vaibhavi Joshi[4]; Zaed Hindi[5]; Clayton Rawson[6]

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[5] California University of Science and Medicine
[6] Noorda College of Osteopathic Medicine

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

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

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 operates with relatively low overhead while achieving 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 far outweighing its financial cost[7-10]; and

Whereas, the *AMA Journal of Ethics* advances the AMA's core mission "to promote the art and science of medicine" by disseminating key educational resources appropriate for health care professionals at all levels of training, including irreplaceable 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, with its discontinuation, 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, so ceasing publication of the *AMA Journal of Ethics* signals that the AMA is 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 thought 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; and be it further

RESOLVED, that our American Medical Association maintain current funding and operations of the *AMA Journal of Ethics* through at least the end of fiscal year 2027; and be it further

RESOLVED, that our American Medical Association 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*; and be it further

RESOLVED, that our AMA-MSS immediately forward this resolution to the I-25 House of Delegates.

Fiscal Note: TBD

Date Received: 11/12/2024

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RELEVANT AMA POLICY

Maintaining Competence of Health Professionals H-300.982
(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.

Medicolegal, Political, Ethical, and Economic Medical School Course H-295.961
(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.

RELEVANT MSS POSITIONS

Bioethics in Medical Education and Practice 140.002MSS
It is the position of the AMA-MSS that (1) In order to facilitate the training of physicians better equipped to assist patients in dealing with bioethical issues, courses in humanities, social sciences, and specifically bioethical issues should be included by medical schools in their recommendations for college courses. (2) More time should be integrated into the medical and post graduate training programs for exposure to bioethics, emphasizing clinical problems. (3) The establishment of standing or ad hoc committees at hospitals, which could facilitate the ethical decisions required to be made by patients and physicians, should be pursued. (4) Physicians should provide patients with medical information necessary to make autonomous informed decisions, should solicit informed consent, and should realize that a significant aspect of their therapeutic role is to assist patients in either making autonomous decisions or restoring their autonomy. The physicians should act with compassion and empathy toward all involved parties. (5) Physicians in organized medicine should take an active role in encouraging legislation that would define the rights of the competent patient to make decisions regarding his or her own health care and the determination of who makes decisions for health care in the non-competent patient.

Responsible Biomedical and Bioethics Journalism 140.023MSS
AMA-MSS will ask the AMA to (1) encourage responsible biomedical and bioethics journalism; and (2) support the efforts of the Association of Health Care Journalists and other organizations to promote responsible biomedical and bioethics journalism.

Standardization of Medical Ethics Core Competencies for Undergraduate Medical Education 140.027MSS
AMA-MSS asked the AMA to (1) recognize the importance of addressing the disparity between current outcomes and the ideal status of undergraduate medical education in bioethics and humanities; (2) in partnership with appropriate AMA-MSS bodies, leverage its internal resources and its relationships with professional society stakeholders to create suggested guidelines for undergraduate medical education of bioethics and humanities guided by LCME requirements and the ASBH Task Force; and (3) advocate for the national adoption of a set of suggested guidelines for undergraduate medical education in bioethics and humanities by allopathic and osteopathic medical schools.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Emergency Resolution 001
(I-25)

Introduced by: Jared Buteau, Sneha Kapil

Affiliations: [1] MSS Section Delegates

Subject: Clarifying MSS and RFS Delegate and Alternate Delegate Vacancy Processes Within the AMA Bylaws

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, the AMA Bylaws state in section 2.3.1 “Medical Student Regional Delegate Qualifications” that “...a medical student may serve as a regional delegate, alternate delegate or any form of substitute (pursuant to Bylaws 2.8.5 or 2.10.4) only for that region”; and

Whereas, section 2.10.4 of the AMA Bylaws provides that substitute delegates or substitute alternate delegates may be appointed to serve as delegates or alternate delegates in the House of Delegates in the event that a delegate or alternate delegate is unable to attend a meeting of the House of Delegates; and

Whereas, in September 2025, the AMA Speakers sent the Medical Student Section (MSS) Governing Council a memorandum stating that only MSS regional delegates and alternate delegates from the Medical Student Section that have been elected at Interim 2024 may be credentialed to serve in the House of Delegates at the Interim 2025 meeting, barring any appointment of medical student regional delegate or alternate delegate vacancies per the AMA Bylaws; and

Whereas, shortly following the initial memorandum to the MSS Governing Council, a secondary memorandum from the AMA Speakers was distributed, informing the MSS Governing Council that “Bylaw 2.10, ‘Registration and Seating of Delegates,’ and its subsections, does not apply to the Medical Student Section because of the specific carve out related to the Medical Student Section in Bylaw 2.3”; and

Whereas, the AMA Speakers informed the MSS Governing Council members that this was a new interpretation of the AMA Bylaws; and

Whereas, this notice created a distinct change in how the MSS has historically operated, as previous interpretation of the bylaws allowed the MSS to appoint substitute medical student regional delegates and alternates as well as temporary substitute medical student regional delegates as any other HOD delegation does; and

Whereas, due to concern regarding the change in interpretation, the MSS submitted a formal request to CEJA to challenge the Speakers' new interpretations of the bylaws; and

Whereas, a CEJA ruling has been pending for over thirty days with no clear deadline for final ruling; and

Whereas, in light of the changing interpretation of the Bylaws, the MSS aims to more explicitly codify the current interpretation of the AMA Bylaws so as to avoid changes 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; and

RESOLVED, that our American Medical Association 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; and be it further

RESOLVED, that this resolution be immediately forwarded to the Interim 2025 House of Delegates meeting.

Fiscal Note: TBD

Date Received: 11/13/2025

REFERENCES

RELEVANT AMA POLICY

AMA Constitution and Bylaws

RELEVANT MSS POSITIONS

AMA Medical Student Section Internal Operating Procedures

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON CIVIL RIGHTS

MSS CCR Report A
(I-25)

Introduced by: MSS Committee on Civil Rights (CCR)

Subject: Establishing Healthcare Monitoring and Accountability in ICE Detention Facilities

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

INTRODUCTION

At the Annual 2025 (A-25) MSS Assembly, MSS Resolution 207, "Establishing Healthcare Monitoring and Accountability in ICE Detention Facilities," asked the AMA to support the establishment of guidelines and allocation of resources to provide quality medical care within ICE detention centers and facilities.

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

> RESOLVED that our AMA-MSS study the updated prevalence of waiver elimination that allows detention facilities to bypass National Detention Standards and oppose the ability of detention facilities to self-assess.

The MSS Reference Committee recommended referral of the resolution with the following rationale:

> VRC testimony was mixed. Your Reference Committee agrees with testimony that the first and third resolves are covered under existing AMA policies D-350.983, H-60.906, H-350.955, H-60.986, and D-430.997. We agree with testimony that the second resolve lacks recent evidence and would benefit from an updated literature review to dig into the prevalence of waiver usage. We believe the substitute resolution calling for a study is the best opportunity for strong policy recommendations to be proffered. Thus, your Reference Committee recommends Substitute Resolution 207 be adopted in lieu of Resolution 207.

During the MSS assembly, the item was not extracted; therefore, the Reference Committee Recommendation to refer to the study was passed via the consent calendar.

- The Assembly voted to agree with the MSS Reference Committee recommendation to refer the resolution:
  - RESOLVED, that our AMA-MSS study the updated prevalence of waiver elimination that allows ICE detention facilities to bypass National Detention Standards and oppose the ability of detention facilities to self-assess.

Your Governing Council assigned this report to the Committee on Civil Rights (CCR) with the following possible questions for consideration:

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1. What is the prevalence of waiver usage?
2. What constitutes a fair standard of care in detention?
3. What are the consequences of delayed or inadequate care for vulnerable populations under ICE detention?
4. What ethical responsibilities do the AMA and physicians working with ICE detention centers have when faced with improper care?
5. What can these physicians focus on to mitigate negative consequences to detained individuals?

In the following whereas clauses and subsequent discussion, we provide an overview of current healthcare practices in federal ICE detention centers and ethical considerations in. We consider the responsibility of detention centers to provide adequate and appropriate care. We discuss the prevalence of waiver usage and reports of misuse. We describe potential areas in which our AMA could expand its advocacy on this topic before ultimately delivering our recommendation on the referred clauses.

WHEREAS CLAUSES

Whereas, United States Immigration and Customs Enforcement's (ICE) Enforcement and Removal Operations (ERO) officers are given the authority to enforce immigration laws within the interior with the stated purpose of protecting national security and public safety;[1] and

Whereas, ERO oversees the identification, arrest, detention, and removal of undocumented individuals subject to removal or not lawfully present in the United States;[1] and

Whereas, immigration officials are authorized by the United States Congress to detain any person who is suspected to be in violation of immigration law;[1] and

Whereas, immigration detention is civil custody, not criminal incarceration, yet ICE and contract facilities use criminal detention infrastructures, creating gray areas that allow facilities to bypass health protections;[2] and

Whereas, as of September 20, 2025, 41,589 out of 58,766, (70.8%) of detainees at ICE detention centers held no criminal convictions;[3] and

Whereas, the number of people detained by ICE rose from 39,587 on January 19, 2025, to 58,766 on September 7, 2025, nationwide with the majority of detainees from states like Texas, Louisiana, California, Georgia, and Arizona, reflecting a rapid escalation in immigration detention practices;[4,5] and

Whereas, in August 2025, the number of detainees in ICE detention facilities hit a record high of 59,000 individuals, and $45,000,000,000 in federal funding allocated to immigration detention capacity through the One Big Beautiful Bill Act is anticipated to further increase the ability of ICE to arrest and detain individuals;[6,7] and

Whereas, ICE detention centers comprise a variety of facilities in order to detain noncitizens of the United States, including county jails, state and federal prisons, private detention centers, hotels, and even federal office buildings;[8] and

Whereas, most individuals detained by ICE are imprisoned in facilities that are either owned or run by private, for-profit prison companies, including CoreCivic and GEO Group;[8,9] and

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Whereas, ICE has announced a plan to expand detention space through the use of military bases in New Jersey and Indiana and to increase the number of detainees in the U.S. Naval Base at Guantanamo Bay, Cuba;[10] and

Whereas, the Trump administration plans to invest billions of dollars into reopening private detention facilities, including facilities with a long-standing history of abuse and poor care;[11] and

Whereas, the National Standards on Transport, Escort, Detention, and Search (TEDS) has created guidelines to ensure individuals in ICE detention centers receive basic necessities, such as basic hygiene, food and water, medical care, and being held in comfortable temperatures;[8] and

Whereas, despite having guidelines, individuals in these facilities experience poor conditions such as cold temperatures, termed “iceboxes,” lack of medical care, and inadequate food with minimal religious dietary accommodations;[8] and

Whereas, individuals held in for-profit, private facilities lack basic necessities due to the money-saving nature of these places;[9] and

Whereas, 42.5% of individuals in ICE detention centers have at least one chronic medical condition, underscoring the elevated need for continuous care, particularly given the average detention stay of 421 days; yet, many detainees report significant disruptions in care, including delays in treatment, medication interruptions, denial of language interpretation services, and lack of follow-up for chronic illnesses;[12,13] and

Whereas, many ICE facilities, including Karnes County Residential Center (Texas), Cibola County Correctional Center (New Mexico), Laredo Processing Center (Texas), West Tennessee Detention Facility (Tennessee), Webb County Detention Facility (Texas), La Palma Correctional Center (Arizona), Tallahatchie County Correctional Facility (Mississippi), Nevada Southern Detention Center (Nevada), and Adams County Correctional Center (Mississippi) do not consistently provide vaccinations for influenza or pneumonia, putting detainees at further risk for these infectious diseases;[14] and

Whereas, between 2018 and 2019, nearly 900 detainees across 57 ICE detention facilities in 19 states were infected during a mumps outbreak, illustrating inadequate infection control measures;[14] and

Whereas, independent reviews of 52 deaths in ICE custody between 2017 and 2021 found that 95% were preventable with adequate medical care, underscoring systemic failures in clinical oversight, chronic disease management, and emergency response protocols;[15] and

Whereas, during investigations of deaths during ICE detainment, ICE allowed facilities to destroy evidence, omit inculpatory facts, fail to interview key witnesses, and lack a standardized criteria for autopsies;[15] and

Whereas, inadequate infection control and delayed treatment of infectious diseases pose public health risks to detainees and may lead to emergency room visits, preventable infections, and downstream strain on local health systems[14] ; and

Whereas, there has been a documented elevenfold increase in suicide rates and preventable deaths in ICE custody, attributed to systemic failures in mental health care, solitary confinement

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practices, and inadequate medical evaluation protocols;[12,16,17] and

Whereas, since the inauguration of Donald Trump in January, 2025, 15 individuals have died while being detained in immigration facilities with 10 of those deaths occurring between January and June;[18] and

Whereas, the death rate in immigration facilities within the first six months of 2025 is the highest rate in the first six months of any publicly available year;[18] and

Whereas, multiple independent investigations and government audits have identified systemic deficiencies in ICE detention facilities, including substandard medical and mental health care, insufficient privacy, unsafe environments, and repeated noncompliance with safety and detention standards;[12, 19-21] and

Whereas, oversight mechanisms remain inadequate: contracted inspections by the Nakamoto Group identify less than half of the deficiencies identified by the Office of Detention Oversight (ODO), and have been criticized as superficial and ineffective, with ICE personnel reporting that inspectors frequently conduct only perfunctory reviews of standards;[20, 22-24] and

Whereas, the ODO conducts only 25% of inspections, with the rest covered by private contractors and self-assessments, which further compromise ICE oversight systems;[20,21] and

Whereas, comprehensive inspections conducted by the ODO occur only once every three years on average, allowing documented violations, such as inadequate medical care, suicide risk, mismanagement, and unreported abuse, to persist without timely corrective action;[20,22-24] and

Whereas, ICE facilities continue to rely on pre-announced inspections, often only every three years, and are frequently granted waivers that allow facilities to bypass critical health and safety standards outlined by the National Detention Standards, ranging from waivers allowing strip searches to those exempting facilities from complying with fire prevention, control, and evacuation standards;[21-24] and

Whereas, when faced with knowledge of over 14,000 deficiencies in adherence to procedures at 106 contract facilities, including those that put the health and safety of detainees at risk, ICE only imposed financial penalties on two instances;[20] and

Whereas, ICE elected to issue waivers rather than impose financial penalties at other contract facilities identified as having deficient conditions;[20] and

Whereas, ICE has no formal policies or procedures in place to guide the waiver process and has allowed Enforcement and Removal Operations (ERO) officers to grant waivers without the clear authority to do so;[20,25] and

Whereas, of 68 waiver requests submitted over the span of 20 months between 2016 and 2018, greater than 96% of these waiver requests were approved by Custody Management;[20] and

Whereas, a sample 65 of waivers evaluated by the department homeland security found that only three had identifiable expirations dates while others had no end date, potentially meaning a facility might permanently avoid compliance for certain standards;[20,25] and

Whereas, reports from legal and medical watchdog groups, such as the National Immigrant Justice Center and the American Immigration Lawyers Association, have documented

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consistent patterns of medical neglect in ICE detention facilities, including denial of medications, delayed care for chronic illnesses, and lack of follow-up for serious conditions, all of which contribute to unnecessary suffering and preventable harm;[26] and

Whereas, independent evaluations have revealed ongoing violations—including failure to report sexual assaults, improper strip searches, and inadequate access to legal and medical resources—without adequate mechanisms for enforcement or follow-up;[22,23] and

Whereas, international human rights frameworks (e.g., the United Nations Standard Minimum Rules for the Treatment of Prisoners, known as the Mandela Rules) and other U.S. correctional health standards such as the National Commission on Correctional Health Care affirm individuals in custody should be entitled to health care equivalent to that available in the community, yet ICE detention facilities consistently fall short of these principles, resulting in treatment far below this recognized standard of care;[27,28] and

Whereas, the current Performance-Based National Detention Standards (PBNDS) lack enforceable health metrics, transparency, or accountability structures, contributing to persistent deficiencies in care delivery;[19] and

Whereas, physicians working within or in relation to ICE detention facilities face a profound ethical conflict: while providing care may alleviate immediate suffering, participation risks perpetuating or legitimizing systemic harms[29]; and

Whereas, in light of the persistent use of detention facilities, it remains an ethical and public health imperative to ensure that detained individuals receive humane, timely, and appropriate medical and mental health care, to the fullest extent possible, as an interim measure of health accountability;[30] and

Whereas, the American Medical Association has policy opposing the use of immigration detention, particularly for vulnerable populations, yet the United States continues to detain ~38,000 individuals daily in Immigration and Customs Enforcement (ICE) facilities under civil—not criminal—custody with an average stay of 421 days;[19,31]; and

Whereas, existing AMA policy (e.g., D-350.983) supports improving medical care in immigrant detention settings broadly, but does not specifically address the mechanisms of independent oversight, inspection frequency, waiver elimination, or data-driven accountability in ICE detention facilities, creating an opportunity to strengthen implementation efforts through more detailed policy guidance;[32] and

Whereas, enhancing transparency through publicly reported health outcomes, establishing independent oversight, and improving resource allocation for quality care are necessary measures to protect the ethical responsibilities of physicians and the health of individuals in custody, even as the AMA continues to oppose the broader system of immigration detention;[30] and

Whereas, evidence from carceral health systems shows that independent, transparent, and frequent reporting of health metrics, particularly when conducted by external monitors and publicly disclosed, can improve care quality, and that carefully structured financial incentives tied to health outcomes may further encourage high standards of care in ICE detention facilities;[32-35] therefore be it

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CURRENT AMA POLICY & EFFORTS

Current AMA policy has set a strong precedent for advocating for healthcare access and oversight in detention facilities. The AMA already calls on Immigration and Customs Enforcement (ICE) to revise and comply with standards set by the National Commission on Correctional Health Care Standards, to track complaints of inadequate care, and to avoid contracts with private institutions that fail to meet appropriate standards (D-350.983). The AMA also recognizes the migration status of an individual as a social determinant of health and supports equitable health care access for refugees, asylum seekers, and migrants (H-350.957, H65.938). Furthermore, the AMA is opposed to any practice that withholds resources or violates the health and safety of migrants and asylum seekers. (H65.934). The AMA also supports transparency and accountability in healthcare systems, including the use of quality metrics, data oversight in order to drive improvements in care (H-406.987).

Beyond these policies, the AMA has consistently engaged in direct advocacy against detaining families in ICE facilities due to health and safety concerns. In 2023, the AMA wrote to the Biden Administration, and in 2025 to the Trump Administration, urging them not to reinstate/continue detention of immigrant families in ICE facilities, citing the adverse health effects it has on children's physical, mental, and behavioral health.[36,37] These letters also heavily underscored the longstanding failure of detention facilities to provide adequate medical and mental health care.

Our recommendations build upon the foundation of existing policy, particularly within D-350.983. While the aforementioned policy calls for the oversight and transparency of these facilities, it does not explicitly address the regulatory loopholes that undermine those standards. A 2018 Department of Homeland Security Report determined that the effectiveness of ICE inspections is limited to ICE's failure to ensure that identified deficiencies are properly corrected. One mechanism for avoiding compliance with standards is through the use of waivers, which exempt detention facilities from specific requirements.[20] Therefore, we believe that ending the inappropriate use of waivers may be a new avenue for AMA advocacy moving forward.

CONCLUSION

This report addresses questions on the standard of care in detention centers and what physicians can do to mitigate negative healthcare consequences in ICE detention facilities. There are existing guidelines that affirm carceral healthcare should parallel community healthcare. However, these guidelines are not implemented as ICE facilities rely on infrequent, pre-announced inspections and the use of waivers to exempt facilities from basic requirements. This is particularly harmful given the high volume of people being detained in ICE facilities due to the current political climate. With the high percentage of individuals in ICE centers experiencing chronic health conditions and the large number of preventable deaths, it is imperative to have more focused guidelines in place. While the AMA's current policies on this issue focus on equitable healthcare for individuals in detention centers, more specific guidelines on oversight, outcome transparency, resource allocation, and physician roles are warranted. This report attempts to address these gaps and provide clearly outlined evidence on existing healthcare injustices in this vulnerable population.

RECOMMENDATION

Your Committee on Civil Rights (CCR) recommends that the following recommendations are adopted in lieu of Resolution 207 and the remainder of this report be filed:

1. RESOLVED, That our AMA oppose the inappropriate use of waivers in ICE detention facilities that allow facilities to bypass National Detention Standards, including critical

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health and safety protections that directly impact detainee care and wellbeing; and be it further

2. RESOLVED, That our AMA call for independent, unannounced inspections of all ICE detention facilities and explicitly reject the practice of pre-announced self-assessments, to ensure consistent, rigorous oversight and full adherence to National Detention Standards for the protection of detained individuals' health and safety; and be it further
3. RESOLVED, That our AMA supports efforts to reform ICE's waiver system by requiring that all waivers include clear expiration dates, transparent public reporting, and standardized criteria that limit their use to cases of demonstrated necessity with documented plans for compliance; and be it further
4. RESOLVED, that our AMA advocate for clear public reporting of health comes in ICE detention facilities, including screening timeliness, continuity of medications, interpreter access, vaccine coverage, and suicide prevention compliance, to hold facilities accountable for providing equivalent care to detainees.

ACKNOWLEDGEMENTS

Authors: Bhavana Gunda, University of Connecticut School of Medicine; Ella Wright, University of Kansas School of Medicine; Zain Ahmad, University of Virginia School of Medicine; Rohini Kambhampati, Chobanian and Avedisian School of Medicine; David Cazares, Jacobs School of Medicine and Biomedical Sciences at the University at Buffalo; Eileen Enriquez, Kirk Kerkorian School of Medicine at University of Nevada, Las Vegas; Adrienne Nguyen, Des Moines University College of Osteopathic Medicine; Nicole Dawson, University of Arkansas for Medical Sciences College of Medicine.

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RELEVANT AMA AND AMA-MSS POLICY

Improving Medical Care in Immigrant Detention Centers D-350.983

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

Addressing immigrant health disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees and encourages the exploration of issues related to refugee health, and supports legislation and policies that address the unique health needs of refugees. 2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees. 3. Our AMA calls for asylum seekers to receive medically-appropriate care, including vaccinations, in a patient-centered, language and culturally appropriate way upon presentation for asylum, regardless of country of origin. 4. Our AMA supports efforts to train physicians to conduct medical and psychiatric forensic evaluations for asylum seekers. 5. Our AMA supports medical education that addresses the challenges of life-altering events experienced by asylum seekers. 6. Our AMA urges physicians to provide medically appropriate care for asylum seekers. 7. Our AMA encourages physicians to seek out organizations or agencies in need of physicians to provide these services. 8. Our AMA encourages the provision of resources to assist people seeking asylum, including social and legal services. Res. 804, I-09Appended: Res. 409, A- Reaffirmation: A-19Appended: Res. 423, A-19 Reaffirmation: I-19Modified: BOT Rep. 08, I-24

Opposition to the Deceptive Relocation of Migrants and Asylum Seekers H-65.934
1. Our American Medical Association opposes the relocation of migrants and asylum-seekers by state or federal authorities without timely and appropriate resources to meet travelers' needs, especially when deceptive or coercive practices are used. 2. Our AMA supports state and federal efforts to protect the health and safety of traveling migrants and asylum-seekers and investigate possible abuse and human rights violations. Res. 006, I-24

Guiding principles for the health care of migrants H-65.938
Our AMA: (1) recognizes migration status as a social determinant of health; (2) advocates for equitable, non-discriminatory access to health care for migrants; (3) supports international coordination and sustainable funding for migrant health systems; and (4) emphasizes that investment in migrant health improves public health outcomes and reduces downstream costs. Res. 016, A-24

Medical Information and its uses H-406.987
Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients, and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but

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build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.
Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.
Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.
Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices. Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information. Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts. Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive use of health care data. Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete. Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages the use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter. Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used. Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement. Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility, and reduce barriers that currently limit access to and use of the health care data. Standardization - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats. Mitigating Administrative Burden - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary. Data Attribution - Our AMA seeks to ensure that those compiling and using the data avoid attribution errors by working to correctly assign services and patients to the appropriate provider(s), as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused on the system-level instead of on individual physicians or providers. BOT Rep. 6, A-15Reaffirmation: I-18Reaffirmed: CSAPH Rep. 2, I-19

Supporting External Accountability for ICE and CBP MSS 270.04
AMA-MSS promotes the health and well-being of immigrants and their families who are affected by immigration raids and/or held in detention by U.S. Immigration and Customs Enforcement or U.S. Customs and Border Protection. (MSS Res. 76, I-19)

Advocating for Alternatives to Immigrant Detention Centers that Respect Human Dignity MSS 65.039

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Our AMA-MSS will ask our AMA to advocate for the preferential use of community-based, non-custodial Alternatives to Detention programs within the United States that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies. (MSS Res. 003, Nov. 2020) (AMA res 215, Nov 202-Not considered)(Reaffirmed: MSS Res. 031, A-21)

Improving Medical Care in Immigration Detention Centers MSS 350.016
AMA-MSS will ask that our AMA (1) issue a pubic statement urging the U.S. Immigration and Customs Enforcement Office of Detention Oversight to 1) revise its medical standards governing the conditions of confinement at detention facilities to meet or exceed those set by the National Commission on Correctional Health Care, 2) take necessary steps to achieve full compliance with these standards, and 3) create a system to track complaints related to substandard healthcare quality filed by detainees; and (2) recommend the U.S. Immigration and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standard of medical, mental, and dental care as guided by the National Commission on Correctional Health Care. (MSS Res22, A-17, Immediate Transmittal)(AMA res 017, A-17 Adopted as Amended [D-350.983])

Compassionate Release for Incarcerated Patients MSS 440.077
AMA-MSS asked the AMA to (1) support policies that facilitate compassionate release on the basis of serious medical conditions and advanced age; (2) collaborate with appropriate stakeholders to draft release; and (3) promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions. (MSS Res 04, I-18) (AMA Res 430, A-19, Referred) (Adopted BOT Rep. 10, I-20 [H-430.980])

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON HUMANISM & ETHICS IN MEDICINE

MSS CHEIM Report A
(I-25)

Introduced by: MSS Committee on Humanism & Ethics in Medicine (CHEIM)

Subject: Standardizing Safe Haven Laws: Ensuring Medical Care & Support for Surrendered Infants

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

INTRODUCTION

At the Annual 2025 (A-25) MSS Assembly, MSS Resolution 433, "Standardizing Safe Haven Laws: Ensuring Medical Care & Support for Surrendered Infants" asked the AMA to support the development of a federal framework to standardize and strengthen the protections rendered by Safe Haven laws, as well as support ongoing quality improvement via a national monitoring system. The resolution, with the following resolve clauses, was referred as amended for study:

> RESOLVED, that our AMA-MSS advocate for the development of a federal framework to standardize Safe Haven laws that promote robust medical protection for surrendered infants, as well as clear, safe, and equitable processes for all parties involved; and be it further
>
> RESOLVED, that our AMA support the development of a national monitoring system to collect data on surrendered newborns, to evaluate and improve the effectiveness of Safe Haven Laws over time.

