MEMORIAL RESOLUTIONS
ADOPTED UNANIMOUSLY

James F. Arens, MD
Introduced by: American Society of Anesthesiologists and Texas Medical Association

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

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

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

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

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

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

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

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

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

Thomas Stautzenbach, MA, MBA, CAE
Introduced by: American Academy of Physical Medicine and Rehabilitation

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

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

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

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

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

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

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

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

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

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

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

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

Richard Sloan Wilbur, MD, JD, FCLM
Introduced by: Illinois and the American College of Legal Medicine

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

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

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

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

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

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

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

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

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

RESOLUTIONS

Note: Testimony on each item is summarized in the reference committee reports.

Alternate resolutions are considered to have been introduced by the reference committee.

REFERENCE COMMITTEE ON ETHICS & BYLAWS

1. CLARIFYING CONSCIENTIOUS OBJECTION
Introduced by New England Delegation

HOD ACTION: ADOPTED
See Policy D-140.945 and H-140.813

RESOLVED, that our American Medical Association study the use of conscientious objection to refuse care to patients based upon their membership in particular groups, including when such refusal does not meet the legal standard of invidious discrimination, and return recommendations strengthening present policy against this practice.

RESOLVED, that our AMA ask the Council on Ethical and Judicial Affairs to consider amending the AMA Code of Medical Ethics--including, but not limited to, its relevant Principles--to ensure that a physician's right to choose their patients is appropriately limited by their duty to provide equitable access to care.

RESOLVED, that our AMA (i) support efforts to include protections for patients, as they are delineated in the AMA Code of Medical Ethics, in state- and federal-level policies codifying conscientious objection and (ii) oppose policies protecting conscientious objection which do not also provide these protections to patients.

2. ENSURING ETHICAL USE OF WEARABLE RECORDING DEVICES IN CLINICAL ENCOUNTERS
Introduced by Women's Physician Section

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association consider developing new ethical guidance to address the use of personal or wearable recording devices—including eyeglass-mounted cameras—by physicians and patients in clinical encounters, including provisions that:

a. Require informed patient consent prior to any recording,
b. Prohibit covert or undisclosed use of such devices in clinical care,
c. Recommend that such non-clinical visual recording devices not be worn during physical examinations of the breast, pelvic, genital, or rectal areas, regardless of recording status.

RESOLVED, that our AMA work with appropriate entities and organizations to develop model institutional policies on the ethical use, disclosure, and documentation of wearable and ambient personal recording technologies in health care settings.

3. REPORT ON GENDER-BASED PAY EQUITY IN MEDICINE
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-385.939

RESOLVED, that our American Medical Association study and report at I-26 the current pay structures and existing gender-based disparities in physician pay.

RESOLVED, That our American Medical Association propose data-driven guidance to end gender-based pay disparities and create strategies to achieve transparency and equitable compensation across medical practice settings.

4. PATIENT OPTIONS TO RESTRICT SECONDARY USE OF THEIR HEALTHCARE DATA
Introduced by Connecticut

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association 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.

5. PRESERVING AUTONOMY IN THE PATIENT-PHYSICIAN RELATIONSHIP
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOD ACTION: ADOPTED
See Policy D-140.944

RESOLVED, that our American Medical Association study relevant sections of the *Code of Medical Ethics* to address outside political and administrative influences on the patient physician relationship and its impact on shared decision making in the clinical setting.

6. AMENDMENT TO AMA BYLAWS TO ENABLE CONTINUITY OF LEADERSHIP
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOD ACTION: ADOPTED
See Policy D-600.950

RESOLVED, that our American Medical Association amend AMA Bylaw 7.1.2 to allow the Resident and Fellow Section (RFS) Immediate Past Chair to serve in the position even if they have graduated from the RFS.

7. IMPROVING PROTECTION FOR REPRODUCTIVE HEALTH INFORMATION
Introduced by California

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-315.966

RESOLVED, that our American Medical Association support legislation and regulations prohibiting the use or disclosure of protected health information (PHI) to conduct criminal, civil, or administrative investigations or to impose criminal, civil, or administrative liability for the mere act of seeking, obtaining, providing, or facilitating reproductive health care

RESOLVED, that our AMA advocate to ensure that the release of protected health information of a decedent to forensic pathologists be unimpeded by unnecessary administrative burdens.

8. HEALTH PLAN IN-NETWORK STEERING OF PATHOLOGY/LABORATORY SERVICES
Introduced by College of American Pathologists

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOD ACTION: ADOPTED
See Policy D-180.975 and H-180.941

RESOLVED, that our American Medical Association support state and federal legislative efforts to expressly prohibit in-network steering by health insurance plans, or by laboratory benefit managers under contract with such plans, to "preferred" or "designated" in-network laboratories or pathologists, thereby excluding other in-network pathology and laboratory providers.

RESOLVED, that our AMA advocate in partnership with state medical societies and medical specialty societies to protect ordering physician discretion to refer pathology and laboratory specimens to any in-network pathologist or in-network laboratory of their choice, based upon relevant medical considerations in the best interest of patient care, consistent with AMA Code of Medical Ethic.