The MSS Reference Committee recommended this resolution not be adopted and be referred with the following rationale:

> "VRC testimony was mixed. While the Reference Committee agrees with testimony that this resolution covers an important issue, the ask of the resolution is better suited for state level advocacy. We agree with concerns from relevant specialty societies that the resolution lacks a clear path for implementation and may have unintended consequences in the current advocacy space. We agree with the spirit of the resolution, but we believe this ask would have the most success by pursuing advocacy at the state level. Thus, your Reference Committee recommends Resolution 433 not be adopted."

During the MSS Assembly, no one extracted the item, so the Reference Committee Recommendation to refer passed via the consent calendar.

Your Governing Council assigned this report to the Committee on Humanities & Ethics in Medicine (CHEIM).

In the following whereas clauses and subsequent discussion, we provide an overview of current Safe Haven Laws and ethical considerations in the development of a unifying federal framework

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and a monitoring system to create improved measurement of outcomes. We consider the potential ramifications on anonymity and privacy when expanding such frameworks. We additionally discuss the difficulties in implementing such measures and frameworks on a federal level at the present time.

WHEREAS CLAUSES (EVIDENCE & RATIONALE)

Whereas, Safe Haven Laws allow for the surrender of unharmed infants[1]; and

Whereas, Safe Haven Laws have been implemented to reduce the rates of infanticide and infant abandonment;

Whereas, most infanticide occurs in areas with low socioeconomic status and rural areas while most infant surrenders occur in areas with lower income levels[2]; and

Whereas, the act of surrendering an infant under Safe Haven Laws in some states may be free from criminal liability and/or include statutory protection of the surrendering individuals' anonymity (excepting scenarios where there is evidence of abuse and neglect)[1]; and

Whereas, safe haven providers will provide any necessary medical care immediately and take on emergency custody of the surrendered infant[1]; and

Whereas, when infants are surrendered at safe havens, the safe haven providers inform the child welfare department, which assumes custody and places the infant into a preadoptive home[1]; and

Whereas, Safe Haven Laws have been enacted in all 50 states, the District of Columbia, Guam, and Puerto Rico[1]; and

Whereas, Safe Haven Laws vary greatly by state with regard to age limits for the surrendered infant[1]; and

Whereas, early age limits represent an attempt to reduce the particular risk of infanticide on the infant's day of birth and to provide an option to mothers who have hidden their pregnancies[2]; and

Whereas, later age limits represent an attempt to allow parents enough time to make a well-considered decision[2]; and

Whereas, Safe Haven Laws vary greatly by state with regard to who may surrender an infant[1]; and

Whereas, some states require the individual surrendering an infant to be either parent, only a mother, a custodial parent or other individual with custody of the infant, or an agent selected by a parent[1]; and

Whereas, the anonymity of safe havens might allow some individuals who are not the infant's parent(s) to surrender the infant against the wishes of the parent(s); and

Whereas, Safe Haven Laws vary greatly by state with regard to locations that may serve as safe havens (such as hospitals, police stations, fire stations, emergency medical providers, and "newborn safety device," also known colloquially as "baby boxes")[1]; and

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Whereas, all states allow hospitals to serve as safe havens, but in some states, this is the only type of safe haven[2]; and

Whereas, concern has been raised that safe haven locations may be inaccessible, particularly to those who live in rural areas or areas inaccessible to those without cars or areas inaccessible by public transportation[2]; and

Whereas, in some states, a parent may call 911 to contact emergency services in order to surrender an infant[1]; and

Whereas, Safe Haven Laws vary greatly by state with regard to whether the nonsurrendering parent can petition for custody after the infant is surrendered[1]; and

Whereas, in some states, the child welfare department will check to ensure the infant has not been reported as a missing child[1]; and

Whereas, in some states, the child welfare department will check the putative father registry[1]; and

Whereas, in some states, the parents may reclaim an infant who was surrendered within a certain period of time[1]; and

Whereas, in some states, surrender of an infant is sufficient for relinquishment of parental rights[1]; and

Whereas, some states require safe haven providers to attempt to obtain the infant's medical history and family medical history while other states do not;[1,3,4]; and

Whereas, Safe Haven Laws have been correlated with decreasing measured rates of infanticide, but there has not been a means to determine the role Safe Haven Laws have played in this decrease in measured infanticide rates compared to the influence of other factors such as available support for parents, adoption processes, and access to contraception and abortion[2,5,6]; and

Whereas, therefore, limited data has been measured regarding the efficacy and areas for improvement of Safe Haven Laws[2]; and

Whereas, the anonymity of Safe Haven Laws makes it inherently complex to collect longitudinal data from those surrendering infants who may not want to share personal information; and

Whereas, data has been collected on callers to the National Safe Haven Alliance Hotline, which showed that 57% of callers called about safe havens, with 14% calling about adoption and 9.3% calling about relinquishing an infant; however, the most common action by staff on such calls was providing information about adoption on 23% of calls, with 19% of calls resulting in an internal referral and 18% giving instructions on relinquishment[7]; and

Whereas, collecting longitudinal data on children without their consent or parental consent may raise ethical concerns in an already-vulnerable population[8]; and

Whereas, any monitoring of Safe Haven Laws and those who utilize them must be done in such a way that does not expose this vulnerable population to any harm; and

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Whereas, it may not be feasible to honor the anonymity inherent in Safe Haven Laws in a national monitoring system and gaining meaningful data from such a system may not be possible; and

Whereas, Safe Haven laws are presently enacted on the state level;

Whereas, the American Academy of Pediatrics (AAP) delegation did not support this resolution, stating "The AAP does not have policy about Safe Haven laws currently. Since there are 50 states that currently have laws, it would seem that this is something each state should tackle and not be something the AMA takes on"; and

Whereas, foster care and adoptions following surrender under Safe Haven Laws, including the measurement of outcomes, as well as putative father registries are also managed on a state level; and

Whereas, a federal approach to regulating and monitoring outcomes of Safe Haven Laws may not be feasible in the current context; and

Whereas, Safe Haven Laws have been critiqued as not addressing the systemic issues that might lead to a parent or other responsible individual surrendering an infant[2,6]; and

Whereas, Safe Haven Laws may inadvertently support the idea that certain kinds of women are destined to be bad parents, and that it is thus better for them to surrender their children, marginalizing these women[9]; and

Whereas, Safe Haven Laws may unintentionally disempower women by acting as an alternative within society to providing them with the support they need in becoming a parent and creating systemic equity[9]; and

Whereas, Safe Haven Laws may allow infants to be surrendered in a context of coercion of the surrendering individual or the context of a crisis, where the surrendering individual may regret their decision; and

Whereas, the UN Committee on the Rights of the Child advocates for a ban on "baby boxes," due to their conflict with the rights of children under the UN Convention on the Rights of the Child as the child should know their parents' identity and as in the use of baby boxes, the state will be failing in its duty to maintain connections between children and parents[6,10];" and

Whereas, in the current context, Safe Haven Laws might be politically utilized as an alternative to proper reproductive healthcare and have been used by advocates of limiting reproductive choices as an alternative to reproductive healthcare access[11]; and

Whereas, the anonymity surrounding Safe Haven Laws may inadvertently limit maternal postpartum healthcare access when women who surrender their infants inconspicuously navigate the postpartum sequelae[9]; and

Whereas, Safe Haven Laws serve a particular role in preventing infant abandonment and infanticide in extreme scenarios, but should not serve as a replacement for access to contraception and abortion, access to adoption pathways, or systemic societal support in parenting; and

Whereas, the AMA does not presently have policy on Safe Haven Laws; and

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Whereas the AMA-MSS does have policy in support of Safe Haven Laws; and

Whereas, this resolution fails to address how the current state-specific framework would feasibly be transitioned to legislation and administration on a federal level; and

Whereas, implementation of a monitoring system to collect data on surrendered infants might violate anonymity principles central to Safe Haven Laws and might fail to produce the kind of data that would provide meaningful insight into Safe Haven Laws and this resolution fails to introduce monitoring within the context of safeguarding a vulnerable population.

CURRENT AMA POLICY & EFFORTS

No current AMA policy explicitly addresses Safe Haven Laws.

However, broader AMA policy does provide relevant context. AMA policy H-420.995 emphasises the importance of obstetric and newborn care and the improvement of this care for the medically indigent and culturally displaced. AMA policy H-60.910 focuses on comprehensive, evidence-based healthcare for children in foster care—an important parallel since relinquished infants become wards of the state, with their medical care overseen by state agencies.

AMA-MSS policy does support the implementation of Safe Haven Laws and the decriminalization of infant surrender.

CONCLUSION

We appreciate the referral of this resolution and acknowledge the critical nature of the issues raised. We acknowledge the inconsistencies among states regarding safe haven laws. However, given the current state-based legislation and the interaction between Safe Haven Laws and state-based foster care, adoption processes, and putative father registries, as well as the lack of support from the AAP alongside their recommendation to utilize a state-level approach, we concurred that the first resolved clause regarding transitioning to a federal approach is not feasible presently. Regarding the second resolved clause, collecting federal data would be challenging to undertake while honoring the anonymity of those surrendering infants under Safe Haven Laws. Individuals surrendering infants may not be likely to share personal information, and there may be ethical concerns that arise by collecting data on these children without formal consent. Additionally, the data may not provide meaningful insight into the safe haven process or address the systemic issues surrounding the utilization of Safe Haven Laws. In alignment with our first stance, we also consider monitoring on a federal level may not be feasible at present. While we value the very particular and important function of Safe Haven Laws, we also caution that the expansion of their use could arise via decreased utilization of adoption processes, decreased access to reproductive healthcare, or decreased utilization of programs designed to support the welfare of children and mothers. Therefore, any future advocacy in this realm should be mindful of the very distinct role of Safe Haven Laws.

RECOMMENDATION

Your Committee on Humanism and Ethics in Medicine recommends that Resolution 433 not be adopted and the remainder of this report be filed.

ACKNOWLEDGEMENTS

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RELEVANT AMA AND AMA-MSS POLICY

RELEVANT AMA POLICY

H-420.995 Medical care for indigent and Culturally Displaced Obstetrical Patients and Their Newborns

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Our AMA (1) reaffirms its long-standing position regarding the major importance of high-quality obstetrical and newborn care by qualified obstetricians, family physicians, and pediatricians and the need to make such care available to all women and newborns in the United States; (2) favors educating the public to the long-term benefit of antepartum care and hospital birth, as well as the hazards of inadequate care; and (3) favors continuing discussion of means for improving maternal and child health services for the medically indigent and the culturally displaced. (CSA Rep. C, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20)

Addressing Healthcare Needs of Children in Foster Care H-60.910
Our American Medical Association advocates for comprehensive, and evidence-based, trauma-informed care that addresses the specific mental, developmental, and physical health care needs of children in foster care. (Res. 907, I-17, Modified: Res. 420, A-23)

RELEVANT MSS POLICY
Safe Haven for Newborns 245.010MSS
AMA-MSS supports efforts to lower barriers to adoption including the coordination of anonymous adoption and supports state efforts to decrease the number of abandoned infants by supporting legislation that would protect parents from prosecution who anonymously deliver their infant safely to a licensed health care facility, thus enabling the facility to initiate the adoption process. (MSS Sub Res 5, A-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Amended and Reaffirmed: MSS GC Rep B, A21)

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON HEALTH JUSTICE, SUBCOMMITTEE ON TRIBAL AFFAIRS

MSS CHJ Report A
(A-25)

Introduced by: MSS Committee on Health Justice, Subcommittee on Tribal Affairs

Subject: Expanding the Native Hawaiian Health Scholarship Program Eligibility

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

INTRODUCTION

At the Annual 2025 (A-25) MSS Assembly, MSS Resolution 309, "Expanding the Native Hawaiian Health Scholarship Program Eligibility" asked the AMA to support efforts to expand the Native Hawaiian Health Scholarship Program (NHHSP) to include Native Hawaiian trainees and providers working in diaspora and in specialties outside of primary care. The resolution, with the following resolve clause, was referred for study:

> RESOLVED, that our American Medical Association support expanded funding and eligibility requirements for the Native Hawaiian Health Scholarship Program (NHHSP), or an equivalent program, to include the following entities:
>
> > (a) Native Hawaiian (NH) trainees and NH providers who are committed to providing primary care health services at Federally Qualified Health Centers (FQHCs), critical access hospitals, and Native health centers to NH patients in all U.S. states, as well as
> >
> > (b) NH trainees and NH providers who provide specialized health care services to NHs in all U.S. states.

The MSS Reference Committee recommended referral of the resolution with the following rationale:

> Testimony from the Virtual Reference Committee (VRC) on Resolution 309 was overall supportive. However, based on some testimony, the MSS Reference Committee was concerned that expanding NHHSP to include trainees living in diaspora would undermine the original intent of NHHSP - to train healthcare providers for Hawaiians in Hawaii. Concerns were also raised regarding the verbiage of the original resolution which included the term 'provider' despite the fact that the NHHSP only benefits trainees as it stands currently.

During the MSS Assembly,

- No one extracted the item, so the Reference Committee Recommendation to refer passed via the consent calendar.

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Your Governing Council assigned this report to the Committee on Health Justice (CHJ) and recommended our gathering input from the Hawaii Delegation and Minority Affairs Section in order to strengthen the ask of this resolution.

In the following whereas clauses and subsequent discussion, we provide an overview of the current federal support of Native Hawaiian (NH) in pursuing medical education. We outline the current distribution of NH patient and healthcare practitioner populations, highlighting disparities in culturally competent care. We consider the implications of expanding the current NHHSP to include NH healthcare practitioners practicing in diaspora and in non-primary care specialties.

WHEREAS CLAUSES (EVIDENCE & RATIONALE)

Whereas, the federal U.S. government has a legal trust obligation to provide quality health care to American Indian and Alaska Native (AI/AN) and Native Hawaiian (NH) populations, as affirmed through treaties, statutes, and executive orders [1-3] ; and

Whereas, despite the federal obligation to improve NH health, NH continue to experience disproportionately high rates of chronic disease, including diabetes, cardiovascular disease, and cancer, as well as significantly lower life expectancy compared to non-Native populations [4-10] ; and

Whereas, this higher burden of chronic conditions often requires co-management across multiple specialties (i.e., cardiology, nephrology, endocrinology, psychiatry)[7, 11-17] ; and

Whereas, cancers in NH populations have poorer stages at presentation and, specifically, NHs have higher colorectal cancer mortality demonstrating the demand of care across the continuum of disease [18-20] ; and

Whereas, data show that NH representation is declining across multiple specialties and there are current specialty gaps in Hawai'i's physician workforce [21-22] ; and

Whereas, the majority of NH live in diaspora or displacement from Hawai'i, with 2020 Census data showing that 53% of NH live on the U.S continent [23] ; and

Whereas, diaspora settings shape NH health needs as evidenced by data showing that living in diaspora increased odds of reporting fair or poor self-rated health, increased odds for screening positive for anxiety, depression, and suicidality, increased odds of health insurance loss, and predicted increased risk of certain conditions such as colorectal cancer [24] ; and

Whereas, regardless of geography, underrepresented and minority physicians tend to serve underserved populations [25-28] ; and

Whereas, research indicates that racial/ethnic concordance between NH patients and their physicians has been associated with improvements in patient-physician communication, greater time spent with physicians, improved shared decision-making, improved patient understanding of disease risk, improved medication adherence, decreased wait times for treatment, improved preventive health screenings, and decreased implicit bias from clinicians [29-30] ; and

Whereas, Native Hawaiian and Pacific Islanders (NHPI) are critically underrepresented in the medical workforce and among medical trainees, with NHPI medical students representing the smallest proportion of any racial/ethnic group in U.S. medical schools (0.4%)[8-9, 21, 31-34] ; and

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Whereas, to fulfill federal trust obligations and workforce shortages, the Native Hawaiian Health Scholarship Program (NHHSP) was implemented as a part of the Native Hawaiian Health Care System and has been effective in increasing the number of NH primary care health professionals serving NH communities in Hawai‘i [35]; and

Whereas, the current eligibility for NHHSP and comparable service scholarships such as the IHS Scholarship exclude NH healthcare trainees planning to pursue primary care who serve diaspora NHs, as well as NH healthcare trainees pursuing specialized fields such as oncology, cardiology, nephrology, and psychiatry, who serve NH patients [10, 33, 35-36]

OPTIONAL SECTION: FURTHER DISCUSSION

The Native Hawaiian Health Scholarship Program (NHHSP) was established in 1991 after the passing of the Native Hawaiian Health Care Act in 1988. The mission of the scholarship program is to increase the number of Native Hawaiians in multiple healthcare fields and thereby build a culturally competent workforce that can serve Hawaiian communities on each of the islands of O'ahu, Moloka'i, Maui, Hawai'i, Lana'i, Kaua'i, and Ni'ihau in the State of Hawaii [37]. Its funding comes primarily from federal grants through the Department of Health and Human Services and it is supervised and administered by Papa Ola Lōkahi, the Native Hawaiian Health Board. The program provides scholarship funds to help with tuition, monthly stipends, and other education costs for students pursuing primary care and behavioral health professions. Eligible students can pursue a wide variety of healthcare professions including, but not limited to medicine (MD/DO), psychology, nutrition, nursing, or social work. In order to be eligible, students must commit to practicing in a medically underserved area of Hawai’i full-time for a total of 2-4 years, depending on the amount and duration of funding provided [38-39]. As of 2020, 277 students have received scholarships across 12 different health professions [40].

There are valid concerns regarding the expansion of the NHHSP to include trainees planning to practice in diaspora and in specialties outside the realm of primary care. The concerns raised highlight the potential consequences of drawing NH healthcare workers away from Hawai’i, which was the geographic area requiring healthcare work expansion at the time of the scholarship’s inception. It is evident that Hawaii remains in need of a strong primary care workforce [41-42]. Over the course of its lifespan, the program has been successful in awarding scholarships to Hawaiians across primary and behavioral health care disciplines. The program states that “of those who have served [in the scholarship program], the majority have continued to work in medically high-need areas and populations in Hawaii.” Given that the NHHSP is a relatively small program and that there is, presumably, limited access to alumni data, there exist no quantitative data outlining program participants who are still actively practicing in Hawaii. Further, there exist no public data as to whether NHHSP has measurably increased the number of NH physicians in underserved areas, and how many remain there long-term versus only during their service requirements. Without such data, observations can be drawn from similar compulsory service programs, such as the National Health Service Corp (NHSC) and other rural placement programs. Data show that these programs are successful in increasing healthcare workers in these communities for the short term, but many leave once their service obligations are complete [43-45]. Additionally, the Indian Health Service (IHS) Scholarship Program is comparable to NHHSP both in eligibility and service requirements. Data from 2018 show that within the IHS program, after service obligations end, about 81% of participants still serve in the same site one year after completion, ~75% after 2 years, ~65% after 3 years, and dropping to ~50% after 4 years [46]. It is believed that these poor longitudinal retention rates are a result of poor community/professional support and low career satisfaction, highlighting that obligation alone is not sufficient to retain clinicians long term [47-49]. While the NHHSP is unique in its populations served, its overall structure of implementation is very similar to that of NHSC and IHS. Thus, we can infer that it likely boasts similar retention

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statistics. Further, given that now 53% of NHs live on the U.S. continent, we can suppose that there will be an increasing number of NH-identifying students who do not call Hawaii home and thereby would be less likely to practice there long term. The question then remains, would loosening geographic constraints on NHHSP lower the total number of NH clinicians in Hawaii? Yes, as there would presumably be less providers serving out their service requirements. However, systematic review data of rural service programs show that loosening strict geographic constraints tends to improve initial recruitment fit and post-obligation retention [50-51]. We believe that this then becomes a matter of increasing the number of NH physicians completing short-term work requirements versus increasing the amount of NH physicians who practice in Hawaii long term. We propose that this second aim is best accomplished by offering sufficient support (mentoring, professional development, community engagement, spousal employment, etc.) to those who do decide to practice in Hawaii long term.

If this scholarship program does expand to include trainees practicing in diaspora, it is important to define what geographic and demographic regions this should incorporate. Expansion in this way should still ensure that NHHSP recipients are indeed contributing to the overall health of NH populations. This could be done several ways, including having recipients submit data on their patient panel demographics. However, this could become cumbersome. Census data from 2020 finds that most NHs living on the continent reside in California followed by Washington, Nevada, and Utah. More specifically, concentrations of NHs can be found in larger metropolitan areas such as Los Angeles, Seattle, Las Vegas, and Salt Lake City [52]. With this, we propose a loose model (open for refinement) that includes the states of CA, WA, NV, and UT and that participants must maintain a NH patient cohort that comprises at least 10% of their practice. Of course, we anticipate that there exist methods that can identify current practices/health systems already meeting these metrics to aid in placement.

Further, there remains the question as to whether allowing trainees pursuing specialties outside the realm of primary care to apply for the scholarship diminishes the primary care workforce in Hawaii. As it stands currently, the majority of return of service programs limit eligibility to primary-care disciplines. We, therefore, have no comprehensive data outlining the roles of specialty care within these models. It remains true that Hawaii faces a physician shortage, both in primary care, but also specialty care [21-22]. We believe that loosening the constraint of primary care will allow specialty-bound NH trainees who want to practice in Hawaii the ability to build a strong foundation for practicing in the state long term.

Lastly, we do recommend removal of the term ‘providers’ from the resolved clause as the NHHSP currently only provides scholarships to healthcare trainees and including the term could be misconstrued as a desire to expand the NHHSP program to include these entities.

CURRENT AMA POLICY & EFFORTS

Current AMA policy sets a strong precedent in advocating for programs that support minority medical trainees in order to promote diversity in the US medical workforce (D-200.982). The AMA acknowledges the existing deficiencies in medical education diversity, and has been operating under the ‘Change in Medical Education Consortium’ since 2013, one of whose goals is to “achieve health equity and increase diversity in the physician workforce” (H-295.871). Further, the AMA has devised an organizational strategic plan to advance health equity and justice in which they outline “[continuing] to convene and provide grants to support minoritized and marginalized physician groups’ efforts to promote increased representation in medicine” (D-180.981). Understanding the financial burdens that come with such expansions, the AMA has adopted policy supporting adequate funding for federal scholarship and loan repayment programs (H-305.925). This has been reaffirmed further by the AMA’s recent opposition of federal student loan

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changes [53]. AMA policy further highlights their recognition of increased funding for programs that "service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas" and include "all medical specialties in need" (H-305.925). The AMA recognizes the importance of partnership with native populations to increase healthcare outcomes for their members (H-350.976). Specifically, the AMA has adopted policy reaffirming their commitment to "evaluate existing regulatory and licensure opportunities and barriers to physician participation in health care services for Native Americans, Alaska Natives, and Native Hawaiians" (H-270.950). While current policy addresses the need for increasing NHs in the healthcare workforce and supports funding of programs, such as the NHHSP, that aim for such outcomes, current NHHSP guidelines still prohibit NHs who plan to practice in diaspora or in specialties outside of primary care from benefitting from this opportunity. AMA advocacy could meaningfully be expanded to include policy directly addressing this discrepancy.

CONCLUSION

Based on our review of the evidence in the resolution provided, we find that current primary care and geographic requirements of the NHHSP limit possibilities for future NH physicians and other healthcare professionals. While the AMA has a strong policy base to advocate for diversifying the physician workforce, specific policy that reinforces the importance of minority primary care and specialty physicians, working both at home and in diaspora, is necessary to help address the persistent gaps for NH in the healthcare workforce. Therefore, we support this resolution's ask of broadening eligibility to include all ACGME-accredited specialties and allowing service fulfillment via care to Native Hawaiian communities in diaspora areas. We believe that support of this resolution would help address structural inequities and improve the health outcomes of NHs everywhere while diversifying the physician pipeline and improving access.

RECOMMENDATION

Your Committee on Health Justice, Subcommittee on Tribal Affairs recommends that the following recommendations are adopted in lieu of Resolution 309 and the remainder of this report be filed:

RESOLVED, that our American Medical Association support expanded funding and eligibility requirements for the Native Hawaiian Health Scholarship Program (NHHSP), or an equivalent program, to include the following entities:

(a) Native Hawaiian (NH) trainees who are committed to providing primary care health services at Federally Qualified Health Centers (FQHCs), critical access hospitals, and Native health centers to NH patients in all U.S. states and territories, as well as

(b) NH trainees who provide specialized health care services to NHs in all U.S. states and territories.

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Destri Eichman, University of Missouri - Columbia

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RELEVANT AMA POSITIONS

H-270.950 Indian Health Service Licensing Exemptions

Our American Medical Association will work with interested parties to evaluate existing regulatory and licensure opportunities and barriers to physician participation in health care services for Native Americans, Alaska Natives, and Native Hawaiians. [Res. 312, A-23.]

D-200.982 Diversity in the Physician Workforce and Access to Care

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

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H-295.871 Accelerating Change in Medical Education: Strategies for Medical Education Reform
Our AMA continues to recognize the need for transformation of medical education across the continuum from premedical preparation through continuing physician professional development and the need to involve multiple stakeholders in the transformation process, while taking an appropriate leadership and coordinating role. [CME Rep. 13, A-07Reaffirmed: CME Rep. 01, A-17]

D-180.981 Plan for Continued Progress Toward Health Equity
Our AMA will develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities. The Board will provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements. [BOT Rep. 33, A-18]

H-305.925 Principles of and Actions to Address Medical Education Costs and Student Debt
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will: Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: inclusion of all medical specialties in need, and service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas...Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties...[CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21; Reaffirmation: A-22; Appended: CME Rep. 02, A-23; Appended: Res. 311, A-23; Reaffirmed: Res. 314, A-24; Reaffirmed: Res. 215, I-24; Reaffirmed: BOT Rep. 07, I-24].

H-350.976 Improving Health Care of American Indians and Alaska Natives
Our American Medical Association recommends that all individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens. Our AMA recommends that the federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives. Our AMA recommends that state and local governments give special attention to the health and health-related needs of nonreservation American Indians and Alaska Natives in an effort to improve their quality of life. Our AMA recommends that American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs. Our AMA recognizes practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives. Our AMA monitors Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care.

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Our AMA supports consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs. Our AMA recommends strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents. Our AMA recommends a team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems. Our AMA will continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians. Our AMA recommends that state and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside. Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian and Alaska Native health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians and Alaska Natives. Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. [CLRPD Rep. 3, I-98Reaffirmed: Res. 221, A-07Reaffirmation A-12Reaffirmed: Res. 233, A-13Reaffirmed: BOT Rep. 09, A-23Modified: CMS Rep. 03, A-24, Reaffirmed: Res. 244, A-24]

RELEVANT MSS POLICY

295.005MSS: Availability of Medical Education
Availability of Medical Education: AMA-MSS supports the following principles: (1) A determined, conscientious effort to accept, matriculate, and graduate minority physicians must be undertaken. (2) Support for programs with a commitment to the training of minority medical professionals, particularly the three predominantly black medical schools (Howard, Meharry, Morehouse) must be increased as necessary and maintained. (3) Adequate financial aid packages for minority students must be provided. These may include combinations of grants, loans, scholarships, or service- obligated programs. (4) Efforts should be made to increase the proportion of minorities in medical school faculties and administrative positions. (5) Efforts must be made to improve retention rates of minority students in medical schools. [MSS Position Paper 2, A-83; Reaffirmed: MSS COLRP Rep B, I-95; Reaffirmed: MSS Rep B, I-00; Reaffirmed: MSS Rep E, I-05; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15; Reaffirmed: MSS Res 19, I-17; Reaffirmed: MSS GC Report A, A-23]

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON HEALTH JUSTICE

MSS CHJ Report B
(I-25)

Introduced by: MSS Committee on Health Justice

Subject: Addressing Housing Needs of the Native Hawaiian and their Diaspora

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

INTRODUCTION

At the Annual 2025 (A-25) MSS Assembly, MSS Resolution 440, "Addressing Housing Needs of the Native Hawaiian and their Diaspora" asks the AMA to support the permanent reauthorization of the Native American Housing Assistance and Self-Determination Act (NAHASDA), expansion of NAHASDA to include Native Hawaiians living outside Hawai'i, recognition of Indigenous Hawaiian lineage as defined by Native Hawaiian organizations (rather than federal blood quantum laws), increased funding and land acquisition for the Department of Hawaiian Home Lands (DHHL), and stronger congressional accountability for DHHL's trust responsibilities to Native Hawaiians. The resolution, with the following resolve clause, was adopted:

> RESOLVED, that our AMA-MSS study the Native Hawaiian diaspora as it relates to the trust relationship between the federal government and Native Hawaiians, specifically focusing on unmet housing needs through the Native American Housing Assistance and Self-Determination Act (NAHASDA), efforts by the Department of Hawaiian Home Lands to fulfill housing needs of Native Hawaiians, and the use of blood quantum to qualify for housing assistance, and report back with recommendations.

The MSS Reference Committee recommended not adoption of the resolution with the following rationale:

> VRC testimony was mixed. The Reference Committee agrees with testimony that this resolution covers an important topic, but we agree with concerns that the asks of the resolution fall outside AMA's scope. We further agree that this resolution is covered under existing AMA policy H-160.903. Thus, your Reference Committee recommends Resolution 440 not be adopted.

During the MSS Assembly, the original resolution was modified to the "Resolve" clause written above. It was not extracted by any party.

Your Governing Council assigned this report to the Committee on Health Justice (CHJ) with the following possible questions for consideration: How does the federal government's trust relationship with Native Hawaiians compare to its obligations to federally recognized tribes under NAHASDA? How effective has NAHASDA been in addressing housing disparities among Native Hawaiians compared to other Indigenous groups? How do unmet housing needs among Native Hawaiians impact broader health outcomes and health equity? How does the use of blood quantum requirements affect eligibility for housing assistance among Native Hawaiians?

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Here, we outline current housing policies affecting Native Hawaiians and the associated ethical considerations. We examine the purpose and effectiveness of federal and state programs, including the Department of Hawaiian Home Lands and NAHASDA, as well as the implications of blood quantum requirements. Finally, we highlight potential areas for the AMA to expand its advocacy on this issue before presenting our recommendations.

WHEREAS CLAUSES

Whereas, Hawaii is ranked as the second-highest state in the U.S. for rate of homelessness;[1] and

Whereas, 51 percent of those experiencing homelessness on the island of Oahu identified as Native Hawaiian/Pacific Islander despite accounting for only 10 percent of the population[2,3]; and

Whereas, according to the Office of Hawaiian Affairs, more Native Hawaiians now reside on the U.S. continent than in Hawai'i itself;[4] and

Whereas, Native Hawaiians and Pacific Islanders have the highest rates of homelessness compared to any other racial group, at a rate of 121 out of every 10,000 people;[5] and

Whereas, Native Hawaiian leaders and advocates have emphasized that housing solutions must be developed in partnership with Native organizations to rebuild trust, promote cultural safety, and ensure community-defined priorities are respected;[6] and

Whereas, mistrust of government institutions has been shown to worsen health disparities by discouraging Indigenous communities from engaging with federal and state programs, including housing and healthcare;[7,8] and

Whereas, stable housing has been consistently linked with improved physical and mental health outcomes, including decreased emergency room visits and improved chronic disease management, particularly among marginalized populations;[9,10] and

Whereas, Native Hawaiian diaspora communities on the continental United States experience significant housing insecurity and discrimination, contributing to increased rates of chronic illness, mental health stressors, and cultural disconnection;[11,12] and

Whereas, equitable housing for Native Hawaiians is consistent with the U.S. commitment under the United Nations Declaration on the Rights of Indigenous Peoples, which affirms the right of Indigenous peoples to determine their membership and maintain their cultural institutions;[13,14] and

Whereas, the Native American Housing Assistance and Self-Determination Act (NAHASDA) consolidated federal housing grant allocation to federally recognized tribes, created the Indian Housing Block Grant program, and offered tribal autonomy by allowing tribes to develop their own "Indian Housing Plans" to address financial needs,[15-18] and

Whereas, despite the beneficial effects of NAHASDA, Native Hawaiians do not have federally recognized sovereign states as federally recognized tribes do;[18] and

Whereas, NAHASDA has been effective for Native Hawaiian housing programs, though at a scale far smaller than federal housing programs for federally recognized tribes,[16] and

Whereas, due to lack of sovereignty, funds allocated to NAHASDA programs are channeled through the Department of Hawaiian Home Lands (DHHL) rather than to any Native Hawaiian government,[15,16] and

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Whereas, the DHHL is the sole administrator of these funds rather than any Native Hawaiian administrative body,[15,16] and

Whereas, while the DHHL is the organization responsible for financial allocation, housing/economic/community development, and land protection, they been repeatedly criticized by Native Hawaiian beneficiaries and the State of Hawai'i for inefficiencies and long waitlists;[15,16,19] and

Whereas, despite administrative challenges, the DHHL is currently the only organization that can legally distribute funding to Native Hawaiians for housing assistance and development,[15,16] ; and

Whereas, the blood quantum requirement severely limits eligibility for Native Hawaiian housing assistance, has been recognized as a colonial strategy that undermines sovereignty, and Native Hawaiian organizations have called for self-determined criteria instead,[20,21] and

Whereas, various Native Hawaiian organizations have called for a re-defining of "blood quantum" to be inclusive of more individuals and as a way to establish some level of sovereignty for tribal affairs, culture, and identity.

CURRENT AMA POLICY & EFFORTS

The AMA has established robust policy supporting the health and well-being of Indigenous populations and individuals experiencing homelessness. Policy H-350.976 recognizes the unique health needs of non-reservation American Indians and Alaska Natives, encourages state and local governments to address these needs, and supports Congressional legislation aimed at improving health services for Indigenous communities. Policy H-160.903 and related MSS policies (440.048MSS, 440.060MSS) affirm that stable, affordable housing is a first priority for improving health outcomes and reducing healthcare costs among the chronically homeless. These policies advocate for clinically proven, high-quality, and cost-effective approaches, including housing-first strategies coupled with voluntary social services, while preserving individual choice. Additionally, AMA-MSS actively works with state medical societies and national organizations to promote legislation and develop a national plan to eradicate homelessness. Collectively, these efforts demonstrate AMA's commitment to addressing social determinants of health, health equity, and the intersection of housing and well-being — providing a foundation for targeted advocacy on Native Hawaiian housing needs as proposed in Resolution 440.

CONCLUSION

Based on our review of the evidence, homelessness and housing instability is a pressing issue for Native Hawaiians, who are disproportionately impacted both in Hawai'i and among diaspora communities on the U.S. mainland. Housing insecurity contributes to adverse health outcomes, including chronic disease exacerbation, mental health stressors, and diminished cultural continuity. Historical and ongoing mistrust between Native communities and government agencies, coupled with restrictive eligibility criteria such as blood quantum, further complicates access to adequate housing. There is a need for expanded federal housing support, recognition of community-defined Indigenous lineage, and greater accountability for the Department of Hawaiian Home Lands.

While the AMA has committed to addressing homelessness (H-160.903) through housing-first models and street medicine, and has separately supported the health of American Indian and Alaska Native peoples (H-350.976) through culturally respectful care and traditional healing, neither policy addresses the intersection of housing as a social determinant of health impacting

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Indigenous health access and outcomes. H-160.903 does not acknowledge the unique drivers of Indigenous homelessness, such as colonization, land dispossession, and the loss of ancestral ties, nor does it support culturally specific housing approaches rooted in Indigenous sovereignty. Similarly, H-350.976 focuses on healthcare delivery and funding mechanisms but does not address housing insecurity, overcrowding, or inadequate housing infrastructure, which are critical determinants of health in Native Hawaiian and Indigenous communities. Additionally, the timeliness of this resolution should warrant its adoption; given the legislative practices of the current administration, NAHASDA programs (i.e. IHBG) may be at risk as reauthorization bills are frequently brought to the Senate and House but are yet to pass. No existing AMA policy directly supports the reauthorization of NAHASDA, which is an actionable task and within the AMA's scope of practice.

Overall, NAHASDA has been shown to be effective in improving housing availability for Native Hawaiian populations, though at a far lesser scale than federally recognized tribes. Additionally, because Native Hawaiians lack sovereign recognition by the U.S. government, they face unique challenges in obtaining funding in a timely manner. Lastly, use of the blood quantum requirement creates increased barriers to housing in an Indigenous population already at a disadvantage; thus, due to these factors, there exists an imperative need for policy to address this unique injustice.

RECOMMENDATION

Your Committee on Community Health Justice and Advocacy recommends that the following recommendations be adopted in lieu of Resolution 440 and the remainder of this report be filed:

1. RESOLVED, that our American Medical Association support reauthorization of the Native American Housing Assistance and Self-Determination Act (NAHASDA) and advocate for NAHASDA to include Native Hawaiians regardless of geographic location; and be it further

2. RESOLVED, that our AMA support proof of Indigenous Hawaiian lineage in accordance with definitions provided by Native Hawaiian Organizations rather than blood quantum; and it be further

3. RESOLVED, that our AMA support the definition of lineage as provided by Native Hawaiian organizations as a qualifying factor for individuals to obtain beneficiary status of the Hawaiian Homes Commission Act; and be it further

4. RESOLVED, that our AMA support efforts by the Department of Hawaiian Home Lands (DHHL) to meet the need for housing Native Hawaiians through the acquisition and establishment of additional trust lands and through increased funding.

ACKNOWLEDGEMENTS

Rishi Kondapaneni, University of Missouri School of Medicine;Mackenzie Joe, McGovern Medical School; Sierra Grounds, Oklahoma State University College of Osteopathic Medicine at Cherokee Nation; Harsimran Makkad, University of Cincinnati College of Medicine; Faiza Chowdhury, Howard University College of Medicine

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RELEVANT AMA AND AMA-MSS POLICY

Improving Health Care of American Indians and Alaska Natives H-350.976

Our AMA: …(3) Our AMA recommends that state and local governments give special attention to the health and health-related needs of nonreservation American Indians and Alaska Natives in an effort to improve their quality of life; and (13) strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. [CLRPD Rep. 3 I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09 A-23; Modified: CMS Rep. 03, A-24; Reaffirmed: Res. 244, A-24]

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Eradicating Homelessness H-160.903
Our AMA: …(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; and (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless; and (11) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods. [Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19; Appended: Res. 414, A-22; Appended: Res. 931, I-22; Reaffirmed in lieu of: Res. 205, A-23]

440.048 MSS Eradicating Homelessness
AMA-MSS asked the AMA to: (1) support improving the health outcomes and decreasing the health care costs of treating the chronically homeless through housing first approaches; and (2) support the appropriate organizations in developing an effective national plan to eradicate homelessness.

440.060 MSS Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States
AMA-MSS will ask that our AMA amend policy H-160.903 by addition and deletion to read as follows: **Eradicating Homelessness H-160.903**
Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance and (2)(3) supports the appropriate organizations in developing an effective national plan to eradicate homelessness.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON MEDICAL EDUCATION

MSS CME Report A
(I-25)

Introduced by: MSS Committee on Medical Education

Subject: Publication of Student-Accessible Tuition Spending Breakdowns

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

INTRODUCTION

At the Annual 2025 (A-25) MSS Assembly, MSS CME Report A, "Quadrennial Review of Medical School Tuition Policies, Affordability, Debt Burden, & Impact on Specialty Choice & Applicant Diversity" was produced in response to MSS COLRP CME Report A. The result of the report was a re-referral of the following resolved clause;

> RESOLVED, that our AMA work with Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other relevant stakeholders to ask medical schools to publicly distribute student-accessible tuition spending breakdowns; and be it further

There were many concerns raised at the A-25 MSS Assembly about this resolved clause, particularly about the feasibility of this ask and the usefulness of the information in furthering advocacy on this topic. Many members that supported re-referral were concerned that some schools may be unable to produce this information due to differences between institutions in how tuition money is dispersed and tracked. Furthermore, some members questioned the utility of transparent breakdowns in furthering advocacy, when many of these breakdowns would likely include broad categories such as 'Research' or 'Physician Salaries,' that may not be useful in the AMA's advocacy regarding tuition burden on students.

WHEREAS CLAUSES

Whereas, Medical school tuition has dramatically increased in the last decade, with the average medical school tuition in 2004-2005 being $14,296/$32,245 (public/private), compared to an average medical school tuition in 2023-2024 of $53,845/67,905 (public/private)[1-2] ; and

Whereas, Medical student debt has been reported as high as $350,000, with the mean indebtedness of a graduating medical student in 2020 at $207,000, an estimated increase of about 3-4% per year[3-8] ; and

Whereas, 69% of 2021 medical school graduates reported having medical education debt with a median of 200,000[9] ; and

Whereas, since 1984, with respect to inflation, physician salary has increased 25% while medical school debt has increased over 400%[10] ; and

Whereas, the funding of medical education is incredibly variable, with some schools relying

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more on government support, and other schools relying heavily on gifts and endowed funds[11]; and

Whereas, in studies on medical school education cost, categories receiving funding from tuition such as “total federal research grants and contracts, other grants and contracts, and total expenditures and transfers from hospital funds” are often excluded from analysis, because they are nearly impossible to fully account for[11].

Whereas, data on medical school revenue sources is collected as part of the LCME Part I-A Annual Medical School Financial Questionnaire (AFQ), and shows that as of 2022, tuition and fees account for only 3% of total LCME-accredited MD-granting institution revenue[12]; and

Whereas, although tuition money does comprise a sizable amount of revenue for schools, the majority of money comes from practice plan and hospital revenue, and federal funding[13]; and

Whereas, a 2024 AAMC survey indicates that schools can report use of tuition revenue in the categories of direct allocation and model/calculated allocation[14]; and

Whereas, this model/calculated allocation involves models or formulas that vary drastically by school, and take into account faculty full-time-equivalents, research productivity, and institution priorities in different proportions based on a school’s individual needs[14]; and

Whereas, these categories in the 2024 survey show that allocation of medical school tuition and fees from the university to the medical school varies by institution, with 57% of schools saying distribution of this money is through direct allocation to departments or programs at their medical school, and 37% of schools saying distribution of this money is through model/calculated allocation[14]; and

Whereas, the same survey shows that the allocation of tuition and fees from the medical school to the departments is even more complex, with 67% of schools saying distribution of the money is through model/calculate allocation, meaning it is distributed through each school’s unique complex system[14]; and

Whereas, there is overall a great deal of uncertainty reported by institutions in these AAMC surveys, with some noting that their “clinical revenue is not very clear” or that they have sources of “other miscellaneous revenue” that they use to fund medical education[14]; and

Whereas, the Liaison Committee on Medical Education is a governing body that works closely with the AMA and accredits the medical programs that lead to the MD degree, but not the overall institutions of higher education that support these programs[15].

CURRENT AMA POLICY & EFFORTS

Current AMA policy has taken steps to address the growing cost of medical education. The AMA has policy to collect information of programs that cap medical education debt, and encourage schools to obtain discounts for students on necessary medical education supplies (**H-305.925**). The same policy also asks the AMA to monitor sources of financial aid for students, whether they be institutional or external (**H-305.925**). Other policy has looked at specific tuition increase methods, and the AMA is opposed to mid-year and retroactive tuition

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increases (**D-305.983**). The AMA also has adopted policy to encourage schools to develop a system of common definitions to support medical students' understanding of the costs associated with a medical education (**H-305.988**). Overall, policy examining the cost of medical education and support for students surrounding costs is expanding as the interest of students and physicians in the debt burden increases.

CONCLUSION

Overall, the issue of tuition burden is significant for medical students across the country. Tuition has risen dramatically over the past two decades, far outpacing inflation and contributing to average indebtedness levels exceeding $200,000. In some form, the AMA has a duty to remain involved in advocacy efforts that alleviate the burden of rising tuition costs on medical students.

We would like to thank the authors of MSS CME Report A (A-25) for all of their hard work. They sought to promote full transparency on behalf of students, so that students can be more aware of how schools are spending their tuition dollars at a time when the cost of medical school is unsustainably high. However, after further review, we found that the original ask from Recommendation B to "publish student-accessible tuition spending breakdowns" is not an effective route for advocacy in this area. Our difficulty finding clarity on how tuition is spent while completing this report reflects the fact that it is exceptionally difficult to produce accurate breakdowns of tuition spending at medical schools.

A 2024 report from the AAMC highlights that although some universities directly allocate tuition revenue to certain operations within the medical school, many do not, and use model/calculated allocation of funding. With the model/calculated system, schools have varying ways of utilizing funds involving their own formulas and methods of allocation that are not readily reported into discrete categories by medical schools.

As we completed this report, we discussed tuition breakdowns with the medical student members of the Council on Medical Education. The physician members of this Council are leaders in undergraduate medical education, and they shared with us how inconsistent the distribution of tuition funding to medical schools is throughout the country, and how difficult it would be to accurately report. The experiences they shared mirror the experiences reported by the 50 medical schools in the 2024 AAMC report, reinforcing how infeasible this ask would be for many medical schools in the country. Simply put, there are more systemic barriers to reporting tuition that are out of the control of medical schools, and they are currently bound to the system their universities use to report revenue.

Although trying to advocate for changing this systemic issue to facilitate creation of tuition breakdowns might still be preferred by some, we also question its usefulness in the AMA's advocacy. For example, if a tuition breakdown shows that 10% of tuition costs are allocated to research, or 40% of costs are allocated to faculty salaries, will the AMA then use that information to intervene and suggest how tuition should be spent? The 2024 AAMC report highlights that schools receive and allocate funds in many different ways due to their status as a public or private institution, or their affiliation with a university. While one school may find it useful to directly allocate funds, another may prefer model/calculated allocation, and may have good reasons for doing so. How tuition should be allocated seems like a decision best made by each school based on their funding structure, and not by the AMA.

Lastly, we have some concern that because funding is collected and allocated by the universities, and not the medical schools themselves, the ask of published tuition breakdowns

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may be outside the scope of the AMA, or be much harder for the AMA to advocate for. The AMA works closely with the Liaison Committee on Medical Education (LCME) in medical education advocacy. However, the LCME only provides accreditation for the medical schools within the universities, and not the universities at large. Therefore, their influence on the universities is uncertain, and the steps the AMA would take to ask for published tuition breakdowns are unclear.

We encourage the AMA to remain in the fight for greater tuition transparency and in opposition to the extreme tuition burden placed on medical students. There are other tuition advocacy initiatives, such as working to change the new federal student loan guidelines established by the "One, Big, Beautiful Bill," that may be more within the AMA's scope, and may actually address the more urgent concerns that medical students are facing. Ultimately, although we agree that tuition costs remain too high in our country, we do not feel that the resolved clause associated with Recommendation B asking for published tuition breakdowns is feasible for medical schools, and is not necessary for the AMA to address students' most pressing concerns.