9. GENDER EQUITY IN DISABILITY INSURANCE FOR PHYSICIANS
Introduced by New England Delegation

Reference committee hearing: see report of Reference Committee on Ethics and Bylaws.

HOD ACTION: ADOPTED
See Policy H-65.928

RESOLVED, that our American Medical supports gender-neutral disability insurance premiums for physicians.

10. CLARIFYING THE MEDICAL STUDENT SECTION'S AND RESIDENT AND FELLOW SECTION'S ABILITIES TO FILL TEMPORARY VACANCIES IN ACCORDANCE WITH THE AMA BYLAWS
Introduced by Resident and Fellow Section and Medical Student Section

Resolution 10 was considered with Council on Constitution and Bylaws Report 3.
See Constitution and Bylaws Report 3 which was referred.

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.

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

REFERENCE COMMITTEE B

201. MODEL STATE LEGISLATION INCORPORATING MEDICAL MALPRACTICE TORT REFORM
Introduced by American Association of Clinical Urologists

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy D-435.966

RESOLVED, that our American Medical Association develop model state legislation incorporating state medical liability tort reforms, including but not limited to provisions that: (1) limit economic damages for past medical expenses to amounts actually paid; (2) safeguard physicians' personal assets; (3) prohibit plaintiffs from making allegations that are irrelevant, coercive, or pertain to a physician's income or personal assets; (4) address prelitigation review panels; and (5) expand circumstances where physicians are entitled to attorney fees.

202. DEEPFAKE TECHNOLOGY AND HARM TO PHYSICIANS AND PATIENTS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED**
See Policy H-478.973

RESOLVED, that our American Medical Association recognize that while there are documented advantages of deepfake technology for medical education, training, and patient engagement, there currently exists a significant regulatory void, and such lack of oversight can result in harmful consequences, including the manipulation of patients, the spread of misinformation, and the potential for injury or death.

RESOLVED, that our AMA support relevant organizations including healthcare professionals, technology developers, government regulators, social media platforms, and the public, to formulate comprehensive federal legislation and regulations regarding deepfake technology to uphold the integrity of the medical profession against malpractice, increase awareness of the risks associated with deepfake content, and safeguard patient well-being across all communities.

203. RESTORE AND ENHANCE FEDERAL LOAN PROGRAMS FOR MEDICAL EDUCATION

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ALTERNATE RESOLUTION 203 ADOPTED**
IN LIEU OF RESOLUTION 203 AND RESOLUTION 217
See Policy H-305.924

RESOLVED, that our American Medical Association continue to advocate for federal student loan limits that accurately reflect the cost of attendance of graduate medical education programs.

RESOLVED, that our AMA continue to support diverse and beneficial repayment plans for federal student loans, including income-based repayment plans that are favorable to individuals who took out loans for graduate medical education.

RESOLVED, that our AMA continue to advocate for the protection of the Public Service Loan Forgiveness (PSLF) Program for physicians.

204. ADDRESSING ANTI-PHYSICIAN CONTRACTUAL PROVISIONS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-225.970

RESOLVED, that our American Medical Association develop model state legislation to prohibit the inclusion of clauses indemnifying employers in physician contracts.

RESOLVED, that our AMA will actively work to increase the education and awareness of physicians on the implications of accepting employment contracts which require physicians to (i) pay for tail insurance, or (ii) indemnify their employers.

205. RESTORING BALANCE BILLING AND ALLOWING COPAY FORGIVENESS TO PRESERVE INDEPENDENT PRACTICE AND IMPROVE ACCESS TO CARE
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association assign high priority to advocacy to support legislation or regulatory reform to restore private physicians' ability to balance bill patients for non-emergency, outpatient medical services, regardless of insurance network participation status.

RESOLVED, that our AMA oppose artificial caps on private physician balance billing amounts, especially of less than 100 percent above the insurer's allowed amount, to reflect and offset decades of reimbursement erosion.

RESOLVED, that our AMA support the continuation of protections from balance billing for emergency care, Medicaid beneficiaries, and other vulnerable populations as currently required under state and federal law.

RESOLVED, that our AMA advocate at the federal level for reform of anti-kickback and payer contracting rules that prohibit physicians from waiving co-pays and deductibles for patients experiencing financial hardship.

206. RESTORE FUNDING TO USAID
Introduced by Colorado

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-250.985 and D-250.986

RESOLVED, that our AMA make public statements regarding the cost in human life of withdrawal of funding for USAID.

RESOLVED, that our AMA make public statements regarding the worldwide health risks associated with withdrawal of funding for treatment of infectious diseases such as Tuberculosis, HIV, Ebola, and others.

RESOLVED, that our American Medical Association policy D-250.986 be reaffirmed.

207. SUPPORT FOR A FEDERAL TAX INCENTIVE FOR VOLUNTEER COMMUNITY PRECEPTORS
Introduced by American Academy of Family Physicians

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-305.923

RESOLVED, that our American Medical Association support proposals to establish a federal tax credit or tax deduction for physicians who serve as community preceptors for medical students and residents, provided these services are rendered without financial compensation from any educational institution.