RECOMMENDATION

Your Committee on Medical Education recommends that MSS CME Report A (A-25), Recommendation B not be adopted and the remainder of this report be filed.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON PUBLIC HEALTH

MSS CPH Report 423
(I-25)

Introduced by: MSS Committee on Public Health

Subject: Addressing Public Health Risks of Online Sports Betting

Referred to: MSS Reference Committee
[TBD]

INTRODUCTION

At the Annual 2025 (A-25) MSS Assembly, MSS Resolution 423, "Addressing Public Health Risks of Online Sports Betting," asked the AMA to support federal regulation, data collection, and updated epidemiological research to address the growing public health risks associated with online sports betting and gambling, particularly among young adults. The resolution was proposed with the following resolved clauses:

> RESOLVED, that our American Medical Association support efforts such as the SAFE Bet Act to expand federal regulations surrounding consumer protections that align with the Internet Responsible Gaming Standards for online gambling and sports betting; and be it further
>
> RESOLVED, that our AMA support federal funding for updated epidemiological studies on gambling addiction, particularly among young people; and be it further
>
> RESOLVED, that our AMA support national data collection on the prevalence of gambling disorder and problem gambling.

The MSS Reference Committee recommended not adoption of the resolution with the following rationale:

> VRC testimony was mixed. The Reference Committee agrees that the issue of sports betting is one that is relevant and timely; however, we agree that existing AMA policy supports the Safe BET Act. Additionally, we agree with testimony that this resolution would be better suited coming from a specialty society who has expertise in this area and can strengthen the language to elicit meaningful AMA action. Thus, your Reference Committee recommends Resolution 423 not be adopted.

During the MSS Assembly, the item was extracted and the following discussion took place.

- The Assembly voted to refer Substitute Resolution 423 in lieu of Resolution 423. This language was submitted to the MSS Governing Council after Assembly concluded:
  - RESOLVED, that our American Medical Association support efforts to improve consumer protections for online gambling and sports betting; and be it further
  - RESOLVED, that our AMA support efforts to update epidemiological studies on gambling disorder.

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Your Governing Council assigned this report to the Committee on Public Health (CPH) for consideration.

In the following whereas clauses and subsequent discussion, we provide an overview of the current public health risks of online sports betting and daily fantasy sports, the potential harms associated with gambling disorder, and existing AMA policy in this area. We describe potential areas in which our AMA could expand its advocacy on this topic before ultimately delivering our recommendation on the referred clauses.

WHEREAS CLAUSES

Whereas, the 2018 Murphy v National Collegiate Athletic Association ruling enabled state authorization of legalized mobile sports betting, leading to widespread expansion, with 33 states and the District of Columbia enacting laws and additional states actively considering legislation;[1-4] and

Whereas, professional sports leagues and broadcasters have fueled growth of this industry through heavy advertising, with the NFL permitting up to six sportsbook ads per broadcast since 2021, ultimately contributing to a 750% increase in industry advertising expenditures between 2019 and 2021;[5,6] and

Whereas, consumer engagement continues to rise, with an estimated 68 million Americans wagering $23.1 billion on the 2024 Super Bowl alone, a 41% increase from the prior year;[7] and

Whereas, Daily Fantasy Sports (DFS) platforms (e.g., FanDuel, with over 12 million users) operate in a legal gray area under the 2006 Unlawful Internet Gambling Enforcement Act, which classifies DFS as a game of skill rather than gambling; however, regulators have increasingly scrutinized DFS contests for their close resemblance to sports wagering, with at least one sportsbook fined millions of dollars in 2025 for offering products that blurred this legal boundary;[8-11] and

Whereas, while DFS outcomes may incorporate elements of skill, evidence indicates DFS participation can act as a gateway to sports betting and impulsive gambling, especially among adolescents and young adults, with recent studies documenting mental health problems and addictive behaviors among DFS players resembling those observed in sports bettors;[12,13] and

Whereas, young adults are the fastest growing group of sports bettors, with 58% of college students aged 18 to 22 reporting sports betting in the past year (often illegally under age 21), and studies show that early exposure increases the likelihood of developing gambling disorder, a condition associated with financial hardship, relationship strain, depression, suicidality, and substance use;[14-19] and

Whereas, national prevalence surveys of gambling disorder largely predate the 2018 Murphy v NCAA ruling, leaving a critical data gap in understanding the scope of gambling-related harm in the online era, especially among adolescents and young adults;[20] and

Whereas, evidence suggests that online sports bettors have double the rates of gambling disorder as compared to those who gamble in other forms, but the lack of data collection since the 2018 ruling obscures the true characterization of the effect of online betting on gambling prevalence;[21] and

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Whereas, state regulatory frameworks for online sports betting differ substantially, with wide inconsistencies in consumer protections, allocation of funds for responsible gaming initiatives, and the types of contests permitted for wagering;[22-24] and

Whereas, even where such protections exist, individuals can easily circumvent state-level regulations through interstate travel, virtual private network (VPN) software, and offshore internet sportsbooks, underscoring the need for uniform federal standards;[25,26] and

Whereas, many state regulatory frameworks fail to require online sportsbooks to meet the Internet Responsible Gaming Standards (IRGS) and the consumer protection guidelines set by the National Council on Problem Gambling (NCPG), leaving major gaps in protections for individuals at risk of gambling disorder;[21,22,27,28] and

Whereas, the NCPG has developed a comprehensive package of responsible online gaming standards, grounded in existing evidence and expert consensus, that includes provision of responsible gaming programming, self-limiting tools, access to betting history, and readily available treatment resources, representing a strong framework for uniform consumer protection and harm reduction;[28] and

Whereas, gambling is increasingly recognized as a public health concern, with recent federal initiatives such as the GRIT Act (2023) and SAFE Bet Act (2024, reintroduced 2025) underscoring bipartisan recognition of gambling disorder as a growing national issue requiring updated epidemiological studies and a stronger understanding of effective consumer protections;[29-32] therefore be it

CURRENT AMA POLICY & EFFORTS

The AMA has longstanding policy addressing gambling-related harms. H-440.922 (“Gambling Disorder”) encourages states to allocate gambling revenue toward education and treatment programs, requires visible warnings at lottery outlets, and urges physicians to counsel patients about gambling addiction. H-275.939 (“Internet Gambling”) highlights the risks of online gambling, particularly for children, and promotes physician and patient awareness.

While these policies provide a foundation for clinical awareness and public health advocacy, they predate the rapid expansion of mobile sports betting and daily fantasy sports following the 2018 Supreme Court ruling overturning PASPA. Existing policies do not address federally standardized consumer protections, the implementation of evidence-based interventions for online gambling disorder, or targeted research on adolescents and young adults, who represent a newly at-risk population. Implementing standardized federal protections, evidence-based interventions, and updated research would allow the AMA to build on existing policy, close critical knowledge gaps, and ensure prevention and treatment strategies are tailored to the realities of online gambling.

CONCLUSION

Based on our comprehensive review of the evidence and current public health landscape, we find that online sports betting and daily fantasy sports are rapidly expanding sources of potential harm, particularly for adolescents, young adults, and other vulnerable populations. Aggressive advertising, widespread legalization, and easy access through mobile platforms have fueled unprecedented engagement, increasing risks for progression to gambling disorder, mental health consequences, and financial and social harms

The patchwork of state regulations, combined with the lack of federally standardized consumer protections and national research, undermines public health efforts. Supporting federal initiatives such as the SAFE Bet Act, implementing evidence-based consumer safeguards, and

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conducting robust epidemiological research will enable the AMA to guide effective interventions, characterize the scope of online gambling-related harms, and protect populations newly exposed to these risks. These actions are essential to uphold the AMA's leadership in safeguarding public health and addressing emerging threats from modern gambling behaviors.

RECOMMENDATION

Your Committee on Public Health (CPH) recommends that the following recommendations be adopted in lieu of Resolution 423 and the remainder of this report be filed:

1. RESOLVED, that our American Medical Association support efforts to establish federal consumer protections for online gambling, including sports betting and daily fantasy sports, to reduce harms associated with gambling disorder and other related behaviors.
2. RESOLVED, That our AMA support epidemiological research to characterize the health impacts of online gambling, including sports betting and daily fantasy sports, with particular attention to adolescents, young adults, and other vulnerable populations.

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RELEVANT AMA AND AMA-MSS POLICY

H-440.922 Gambling Disorder
The AMA: (1) encourages physicians to advise their patients of the addictive potential of gambling; (2) encourages states which operate gambling programs to provide a fixed percentage of their revenue for education, prevention, and treatment of gambling disorder; and (3) requests that states which operate gambling programs affix to all lottery tickets and display at all lottery counters a sign which states that gambling may become a gambling disorder and help is available through your local gambling hotline. [Res. 430, A-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Modified: CSAPH Rep. 01, A-24]

H-275.939 Internet Gambling
Our AMA informs physicians and patients of the dangers of addiction associated with Internet gambling and supports prohibiting the availability of Internet gambling to children. [Res. 217, A-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 01, A-18]

Recognition of Addiction as Pathology, Not Criminality 95.005 MSS
AMA-MSS encourages government agencies to re-examine the enforcement-based approach to illicit drug issues and to prioritize and implement policies that treat drug abuse as a public health threat and drug addiction as a preventable and treatable disease.

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REPORT OF THE MEDICAL STUDENT SECTION

COMMITTEE ON SCIENCE & TECHNOLOGY

MSS CST Report A
(I-25)

Introduced by: MSS Committee on Science & Technology (CST)

Subject: Mandatory Gluten Labeling in Medications, Supplements, & Herbal Remedies (432-A-25-MSS)

Referred to: MSS Reference Committee

INTRODUCTION

At the Annual 2025 (A-25) MSS Assembly, MSS Resolution 432, "Mandatory Gluten Labeling in Medications, Supplements, & Herbal Remedies" asked the AMA to support research to assess the clinical impact of gluten exposure from medications, supplements, and herbal remedies, support the FDA and other stakeholders in creating and implementing standardized testing, and encourage the inclusion of such information in electronic health records and pharmacy dispensing systems. The resolution, with the following resolve clauses, was referred for study:

> RESOLVED, that our American Medical Association support further research to assess the clinical impact of gluten exposure from medications in individuals with celiac disease and gluten sensitivity, evaluating whether trace amounts pose a significant health risk to warrant mandatory labeling regulations; and be it further
>
> RESOLVED, that our AMA support efforts by the U.S. Food and Drug Administration (FDA), pharmaceutical manufacturers, and other relevant stakeholders to develop and implement standardized testing; and be it further
>
> RESOLVED, that our AMA encourage the inclusion of allergen-related information, including gluten and wheat-derived ingredients, in electronic health records and pharmacy dispensing systems to improve the identification of safe medications for patients with celiac disease and gluten sensitivity.

The MSS Reference Committee recommended NOT ADOPT for the resolution with the following rationale:

> VRC testimony was mixed. The Reference Committee agrees with concerns that resolution lacks strong peer-reviewed sources. Additionally, we agree with relevant specialty society testimony that the first resolved clause lacks evidence, the second resolved clause is out of scope, and the third resolved clause is premature. Thus, your Reference Committee recommends Resolution 432 not be adopted.

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- During the MSS Assembly, the item was extracted by the authorship team to propose an amendment by deletion of the second and third resolves. Region 3 moved to refer the item, and the MSS Assembly ultimately referred Resolution 432-A-25-MSS for study.

Your Governing Council assigned this report to the Committee on Science and Technology with the following possible questions for consideration:

Is gluten in medications, supplements, and herbal remedies harmful to patients with gluten intolerances and celiac disease? Would mandating gluten labeling fall under the AMA's scope? Are there instances where a patient was harmed by gluten presence in medications, supplements, and herbal remedies? In the following whereas clauses and subsequent discussion, we provide an overview of the current evidence on the harmful effects of gluten in medications, supplements and herbal remedies on patients with gluten intolerances and celiac disease. We consider the efforts that are being made to minimize gluten presence in these products and the consequences that can occur if this is not addressed. We describe potential areas in which our AMA could expand its advocacy on this topic before ultimately delivering our recommendation on the referred clauses.

WHEREAS CLAUSES (EVIDENCE & RATIONALE)

Whereas, the incidence of celiac disease is increasing at a rate of 7.5% per year, particularly among women and children, highlighting the potential harms of inadvertent gluten exposure to an increasing proportion of the population [21]; and

Whereas, the "economic iceberg" of celiac disease shows that visible costs (gluten-free foods and routine follow-up) are only the tip, while larger, hidden costs—excess care for complications and comorbidities and reduced or lost productivity—account for a substantial, often overlooked share of the total burden of disease [10]; and

Whereas, adults with celiac disease experience higher rates of depression and anxiety compared to their peers, which may be precipitated by the personal and social limitations imposed by living with a chronic, incurable illness, underscoring the need to minimize avoidable exposures of gluten [1]; and

Whereas, due to uncertainty over potential gluten contamination, patients may forego important medications to avoid the risks associated with gluten ingestion, regardless of whether significant contamination is present [2]; and

Whereas, celiac disease patients and the health professionals who care for them require reliable information regarding the gluten content of all pharmaceutical products intended for ingestion—including prescription and nonprescription drugs, vitamins, nutritional supplements, and oral health or cosmetic products—yet such information is rarely available on labeling, leaving patients vulnerable to inadvertent exposure [3,4,5]; and

Whereas, pharmacists are essential to ensuring safe medication use by counseling patients and because trust between patients and pharmacists is vital to achieving positive health outcomes,

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access to accurate information on drug ingredients—through clear and mandatory gluten labeling—is necessary for pharmacists to fully meet their responsibilities [8,9]; and

Whereas, gluten in pharmaceutical and nutritional products is typically introduced through inactive ingredients added during manufacturing, with common sources including starches, flours, or sweeteners derived from wheat, barley, rye, spelt, kamut, or triticale, while "unspecified starch," pregelatinized starch, and wheat-based dextrin or maltodextrin pose particular risks for gluten contamination [6,7]; and

Whereas, a 2025 analysis of 308 medicinal products in Portugal found that 51.2% of solid oral analgesic and antipyretics and 40% of liquid oral formulations contained gluten-derived excipients, underscoring the widespread presence of hidden gluten in commonly used medications [11]; and

Whereas, only 5% of pharmaceutical companies surveyed in a published study reported a formal policy of producing gluten-free products, with many unable to guarantee that their raw materials or inactive ingredients were free of gluten contamination, underscoring the lack of standardized safeguards to protect patients with celiac disease [6]; and

Whereas, a 2025 review of the top 100 most commonly prescribed pediatric medications found that, although all medications had at least one formulation confirmed or verified as gluten-free, only 21 were explicitly labeled gluten-free, 31 required direct manufacturer inquiry for verification, and 48 provided no definitive information, highlighting that nearly half of pediatric formulations lack transparent disclosure of gluten content [15]; and

Whereas, in a 2024 documented case, ingestion of prednisone tablets containing wheat starch by a patient with celiac disease adhering to a strict gluten-free diet precipitated a severe disease flare, resulting in persistent diarrhea, 8 kg weight loss, elevated alkaline phosphatase, and secondary hyperparathyroidism [13]; and

Whereas, a 2023 systematic review and meta-analysis showed that even small daily doses of gluten were associated with increased risk of celiac disease at levels as low as 6mg/day in a dose-dependent manner, reaching ~50% risk of CD relapse 881 mg/day [14]; and

Whereas, gluten detection methods in food products include ELISA-based assays and portable lateral flow devices, however, their application to medications and dietary supplements is not standardized and the performance metrics of these assays in these products have not been rigorously established [16,17,18]; and

Whereas, the European Medicines Agency (EMA) maintains that oral medicinal products containing wheat starch with gluten must clearly label it as an excipient, and may claim "gluten-free" only if the gluten content in the final product is less than 20 parts per million (ppm) [19]; and

Whereas, although the U.S. Food and Drug Administration (FDA) issued a draft guidance for Industry in December 2017 recommending that manufacturers optionally include statements such as "Contains no ingredient made from a gluten-containing grain (wheat, barley, or rye)," this

remains voluntary and lacks the force of law, resulting in inconsistent disclosure practices across medications [20]; and

Whereas, this contrast between EU mandatory labeling standards and U.S. voluntary practices illustrates that mandatory gluten labeling in pharmaceutical products is both feasible and already implemented in comparable regulatory frameworks; therefore be it

CURRENT AMA POLICY & EFFORTS

Current AMA policy establishes a strong precedent for transparency, safety, and patient protection in drug and allergen labeling. The AMA supports full qualitative labeling of all drugs and dietary supplements, requiring both active and inactive ingredients to be listed on manufacturer labels or package inserts (H-115.988). Complementing this, AMA policy recognizes that FDA-approved labeling should not be considered the sole standard of medical practice and advocates for faster FDA processes to update labeling when new evidence becomes available, ensuring clinical use is guided by current peer-reviewed standards (H-115.994). The AMA has also prioritized patient safety through drug and allergen labeling reforms. Policies encourage more obvious distinctions in food packaging for common allergens (H-150.924) and support accentuated warning labels when major food allergen ingredients change (H-440.794). The AMA defends the continuation of office-based compounding for allergen extracts under USP 797 rules (H-120.930) and calls for standardized FDA processes to improve patient-facing Risk Evaluation and Mitigation Strategy (REMS) materials, including readability and cultural competency (H-100.961). Dietary supplement oversight is another area of active AMA advocacy. The AMA has repeatedly urged Congress to modernize the Dietary Supplement Health and Education Act to require FDA approval of supplements for safety and efficacy, mandate USP standards for identity, strength, and purity, and create a mandatory FDA product listing system with unique identifiers such as QR codes. AMA policy also calls for labeling to include adverse effects, contraindications, and drug interactions, protecting the public from unsafe or mislabeled supplements (H-150.954). AMA-MSS has built on these foundations with an equity focus. AMA-MSS policy supports using international drug price indices to guide U.S. pharmaceutical pricing and advocates for the establishment of a nonprofit government manufacturer to address generic drug shortages and market failures (155.011MSS). In addition, AMA-MSS supports federal and state efforts to improve affordability and quality of gluten-free and allergen-safe foods, extend mandatory nutrient fortification to such alternatives, and expand nutrition assistance programs to equitably support households affected by celiac disease and food allergies (150.049MSS). Taken together, these policies demonstrate that the AMA strongly supports comprehensive labeling of drugs and supplements, rapid evidence-based updates to official labeling, enhanced allergen transparency, and affordability of essential medications and food alternatives.

CONCLUSION

Based on our review of the evidence in the resolution provided below, we find that there is little quantitative evidence regarding the damage gluten contamination in medication, supplements, and herbal remedies poses to patients with gluten intolerances and celiac disease. Celiac disease is a well-studied condition and gluten contamination poses a very real risk to patients, but there were no recent documented instances of patients definitively suffering harm from gluten contamination in these products. However, just because there are no documented instances, does not mean that there are no instances at all. Patients with celiac disease and other chronic

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illnesses experience many symptoms of unknown etiology, and these symptoms are frequently dismissed by clinicians and understudied by researchers. Increased study of this issue may be warranted to determine the extent of gluten presence in these products and safe thresholds. A comprehensive review of AMA Policy and MSS Positions suggests that if there are specific advocacy targets, the AMA would have ample support to act on them, and so additional policy is not needed. We recommend that advocacy on this topic be pursued through alternate routes of advocacy available to our MSS, including an MSS Action Item (MSSAI) or MSS Advocacy Referral (MSSAR). This is most likely to result in expedient and effective advocacy on this topic. Your Committee on Science & Technology would like to commend the original authorship team for their passionate advocacy and thank the MSS Assembly for the opportunity to investigate this topic further.

RECOMMENDATION

Your MSS Committee on Science & Technology (CST) recommends that Resolution 432-A-25-MSS not be adopted and that the remainder of this report be filed.

ACKNOWLEDGEMENTS

Your Committee on Science & Technology would like to thank the original authorship team of Resolution 432-A-25-MSS for their time and effort in bringing this important issue to light. The primary authors of this report were Druv Bhagavan, Maya Livni, Shragvi Balaji, and Vishal Reddy. We would also like to thank all of the individuals who took the time to review the original resolution and this report, as well as all members of CST and other MSS members who assisted with the creation of this report in any way. Finally, we would like to acknowledge the people living with celiac disease, gluten intolerance, and other related conditions and the struggles they face. We hope this report will help to enable effective advocacy for their needs.

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RELEVANT AMA AND AMA-MSS POLICY

Qualitative Labeling of All Drugs H-115.988
The AMA supports efforts to promote the qualitative labeling of all drugs and dietary supplements, requiring both active and inactive ingredients of over-the-counter and prescription drugs and dietary supplements to be listed on the manufacturer's label or package insert. [Res. 96, A-84; Reaffirmed by CLRPD Rep. 3 – I-94; BOT Rep. 1, A-95; Reaffirmed: CSA Rep. 8, A-05; Modified: Sub. Res. 504, A-10; Reaffirmation: A-19]

Allergen Labeling on Food Packaging H-150.924
Our AMA encourages food manufacturers to pursue more obvious packaging distinctions between products that contain the most common food allergens identified in the Food Allergen Labeling and Consumer Protection Act and products that do not contain these allergens. [Res. 918, I-18]

USP Compounding Rules H-120.930
Our AMA will engage in efforts to convince United States Pharmacopeia (USP) to retain the current special rules for procedures in the medical office that could include but not be limited to allergen extract compounding in the medical office setting and, if necessary, engage with the U.S. Food and Drug Administration (FDA) and work with the U.S. Congress to ensure that small volume physician office-based compounding is preserved...Our AMA supports the current 2008 USP Chapter 797 sterile compounding rules as they apply to allergen extracts, including specifically requirements related to the beyond use dates of compounded allergen extract stock. [Res. 204, A-16; Reaffirmation: A-17; Reaffirmation: A-18; Appended: Res. 501, A-19]

Safety Concerns Regarding Inadequate Labeling of Food Products Upon Ingredient Changes with Known Major Food Allergens H-440.794
Our AMA supports legislation or regulation requiring major food allergen ingredient changes be labeled and packaged with accentuated, obvious warning labeling identifying such change. [Res. 929, I-24]

The Evolving Culture of Drug Safety in the United States: Risk Evaluation and Mitigation Strategies (REMS) H-100.961

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Our AMA urges to the extent practicable, a process is established whereby the FDA and sponsors work toward standardizing procedures for certification and enrollment in REMS programs, and the common definitions and procedures for centralizing and standardizing REMS that rely on ETASU are developed. Our AMA urges REMS-related documents intended for patients (e.g., Medication Guides, acknowledgment/consent forms) be tested for comprehension and be provided at the appropriate patient literacy level in a culturally competent manner.

Dietary Supplements and Herbal Remedies H-150.954
(6) Our AMA continues to strongly urge Congress to modify and modernize the Dietary Supplement Health and Education Act to require that:
(a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy;
(b) dietary supplements meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling;
(c) FDA establish a mandatory product listing regime that includes a unique identifier for each product (such as a QR code), the ability to identify and track all products produced by manufacturers who have received warning letters from the FDA, and FDA authorities to decline to add labels to the database if the label lists a prohibited ingredient or new dietary ingredient for which no evidence of safety exists or for products which have reports of undisclosed ingredients; and
(12) Our AMA urges that in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label. [Res. 513, I-98; Reaffirmed: Res. 515, A-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 516, I-00; Modified: Sub. Res. 516, I-00; Reaffirmed: Sub. Res. 518, A-04; Reaffirmed: Sub. Res. 504, A-05; Reaffirmation A-05; Reaffirmed in lieu of Res. 520, A-05; Reaffirmation I-09; Reaffirmed in lieu of Res. 501, A-10; Reaffirmation A-11; Reaffirmation I-14; Resolution 432 (A-25) Modified: Res. 511, A-16; Reaffirmation: A-17; Reaffirmation: A-19; Modified: CSAPH Rep. 3, I-20; Reaffirmed: Res. 510, A-24]

Prescription Product Labeling H-115.994
(1) The official labeling should not be regarded as the sole standard of acceptable or accepted medical practice nor as a substitute for clinical judgment or experience nor as a limitation on usage of the drug in medical practice. The official labeling statements approved by the FDA establish the parameters governing advertising or promotion of the drug product.
(2) Our AMA will advocate that the FDA work to establish a process whereby the official drug labeling can be updated in a more expeditious fashion when new evidence becomes available affecting the clinical use of prescription medications and that evidence-based standards or peer-reviewed medical literature can add to legacy information contained in official drug labeling statements to guide drug administration and usage.

Pharmaceutical Drug Pricing: Parameters Around Medicare Negotiation & Government Manufacturing of Generic Drugs 155.011MSS
(1) AMA-MSS supports the use of the international drug price indices and averages, which may include data from countries regardless of structure of healthcare system or any price controls used, in determining the price and payment for drugs; and
(2) AMA-MSS will ask the AMA to support the formation of a non-profit government pharmaceutical manufacturer to produce generic drugs to address market failures, including the existence of small markets for generics, the absence of generics in the market after expiration of patents and exclusivity, and shortages of necessary medications. (MSS Res. 36, I-21)

Equity in Celiac Disease and Food Allergies Research and Resources 150.049MSS

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AMA-MSS will ask the AMA to support (1) federal and state efforts to increase the affordability and quality of food alternatives for people with celiac disease, food allergies, and food intolerance; (2) federal and state efforts to extend requirements for mandatory nutrient fortification to food alternatives for people with celiac disease, food allergies, and food intolerance; and (3) efforts to expand nutrition assistance eligibility and benefits to equitably meet the needs of households affected by celiac disease, food allergies, and food intolerance and increase access to food alternatives for people with celiac disease, food allergies, and food intolerance, including but not limited to efforts by food banks and pantries, food delivery systems, and prescription produce programs.

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REPORT OF THE MEDICAL STUDENT SECTION DELEGATES

SD Report
(I-25)

Introduced by: Sneha Kapil, Section Alternate Delegate; Jared Buteau, Section Delegate; Druv Bhagavan, Immediate Past Section Alternate Delegate; Kayla (K.B.) Jernigan, RefCom E&B Lead; Dakota Hitchcock, RefCom E&B Lead; Rusty Hawes, RefCom A Lead; Akhil Mahant, RefCom A Lead; Jordan Samuel, RefCom B Lead; Adrienne Nguyen, RefCom B Lead; Lauren St. Peter, RefCom B Lead; Rianna McNamee, RefCom C Lead; Jessica MacIntyre, RefCom C Lead; Andrew Norton, RefCom F Lead; Kylie Ruprecht, RefCom G Lead; Priscilla McElhinney, RefCom G Lead

Subject: Delegate Report: Policy Proceedings of the Annual 2025 House of Delegates Meeting

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

INTRODUCTION

The following report details the actions taken by the MSS Caucus at the Annual 2025 Meeting of the AMA House of Delegates, pursuant to MSS Internal Operating Procedure (IOP) 9.3, which states,

> "9.3 Reporting of Caucus Actions. The Section Delegates shall be responsible for authoring a report of actions taken, which shall be presented to the MSS Assembly at the next national meeting. This report will list the resolved clauses of all AMA HOD items of business for which the MSS took a position, and will specifically identify those items of business for which the MSS Caucus took a position that was not grounded in existing internal policy."

Per the MSS IOPs, positions of the MSS Caucus are decided in the following manner:

Amended MSS Internal Operating Procedure 9.2, "Determining MSS Caucus Positions" states:

> "9.2 Determining MSS Caucus Positions.
>
> 9.2.1 For all MSS Caucus activities requiring a vote, all members of the MSS Caucus shall be given one vote.
>
> 9.2.2 A quorum of at least one half of voting members must participate for a vote to be valid.
>
> 9.2.3 In the AMA HOD, the MSS Caucus must take positions on items of business that are consistent with the existing policy of the MSS as defined in the MSS Digest of Actions whenever relevant MSS policy exists.
>
> 9.2.4 In areas where relevant MSS policy exists, but the interpretation is uncertain, a majority vote of a quorum of MSS Caucus will determine the MSS Caucus's interpretation.
>
> 9.2.5 When an item of business is before the AMA HOD that is of significant importance to the MSS, but for which no MSS policy exists, any member of the MSS Caucus may move that the MSS take a position on the item. Such a motion requires a second by another Caucus member and a two-thirds (⅔) majority vote of a quorum of the MSS Caucus to pass.
>
> 9.2.5.1 Positions set using these procedures are only valid for the duration of that AMA HOD meeting.
>
> 9.2.6 The MSS Caucus may not take positions that are contrary to existing MSS policy."

In an effort to make this report more usable and enduring for institutional memory purposes, the 2023-24 Section Delegates structured this report such that it contained only links to all resolutions and the final

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recommendations from the annotated Reference Committee reports. Your 2024-25 Section Delegates streamlined this report's structure in an effort to wield this as a tool to improve the institutional memory of the MSS. Your 2025-26 Section Delegates have utilized a similar structure for this report and continued the newer format provided in the previous Delegate report, SD-A-A-25. We have updated the MSS Archive of HOD Proceedings (colloquially referred to as "the Membrick"), which is publicly available to all MSS members (current and future) and will contain records of all HODs moving forward in a single easily accessible location. In efforts to continue to streamline this report, the Membrick link is provided to serve as an official record of HOD proceedings.

MSS RESOLUTIONS AT HOD A-25

The MSS transmitted a total of **21** resolutions to the House of Delegates. Outcomes are as follows:

- Adopted: **6**
- Adopted as Amended: **10**
- Adopted in Lieu: **1**
- Referred for Decision: **0**
- Referred for Study: **2**
- Reaffirmed in Lieu: **1**
- Not Adopted: **1**

The following MSS resolution was immediately forwarded by the MSS A-25 Assembly. This was considered on time under AMA Bylaw 2.11.3.1.2, "Resolutions - AMA Sections." This resolution is included in the statistics above.

- 121 - Opposing Pharmacy Benefit Manager Spread Pricing

As part of our ongoing efforts to establish and strengthen connections with other delegations, the MSS was able to successfully route five (5) resolutions that have previously passed the MSS Assembly through other delegations for transmission to the A-25 House of Delegates meeting. Of these, the MSS Caucus voted to co-sponsor Resolution 402-A-25, which was primarily sponsored by the American Association of Public Health Physicians (AAPHP). The remaining four resolutions were not co-sponsored by the MSS. While not officially listed as co-authors on these resolutions, the MSS gave these resolutions the same degree of support given to other MSS-authored items. Of these five resolutions, two (2) were ultimately Adopted and three (3) were Adopted as Amended. These items are as follows:

- 004 - Reducing the Harmful Impacts of Immigration Status on Health
- 118 - Improving Access to Peripartum Pelvic Floor Physical Therapy
- 215 - Support for Changing Standards for Minors Working in Agriculture
- 402 - Protecting In-Person Prison Visitations to Reduce Recidivism
- 415 - Promoting Child Welfare and Communication Rights in Immigration Detention

Due to exigent circumstances during the Annual Meeting (the sudden dismissal of all members of the Advisory Committee on Immunization Practices, or ACIP, by the Secretary of Health and Human Services on June 9th, 2025), a large coalition of delegations submitted an emergency resolution for consideration. MSS Caucus voted to co-sponsor this resolution, which was ultimately accepted as business and adopted as written by the AMA House of Delegates on June 10th, 2025.

- Emergency Resolution 1001 - Advisory Committee on Immunization Practices

The MSS Archive of HOD Proceedings contains the final HOD Actions taken pursuant to each MSS-authored and MSS-originated resolution as their final outcome. For all MSS resolutions, the MSS Delegates supported the items as their original authors. Items that were successfully transmitted through other delegations were similarly supported. Resolutions are listed in order of HOD Reference Committee, with the eight resolutions transmitted through other delegations, as well as the resolution that was not considered at the meeting, listed at the end. Each resolution is linked to its original transmittal. Each outcome is linked to the final outcome in the HOD Annotated Reference Committee Reports, its final language in PolicyFinder, or other outcome, as applicable.

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NON-MSS ITEMS AT HOD A-25
There were **233** items of business at the HOD A-25 Meeting, including informational reports. Of these, one emergency resolution was considered, four late resolutions were considered, and three late resolutions were not considered; ultimately resulting in **230** items of business considered at this meeting. Of the **219** items considered that were not officially authored or co-sponsored by the MSS, the MSS took an active position on **92** items. The MSS Archive of HOD Proceedings contains the MSS actions and HOD actions for each item of business. Resolutions are listed in order of HOD Reference Committee. Each resolution is linked to its original transmittal. Each outcome is linked to the final outcome in the HOD Annotated Reference Committee Reports, its final language in PolicyFinder, or other outcome, as applicable.

MSS POSITIONS UPDATE
Furthermore, per clauses 9-11 of 630.044MSS "Review and Revision of the MSS Positions Compendium via the Sunset and Consolidation Mechanisms" (as modified by A-24 MSS GC Report A):

> "(9) in their report on the previous HOD's proceedings, the Section Delegates will recommend changes to any MSS positions that amend AMA Policy and were considered by HOD, in order to summarize the amendment's ask and simplify the language; and
>
> (10) any MSS positions written as "MSS will ask the AMA" will be automatically converted to past tense ("asked the AMA") after consideration by HOD as either a resolution or an amendment; and
>
> (11) any MSS position (or portion of a position) requesting an AMA or MSS study will automatically sunset after the study is completed by either the AMA or MSS or after consideration of the study request by HOD."

Your Section Delegates have provided recommendations at the end of this report that propose modifications to MSS positions in accordance with the actions taken at the Annual 2025 Meeting of the AMA House of Delegates. Please note that your Section Delegates have incorporated MSS positions that will be converted to the past tense in accordance with Clause (10) of 630.044MSS for the sake of completeness and transparency. However, we acknowledge that future versions of this report need not include these recommendations, as they will be implemented automatically.

In addition to the MSS Digest of Policy Actions, your Archives Task Force has created the MSS Positions Compendium, intended to be a living, searchable document containing updated current and rescinded MSS policy stances. Additionally, we direct you to the MSS Positions Outcomes Archive, which provides a longitudinal history of the outcomes of MSS positions and actions.

RECOMMENDATIONS:

Your MSS Section Delegates recommend the adoption of the recommendations for MSS positions outlined in Appendices A and B of this report and the remainder of the report be filed.

ACKNOWLEDGEMENTS
Your Section Delegates would like to extend our gratitude to our incredible A-25 MSS Caucus RefCom Leads as listed at the beginning of this report who assisted in updating the "Membrick" on HOD proceedings for their respective Reference Committees. We would also like to extend our profound gratitude to Sarah Langill, our MSS Policy Analyst, for being amazing, as always.

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APPENDIX A – RECOMMENDATIONS FOR MSS POSITIONS

RECOMMENDED FOR RETENTION WITH AMENDMENTS: PAST TENSE

Your MSS Section Delegates recommend that the external asks of the following MSS positions be converted to the past tense to reflect their transmittal to and consideration by the AMA House of Delegates:

1. 140.046MSS Military Deception as a Threat to Physician Ethics
2. 550.011MSS Use of Inclusive Language in AMA Policy
3. 295.247MSS Humanism in Anatomical Medical Education
4. 100.036MSS Opposing Pharmacy Benefit Managers Spread Pricing
5. 345.026MSS Supporting Aged-Out Foster Youth with Mental Health and Psychotropic Needs
6. 200.022MSS Distribution of Resident Seats Commensurate with Shortages
7. 460.030MSS Opposing Unwarranted NIH Research Institute Restructuring
8. 295.249MSS Addressing Misuse of Professionalism Standards in Medical Training
9. 310.062MSS Improvements to Burnout Prevention Programs
10. 460.028MSS Research of Plastic Use in Medicine
11. 60.049MSS Advocating for Universal Summer Electronic Benefit Transfer Program for Children (SEBTC)
12. 150.046MSS Advocating for Plant-Based Meat Research and Regulation
13. 440.134MSS Standardizing Safety Requirements for Rideshare-Based Non-Emergency Medical Transportation
14. 150.050MSS Allergen Labeling for Spices and Herbs
15. 315.006MSS Improving Cybersecurity in Healthcare Facilities
16. 120.019MSS Increased Transparency in Psychotropic Drug Administration in Prisons
17. 460.021MSS Researching Drug Facilitated Sexual Assault Testing
18. 105.005MSS Transparency on Comparative Effectiveness in Direct-to-Consumer Advertising
19. 540.003MSS Advisory Committee on Tribal Affairs
20. 65.074MSS Protecting in-person Prison Visitations to Reduce Recidivism
21. 65.076MSS Reducing the Harmful Impacts of Immigration Status on Health
22. 420.023MSS Improving Pelvic Floor Physical Therapy Access for Pregnancy
23. 365.010MSS Support for Changing Standards for Minors Working in Agriculture
24. 440.133MSS Promoting Child Welfare and Communication Rights in Immigration Detention

RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE (TABLE 1)

Your MSS Section Delegates recommend that the following MSS positions be amended to update language, summarize language asking to modify AMA policy, and reflect their transmittal to and consideration by the AMA House of Delegates:

1. Resolution 217-A-25 (Troubled Teen Industry) modifies H-60.896.

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APPENDIX B

TABLE 1: RECOMMENDED FOR RETENTION WITH AMENDMENTS: SUMMARIZE AND/OR UPDATE LANGUAGE			
Position #	**Title**	**Original Position**	**Final Summarized Language & Rationale**
60.048MSS	Regulation and Oversight of the Troubled Teen Industry	AMA-MSS will ask that our that our AMA amends "Youth Residential Treatment Program Regulation (H-60.896) by addition as follows: Youth Residential and Other Treatment Program Regulation 1. Our American Medical Association recognizes the need for licensing standards for all youth residential treatment facilities (including private and juvenile facilities) as well as other treatment facilities (including wilderness therapy programs and other programs aimed at treating behavioral and mental health issues in youths) to ensure basic safety and well-being standards for youth. 2. Our AMA supports recommendations including, but not limited to, patient placement criteria and clinical practice guidelines, as developed by of nonprofit health care medical associations and specialty societies, as the standard for regulating youth residential treatment and other relevant youth programs. 3. Our AMA opposes the use of any non-evidence-based therapies and abusive measures in Youth Residential and Other Treatment Programs and supports that only appropriately qualified and certified child and adolescent medical and mental health professionals provide services to participants, and support oversight and review by licensed physicians, mental health professionals, and any other appropriate healthcare professionals 4. Our AMA supports efforts to improve information sharing between states on promising practices for preventing and addressing maltreatment in residential facilities.	AMA-MSS asked the AMA to amend "Youth Residential Treatment Program Regulation (H-60.896) by addition as follows: Youth Residential and Other Treatment Program Regulation 1. Our American Medical Association recognizes the need for licensing standards for all youth residential treatment facilities (including private and juvenile facilities) as well as other treatment facilities (including wilderness therapy programs and other programs aimed at treating behavioral and mental health issues in youths) to ensure basic safety and well-being standards for youth. 2. Our AMA supports recommendations including, but not limited to, patient placement criteria and clinical practice guidelines, as developed by nonprofit health care medical associations and specialty societies, as the standard for regulating youth residential treatment and other relevant youth programs. 3. Our AMA opposes the use of any non-evidence-based therapies and abusive measures in Youth Residential and Other Treatment Programs and supports that only appropriately qualified and certified child and adolescent medical and mental health professionals provide services to participants, and support oversight and review by licensed physicians, mental health professionals, and any other appropriate healthcare professionals 4. Our AMA supports efforts to improve information sharing between states on promising practices for preventing and addressing maltreatment in residential facilities.

REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

MSS GC Report
(I-25)

Introduced by: Kaylee Scarnati, MSS Chair

Subject: MSSAI Report

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

Pursuant to 645.031MSS, the following informational report details the actions taken by your Medical Student Section Governing Council (MSS GC) in response to submitted Medical Student Section Action Items (MSSAIs). The MSS GC aims to ensure that member voices are heard throughout the MSS and provides the Medical Student Section Action Item Request Form to allow any member to submit ideas or concerns they would like to be addressed by the MSS GC. Upon receipt of an MSSAI, the MSS GC will meet to discuss the request and respond to the author individually with the course of action to be taken in response to their submission. The status of all GCAIs that have been submitted since the Annual 2025 meeting are detailed in the report below. The status of MSSAIs submitted prior to the Annual 2025 meeting can be found in the MSSAI digest located on the Medical Student Section Action Item Request Form webpage linked above.

There were 10 MSSAIs submitted between June 2025 and October 2025 when this report was finalized.

Support HR: Direct MSS leadership to request that the AMA Litigation Center write a letter in support of H.R.2850 as it is currently written to the chair the House Transportation and Infrastructure committee, emphasizing the positive impact on public health the bill will have. I do not currently have important dates to provide due to the government shutdown.

Action: Pending GC vote.

Submitted: 10/5/2025

Litigation Center Amicus Brief on Healthcare Tariffs: Direct MSS leadership to urgently request that the AMA Litigation Center file an amicus brief in V.O.S. Selections, Inc. v. United States, delineating the impact of tariffs on healthcare costs, supply chains, and patient access.

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Action: The MSS GC voted to forward this request on to AMA staff. Pending staff response.

Submitted: 09/15/2025

Protecting Harm Reduction Programs: We urge our American Medical Association to send a letter to the Secretary of Health and Human Services (HHS) advocating for the preservation of harm reduction programs to decrease rates of overdose death and the transmission of communicable disease. We ask our American Medical Association Litigation Center to re-join United States v. Safehouse (remanded to district court) in support of Safehouse. We urge the President of the American Medical Association (AMA) to post a public statement or short-form video expressing the AMA's concerns about the impact of the executive order on harm reduction and evidence based substance-use management to social media.

Action: The MSS GC voted to forward this request on to AMA staff. Pending staff response.

Submitted: 08/27/2025

Federal Investigations: The physical presence of federal investigation-affiliated officers should be determined by physical need, and not used for the purposes of censorship. In line with this concept, it should also be possible to establish that the presence of plainclothes federal investigation-affiliated officers is not necessary in medical schools (eg. harvard) as it may affect student learning and experiences with co-workers. Thus, opposing the presence of plainclothes federal investigation-affiliated officers in medical schools, hospitals and involvement in medical decision making would improve transparency and trust in medical care. Physical presence should also be appropriate for the person and resource allocation needs - ie it shouldn't be in excess of the minimum necessary, and if such costs are deflected onto taxpayers, there should be cost transparency with clear rationale in advance.

Opposing utilizing institutionalization (e.g. hospitals, prisons) or deportation as venues for federal investigations that don't qualify for a subpoena is contradictory and lends to inherent power dynamics in the situation and delays if individuals do not "qualify" for institutionalization. In such situations a subpoena or access to due process should be made possible if it has been more than a certain timeframe (eg 60 days). This would improve efficiency in the future, and rather than being left in a state of limbo that also unnecessarily extends time. With hospitals, someone can only present to the hospital with a valid concern, asking someone to engage in self-injury or perjury in reporting symptoms, or asking others to subject someone to involuntary hospitalization is unethical and their objection to doing so is not a crime, particularly when federal investigations are the responsibility and purview of the agency and can be conducted through other means and would be supported by AMA policy D-160.921.

Action: The MSS GC voted to forward this request onto AMA staff. Pending staff response.

Submitted: 08/27/2025

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Transportation Regulations: The specific advocacy target for this request is to advocate for regulations to improve transparency in flight destination and verification of citizenship or legal resident status should be conducted at airports or borders to prevent such deportation, and undocumented immigrants should have access to due process.

Action: The MSS GC voted to not forward this request onto AMA staff. While the MSS GC strongly agrees with the sentiment provoking this MSSAI submission, it was felt that overall the scope of the requests was outside the expertise of the AMA. The GC also notes that other MSSAIs which focus on the broader, health-centered impacts on immigration health are currently being pursued.

Submitted: 08/27/2025

Opposing Federal Student Loan Caps that Restrict Access to Medical Education: We urge our AMA to publicly oppose federal legislation or regulations that cap or eliminate access to graduate and professional loans. Specifically, we call on the AMA, using the evidence provided in this brief, to advocate for legislative changes that reverse or amend the harmful student loan provisions within H.R.1, “One Big Beautiful Bill Act.” We further urge the AMA to explore potential legal challenges to the federal loan caps established under H.R.1.

Action: The MSS GC voted to forward this request onto AMA staff. AMA has been very vocal in opposing the harmful student loan provisions included in H.R. 1through letters to Congress, public comments to the Department of Education, advocacy updates on the AMA website and social media, and even remarks at Annual—all underscoring that the cost of medical education should never be a barrier for future physicians. At this point, there aren’t any active legislative vehicles to reverse H.R. 1 directly, but the AMA is continuing to push for ways to ease the impact

Submitted: 08/22/2025

Protecting NIH/CDC Funding: AMA should: 1) oppose unilateral executive control over CDC/NIH grants; 2) resist consolidating CDC/NIH agencies into new entities; and 3) lobby for a federally recognized panel of health and economic experts with authority to approve or reject congressional or presidential funding cuts or reallocations affecting NIH and CDC.

Action: The MSS GC voted to forward this request onto AMA staff. The first ask cannot be accomplished because the CDC and NIH are agencies within the Department of Health and Human Services (HHS), which is part of the executive branch. By design, these agencies operate under executive branch oversight; however, the AMA will advocate against harmful executive actions toward these branches.The second ask is in the works after Res 219 at

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Annual 2025 titled “Opposing Unwarranted National Institutes of Health Research Institute Restructuring” was passed. The AMA is actively monitoring HHS and relevant government agency communications for any updates on potential restructuring and will act when a restructuring proposal is formally introduced. The third ask is not realistically achievable and there is no legislative vehicle for the AMA to pursue this ask.

Submitted: 08/21/2025

Humanitarian Aid and Protection of Healthcare in Gaza: We urge our American Medical Association to write a letter to the House Committee on Foreign Affairs expressing support for H.Res.473 (Calling for the urgent delivery and disbursement of humanitarian aid to address the needs of civilians in Gaza).
We urge our American Medical Association to write a letter to the Senate Committee on Foreign Affairs expressing support for S.898 (UNRWA Funding Emergency Restoration Act of 2025) and S.Res.224 (Calling for the urgent delivery and disbursement of humanitarian aid to address the needs of civilians in Gaza).
We urge the AMA to write a letter to the U.S. Secretary of State to express the AMA’s concerns and ask the Secretary to intervene to allow humanitarian aid into Gaza, preserve healthcare infrastructure, and protect physicians and humanitarian aid workers.
We urge the AMA to post a public statement or short-form video expressing the AMA’s concerns about the impedance of large scale life-saving humanitarian aid and the attacks on healthcare workers and health infrastructure in Gaza to social media.

Action: The MSS GC voted to send this request forward. Pending staff response.

Submitted: 08/11/2025

Student Member of Repro Justice Task Force: Request a student member of the task force to preserve the patient physician relationship.

Action: The MSS GC voted to forward this request onto the task force. A student member will not be added to the task force at this time, but updates will be provided to the MSS GC by the Board of Trustees liaisons.

Submitted: 07/14/2025

COVID-19 Vaccines for Children/Pregnant Women: The AMA should join as a plaintiff in AAP et al. v. RFK Jr. et al. (Case 1:25-cv-11916), seeking an injunction against the removal of the COVID-19 vaccination for healthy children and healthy pregnant women from the CDC

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recommended immunization schedules. Failing this, the AMA should file an amicus curiae brief in strong support of the plaintiffs.

Action: The MSS GC voted to forward this request onto AMA staff. Staff is waiting for further developments in this case on timing, including discussions with other Federation partners and the plaintiffs in this case. Staff will follow the case and monitor any opportunity in the coming weeks or months to file a brief.

Submitted: 07/08/2025

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REPORT OF THE MEDICAL STUDENT SECTION
RESOLUTION TASKFORCE

RTF Report
(I-25)

Introduced by: MSS Resolution Task Force

Subject: Resolution Taskforce Interim Report

Referred to: MSS Reference Committee
(Andrew Norton and Druv Bhagavan, Co-Chairs)

INTRODUCTION

Mission Statement:

The 2025–2026 MSS Resolution Task Force is dedicated to evaluating and improving the MSS policy and archiving processes to enhance clarity, continuity, accessibility, and long-term impact.

Objectives:

Pursuant to MSS Position 645.032MSS(10), the 2025-26 MSS Governing Council is reconstituting the Resolution Task Force (RTF) to review the implementation of MSS positions 645.032MSS and 645.033MSS and evaluate the MSS policy process more broadly. Additionally, the MSS GC is charging this Resolution Task Force with reviewing both MSS Assembly and HOD formal archiving processes to establish clear lines of responsibility, ensure longitudinality and preservation of institutional knowledge, and enable contemporary MSS membership and leadership to access appropriate information easily.

- Review the implementation of 645.032MSS and 645.033MSS
- Ensure appropriate coincidence of MSS IOPs and the current practices of the MSS policy-making process, including making changes to the IOPs where necessary
- Formalize the MSS Archiving process for both MSS Assembly and HOD by:
    - Standardizing the process for archiving policy and actions relevant to the MSS
    - Outlining this process such that there exist clear instructions that allow for efficient archiving by future members
    - Delineating clearly what individuals or groups are responsible for completing each aspect of the archiving process, including training of these individuals or groups on how to complete their archiving responsibilities
    - Optimizing the archiving process ensures the efficiency of archiving efforts and makes archived resources easily accessible to the general membership.
    - Defining the extent to which the MSS will back-archive

Structure & Representation on the Task Force:

The Task Force will be made up of nine voting members selected by the Task Force Co-Chairs and four non-voting members, including the Task Force Co-Chairs, the MSS Councilor on Constitution and Bylaws, and the MSS Counselor on Long Range Planning and Development. The 9 voting members will be at-large members from across the Section selected by the Co-Chairs.