208. CENTRALIZATION OF MEDICARE PROVIDER DATA SOURCES
Introduced by Tennessee

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICIES D-478.984, H-285.902 AND H-355.979 REAFFIRMED IN LIEU OF RESOLUTION 209

RESOLVED, that our American Medical Association advocate that the Centers for Medicare and Medicaid Services (CMS) adopt centralized, standardized, and interoperable provider data repositories for Medicare and Medicare Advantage provider directory purposes, including acceptance of validated data from nationally recognized sources such as the Coalition for Affordable Quality Healthcare (CAQH) or equivalent, and eliminate duplicative attestations by physicians when accurate data has already been submitted through such systems.

RESOLVED, that our AMA continue to urge CMS to harmonize provider directory requirements across programs and promote automation, data governance standards, and streamlined workflows that improve directory accuracy, reduce administrative burden, and ensure patients have timely access to reliable provider information.

209. SUPPORT FOR LEGISLATIVE CHANGES ALLOWING PARTIAL MEDICARE OPT-OUT FOR PHYSICIANS
Introduced by Florida

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association advocate for federal legislation or regulatory changes to allow physicians to opt out of Medicare in one employment setting while maintaining the ability to bill Medicare for services provided in other practice settings (e.g., private practices, hospice, inpatient hospital care, or other defined roles).

210. PBM DIVESTITURE AND TRANSPARENCY
Introduced by Florida

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-120.919

RESOLVED, that our American Medical Association will work with appropriate parties to support and lobby for divestment of Pharmacy Benefit Managers (PBMs) from ownership by insurance companies.

RESOLVED, that our AMA will work with appropriate parties to support and lobby for divestment of PBMs from owning affiliate pharmacies and infusion centers.

211. ACCESS TO, AND RETENTION OF, ELECTRONIC MEDICAL RECORDS
Introduced by Utah

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association support federal legislation to standardize the duration of all medical record retention and to require that records of discharged patients be compiled, reviewed for completeness, and authenticated within 30 days of discharge.

RESOLVED, that our American Medical Association adopt as its formal policy and also support federal legislation that mandates the following:

a) All EMR vendors must retain patient data electronically to comply with state laws regardless of whether the provider or health-care system contract is still in effect;
b) All EMR vendors must arrange for custodians of all electronic medical files to comply with state law regarding medical record retention in case of insolvency; and
c) All EMR vendors must deliver an individual patient's medical records when requested to lawful recipients in a timely manner, at reasonable or no cost, and in formats that are readily accessible to the general public.

212. ACKNOWLEDGING FLEXIBILITY ON BUPRENORPHINE MONO-PRODUCT USE FOR OPIOID USE DISORDER
Introduced by American Society of Addiction Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-95.948

RESOLVED, that our American Medical Association advocate at the state and federal level to remove "red-flag" or "suspicious order" designations suspecting or distinguishing between buprenorphine mono-product and buprenorphine/naloxone that are approved for treatment of OUD.

RESOLVED, that our AMA advocate that Medicare, Medicaid, and all commercial health plans and other payers, be required to cover medications to treat opioid use disorder in all formulations without prior authorization, step therapy, fail first requirements, or other inappropriate utilization management.

213. PHYSICAN VISA PROTECTION AND PATHWAY TO U.S. PERMANENT RESIDENCY

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ALTERNATE RESOLUTION 213 ADOPTED
IN LIEU OF RESOLUTION 213 AND 214
See Policy D-255.967

RESOLVED, that our American Medical Association advocate for a viable, expedited, and separate pathway for physicians to obtain permanent residence in the United States.

RESOLVED, that our American Medical Association advocate for the federal government to work to ensure physicians are exempt from unreasonable increases in H-1B visa fees.

RESOLVED, that our AMA advocate for the creation of a dedicated visa pathway specifically for physicians.

214. PHYSICIAN VISA PROTECTION AND PATHWAY TO SERVE UNDERSERVED COMMUNITIES

Resolution 214 was considered with Resolution 213. See Resolution 213.

RESOLVED, that our American Medical Association advocate for the federal government to work to ensure physicians are exempt from any proposed increases in H-1B visa fees, including the proposed $100,000 charge, through feasible alternatives such as by including them in the National Interest Waiver.

RESOLVED, that our AMA advocate for the creation of a dedicated non-immigrant visa pathway specifically for physicians, in recognition of their essential role in U.S. healthcare and to prevent them from being unintended casualties of broader immigration policy changes.

215. EXTENDING THE MEDICAID WORK REQUIREMENT EXEMPTION UP TO 12 MONTHS POSTPARTUM
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-420.945

RESOLVED, that our American Medical Association supports a clear, mandatory exemption from Medicaid work requirements for all postpartum individuals for 12 months postpartum.

216. ENSURING TIMELY J-1 VISA PROCESSING TO PROTECT IMG PARTICIPATION IN RESIDENCY PROGRAMS

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ALTERNATE RESOLTUION 216 ADOPTED IN LIEU OF RESOLUTION 216**
See Policy D-255.966

RESOLVED, that our American Medical Association work with all relevant federal agencies to support timely J-1 visa appointments and expedited processing for international medical graduates matched into U. S. residency and fellowship programs.