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Responsibilities:

Attendance and Active Participation:

Members of the RTF are required to attend discussion meetings where the RTF will formulate its recommendations. Active participation is crucial in shaping the future of our policy and archiving processes. The RTF will convene approximately 5 times between August 2025 and November 2025 to finalize the preliminary report for I-25. During these meetings, the group will also determine a schedule for incorporating feedback into the final report, which is due at A-26. If a member is unable to attend a meeting, it is mandatory to communicate the absence in advance to the Co-Chairs.

Proposal and Recommendation:

Based on the feedback and research conducted, the RTF will propose recommendations for improvements to methods and systems to improve the MSS policy process, preserve institutional memory, and track actions and outcomes. The RTF will make recommendations on the implementation of these strategies to the MSS Assembly.

Collaboration:

The RTF will collaborate with the AMA MSS Governing Council, the Government Relations and Advocacy Fellow, the Student Board of Trustees Member, Standing Committee Leadership, Region Leadership, AMA Staff, and other relevant stakeholders to ensure comprehensive tracking, reporting, and archiving of MSS actions and outcomes.

Task Force Duration & Reporting:

The MSS GC will consider the Task Force's recommendations and will jointly produce a report with the Task Force for the 2026 Annual Meeting detailing those recommendations, the associated rationale, and any recommended changes to the MSS Positions Compendium or the MSS Internal Operating Procedures (IOPs).

BACKGROUND

The MSS Resolution Process encompasses multiple facets, involving a variety of individuals and steps. The following sections break down these individuals and steps to define, explain, and showcase each of them.

Previous Resolution Taskforce Reports

There have been several resolution taskforces in the past. The reports generate from those task forces are provided below:

- A-23: MSS GC Report B_Report of the 2023 Resolution Task Force
- A-22: MSS GC Report X - Resolution Task Force Update 2022.pdf
- A-18: 2018 RTF Report.pdf

Roles and Responsibilities

Section Delegates

The Section Delegates (SDs) oversee and coordinate the MSS policy process in conjunction with the AMA-MSS Policy Analyst Staff member. This includes the development, implementation, and coordination of the MSS policy cycle where MSS members can submit resolutions for consideration at the MSS assembly. The SDs also represent the MSS at the AMA House of Delegates where they are responsible for

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transmitting adopted MSS resolutions and leading the MSS Caucus in representing the stances of the MSS on all items of business.

MSS Caucus

MSS Caucus is composed of MSS members who are elected or selected to serve as voting members in the AMA House of Delegates (HOD) meetings on behalf of their Region or another representative organization. A majority of MSS Caucus members are Regional Delegates (RDs) and Region Alternate Delegates (ADs) who are elected by their Region and serve as representatives for the MSS at the House of Delegates. Other medical student members who are chosen to represent organizations besides the MSS (ie, state medical societies, specialty societies, etc.) in HOD may also be invited by the SDs to join the MSS Caucus as voting members. These individuals assist the MSS policy process by reviewing and providing input on resolutions and reports throughout both the MSS and HOD policy processes. MSS positions guide the actions of the Section Delegates and MSS Caucus in the House of Delegates. Where no relevant or unambiguous MSS positions exist, the MSS Caucus may determine stances by a two-thirds (⅔) vote.

Bonus Caucus

Bonus Caucus members are non-voting members of Caucus composed of non-RD/AD members, including but not limited to IMPACT Analysts, Councilors, Past/Present Governing Council, AMA-MSS liaisons to external organizations, and experienced MSS members. These individuals also assist the MSS policy process by reviewing and providing input on resolutions and reports throughout the policy process to prepare for both MSS and HOD meetings.

Region Policy Chairs

Region Policy Chairs (RPCs) help coordinate and run region-specific efforts in relation to the MSS policy process. They oversee and guide region policy committees and region members in determining stances for each resolution/report based on region-specific bylaws, discussions, and votes, and share them through testimony on the virtual reference committee and during the MSS Assembly.

Standing Committees

Standing Committees are topic-based groups within the MSS, composed of approximately 40 members, including 1 Chair and 3 Vice Chairs who work on programming, resolution review, and report writing based on their topic(s). Standing Committees are roughly analogous to AMA Councils. The Standing Committees' existence and purview are determined by the Governing Council and/or by action of the MSS Assembly, and their operation is primarily coordinated by the MSS Vice-Chair. Currently, Standing Committees within the MSS assist throughout the MSS policy process, similar to Caucus and Bonus Caucus, reviewing and providing input on MSS resolutions and reports. They focus on resolutions/reports relevant to the topics covered by the Standing Committee. For example, the Committee on Science and Technology (CST) covers MSS resolutions within its special focuses including mobile and digital health applications, health information management, climate change, pharmaceutical development, and sports. Pursuant to this description, recent resolutions assigned to CST relate to electronic medical records, AI in medicine, and energy policy. Furthermore, CST is assigned to complete reports for resolutions referred to study by the AMA-MSS that fall within its purview. At A-25, Resolution 432 "Mandatory Gluten Labeling in Medications, Supplements, and Herbal Remedies" was referred to study. MSS

Governing Council routed this item to CST and directed it to complete a report with recommendations to be presented to the MSS Assembly at I-25.

External Organization Representation in the MSS Assembly

- **National Medical Student Organizations (NMSOs)** (e.g. APAMSA (Asian Pacific American Medical Student Association) are national-level groups that bring together medical students from across the country to advocate for medical education improvements, professional development, and collaborative activities within the medical community.
- **National Medical Specialty Societies (NMSSs)** are organizations that represent physicians within specific medical specialties at a national level, working to advance professional standards, provide educational resources, advocate for their specialty, and shape healthcare policies and practice guidelines to improve patient care.
- **Federal Services** includes medical professionals serving in the U.S. Army, Navy, Air Force, Public Health Service, and Department of Veterans Affairs, where they provide healthcare to service members, veterans, and the public through specialized medical branches and facilities across these agencies.
- **Professional Interest Medical Associations (PIMAs)** (e.g., American Physician Scientists Association) are organizations that connect physicians according to shared factors such as ethnicity, culture, demographic background, or minority status, rather than by specialty or geographic region, to promote collaboration, advocacy, and support related to those specific interests.
- Of these groups, those that have established a medical student component are entitled to representation in the MSS Assembly at a rate of one voting representative and one non-voting alternate representative per organization.

Resolutions

A resolution is a formally structured proposal submitted by MSS members that requests the MSS to take a specific position or action on an issue, organizational policy, or advocacy effort relevant to the AMA's mission. The resolution contains at least one directive to act or establish a new/amended position (known as "resolves" or "resolved clauses"). It is accompanied by supporting statements and facts addressing an identified problem, the rationale for action, and a proposed solution (known as "whereas clauses"). The resolution is drafted based on the following template: https://www.ama-assn.org/system/files/mss-resolution-template.docx.

Examples of previous MSS resolutions can be found in the MSS Resolutions Outcomes Archive (Under Construction).

Resolutions are member-submitted items of business that propose AMA or AMA-MSS action or policy, either as internal MSS positions or as external asks for the AMA House of Delegates. They must be novel, timely, impactful, feasible, and evidence-based. While resolutions are no longer used to reaffirm existing MSS policy, MSS resolutions with external asks can still request that HOD policy be reaffirmed. Furthermore, the HOD can reaffirm policy in lieu. Once posted to the Virtual Reference Committee (VRC), resolutions become MSS property and cannot be altered except by action of the MSS Assembly. Section Delegates retain the authority to nominate existing MSS positions for transmittal to the AMA HOD when strategically advantageous, with approval by the MSS Caucus.

The policy process follows a structured workflow. Authors post ideas during the Open Forum (an online forum accessible to MSS members) to receive feedback from Region Delegates, Standing Committees, and IMPACT Analysts (formerly HCC members), as

well as any MSS member who chooses to comment on the Open Forum. Throughout the policy process, the Section Delegates may forward MSS resolution ideas to relevant AMA staff and specialty societies to solicit feedback, which may benefit MSS authors in developing their resolution idea. First drafts are then submitted formatted as resolutions, and each draft undergoes a thorough review and commentary process, similar to that of the Open Forum. Resolutions that are submitted as final drafts are then posted to the Virtual Reference Committee (VRC) for a specified period of time in which testimony may be provided in an online forum (similar to the MSS Open Forum and the HOD Online Reference Committee forums). This testimony, all previous review materials, and any additional feedback from external entities are then reviewed by the MSS Reference Committee, which subsequently issues a consent calendar report with recommendations for each item, such as Adopt, Amend, Refer, or Not Adopt. Members of the MSS Assembly (including delegations) may extract any item from the report for further discussion on the floor of the MSS Assembly. Extracted items are removed from the MSS Reference Committee's consent calendar and become items of business.Typically, the remaining non-extracted recommendations on the consent calendar are then ratified as the first order of business of the MSS Assembly. The remaining business of the MSS Assembly meeting is ordered by their appearance in the Reference Committee Report, which orders items by recommendation and resolution number.

Recent reforms consolidated existing MSS positions governing the policy cycle into a new omnibus "MSS Policy Process" to streamline procedures and improve flexibility. This policy requires Section Delegates to set timelines, ensure broad stakeholder input, and maintain a public resolution template. Submissions that meet deadlines and formatting rules cannot be rejected on the basis of content (except if determined to no longer be germane to the original submission by the MSS Speakers), and the MSS Internal Operating Procedures and the MSS Positions Compendium must be updated online within two months of each meeting.

Reports

A report is a formal, detailed document prepared by MSS committees or governing councils that provides analysis, recommendations, and/or updates on specific medical, policy, or organizational issues. Reports serve to inform the MSS during policymaking meetings, offering data, background review, expert opinion, and suggested courses of action for discussion and possible adoption. Reports are composed based on the following template: MSS Committee Study Template. Standing Committee reports organize their evidence-based arguments into whereas clauses (similar to resolutions) and present recommendations (which are analogous to resolves). Examples of previous reports can be found within the "MSS & HOD Reports" tab of the Microbrick, the MSS Archive of HOD Proceedings ("Membrick"), and the MSS Resolutions Outcomes Archive (Under Construction). Reports are generally completed by the Governing Council or Standing Committees (i.e., "studies" from referred resolutions). Following the Standing Committee Taskforce at A-24, standing committees are no longer able to "self-generate" reports (develop a report without a directive from the MSS Assembly to do so) without the Governing Council's approval.

Microbrick

The "Microbrick" is a shared resource that provides all MSS members with rapid access to resources and information about the MSS, as well as resolutions/reports in progress and feedback received. The Microbrick is constantly updated so that individuals can engage with the resolutions/reports throughout the policy process. The I-25 Microbrick

can be found at the following link: I-25 MSS Microbrick. Furthermore, individual Regions, Standing Committees and other entities may also create and operate their own Region- or committee-specific microbrick optimized for their own internal use. By consolidating policy drafts, reviewer assignments, reference committee reports, and author resources onto one platform, the MSS Microbrick promotes transparency and facilitates collaboration across regions and standing committees while providing rapid access to educational tools such as templates and author guides for new members. The Microbrick is maintained by the Section Delegates, other members of the Governing Council, and AMA-MSS Staff, and is updated in real time during the policy cycle and business meetings to reflect Assembly actions. The name microbrick comes from electronic consolidation of the paper version of this resource which was referred to as "the brick" due to its size.

Policy Process

General MSS Resolution Process

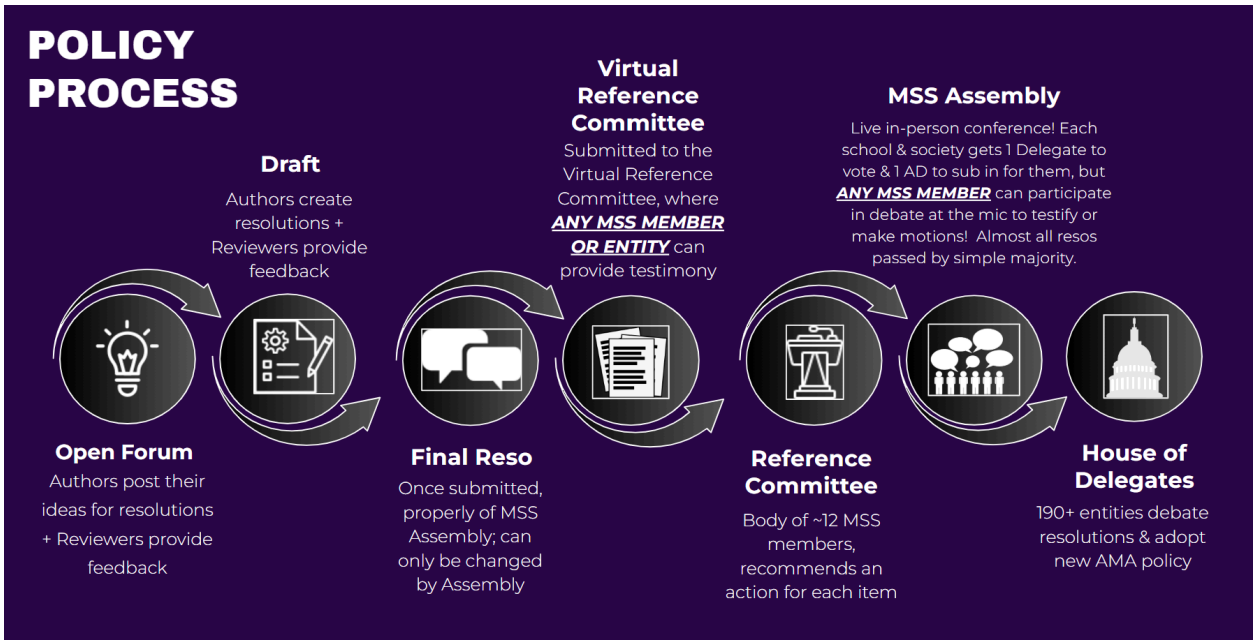

Figure 1: The AMA-MSS Policy Process

The current MSS Resolution/Report Process follows the figure above with some additions and exceptions. External resolutions (i.e. those being sent to HOD) adopted by the MSS Assembly are typically transmitted for consideration by the full AMA House of Delegates either at the next AMA Meeting (i.e., passed by MSS Assembly at A-25, brought to HOD at I-25) or at the discretion of the SDs and Caucus; Per MSS-IOP 10.8.7:

- Once resolutions with external asks are adopted by the MSS Assembly, they must be submitted in the name of the MSS to the AMA HOD meeting within one year of adoption at the Section Delegates' discretion, unless withdrawn from the queue by the MSS Assembly or directed by the MSS Assembly to be submitted at a specific AMA HOD meeting. Transmittals may be delayed up to one additional year, by a two-thirds (⅔) vote of the MSS Caucus, taken prior to each additional meeting."
- Note that the Resolution Committee (AMA Bylaw 2.13.3) has the power to determine which resolutions are accepted for consideration at each AMA Interim Meeting, based on criteria of advocacy and legislation (and, in practice, urgency and ethics). Items slated

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not for consideration may be extracted and considered by majority vote of the House of Delegates. The MSS Caucus will determine the approach to MSS resolutions that are screened out. Any items that are not considered at the Interim Meeting are typically transmitted at the following Annual Meeting. This process is unique to the Interim Meetings and may impact the timeline of transmittals set by the procedures in MSS-IOP 10.8.7.

Exceptions to the policy process described above include:

- Items Referred for Study

  Resolutions or reports that are referred to study, or those that explicitly call for the creation of a report, are assigned to the appropriate standing committees by the GC, are written by the GC, or are assigned to a Task Force or other ad hoc committee. Items referred for study by the MSS Assembly are not transmitted to the HOD, even if they contain external requests. A report with recommendations is then submitted for consideration to the MSS Assembly, generally within 6 months to a year. MSS reports undergo the same review process as submitted resolutions, with the exception of certain Governing Council and Task Force reports. The MSS Assembly will then vote on the recommendations. Depending on the nature of the recommendations, once adopted, the recommendations may be transmitted to HOD as a resolution, become an internal MSS position, or be filed (if there are no recommendations).

- Late and Emergency Resolutions
  - Late resolutions and emergency resolutions for the MSS Assembly are governed as described by MSS-IOP 10.8.3 and 10.8.4, respectively. Late and emergency resolutions may bypass one or more steps preceding the Annual or Interim meetings, based on the precise timing of their submission.
  - Late resolutions are those which are submitted beyond the published policy process deadlines set by the Section Delegates but prior to the start of the MSS Assembly. The AMA-MSS Rules Committee is convened to recommend whether the late resolutions meet the criteria described by the IOPs for a late resolution. Late resolutions that are not recommended for consideration by the Rules Committee may be considered as items of business by a two-thirds vote of the MSS Assembly.
  - Emergency resolutions are those that are submitted after the start of the MSS Assembly. Emergency resolutions do not undergo Rules Committee review and are only accepted for consideration as business if 3/4 of the voting delegates present vote to accept them as business.

- Immediate Forward Clauses

  The MSS Assembly has the power to direct the Section Delegates to immediately forward (IF) a resolution for consideration by the HOD at the same meeting in which the MSS Assembly passes the resolution. The ability to immediately forward a resolution without it being considered as a late resolution by the HOD is reserved for AMA Sections. A resolution of immediate relevance, such as one concerning active legislation in Congress or a significant world/national event co-occurring at the AMA Meeting, may be a resolution that the MSS Assembly chooses to immediately forward. For example, at A-25, Resolution 122, “Opposing Pharmacy Benefit Managers Spread Pricing,” was immediately forwarded to the A-25 House of Delegates Meeting due to a provision regarding pharmacy benefit manager spread pricing in HR1, the One Big Beautiful Bill Act, which at the time was being discussed in Congress. This resolution was considered, debated, and ultimately adopted by the AMA House of Delegates.

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- Internal MSS Positions

  A resolution submitted to be considered for adoption as an internal MSS Position will undergo the same review process as any other submitted resolution. However, upon passage by the MSS Assembly, it will not be transmitted to the AMA House of Delegates. Instead, it will directly enter the MSS Policy Compendium as an official MSS Position. There are generally two main reasons for a resolution to be considered only for an internal position. The first is that the resolution addresses MSS governance, functioning, or other operations that are not relevant to the larger AMA. The second is to develop MSS positions to guide the actions of the MSS Caucus on resolutions and reports considered by the AMA House of Delegates. This may occur for the MSS to develop a stance on a topic the MSS is aware of another delegation bringing forward at an upcoming conference or to develop a stance for potential future HOD consideration that may not be timely or appropriate for the MSS to bring up imminently. Of note, the MSS Assembly can also recommend that a resolution originally recommended for transmittal to HOD be considered as an internal MSS position instead. This can be done prior to the adoption of that resolution through the extraction and amendment process.

Reviewers

AMA-MSS Section Delegates (SDs) review these Open Forum posts to determine if posts meet minimum eligibility and formatting requirements and organize review processes. SDs have specifically assigned Region Delegates / Region Alternate Delegates (RDs/ADs), Standing Committees (SCs), IMPACT members, Councilors, past and present Governing Council members, and general MSS members to review Open Forum posts and provide feedback on impact, novelty, evidentiary support, alternative and parallel routes of advocacy, and any other relevant considerations. These individuals follow and provide feedback on the open forum posts throughout the resolution process, up to the Virtual Reference Committee closure. At this point, any MSS member can provide input on the resolutions. The Reference Committee then reviews and provides a report to the MSS, providing recommendations on each resolution, which is subsequently reported to the MSS Assembly. During extractions and MSS Assembly, any MSS member or group can extract and provide testimony on the floor of the MSS Assembly. The most significant policy change in comparison to the most recent report of the Resolutions Task Force in 2023 is the upcoming elimination of the House Coordinating Committee (HCC) and the Committee on Long-Range Planning (COLRP) from the MSS Internal Operating Procedures (IOPs) at the time of the next review. At A-23, HCC became part of the Impact, Policy, and Action Committee (IMPACT). The adoption of the Standing Committee Task Force report at A-24 transitioned the IMPACT standing committee to a group directly under the purview of the Section Delegates (rather than the Vice Chair) beginning after A-25. Moving IMPACT directly under the Section Delegates' purview has rendered the existence of the HCC obsolete, since IMPACT members are already expected to be present at House of Delegates meetings. As such, IMPACT should be considered to have assumed the role of HCC in the resolution process until HCC is officially phased out at the time of the next review of the MSS internal operating procedures.

Open Forum

The AMA-MSS policy process begins with the open forum, where prospective resolution authors post their ideas to facilitate collaboration and feedback before draft resolution submission. The open forum generally opens about two months after the conclusion of

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the prior national meeting (either Interim or Annual) and concludes approximately one month after opening. Any individual who desires to submit a resolution to the AMA-MSS in that policy cycle must post their idea to the Open Forum during that time. Only late and emergency resolutions are exempt, as detailed above. Open Forum posts are categorized by topic. Those topics are: Health Coverage, Civil Rights & Social Policy, Medical Education, Public Health, Science & Technology, Clinical Practice & Ethics, and AMA/MSS Finance & Governance. Resolutions will remain in these categories throughout the remainder of the policy process. Upon posting on Open Forum, any MSS member may comment on the post, adding suggestions, advice, and collaboration opportunities. After the closure of Open Forum, each resolution category detailed above is assigned 3-4 review captains, typically highly experienced RDs, ADs, and IMPACT members. The review captains lead a team of additional reviewers, consisting of RDs, ADs, State Delegates, IMPACT members, MSS Councilors, Standing Committees and members, and other relevant MSS parties and individuals. These reviews are compiled and presented to the authorship teams of the open forum posts through the review document shown here: AMA-MSS Open Forum Review TEMPLATE. In a typical cycle, ~100-150 eligible ideas are posted to the Open Forum; the A-25 cycle saw 159 eligible ideas posted to the Open Forum.

First Drafts

Resolution first drafts are submitted through a Google Form provided to Open Forum post authors. To submit their resolution, authors must certify that they have completed the requirements of the Draft Resolution Checklist. This checklist generally requires authors to review relevant MSS and AMA policy, resolution alternatives, AMA advocacy actions, and to understand the additional requirements that will need to be fulfilled later in the process. Resolution drafts are blinded by the AMA-MSS Policy Analyst to remove authorship names and are assigned by the SDs to Reviewers for review. The resolutions are then assigned to reviewers, consisting of RDs, ADs, State Delegates, IMPACT members, MSS Councilors, Standing Committees and members, and other relevant MSS parties and individuals, exactly the same as the Open Forum review with a similar review document. In addition, reviewers offer comments directly onto the draft resolution, providing more direct feedback for the authorship team to take into account when making revisions. The filled out review document and resolution with comments is then shared with the authorship team approximately 1 week after submission. Typically, approximately 50-120 eligible first drafts are submitted. For the A-25 cycle, 71 eligible first drafts were submitted and reviewed.

Final Resolutions/Reports

Final draft resolution submission follows a similar process to the first draft stage. Primary authors of resolutions are required to submit their final drafts through a Google Form provided to eligible draft resolution primary authors. Final resolutions are then posted to the Virtual Reference Committee (VRC) website.

Typically, anywhere from 40 to 80 eligible final resolutions are submitted. For the A-25 cycle, 48 eligible final resolutions were submitted.

Virtual Reference Committee (VRC)

The Virtual Reference Committee (VRC) is an online Reference Committee that allows any AMA-MSS member to provide written testimony on eligible final resolutions submitted through the MSS resolution process. The VRC generally stays open for approximately one to two weeks, after which time comments are sent to the Reference Committee for consideration.

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- All MSS Members & AMA-MSS and AMA Associated Groups

  All AMA-MSS members have the opportunity to publish their thoughts on the Virtual Reference Committee for the MSS Reference Committee to take into account when determining their suggested positions to the MSS Assembly. Standing Committees, National Medical Student Organizations (NMSOs), National Medical Specialty Societies (NMSSs), Councilors, Governing Council Members, and other associated AMA-MSS and AMA groups are also able to post their opinions on each resolution to the Virtual Reference Committee.

- Region Stances/Sponsorship

  Prior to A-24, the AMA-MSS Regions were able to “sponsor” a resolution, meaning that they could support the resolution through a formal process executed by the SDs. This process is similar to groups sponsoring resolutions within the House of Delegates, aiming to strengthen the argument for their adoption. At A-24, this process was changed to remove “sponsorship” and transition to “stances”. These Regional “stances” are similar to other MSS groups and associated organizations in that they can share the Region's opinions on VRC without directly linking the region to resolutions/reports. This streamlined the process by removing the additional “sponsorship” step, making Region’s VRC posts the same as those of other AMA and AMA-MSS groups and members.

External Feedback on MSS Resolutions:

Throughout the policy process, the SDs solicit feedback from delegations and AMA staff. This feedback may not be received in time to be posted on VRC. This feedback is included in the MSS Reference Committee Background Book for consideration during RefCom deliberations.