217. PROTECTING ACCESS TO PUBLIC SERVICE LOAN FORGIVENESS (PSLF), INCOME-DRIVEN REPAYMENT (IDR), AND DIRECT PLUS LOANS FOR GRADUATE OR PROFESSIONAL STUDENTS (GRAD PLUS LOANS)
Introduced by New Jersey

Resolution 217 was considered with Resolution 203. See Resolution 203.

RESOLVED, that our American Medical Association advocates for protection of access to Public Service Loan Forgiveness (PSLF), Income-Driven Repayment (IDR), and Direct Plus Loans for Graduate or Professional Students (Grad PLUS Loans).

218. AMEND AMA POLICY D-160.921 ON SENSITIVE LOCATIONS TO PROTECTED AREAS
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-160.921

RESOLVED, that our American Medical Association amend policy D-160.921 by addition and deletion as follows:

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

219. ADDRESSING THE HARMS AND MISLEADING NATURE OF MEDICARE ADVANTAGE PLANS
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICIES D-70.950, D-185.979, D-330.888, D-330.923, D-330.930, D-390.967, H-390.832, H-330.862 AND H-330.878 REAFFIRMED IN LIEU OF RESOLUTION 219

RESOLVED, that our American Medical Association emphasize to Congress the excessive cost, the use of taxpayer funding, the depletion of taxpayer monies supporting traditional Medicare by the Medicare Advantage (MA) programs.

220. MEDICARE SHOULD NOT UNFAIRLY PENALIZE PHYSICIANS
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RESOLUTION 220 AND RESOLUTION 223 REFERRED

RESOLVED, that our American Medical Association advocate for the repeal of any law or regulation that imposes a penalty or deduction on Medicare physician payment based upon the result of a value-based payment program.

221. NOT-FOR-PROFIT STATUS
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association advocate that the granting and maintenance of healthcare entities of not-for-profit status be reassessed by both the state legislature and the US Congress.

222. TACKLING ADMINISTRATIVE WASTE—LET US BE PART OF THE SOLUTION TO PUTTING OUR HEALTH SYSTEM ON A SUSTAINABLE PATH
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICY D-155.996 REAFFIRMED IN LIEU OF RESOLUTION 222

RESOLVED, that our American Medical Association work with all relevant government agencies to identify sources of administrative waste to advocate for elimination of high-cost bureaucratic excesses and revision or replacement of the counterproductive payment strategies of the past two decades.

223. HALT THE ROLLOUT OF NEW PAYMENT MODELS BY THE CENTER FOR MEDICARE & MEDICAID INNOVATION (CMMI)—A NEW ADMINISTRATION OFFERS AN OPPORTUNITY
Introduced by Private Practice Physicians Section

Resolution 223 was considered with Resolution 220. See Resolution 220.

RESOLVED, that our American Medical Association advocate and urge Congress to halt the Center for Medicare & Medicaid Innovation's (CMMI) creation and rollout of new value-based payment models, quickly discontinue programs that have had negative effects on care, while supporting CMMI's evaluation of the models currently being tested.

224. RECOUPMENT BY CMS RECOVERY AND AUDIT CONTRACTORS (RAC)—DUE PROCESS
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-265.985, D-320.991, H-28 330.921, and H-335.981

RESOLVED, that our American Medical Association advocates for legislation and regulation that Medicare contractors must be compelled to appear during administrative or legal proceedings if requested.

RESOLVED, that existing AMA policies D-320.991, H-330.921, and H-335.981 be reaffirmed.

225. FEDERAL LEGISLATION TO PROHIBIT THE CORPORATE PRACTICE OF MEDICINE
Introduced by American Academy of Emergency Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED WITH REPORT BACK AT A-26

RESOLVED, that our American Medical Association advocate for federal legislation that prohibits lay corporations, including insurance companies, private equity firms, and other non-physician-owned entities, from owning or controlling medical practices and healthcare decision-making, and prohibits such entities from participation in federal healthcare payment programs, in order to protect physician autonomy and strengthen the physician-patient relationship.

RESOLVED, that our AMA amend Policy H-215.981 - Corporate Practice of Medicine under items #1 and #2 by addition and deletion as follows:

1. Our American Medical Association ~~vigorously opposes any effort to pass federal legislation or regulation preempting state laws~~ supports the passage of federal legislation prohibiting the corporate practice of medicine.
2. Our AMA vigorously opposes any effort to pass state or federal legislation or regulation that removes or weakens existing state laws prohibiting the corporate practice of medicine.

226. TRANSPARENCY WITH THE TERM "EMERGENCY DEPARTMENT"
Introduced by American Academy of Emergency Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association advocates for the designation of "emergency department" or "emergency room" to be restricted to facilities with the presence of at least one physician on-site and on-duty, who is responsible for the emergency department at all times.

RESOLVED, that our AMA recommends that facilities without physician staffing use alternative terminology, such as Acute Care Unit, as a matter of truth and transparency for patients, so that patients are not expecting care by a physician.

RESOLVED, that our AMA work with the Joint Commission, Det Norske Veritas (DNV), and other authorities/regulators to educate them about this issue, and to encourage them to implement correct "emergency department" terminology designations to ensure truth and transparency at all times for our patients.

227. CALL FOR ACTION BY THE AMA TO REVERSE OR MITIGATE MEDICAID CUTS
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-290.970

RESOLVED, that our AMA publicly denounce cuts to Medicaid in Public Law 119-21 (known as the "One Big Beautiful Bill Act of 2025").

RESOLVED, that our AMA through, but not limited to, press releases, position statements, op-eds in major outlets, press conferences and lobbying, work to reverse or mitigate Public Law 119-21 as it relates to Medicaid.

RESOLVED, that our AMA continue working with state medical societies, specialty societies, patient advocacy groups, hospital systems and safety net organizations to advocate for the reversal or mitigation of Medicaid-related cuts in Public Law 119-21.

RESOLVED, that our AMA report back to the AMA's House of Delegates at A-26.

228. SUPPORT PERMANENT FUNDING AND EXPANSION OF NATIVE HAWAIIAN HEALTHCARE
Introduced by Underrepresented in Medicine Advocacy Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy H-350.933

RESOLVED, that our American Medical Association supports federal policies that uphold the federal trust obligations to improve the health of Native Hawaiian communities by strengthening access to comprehensive, culturally informed, and physician-led health care.

RESOLVED, that our AMA supports stable, long-term federal funding and infrastructure for Native Hawaiian health care programs to ensure continuity of care, workforce development, and equitable access to services across all islands.

RESOLVED, that our AMA supports the expansion of Native Hawaiian Health Care Systems, including additional sites, mobile clinics, transportation support, workforce development, and culturally grounded health services that integrate traditional Indigenous healing alongside physician-led care.

RESOLVED, that our AMA encourages collaboration with Native Hawaiian organizations, leaders, and communities to ensure that federally supported health care initiatives are responsive to local needs, culturally respectful, and community-driven.

229. PROTECTION OF MEDICAID BENEFICIARIES' PRIVATE HEALTH INFORMATION FROM IMMIGRATION ENFORCEMENT

Introduced by Underrepresented in Medicine Advocacy Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-315.966

RESOLVED, that our American Medical Association amend H-315.966 "Patient and Physician Rights Regarding Immigration Status" by addition and deletion to read as follows:

> Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records, Medicaid, Children's Health Insurance Program (CHIP), or other health program data, including but not limited to Emergency Medicaid and related immigrant-specific programs, ~~to pursue immigration enforcement actions against patients who are undocumented~~ for immigration enforcement purposes.

RESOLVED, that our AMA support efforts by interested parties to educate physicians, medical students, and patients about existing privacy protections to safeguard confidential health information, and to help ensure that this information reaches immigrant and mixed-status families.

230. BANNING NON-COMPETE AGREEMENTS IN STATES

Introduced by American College of Rheumatology

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED**
See Policy D-265.984

RESOLVED, that our American Medical Association will work with state medical societies, national specialty societies and/or other interested parties to advocate for legislation or regulation that would prohibit covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers, across all states in which a ban on non-to-compete agreements is not in place.

231. ENSURING EQUITABLE AND TIMELY MEDICAL LICENSURE FOR PHYSICIANS PROVIDING ABORTION AND GENDER-AFFIRMING CARE
Introduced by LGBTQ+ Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-275.942

RESOLVED, that our American Medical Association advocate that no physician be disqualified from medical licensure or subject to unnecessary delay in the licensure process solely due to having provided abortion care or gender-affirming care in accordance with then-current standards of medical practice and/or while such care was legal in their jurisdiction.

RESOLVED, that our AMA support policies, legislation, and state medical society initiatives that prohibit discrimination by state medical boards or licensing authorities against applicants based on their provision of abortion or gender-affirming care; and be it further

RESOLVED, that our AMA work with relevant interested parties, including state medical boards and specialty societies, to support the development of guidance ensuring that physicians seeking licensure are evaluated in a timely manner, equitably and without bias relating to reproductive or gender-affirming care practices.

232. SAFEGUARDING ACCESS TO IVF AMID RESTORATIVE REPRODUCTIVE MEDICINE LEGISLATION
Introduced by American Society for Reproductive Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-425.962

RESOLVED, that our American Medical Association opposes any efforts to limit patient access to the full scope of evidence-based fertility treatments, including but not limited to: In Vitro Fertilization (IVF).

RESOLVED, that our AMA should advocate for NIH funding for women's health, including reproductive health, so that we can expand research on the potential underlying causes of infertility.

RESOLVED, that our AMA acknowledges that practices considered “restorative reproductive medicine” constitute part of what Reproductive Endocrinology and Infertility physicians, Urologists, and other fertility specialists provide in their daily practice through patient-centered evaluation and individualized treatment of underlying.

RESOLVED, that our AMA acknowledges that IVF is an important part of the comprehensive, evidence-based infertility treatment options that should be offered to patients and is often the most successful option for many patients looking to grow or start their families.

233. RENEWING MENTAL HEALTH INFRASTRUCTURE IN THE SCHOOL SYSTEM
Introduced by American Academy of Child and Adolescent Psychiatry

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-345.968

RESOLVED, that our American Medical Association support sustained, stable, and equitable state and federal funding and infrastructure, for the training, placement, and retention of school-based mental health professionals, with priority given to rural and underserved communities.