Reference Committee (RefCom)

The MSS Reference Committee is a convention committee composed of members of the MSS chosen by the MSS Speaker and Vice Speaker with input from the MSS Governing Council. The Speaker and Vice Speaker also select the Chairs and Vice Chairs of the Reference Committee. The members of the Reference Committee review all resolutions, all comments left on the VRC, and any testimony from outside groups or stakeholders in the AMA who may provide feedback. The Reference Committee makes recommendations for each item, including “adopt”, “adopt as amended”, “adopt in lieu of”, “refer for study”, or “not adopt”. Traditionally, “reaffirm in leu” was an additional outcome to resolutions/reports that were similar enough to the current AMA policy or AMA-MSS positions that they would functionally be covered under them. This was removed following A-23 given that the MSS does not have “policy”, but rather a “ position". Thus, “reaffirm in leu” was moved under “not adopt” since they functionally have the same outcome. These recommendations are collated into the Reference Committee Report by staff, which contains the Reference Committee recommendations for each item alongside the Reference Committee’s rationale. This report is made public, generally 1-2 weeks before the MSS Assembly.

Extractions

Upon the release of the RefCom Report, *any* MSS member may extract an item from the report for consideration and debate at the MSS Assembly. Following a successful trial, it is now standard to extract items virtually, through a Google Form available to the entire

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MSS. Virtual extractions may be done without any vote or discussion. Extractions are also permitted on the floor of the MSS Assembly with a majority vote. Regions and Standing Committees may also choose to extract items from the RefCom report. These decisions are generally made following a meeting of the Region or the Standing Committee. All extracted items are discussed on the floor of the MSS Assembly, in the order of business as determined by the MSS Speaker and Vice-Speaker.

MSS Assembly

The AMA-MSS Assembly is the principal policymaking body of the American Medical Association's Medical Student Section, convening biannually during the AMA Annual and Interim meetings to debate, amend, and adopt resolutions, elect leadership, and represent medical students in organized medicine. It is composed of delegates representing local campus sections, geographic regions, and recognized student organizations, enabling broad participation and direct input from medical students nationwide. Through its democratic processes, the Assembly shapes national student policy, advocates for educational and healthcare improvements, and develops future physician leaders within the AMA. During the MSS Assembly, resolutions and reports extracted prior to or during assembly are discussed and voted on, with the outcomes listed under "Outcomes". In order to make this a democratic process, parliamentary procedures are followed.

Parliamentary Procedures

The MSS follows Parliamentary Procedures in alignment with the HOD, which use those outlined by the American Institute of Parliamentarians Standard Code of Parliamentary Procedure Voting. The American Institute of Parliamentarians Standard Code of Parliamentary Procedure is a modern parliamentary authority designed for clarity, efficiency, and user-friendliness, simplifying meeting processes that the AMA utilizes for all official business. It provides a comprehensive, plain-language guide for conducting business, making motions, voting, and resolving procedural issues—ensuring fairness, equal participation, and effective decision-making for organizations of all sizes. The Standard Code emphasizes streamlined terminology, contemporary practices, and practical procedures for both in-person and virtual meetings, with the organization's bylaws taking precedence in any procedural conflict. The "MSS Parliamentary Procedure Survival Guide", that the MSS has continued to update and provide to the MSS Assembly over the last several years, outlines the specifics of this process as they relate to the MSS and other MSS-specific procedures to support members in guiding their actions during assembly.

Outcomes

Internal (MSS Position)

MSS resolutions/reports that are adopted as "internal" become part of the MSS Policy Digest and are considered "MSS Positions". These positions serve two primary purposes: (1) to address MSS governance, functioning, or other operations that are not relevant to the larger AMA or (2) to inform and direct the MSS Caucus on the stance the MSS should take on House of Delegates resolutions/reports transmitted by other delegations.

External/Transmittals (HOD)

MSS resolutions/reports that are "adopted", "adopted in leu", or "adopted as amended" and not considered internal are transmitted to the House of

Delegates at the discretion of the SDs. All of these are moved to the House of Delegates, with most being at the next House of Delegates (i.e. if adopted at Annual, likely to be brought forward at Interim) unless they do not match requirements to be submitted (i.e. Interim specific limitations on what resolutions can be submitted) or timing at the SDs discretion (i.e. increase the chances based on the timing of other resolutions).

Adopt

"Adopt" refers to a resolution/report being adopted without edits

Adopt In Lieu

"Adopt In Leu" refers to a resolution/report that has been significantly edited compared to the original version. This generally means that a resolve clause has been rewritten, removed, combined, or otherwise changed outside of minor edits. A substitute resolution is proposed in lieu of the original resolution.

Adopt as Amended

"Adopt as Amended" refers to a resolution/report whose resolves have been edited from the original language by addition and deletion. Generally, amendments that substantially change the language of a resolution (with the exception of the addition or removal of resolves) are instead presented as a substitute resolution that may be adopted in lieu of the original.

Not Adopt

"Not Adopt" refers to resolutions/reports that were not adopted by the MSS and will not become an internal MSS position or be transmitted to the House of Delegates. These also now include resolutions/reports that were traditionally considered "reaffirmation".

Referral

"Referral" assigns a resolution/report to the Governing Council to perform a study (or direct a standing committee, task force, or other ad hoc committee to do so) and write a report to be considered by the MSS Assembly at a time specific (generally within 6 months to 1 year).

Documentation of Outcomes

The outcomes of the MSS policy process are outlined in the Annotated RefCom Report and outcomes of HOD are reported in Delegate Report A (memebrick), which is considered for adoption at the next MSS Assembly as an informational report. In addition, the Archives Task Forces have worked to archive all MSS outcomes so that they can be followed across time by all MSS members.

- MSS Resolutions Outcomes Archive (Under Construction)

Resolutions/Reports that are Adopted, Adopted in Lieu, or Adopted as Amended

- All final resolved clause language adopted by the MSS assembly become MSS Positions and are input into the MSS Positions Compendium.
- "Internal" resolved clauses that direct "the AMA-MSS" to conduct a specific action or take a specific stance are recorded and MSS leadership is required to interpret and act on the position as appropriate.
- "External" resolved clauses that call upon "the AMA" to conduct a specific action or take a specific stance also become MSS Positions that are tracked in the MSS Positions Compendium. However, these Positions are also added to the transmittal queue that can be viewed on the Microbrick. The Section Delegates have the responsibility of overseeing their transmittal in a timely fashion and coordinates with the MSS Caucus to determine if the resolution should be sent

directly or held for consideration at the next HOD meeting. The Section Delegates will also coordinate the process to garner support for the transmitted MSS resolutions and provide the MSS Caucus with support to share information about the resolutions with their state and specialty society delegations as well. After a resolution has been transmitted, the associated MSS Position language is converted from "*Our AMA-MSS will ask the AMA*" to "*Our AMA-MSS asked the AMA*" to provide extra clarity to the status of the Position in our Positions Compendium. This is reported and voted on through the Delegate Report on HOD Policy Proceedings.

House of Delegates (HOD)

Resolutions with resolve clauses that would create or amend AMA policy, commonly referred to as "external resolutions", are transmitted to the House of Delegates after passage by the MSS Assembly. Per the MSS Internal Operating Procedures (IOPs), adopted external resolutions must be transmitted to the HOD as an MSS-authored resolution within one year of adoption by the Assembly unless a supermajority of the MSS Caucus votes to delay transmittal of the resolution for strategic reasons, which it may do for up to one additional year. The Section Delegates and the MSS Caucus are responsible for formulating strategy on MSS-authored resolutions and other items of interest to the MSS as guided by MSS internal positions. The Caucus testifies on items of interest to the MSS on virtual and in-person Reference Committees and the HOD floor. When necessary, the Section Delegates lead negotiations between the MSS and other delegations and stakeholders at the HOD. At all times, the MSS Caucus is obligated by the IOPs to advocate for MSS-authored resolutions to the maximum extent feasible.

As noted above, in current practice the Section Delegates frequently work with partner delegations to present MSS-authored items to the HOD so as to reduce the apparent total number of MSS-authored resolutions at each HOD meeting. When MSS-authored items are successfully presented at the HOD through a partner delegation, the Section Delegates report that transmittal in the Delegate Report on HOD Policy Proceedings. Adoption of the Delegate Report by the MSS Assembly certifies the transmittal as having accomplished the original external resolution. Extraction of the Delegate Report provides an opportunity to contest an alternatively-routed transmittal if the authors feel the transmittal did not faithfully address the original ask of the adopted external resolution.

Alternative Outcomes for Resolutions

Resolutions/reports that do not progress through the MSS policy process due to any reason can go through alternative routes.

MSS Action Item (MSSAIs)

MSSAIs are formal requests for the AMA or AMA-MSS to conduct a specific formal action. MSSAIs allow members to ask for the larger AMA to take action on issues where active AMA policy already exists via the MSS Governing Council. Additionally, members can use this form to request the MSS take a specific action within their scope such as host a formal educational session, develop or update an official resource, or consider a minor MSS process change. The submission form and digest (compendium) of prior action items are provided below:

- MSS Action Item (MSSAI) Submission
- MSS Action Item (MSSAI) Digest

Advocacy Referral System/Advocacy Toolkit

The Committee on Long Range Planning and relevant parties are currently piloting a new "Advocacy Referral System" to implement alternate routes of advocacy when a formal resolution or action request may not be the most effective pathway with a goal of scaling to a year round avenue for student's advocacy interests. This system is aimed toward supporting students with developing their own grassroots initiatives that do not utilize official AMA branding.

- Concept: Advocacy Pathway Referral System
- Referral Google Form

State Advocacy Collaborative

The goal of the State Advocacy Collaborative is to build connections between students who are working on similar advocacy goals and encourage resource sharing as well as cross region collaboration.

- ATF Report: State Advocacy
- [PUBLIC] State Medical Societies Collaborative

Sunset and Consolidation Mechanism

The MSS engages in a review of their internal positions every 5-10 years. In addition, consolidation of positions can be completed at any time through a consolidation report. These processes allow for the review of the internal positions to remove them (if they are no longer needed), combine (to reduce the size and number of positions), or retained (keep current position). Examples of the sunset process and a consolidation report are provided below:

- Landmark Reports:
  - A-24 GC Report A - Sunset Report:
    - This report conducted a major review and refinement of the Sunset Process and was adopted with amendments at the A-24 Assembly. The 2024 - 2025 GC elected not to undergo a formal sunset and consolidation review and the first new sunset review at A-26.
  - A-25 GC Report B_Sunset Report:
    - While the 2024 - 2025 GC elected not to produce a formal sunset report, they provided key amendments to ensure any MSS positions accidentally missed during review do not automatically expire and identified several MSS positions that had been previously missed to be included in the upcoming review.
- Example Ideal Consolidation Report:
  - A-24_GC_Report_E:_MSS_Employment_&_Educational_Leave_Positions Review & Consolidation
- Sunset Review Instructions from 2024 Review:
  - Sunset Review Instructions 2024
  - Sunset Review Suggestions for SC Leaders

Additional Information and Resources

Additional information and resources into the MSS Policy Process can be found below:

- AMA MSS Policymaking Website
  - Medical Student Section (MSS) policymaking
- Resolution Author Guide
  - https://www.ama-assn.org/system/files/mss-resolution-author-guide.pdf

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Archiving

The MSS Archives Task Force has transformed the Section's archiving process over the past two years, developing entirely new archives, methods, and resources to document and showcase policy processes and outcomes. A brief overview is provided below, with further details available in the A-25 ATF Report B: MSS Policy Archives: MSS Positions, Policy Outcomes, and Other Records.

Major MSS Archives:

- MSS Positions Compendium for I-25 Policymaking:
  - Archive of active MSS Positions that guide MSS functions, actions, and stances at the AMA House of Delegates. Of note, the Archives Task Force converted this archive to a more easily navigable spreadsheet and added a section that is still under development that includes rescinded MSS Positions.
- MSS Resolutions Outcomes Archive:
  - Archive of all resolutions considered by the MSS Assembly regardless of outcome, authorship information, and if applicable HOD outcomes and subsequent actions taken by the AMA following adoption at the HOD. This is meant to be a comprehensive archive to explore what the MSS has considered over the years and follow a resolution from conception to AMA action. This archive also includes links to MSS Handbooks, MSS Microbricks, MSS Annotated RefCom Reports (*another new development recommended by the ATF that include the RefCom recommendation, rationale, and final assembly outcome*), and other associated materials for deep dives into topics previously considered and is organized by year of consideration at the MSS Assembly. Of note, the RTF elected to change the name of this archive to "MSS Resolutions Outcomes Archive" from "MSS Positions Outcomes Archive" this fall to help clarify its purpose and content as it is an archive of all MSS resolutions and includes resolutions that were not adopted and never became MSS Positions.
- MSS Archive of HOD Proceedings - "Membrick":
  - Archive of resolutions that the MSS took a stance on at the AMA HOD for recent conferences including both resolutions authored by the MSS and resolutions authored by other delegations that the MSS testified on. This archive provides a more easily navigable resource to report outcomes of each HOD meeting that had traditionally been reported directly in the Delegate Report on HOD Policy Proceedings (i.e. A-23 Delegate Report B, I-23 Delegate Report B) which is required by the MSS IOPs Section 9.3 Reporting of Caucus Actions and reported on outcomes and MSS actions on resolutions considered at the previous HOD. The current version of the Delegate Report on HOD Policy Proceedings provides a brief overview of transmittal numbers and outcomes statistics, amendments to MSS Positions to reflect transmittal status, and a link to the Membrick for more detailed information. In addition, this archive allows for a location for easy access to view actions taken by the AMA on the resolutions considered at each HOD and an ability for members to quickly navigate and search outcomes across years. The RTF hopes to conduct back-archiving to track outcomes of older MSS resolutions transmitted to the HOD of which we have some information for in the potentially soon to be obsolete Summary of MSS Assembly actions 1999-2025 and further information that can be found in the AMA Archives.

Internal Operating Procedures (IOPs)

IOPs, or Internal Operating Procedures, are detailed rules and guidelines adopted by the MSS

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to govern their internal structure, operations, decision-making processes, and conduct of business. The IOPs contain multiple sections that are directly related to the MSS Policy Review Process that need to be reviewed and updated.

- AMA MSS IOPs Official Version
- RTF MSS IOPs RTF Comment Version
- IOP Task Force Reports
    - A-23 IOPTF Report
    - Copy of IOPTF Response to Refcom

Changes to the MSS IOPs are governed by AMA Bylaw 7.0.7 and MSS-IOP 14. Any revisions must be passed by the MSS Assembly with a two-thirds (⅔) vote and subsequently approved by the AMA Board of Trustees (BOT). IOP revisions are not considered to be in force until they have been formally approved, even if they have passed the MSS Assembly. If proposed amendments to MSS IOPs would necessitate changes to the AMA Bylaws, then those changes must first be adopted by the AMA House of Delegates before said IOP amendments can be in force.

Typically, the MSS coordinates with the AMA Council on Constitution & Bylaws (CCB) and the Board to help ensure that the language that ultimately passes MSS Assembly avoids potential concerns about internal self-consistency, conflicts with the AMA Bylaws (which hold supremacy), and general governance issues. In order to minimize the number of times this process must occur, the MSS prefers to consolidate proposed IOP changes into one report at regular intervals. However, this does not preclude IOP changes from being made at other times via an MSS resolution. MSS-IOP 14, “Amendments to the Internal Operating Procedures,” is reproduced below:

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14 **Amendments to the Internal Operating Procedures.**

14.1 **Requirements.** All rules, regulations, and procedures adopted by the MSS are subject to the approval of the Board of Trustees (AMA Bylaw 7.0.7). Amendments to the Internal Operating Procedures may also be contingent upon corresponding changes to the AMA Bylaws, which require approval of two-thirds (⅔) of the members of the AMA HOD.

14.2 **Regular Review of the Internal Operating Procedures.** Every four (4) years, the Speakers will direct the Committee on Long Range Planning (COLRP), an MSS Standing Committee, to submit a report proposing necessary amendments to the IOPs.

14.2.1 COLRP will design and implement a protocol for IOP review and report writing.

14.2.1.1 This protocol may be updated as necessary by COLRP. A review of IOPs may occur asynchronously from the COLRP report; however, any amendments should be detailed in the quadrennial report. COLRP shall include the student Councilor from the Council on Constitution & Bylaws as an ex-officio member during IOP review and report writing. COLRP may recruit additional voting representatives for IOP review to promote representation from all regions

14.2.1.2 IOP review and report writing shall be co-chaired by the Speakers as non-voting members.

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14.3 **Resolutions.** Amendments to the IOPs may occur by adoption of a resolution with a two-thirds (⅔) vote of the MSS Assembly (Section 10.8.5).

Since the last revision to the MSS IOPs per the recommendations of the 2022-23 MSS Internal Operating Procedures Task Force (IOPTF) and the 2021-22 MSS Internal Operating Procedures & Elections Task Force (IOPETF), there have been a number of proposals to change our IOPs (or which would necessitate changes to the IOPs) that have subsequently been adopted by the MSS Assembly.

1. Resolution 601-A-25-MSS "Removal of HCC from MSS IOPs" was adopted by the MSS Assembly at the A-25 Meeting. The language is as follows:

   > RESOLVED, that our AMA-MSS remove specific reference to the AMA HOD Coordinating Committee (HCC) at the time of the next review of the MSS internal operating procedures (IOPs).

2. GC-C-A-25 "Governing Council Report C: Membership Report" was adopted by the MSS Assembly at the A-25 Meeting and includes the following language (irrelevant recommendations and clauses excluded for brevity):

   > (3) RESOLVED, That our AMA-MSS amend 665.014MSS "Region Restructure Assessment During IOP Revision Process" by addition and deletion as follows:
   >
   > 2) in preparation for or at the time of review for possible revisions of the MSS IOPs a comprehensive report will be prepared for the MSS Assembly, to explore current barriers to medical student participation in the AMA including but not limited to cost and value of membership and conference attendance, ~~and~~ consider potential changes to the Region structure and function (i.e. state and school delegate allocation allocated in each Region) to be included in those revisions, and report updated demographics data and actions to address any disparities found; and be it further;
   >
   > (8) RESOLVED, That our AMA-MSS amend 645.038MSS "MSS Study of Assembly Representation" by addition to read as follows:
   >
   > AMA-MSS study and report back at A-26 possible approaches to amend AMA Bylaws regarding delegate representation in the MSS Assembly to:
   > a. change the definition of satellite campuses to address disproportionate overrepresentation of some medical schools; and
   > b. adjust the threshold at which a medical school is granted more than 1 voting delegate and 1 alternate delegate.

3. GC-D-A-25 "Governing Council Report D: MSS Standing Committee Restructuring: A-25 Update" was adopted by MSS Assembly at the A-25 Meeting. It updates position 640.015MSS, which resulted from SCTF-I-24 "MSS Standing Committee Restructuring: Progress Update" (which made no recommendations and was filed), which itself updated

SCTF-A-24 “MSS Standing Committee Task Force Annual Report” (which was Adopted as Amended at the A-24 Meeting). Concerning language that would inform updates of the MSS IOPs, GC-D-A-25 includes the following recommendation (irrelevant clauses excluded for brevity):

> Your MSS Governing Council recommends that MSS Position 640.015MSS “Standing Committee Task Force Report” be amended by addition and deletion as below and the remainder of this report be filed:
>
> (3) AMA-MSS Governing Council restructure the Committee on Long Range Planning to serve in an advisory capacity led by the MSS GC Chair, who will appoint members to the committee based on applications demonstrating significant previous AMA experience, including, but not limited to, considering applications from former Governing Council and BOT members as well as current and former Councilors; and be it further
>
> (9) the revision and implementation of changes to Standing Committee structures and functions will be reviewed after three years at A-30 prior to the Quadrennial Internal Operating Procedures (IOPs) Review Report and following this, this review will be ~~are~~ exclusively done at four-year intervals~~ after the completion of the 2025-2026 task force with the next report due at A-30~~.
>
> (11) that our MSS remove specific reference to the Committee on Long Range Planning (COLRP) from the MSS IOPs during its next scheduled revision, to allow for flexibility as our Standing Committee structure continues to evolve and prevent possible incongruence between the IOPs and future MSS practice, without compelling the MSS to maintain COLRP simply because it is outlined in the IOPs.

4. ATF-E-A-25 “MSS Archives Task Force Report E: Membership and Engagement Report” was adopted by the MSS Assembly at the A-25 meeting and includes the following language:

> RESOLVED, At the next scheduled revision of the MSS Internal Operating Procedures (IOPs), the AMA-MSS amend IOP 4.4.4 by addition and deletion as follows:
>
> 4.4.4 **At-Large Officer.** The At-Large Officer shall:
>
> > 4.4.4.1 Perform such functions as determined by the Governing Council, and assist the other officers in the performance of their duties.
> >
> > 4.4.4.2 Coordinate the activities of the MSS Regions, including the organization of r~~R~~egional conferences.
> >
> > 4.4.4.3 Maintain up to date contact information for local, state, and regional Medical Student Section leaders.

In addition to the directives from MSS Assembly discussed in the Background of this report, there have been additional developments in the AMA House of Delegates (including updates to the AMA Bylaws) that necessitate changes to the IOPs:

1. The Minority Affairs Section (MAS) has officially been renamed the “Underrepresented in Medicine Advocacy Section (UMAS).” This necessitates revision of MSS-IOP 4.4.6.3.

2. The Advisory Committee on LGBTQ+ Issues has since formally transitioned to Section status and is now known as the LGBTQ+ Section (LGBTQ+). This necessitates revision of MSS-IOP 4.4.6.3.

3. Other AMA Sections have initiated discussions about changing their IOPs to clarify the specific circumstances of processing and presentation of Late and Emergency Resolutions with respect to the timing of submission. The MSS IOPs may benefit from similar clarifying amendments. This would likely involve revision of 10.8.3 and 10.8.4.

4. A number of changes to the AMA Bylaws will likely be proposed at the Interim 2025 meeting of the House of Delegates. Should these pass, additional revisions of the MSS IOPs will likely be necessary.

Additionally, we have identified a number of clerical and grammatical errors that need to be corrected. These changes would not substantively affect the text or interpretation of the IOPs.

IOP discrepancies like these need to be addressed and resolved, and will be included in the A-26 final report. These changes can then be considered and formally changed in the IOPs during the IOP Taskforce that will be convened following A-26.

DISCUSSION

The 2025–2026 MSS Resolution Task Force is an ad hoc committee charged with reviewing and improving MSS policy and archiving processes to enhance clarity, continuity, accessibility, and long-term organizational impact. Convened by the MSS Governing Council under the authority of 645.032MSS(10), this temporary group is tasked with evaluating the implementation of MSS positions 645.032MSS and 645.033MSS, revising related internal practices, and formalizing standardized procedures for archiving both Assembly and HOD activities. The Task Force will dissolve upon submitting its report and recommendations for consideration at the 2026 Annual Meeting, exemplifying the focused and temporary nature of ad hoc committees.

In order to address the many facets of the MSS Policy Process, the RTF has created several smaller workgroups with a specific scope. Their work is outlined below, as well as future considerations the RTF plans to address in their final report, which will be brought forward to the MSS for consideration at A-26.

Survey/Town Hall Workgroup

The Survey and Town Hall Workgroup are focused on providing spaces for all MSS members to have a voice in the RTF by providing direct feedback throughout the report writing process.

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They hosted a Town Hall for the entire MSS on September 17th over Zoom and received the following verbal feedback. The taskforce hosted a town hall and received the following input:

Policy Process

a. *Incorporation of Various Parties in the Resolution Review Process*
    i. Attendees commented on a desire to continue to better incorporate NMSO and NMSS student representatives as well as student representatives from other sections (WPS, UMAS, etc.).
    ii. Members commented on the importance of ensuring that standing committees engage with the relevant liaisons.

1. *Support for Newer Members*
    a. Attendees commented that additional direct mentorship and training continues to be valuable to newer reviewers, especially considering not all members join at the beginning of the policy cycle.
    b. Some items that were indicated to be helpful were RPC office hours, meeting with seasoned region members, joining resolution review committees, and attending interim or annual meetings.
2. *Microbrick*
    a. Attendees noted that while the Microbrick has evolved and improved over the years, some challenges remain, particularly with regards to determining the most effective way to incorporate Standing Committee review assignments.
    b. Members are very pleased with the new document setup for resolution reviews (as of I-25) where all reviews are located in a single document with tabs.

MSS Archives

b. *Value and Accessibility*
    i. While the MSS Archives are a highly valuable resource, newer members may experience difficulty finding and navigating the archives, which increases the likelihood of duplicate resolution submissions. Several attendees, including a first-time MSS member, commented on interest in training resources on how to use the MSS archives, particularly those brought forward at the previous annual or interim meeting.

c. *Tracking and Reporting MSS Resolution Outcomes*
    i. Attendees supported the continued tracking of resolution authors by Region of origin as valuable data for Region leaders and Regional membership.

d. *Back-Archiving*
    i. When asked about the preferred extent of backarchiving, several attendees expressed interest in having long-term data on MSS outcomes. Five years of back-archive data was suggested as a minimum goal.

e. *Archival Group*

i. Several attendees commented in support of a permanent archival group. Participants discussed how an Archival Group could best reflect individuals at all stages of the AMA experience.

Future Directions and Communications

f. Participants expressed interest in receiving regular communications on historical and current MSS wins in AMA advocacy.

To continue gathering feedback, the Resolution Task Force MSS survey includes questions about members' experiences across all areas covered during this Town Hall. The survey can be found here: https://docs.google.com/forms/d/e/1FAIpQLSdIS1bKOY6Aeh43cnrS8d1ld5HQDKjU6txYvpScopLfFn_PIA/viewform . Once the survey has closed, this workgroup will review and analyze the results.

The feedback and suggestions gathered during this Town Hall and Survey will be taken into consideration as this Task Force's final recommendations are developed.

Internal Operating Procedures Review Workgroup

The MSS Internal Operating Procedures (IOPs) contain and govern the MSS. Currently, the IOPs contain multiple sections that are directly related to the MSS Policy Review Process. The RTF plans to provide recommendations on changes that should be made to the IOPs to align them with our current practices and solidify the process.

For example:

Reconciliation of HCC to IMPACT

The House Coordination Committee (HCC) was a previous convention committee of the MSS that functioned as part of Bonus Caucus to help support the MSS efforts during HOD meetings. HCC members were determined based on the Speakers of the MSS, not the SDs. At A-23, it was determined that HCC and IMPACT covered similar roles, since IMPACT served as part of HCC in addition to additional individuals from the MSS. At A-24, after the passage of the Standing Committee Taskforce (SCTF), IMPACT was moved to be under the purview of the SDs. These transitions allowed for a more streamlined, less confusing process (i.e. IMPACT to HCC at HOD meetings and Speakers picking individuals to be on HCC -> SDs overseeing IMPACT and those at HOD directly). Thus, HCC was moved under IMPACT which is now under the purview of the SDs until the Internal Operating Procedures for the MSS are updated (i.e. during the IOP Taskforce starting after A-26).

Sunset of Reaffirmation

Prior to A-23, there was an additional outcome called "reaffirmation" / "reaffirm in lieu" that was an additional outcome to resolutions/reports that were similar enough to the current AMA policy or AMA-MSS positions that they would functionally be covered under them. These items were presented on a reaffirmation consent calendar at the MSS Assembly. This mechanism was removed following the A-23 MSS Assembly meeting to reflect the House of Delegates process and minimize the substantial confusion resulting from this process. Further discussion can be found beginning on page 10 of the 2022-23 MSS RTF Report (GC-B-A-23). At

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present, there are no MSS positions prescribing the use of a reaffirmation consent calendar. Subsequently, this process is formally governed by the Standing Rules of Order (as prescribed by MSS-IOP 10.7.2), so no formal changes to MSS IOPs or MSS positions are required at this time.

Removal of COLRP

The MSS Committee on Long Range Planning (COLRP) is explicitly referenced in the MSS IOPs. Following the Standing Committee Task Force report(s) and ongoing remodeling of the standing committees, it is unnecessarily restrictive to prescribe the existence and purview of COLRP (or any standing committee) in the IOPs. MSS-IOP 7.2 prescribes that "The existence and purview of MSS Standing Committees and Task Forces may be determined by the Governing Council or by action of the MSS Assembly." Currently, 640.015MSS prescribes the existence and purview of our extant standing committees. Other positions prescribe the creation of task forces and other ad hoc committees, and the Governing Council has authority in the absence of MSS Assembly action.

Please see the Background section for a comprehensive discussion of all considerations for MSS IOP revisions.

- We currently anticipate proposed **clerical** amendments to 4.4.4.2, 4.4.6.1, 4.4.6.3, 4.7.1, 6.5.9.3.2.2, 6.5.12.1, 8.2.2, 8.3.2, 8.3.3, 9.2.4, 10.4.2, 10.8.1, and 11.3.1.4.

- We currently anticipate proposed **substantive** amendments to 4.4.4.3, 4.4.6.3, 9.1.2, 9.1.4.3, 10.8.3, 10.8.4, 10.9.5, and 14.2, as well as any changes necessitated by AMA Bylaws revisions.

At this time, your Resolution Task Force is making **no formal recommendations** regarding amendments to the MSS Internal Operating Procedures. RTF will solicit feedback and suggestions from MSS members regarding any potential changes. Formal recommendations will be included in the final version of the RTF Report to be presented to the MSS Assembly for consideration at the Annual 2026 Meeting.

Compendium Review Workgroup

The MSS Positions Compendium Review Workgroup reviewed MSS internal positions relevant to the MSS policy process for consistency with current MSS practice and opportunities for further improvement. The Workgroup has recommended that the following internal positions be considered for rescission, amendment, or consolidation into a new MSS position as follows:

Title	Position Text with Changes for Consideration	Rationale
630.078MSS: Optimizing MSS Communications	AMA-MSS will continue to support and explore strategies to optimize communications with general members, including at minimum: (1) Production of an electronic newsletter; (2) Maintenance of virtual platforms for direct communication with members (i.e. GroupMe) at the national and regional levels; (3) Maintenance of an easily accessible and regularly updated list of important events and deadlines for MSS and AMA activities; (4) Maintenance of an easily accessible list of items important to the MSS that will be coming before the AMA House of Delegates, updated before each HOD meeting;	Feasible and consistent with current MSS practice. Consider incorporating language from 645.031MSS to further streamline the Positions Compendium.

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	(5) Maintenance of an easily accessible list of outcomes of items important to the MSS considered at the AMA House of Delegates updated after each House of Delegates meeting; (6) Maintenance of an easily accessible list of implementation outcomes of items important to the MSS considered at the AMA House of Delegates upon publication of the annual House of Delegates Follow Up Implementation Report; (7) Regular dissemination of information about shared initiatives with other AMA entities; (8) Ensure MSS Regions maintain active and timely communication with MSS delegates and other general Region members regarding responsibilities and opportunities; and (9) Developing and maintaining a series of free online materials providing detailed information on MSS functions and engagement opportunities; (10) A list of all MSS Action Items received during the period between MSS national meetings will be included in the Meeting Handbook as official MSS Actions.	
645.031MSS: MSS Action Items	A list of all MSS Action Items received during the period between MSS national meetings will be included in the Meeting Handbook as official MSS Actions, along with their implementation status. Additionally, the MSS should create an opportunity for the Governing Council to discuss MSS Action Item implementation status with interested students.	Your Resolution Task Force discussed several options regarding this policy including consolidating it into 630.078MSS "Optimizing MSS Communications" for conciseness and clarity as this language is largely about communicating past MSSAI actions. Recommend amending the first sentence into 630.078MSS and leaving the second sentence out as open communication is consistent with current MSS practice and unnecessary to explicitly delineate in policy. However, there were also discussions regarding keeping a comprehensive standalone position to clarify the nature and scope of MSSAIs to better reflect current practice and the authority of the MSS Governing Council, in addition to communication and reporting of outcomes to the MSS.

645.032MSS: MSS Policy Process	1. The MSS Section Delegates will ensure that all items of business submitted for consideration to each MSS Assembly meeting undergo a comprehensive review process evaluating their impact, feasibility, timeliness, and evidence basis. 2. The draft resolution review process should include opportunities for participation by MSS Caucus members; MSS members on AMA Councils; appropriate MSS region officers; MSS standing committees; MSS members with significant HOD experience; and MSS members who liaise with other AMA Sections and groups, specialty societies, professional interest medical associations, medical student organizations (including identity-based groups), and medical education bodies. 3. The MSS Section Delegates will decide the timeline for the policy cycle preceding each MSS Assembly and will design the criteria used to review items of business. 4. Resolutions submitted by the correct deadline in the correct format as determined by the MSS Section Delegates prior to start of the policy cycle may not be rejected for submission for consideration by the MSS Assembly based on their content after organizational review for legal issues. 5 . Per the MSS IOPs, submitted resolutions will be sent to the MSS Reference Committee, which will make recommendations to the Assembly for disposition of its items of business. The Reference Committee Report will use a consent calendar format. In order for an item to be heard by the MSS Assembly, it must be extracted from the Reference Committee Consent Calendar. The Order of Business for each MSS Assembly meeting will follow the order listed in the MSS Reference Committee report for that meeting. Items of business will be categorized by Reference Committee recommendations for “adoption,” “adoption as amended,” “adoption in lieu of,” “referral,” “not adoption,” “reaffirmation in lieu of,” etc. The order of items in each category will be ~~randomized~~ based on the resolution number assigned at the beginning of the policy process. The MSS Reference Committee must include a meaningful rationale for their recommendations made on each item of business. Any MSS member may extract any item from the Reference Committee Report for debate at the MSS Assembly. No other requirements, such as testimony or votes, are necessary for an item to be extracted. The Section Delegates shall provide opportunities for extraction both in advance of the MSS Assembly remotely and at the beginning of the Assembly. Extractions made in advance of the MSS Assembly should be published in real-time as they are submitted. 6. The AMA-MSS Internal Operating Procedures (IOPs) and Digest of Actions will be made available on the AMA-MSS Web site, with updates made prior to the beginning of the Policy Cycle for each Annual and Interim Meeting of the Assembly. 7. A resolution template will be made publicly available to assist resolution authors in formatting their resolutions. 8. Upon final submission to the MSS for consideration by the Assembly, MSS resolutions, including the “whereas” and “resolve” clauses and footnotes, may not be altered by staff or any MSS leader, member, committee, or other entity prior to the MSS Assembly Meeting without the consent of the author, with the exception of retyping and reformatting. 9. The MSS Section Delegates (when they agree) may make grammatical or syntax changes to the resolve clauses of MSS resolutions after they are adopted by the Assembly and before they are forwarded to the House of Delegates, but in no circumstances can the meaning or intent of the resolve clauses be altered. Further, the MSS Speaker and Vice Speaker must be advised of any change made to resolve clauses before the resolution is forwarded to the House of Delegates and must concur that the change in grammar or syntax does not alter the meaning or intent of the resolve clauses. The MSS Speaker or Vice Speaker, may not, under any circumstance, initiate the change in grammar or syntax on any MSS resolution. ~~10. Our AMA-MSS will reevaluate 645.032MSS, 645.033MSS, and the MSS Policy Process in general in a Governing Council report to be presented to the MSS A-26 Assembly.~~	Recently amended in A-24 and broadly consistent with current practice. Recommend small grammatical amendment, and striking of clause 10 calling for a review of this and other policies and the policy process, as that review is being accomplished by this RTF report.

645.033MSS: Additional MSS Caucus Operations	~~1. The MSS Section Delegates have the ability to nominate existing policies in the MSS Digest of Actions to the queue to be transmitted to a future HOD meeting, based on strategic considerations. These nominations must be approved by a majority vote of the MSS Caucus.~~ 1~~2~~. The MSS Caucus can co-sponsor resolutions in the name of the MSS with another HOD delegation. a. Co-sponsoring a resolution authored by another delegation must be approved by a ⅔ vote of the MSS Caucus. b. The MSS Section Delegates have the authority to add other delegations as co-sponsors of MSS-authored resolutions. 2~~3~~. The MSS Caucus can decide by a ⅔ vote in any given election cycle whether it wants to offer the opportunity to seek an MSS endorsement to candidates for elections in the AMA House of Delegates, and this vote shall apply to all candidates in all elections for that cycle. Once a candidate for an election in the AMA House of Delegates confirms they are seeking an MSS endorsement, the MSS Caucus can endorse that candidate by a ⅔ up or down vote specific for that candidate. The number of endorsements given for a race shall not exceed the number of open seats. If more candidates surpass the 2/3 threshold than there are open seats, available endorsements will be given to the candidates receiving the highest vote percentage. The MSS Caucus may also withdraw an endorsement of a candidate by a ⅔ vote.	Recently amended in I-24. Potential amendment to remove the ability for SDs/Caucus to unilaterally send transmittals to the HOD, as this power has never been used and could permit SDs/Caucus to bypass the Assembly on important strategic considerations.

Archiving Workgroup

The Archiving Workgroup is focused on creating a sustainable and streamlined process to log what happens to MSS resolutions, while continuing the work of the Archives Task Force. The RTF has continued to actively update the MSS archival resources and has plans to recruit additional members to complete the back-archives by the end of this year. In addition, the RTF has been gathering feedback on the utility of these resources and has plans to create user guides and implement enhancements if deemed appropriate.

The RTF is also reviewing the forward-archiving procedures. This will be the first cycle that the ATF proposed process will be fully implemented and the RTF will be working with MSS staff and leadership to discuss if alterations to the process need to be made.

In addition, the RTF will be continuing the investigation of the best mechanisms of reporting and highlighting “MSS Big Wins” and is very interested in feedback from the MSS regarding what would be most meaningful in this area. The A-25 ATF Report C: Big Wins Report: Identifying & Highlighting Notable MSS Advocacy outlines the 2024 - 2025 ATF discussions and recommendations that RTF will be using as a starting point.

Future Considerations

Based on review of MSS policies and procedures, feedback from the survey and town hall, discussions among RTF members, and other MSS input, here is a list of potential items the RTF would like to address in their final report at A-26.

- Policy Process:
  - Current changes to the Review Document for the OF and First Draft Reviews
    - Moving documents and resolutions into 1 google document rather than individual documents)
  - “Self-Generated” Reports from Standing Committees
    - Per Standing Committee Taskforce A-24, Standing Committees cannot “self-generate” reports without approval from GC/SDs

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    - Increased Student Councillor involvement
    - Clearer onboarding and collaboration with NMSS/NMSO and other section liaisons to strengthen their contributions to the MSS policy process and how best to define and support these roles
    - Topic Reference Committees similar to HOD (previously existed in MSS)
    - Summary of Individual Region and Organizational Policy Review/Stance Process
- HOD Proceedings:
    - Considering written guidelines for forwarding existing but recently timely internal AMA-MSS Positions to HOD (645.033MSS)
    - Notetaking during HOD Reference Committees & HOD
- Positions Review and Consolidation:
    - MSS Position Sunset Timeline and Directions
    - MSS Consolidation Timeline and Procedures
- Archives:
    - Archives usability
    - Establishing a Permanent Archival Group (Per ATF Report recommendation)
    - Communication of MSS advocacy wins
- Additional Systems/Workgroups:
    - Advocacy Referral System changes and integration
    - Additional workgroups
- Reconciliation of IOPs:
    - Reconciliation of HCC to IMPACT
    - Sunset of Reaffirmation
- Other topics suggested on VRC testimony, Reference Committee Recommendations, Town Hall and Feedback Survey, etc…

****Submit feedback and/or your own suggestions for us to consider here!****

RECOMMENDATIONS

Your Resolution Task Force recommends that no actions be taken at this time and the remainder of this report be filed.

Acknowledgements
We would like to acknowledge our RTF Co-Chairs, Jared Buteau and Sneha Kapil. Additionally, we would like to acknowledge our MSS Staff members Shane Mcgoey and Sarah Langill for their support. Finally, we would like to acknowledge our wonderful RTF members below:
Natasha Topolski, Andrew Norton, Layla Ahmadi, Vignesh Senthikumar, Akhila Swarna, Druv Bhagavan, Katherine Yu, Ryan Englander, Sanjay Neerukonda, Ishwarya Maganti, Lauren St. Peter.

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RELEVANT MSS POSITIONS:

Medical Student Section Action Item 645.031

A list of all MSS Action Items received during the period between MSS national meetings will be included in the Meeting Handbook as official MSS Actions, along with their implementation status. Additionally, the MSS should create an opportunity for the Governing Council to discuss MSS Action Item implementation status with interested students.

MSS Policy Process 645.032

1. The MSS Section Delegates will ensure that all items of business submitted for consideration to each MSS Assembly meeting undergo a comprehensive review process evaluating their impact, feasibility, timeliness, and evidence basis.
2. The draft resolution review process should include opportunities for participation by MSS Caucus members; MSS members on AMA Councils; appropriate MSS region officers; MSS standing committees; MSS members with significant HOD experience; and MSS members who liaise with other AMA Sections and groups, specialty societies, professional interest medical
associations, medical student organizations (including identity-based groups), and medical education bodies.
3. The MSS Section Delegates will decide the timeline for the policy cycle preceding each MSS Assembly and will design the criteria used to review items of business.
4. Resolutions submitted by the correct deadline in the correct format as determined by the MSS Section Delegates prior to start of the policy cycle may not be rejected for submission for consideration by the MSS Assembly based on their content after organizational review for legal issues.
5 . Per the MSS IOPs, submitted resolutions will be sent to the MSS Reference Committee, which will make recommendations to the Assembly for disposition of its items of business. The Reference Committee Report will use a consent calendar format. In order for an item to be heard by the MSS Assembly, it must be extracted from the Reference Committee Consent Calendar. The Order of Business for each MSS Assembly meeting will follow the order listed in the MSS Reference Committee report for that meeting. Items of business will be categorized by Reference Committee recommendations for “adoption,” “adoption as amended,” “adoption in lieu of,” “referral,” “not adoption,” “reaffirmation in lieu of,” etc. The order of items in each category will be
randomized. The MSS Reference Committee must include a meaningful rationale for their recommendations made on each item of business. Any MSS member may extract any item from the Reference Committee Report for debate at the MSS Assembly. No other requirements, such as testimony or votes, are necessary for an item to be extracted. The Section Delegates shall
provide opportunities for extraction both in advance of the MSS Assembly remotely and at the beginning of the Assembly. Extractions made in advance of the MSS Assembly should be published in real-time as they are submitted.
6. The AMA-MSS Internal Operating Procedures (IOPs) and Digest of Actions will be made available on the AMA-MSS website, with updates made prior to the beginning of the Policy Cycle for each Annual and Interim Meeting of the Assembly.
7. A resolution template will be made publicly available to assist resolution authors in formatting their resolutions.; and be it further

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8. Upon final submission to the MSS for consideration by the Assembly, MSS resolutions, including the “whereas” and “resolve” clauses and footnotes, may not be altered by staff or any MSS leader, member, committee, or other entity prior to the MSS Assembly Meeting without the consent of the author, with the exception of retyping and reformatting.
9. The MSS Section Delegates (when they agree) may make grammatical or syntax changes to the resolve clauses of MSS resolutions after they are adopted by the Assembly and before they are forwarded to the House of Delegates, but in no circumstances can the meaning or intent of the resolve clauses be altered. Further, the MSS Speaker and Vice Speaker must be advised of any change made to resolve clauses before the resolution is forwarded to the House of Delegates and must concur that the change in grammar or syntax does not alter the meaning or intent of the resolve clauses. The MSS Speaker or Vice Speaker, may not, under any circumstance, initiate the change in grammar or syntax on any MSS resolution.
10. Our AMA-MSS will reevaluate 645.032MSS, 645.033MSS, and the MSS Policy Process in general in a Governing Council report to be presented to the MSS A-26 Assembly.

Additional MSS Caucus Operations 645.033

1. The MSS Section Delegates have the ability to nominate existing policies in the MSS Digest of Actions to the queue to be transmitted to a future HOD meeting, based on strategic considerations. These nominations must be approved by a majority vote of the MSS Caucus.
2. The MSS Caucus can co-sponsor resolutions in the name of the MSS with another HOD delegation.
a. Co-sponsoring a resolution authored by another delegation must be approved by a ⅔ vote of the MSS Caucus.
b. The MSS Section Delegates have the authority to add other delegations as co-sponsors of MSS-authored resolutions.
3. The MSS Caucus can decide by a ⅔ vote in any given election cycle whether it wants to offer the opportunity to seek an MSS endorsement to candidates for elections in the AMA House of Delegates, and this vote shall apply to all candidates in all elections for that cycle. Once a candidate for an election in the AMA House of Delegates confirms they are seeking an MSS endorsement, the MSS Caucus can endorse that candidate by a ⅔ up or down vote specific for that candidate. The number of endorsements given for a race shall not exceed the number of open seats. If more candidates surpass the 2/3 threshold than there are open seats, available endorsements will be given to the candidates receiving the highest vote percentage. The MSS Caucus may also withdraw an endorsement of a candidate by a ⅔ vote.

Standing Committee Task Force Report 640.015MSS

AMA-MSS
(1) Governing Council (a) implement the recommendations adopted by the MSS Assembly from the Standing Committee Task Force to restructure the Standing Committee framework and leadership model, (b) clarify Standing Committee responsibilities and objectives, and (c) enhance operational efficiency;
(2) AMA-MSS Governing Council (a) restructure the existing Standing Committees into the delineated structure below with flexibility for Standing Committees to create additional subcommittees as appropriate and (b) include a timeline and requirements for leadership selection;

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a) Committee on Health Economics & Coverage (CHEC)
b) Committee on Humanism & Ethics in Medicine (CHEIM)
c) Committee on Civil Rights (CCR)
d) Committee on Public Health (CPH)
e) Committee on Science & Technology (CST)
f) Committee on Medical Education (CME)
g) Committee on Gender & Sexual Health (CGSH)
Subcommittee on Women in Medicine
Subcommittee on LGBTQ+ Affairs
h) Committee on Health Justice (CHJ)
Subcommittee on Disability Affairs
Subcommittee on Minority Affairs
Subcommittee on Tribal Affairs

(3) AMA-MSS Governing Council restructure the Committee on Long Range Planning to serve in an advisory capacity led by the MSS GC Chair, who will appoint members to the committee based on applications demonstrating significant previous AMA experience, including, but not limited to, considering applications from former Governing Council and BOT members as well as current and former Councilors; and be it further

(4) AMA-MSS Governing Council restructure the Committee on Impact, Policy, and Action (IMPACT) to serve as a group led by the MSS Section Delegates, to assist with resolution review responsibilities as needed, document HOD results and implementation actions related to MSS resolutions for the MSS archives, participate in the sunset and consolidation processes for MSS positions, and emphasize training for new MSS members;

(5) every Standing Committee leadership team develop a detailed strategic plan at the beginning of their terms;

(6) AMA-MSS Governing Council develop a leadership and membership review and recall system and outline this system in the I-24 report;

(7) AMA-MSS retain the current committee structure for the 2024-2025 term and implement the new committee structure, including a new timeline where the Governing Council elects standing committee chairs and vice chairs prior to the Annual meeting for the 2025-2026 term.

(8) a new Standing Committee Task Force will be formed to review the functioning of the new structure and write an informational report regarding the progress of transitions at the I-25 meeting. They will also write a final report with any recommendations at the A-26 meeting;

(9) the revision and implementation of changes to Standing Committee structures and functions are exclusively done at four-year intervals after the completion of the 2025-2026 task force with the next report due at A-30.

(10) the MSS standing committees execute, at minimum, the following functions under the direction of the MSS Governing Council:

a) Provide recommendations for the policies reviewed as part of the AMA-MSS sunset and consolidation mechanisms under the coordination of the MSS Chair, Vice Chair, and Section Delegates;

b) Assist in the resolution review process under the coordination of the Section Delegates and Vice Chair;

c) Host resolution onboarding twice a year led by appropriate Standing Committee leadership to ensure Standing Committee members are all adequately trained to review resolutions.

d) Author reports requested by the MSS Assembly and/or MSS Governing Council, with reports expected at the next MSS Assembly meeting

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e) One report extension can be granted without question with further extensions will be granted upon approval of appropriate Governing Council members. This timeline will be shared with Assembly at the original deadline meeting;
f) Produce whereas clauses to facilitate the transfer of any adopted report and, if applicable, to MSS-sponsored resolutions submitted to the AMA House of Delegates.
g) Monitor federal legislation, regulation, and litigation relating to their subject area and work with other MSS members and the MSS Governing Council to organize student-led advocacy efforts and request actions by AMA staff as appropriate;
h) Organize educational programming and advocacy initiatives as necessary and appropriate; and be it further
i) Author comments for AMA Council reports, as directed by the MSS Section Delegates; and be it further
j) Support the MSS Governing Council and Staff in tracking and publicizing outcomes and implementation of MSS authored items at the AMA House of Delegates in the Standing Committee area of expertise; and be it further
(11) that our MSS remove specific reference to the Committee on Long Range Planning (COLRP) from the MSS IOPs during its next scheduled revision, to allow for flexibility as our Standing Committee structure continues to evolve and prevent possible incongruence between the IOPs and future MSS practice, without compelling the MSS to maintain COLRP simply because it is outlined in the IOPs.

MSS IOP 9.3 Reporting of Caucus Actions

The Section Delegates shall be responsible for authoring a report of actions taken, which shall be presented to the MSS Assembly at the next national meeting. This report will list the resolved clauses of all AMA HOD items of business for which the MSS took a position, and will specifically identify those items of business for which the MSS Caucus took a position that was not grounded in existing internal policy.

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