RESOLVED, that our AMA advocate for federal legislation incorporating automatic continuity protections (such as bridge funding or carryover authority) within school-based mental health programs, to prevent disruptions in student services and workforce stability when federal appropriations are delayed or rescinded.

234. STUDY ON IMPACT OF INFLATION REDUCTION ACT ON ONCOLOGY, OTHER PHYSICIAN PRACTICES
Introduced by Association for Clinical Oncology

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-345.968

RESOLVED, that our American Medical Association will work with relevant stakeholders to conduct a comprehensive study on the impact of the Inflation Reduction Act's (IRA) drug price negotiation provisions, particularly for drugs covered under Medicare Part B and physician-administered drugs due to concerns it could jeopardize patient access to critical therapies as the IRA's potential for reimbursement reductions may lead to less availability of these medications in smaller, community-based clinics where a significant amount of care is provided.

RESOLVED, that our AMA will specifically evaluate the potential impact of the Inflation Reduction Act on the sustainability of community-based physician practices, with a particular focus on oncology practices.

RESOLVED, that our AMA will consider using the findings of the study on the impact of the Inflation Reduction Act (IRA) drug price negotiations provisions on the sustainability of community based practices to inform its advocacy efforts to ensure that any future drug pricing policies balance patient affordability with the stability of physician practices, patient access, and the continued advancement of drug innovation.

235. ENSURING MEDICAL LIABILITY INSURANCE TRANSPARENCY AND CONTINUITY
Introduced by American College of Emergency Physicians

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: FIRST RESOLVE ADOPTED AS FOLLOWS
SECOND RESOLVE REFERRED
THIRD RESOLVE ADOPTED
See Policy D-215.980 and D-435.965

[Editor's note: the following resolve was adopted as follows]
RESOLVED, that our American Medical Association advocate for legislation requiring prior notification of at least 30 business days by the medical liability insurance carrier to the covered physician for any policy changes or cancellation, and immediate (within 10 business days) notification of a missed payment.

[Editor's note: the following resolve was referred]
RESOLVED, that our AMA recognize that occurrence-based medical liability insurance or claims-made medical liability insurance with a pre-paid tail is the gold standard for medical liability coverage.

[Editor's note: the following resolve was adopted]
RESOLVED, that our AMA policy D-215.980 "Support Before, During, and After Hospital Closure or Reduction in Services" be amended so as to include physician group closures.

236. DECEPTIVE ADVERTISING IN ACCREDITED ALLIED HEALTH PROFESSIONAL, NON-PHYSICIAN GRADUATE PROGRAMS
Introduced by College of American Pathologists

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED**
See Policy D-405.964

RESOLVED, that our AMA support state and national medical societies to advance "Truth & Transparency" legislation, inclusive of accredited allied health professional, non-physician graduate education programs to instill transparency in non-physicians' scope of practice and training under the direction of a licensed physician.

RESOLVED, that Our AMA advocate for legislation and refinements to "Truth & Transparency" laws to prohibit production and dissemination of deceptive advertising and marketing materials by accredited allied health professional, non-physician graduate programs. These requirements should:

1. Prohibit deceptive, misleading or false advertising inclusive of professional titles and scope of the allied health professional completing the program.
2. Require that the advertised course of study at such programs is clearly consistent with applicable state laws and well-established and widely accepted medical standards for allied health professionals' training, certification, and scope of practice.
3. Mandate all advertising materials include clear and unambiguous statements that clarify the requisite levels of physician supervision for non-physician, allied health professionals, that will complete the program.

237. PROTECTING AND IMPROVING RURAL HEALTH
Introduced by California

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **POLICIES H-130.954, H-200.949, H-200.954, H-290.951, AND H-465.994 REAFFIRMED IN LIEU OF RESOLUTION 237**
See Policy TBD

RESOLVED, that our American Medical Association assist state medical associations, specialty societies and physician practices with the implementation of HR 1, The One Big Beautiful Bill Act, to mitigate the negative impact of the Medicaid, ACA and student loan cuts to physicians and patients, particularly in rural areas.

RESOLVED, that our AMA continue to assist state medical associations and physician practices with the HR 1 implementation of the Rural Transformation Program to ensure funding and assistance for physician practices.

RESOLVED, that our AMA support the provision and payment of physician-to-physician virtual telehealth consultations as an option to increase access to primary and specialty care in rural communities, acknowledging that significant investments in rural telehealth broadband must be made in order to effectively deliver telehealth services.

RESOLVED, that our AMA encourage the development of programs and financial assistance models for rural physician practices in need of health information technology and other technological modernization and security, as well as access to specialty equipment to provide quality care.

RESOLVED, that our AMA support investments in and payment for a wide variety of medical transportation options to connect rural residents to primary and specialty care services and return to their communities.

RESOLVED, that our AMA continue to address the nation's obstetrics and gynecology training and workforce needs, including but not limited to increasing postgraduate positions in OB-GYN and family medicine OB fellowships, increasing ACGME funding, and evaluating other ways to increase physicians providing OB-GYN services in shortage areas.

RESOLVED, that our AMA support expansion of Family Practice Obstetricians (FPOB) who are family practice physicians that are certified after completing an obstetrics fellowship.

RESOLVED, that our AMA urge the Centers for Medicare and Medicaid Services and others to provide funding for standby capacity payments to sustain obstetric services at hospitals at risk of closing access to maternity care.

RESOLVED, that our AMA urge the Department of Defense to provide health care coverage, funding and improved access to labor and delivery services for military personnel, military families, and non-military individuals working on military bases in maternity care health professional shortages areas.

RESOLVED, that our AMA continue to research and distribute successful state and specialty society models that have improved access to maternal care in rural areas and reduced maternal mortality rates.

238. OPPOSE UNFAIR HOSPITAL PRIVILEGE DECISION BASED ON INSURANCE PLAN PARTICIPATION

Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-230.981

RESOLVED, that our American Medical Association advocate for legislation, regulation, or other interventions to prevent health insurers from threatening hospitals with payment cuts, administrative fee imposition, network termination, or other negative financial policies, if an out of network physician is involved in the treatment or care of a patient at that hospital.

RESOLVED, that our AMA collaborates with specialty societies and state medical societies to oppose unfair and/or coercive business practices which undermine patient access and/or physician practices.

REFERENCE COMMITTEE C

301. PREVENTING SLEEP DEPRIVATION AND SUPPORTING MEDICAL STUDENT WELLNESS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-295.296

RESOLVED, that our American Medical Association support encourage the LCME, COCA, AAMC, and AACOM to continue the development of guidelines for medical student work-hour limits, time off after a 24-hour shift, and work-hour guidelines.

302 was not considered

303 was not considered

304. SYSTEMIC EXCLUSION OF IMGS FROM RESIDENCY PROGRAMS
Introduced by International Medical Graduates Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-255.988 and H-295.860

RESOLVED, that our AMA uphold its commitment to opposing discrimination against IMGs in all aspects of medical education and training.

RESOLVED, that our AMA will work with relevant parties to advocate for universal transparency of residency program eligibility requirements, including IMG eligibility and visa sponsorship policies, in electronic residency application systems and FREIDA™ to be published in a standardized, accessible format, to reduce unnecessary financial and emotional burdens on applicants.

305. PAID SICK LEAVE AND FLEXIBLE WORK ARRANGEMENTS FOR PHYSICIANS WHO ARE CAREGIVERS
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy D-310.968 and H-420.979

RESOLVED, that our American Medical Association amend H-420.979, "AMA Statement on Family, Medical, and Safe Leave".

Our American Medical Association supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions, caregiving obligations, or reasons related to personal safety. Such policies should provide for reasonable periods of paid or unpaid:

1. Medical leave for the employee, including pregnancy, abortion, and stillbirth.
2. ~~Maternity~~ Parental leave for the employee.
3. Leave if medically appropriate to care for a member of the employee's ~~immediate~~ family, i.e., a

spouse, ~~or~~ children~~.~~, or other individuals for whom the employee is the primary caregiver.

4. Leave for adoption or for foster care leading to adoption.
5. Safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking.
6. Flexible work arrangements such as flexible work hours and the ability to work remotely, without creating intolerable increases in the workloads of other physicians and students.

Such periods of leave may differ with respect to each of the foregoing classifications and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. Our AMA recognizes the positive impact of paid safe leave on public health outcomes and supports legislation that offers safe leave.

RESOLVED, that our AMA supports physicians who are caregivers to alleviate physician burnout.

306. SUPPORT FOR PAID LEAVE FOR PRENATAL CARE
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy H-405.960

RESOLVED, that our American Medical Association supports policies that provide physician employees with paid leave for routine prenatal care or any medical care related to pregnancy in addition to other existing forms of leave.

307. INTEGRATING AUGMENTED INTELLIGENCE (AI) LITERACY INTO UME, GME, AND CME
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy H-295.857

RESOLVED, that our American Medical Association develop and disseminate model AI learning objectives and curricular toolkits aligned with existing AMA policy and AAMC principles.

RESOLVED, that our AMA collaborate with medical organizations to recognize AI literacy elements where appropriate.

RESOLVED, that our AMA support AI CME offerings to upskill the current workforce.

RESOLVED, that our AMA advocate for funding and faculty-development resources to implement and evaluate AI training initiatives.

308. ENHANCING THE PATHWAY FOR BLACK MALE MEDICAL STUDENTS
Introduced by New York

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies D-200.980, D-200.982, H-295.836, H-295.851 and H-305.925

RESOLVED, that, consistent with applicable laws, our American Medical Association support the development and funding of comprehensive mentorship programs connecting Black male pre-medical students with physician mentors, guiding academic preparation, MCAT preparation, the medical school application process, and career development.

RESOLVED, that, consistent with applicable laws, our AMA support the development of leadership training programs for Black male physicians, equipping them with the skills and knowledge to assume leadership roles in academic medicine, healthcare administration, and public health.

RESOLVED, that our AMA encourage collaboration between our AMA, medical schools, HBCUs, and community organizations to increase pathways for Black male students in medicine.

RESOLVED, that policies D-200.980, D-200.982, H-295.851, and H-305.925 be reaffirmed.

309. REASONABLE WORKPLACE ACCOMMODATIONS FOR RESIDENTS AND FELLOWS DURING PREGNANCY
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-420.944

RESOLVED, that our American Medical Association advocate that relevant parties provide evidence-based accommodations for all pregnant physician trainees and physician staff and should implement them in such a way that they do not place an intolerable burden of work on other physician trainees and physician staff, and minimize departmental disruption in the event of medical necessity or early delivery.

RESOLVED, that our AMA supports evidence-based policies and procedures which prioritize the safety and well-being of all pregnant physicians.

310. REMEDYING THE HARMS OF AMA'S ROLE IN THE FLEXNER REPORT

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ALTERNATE RESOLUTION 310 ADOPTED
IN LIEU OF RESOLUTION 310
See Policies D-295.963 and H-350.960

RESOLVED, that our American Medical Association (AMA) partner with relevant public and private sector organizations and relevant parties to advance restorative efforts that address the harms of the 1910 Flexner Report by promoting and supporting the development, opening, and/or reopening of medical schools in historically marginalized and underserved communities, including those affiliated with Historically Black Colleges & Universities (HBCUs), Tribal Colleges & Universities (TCUs), and Minority-Serving Institutions (MSIs) through collaborative feasibility assessments, resource development partnerships, and community-guided planning processes, among others.

RESOLVED, that our AMA prioritize our organization's efforts to bolster diversity, equity, and inclusion across the medical education continuum, including but not limited to supporting structural pathways, culturally responsive

curricula, and accountability mechanisms that strengthen recruitment, retention, and advancement of historically marginalized groups in medicine.

311. GENDER AND UNDERREPRESENTED IN MEDICINE DISPARITIES IN PROCEDURAL AND SURGICAL TRAINING VOLUMES
Introduced by American Academy of Ophthalmology

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy H-310.895

RESOLVED, that our American Medical Association recognizes gender- and underrepresented in medicine-based disparities in procedural and surgical training volumes as an equity issue in graduate medical education, distinct from resident competency.

RESOLVED, that our AMA encourage the Accreditation Council for Graduate Medical Education (ACGME) and specialty boards to collect aggregate, de-identified procedural and surgical case volume data stratified by gender and underrepresented in medicine status, and to make these data available through a controlled-access process to institutional leaders and residency and fellowship programs.

RESOLVED, that our AMA encourage residency and fellowship programs to implement mechanisms to promote equitable procedural and surgical case allocation, while recognizing that all graduates must meet established training requirements.

RESOLVED, that our AMA encourage the development and dissemination of best practices to include mentorship and equitable case distribution systems to ensure fairness in procedural and surgical case experience across all specialties.

312. PROMOTING THE EQUITABLE EVALUATION OF NON-RESEARCH DOMAINS IN TRAINEE SELECTION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED**
See Policy H-295.835

RESOLVED, that our American Medical Association support efforts and work with relevant parties to:
a)Improve the holistic and equitable consideration of research, advocacy, service, teaching, mentorship, and other non-research domains in medical school and residency/fellowship selection; and
b)Reduce the emphasis on research expectations for applicants; and
c)Improve medical school and residency/fellowship application services to allow applicants to comprehensively showcase the non-research domains that best align with their experiences and career goals.

313. HARDSHIP FOR INTERNATIONAL MEDICAL GRADUATES FROM PALESTINE
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: REFERRED

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

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

REFERENCE COMMITTEE F

601. REIMAGINING AND MODERNIZING THE U.S. HEALTHCARE DELIVERY SYSTEM
Introduced by New England Delegation

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, that our American Medical Association will convene a multidisciplinary Task Force, under the direction of the Board of Trustees, that may include physicians and trainees, allied health professionals, leaders from hospitals and health systems, public and private payers, health economists, ethicists, patient advocates, and other relevant parties from across the health sector, to develop a legislative roadmap to reform the U.S. healthcare delivery system, drawing from and building upon existing AMA policy, and positioning our AMA as a convener of a broader national coalition to advance this vision; and that this roadmap will be structured around the following components:

1. Foundational Principles: The roadmap will specifically incorporate the following principles:
    a. Equitable access to affordable, high-quality healthcare for all as a basic human right;
    b. Physician autonomy and the primacy of the patient-physician relationship;
    c. Physician-led care as the foundation of clinical decision-making and healthcare delivery;
    d. Freedom of patients and physicians to choose care settings and models of practice;
    e. Physician practice sustainability through fair and predictable payment;
    f. Science-based innovation that improves healthcare value and efficiency; and
    g. Prevention, public health, and health equity as central pillars of a sustainable healthcare system;
2. Scope of Review: In developing the roadmap, the task force will consider issues related to healthcare delivery and financing, including, but is not limited to, the following systemic problems and potential solutions:
    a. Physician payment and workforce sustainability;
    b. Comprehensive valuation of physician work;
    c. Incentives that support timely, patient-centered care and uphold clinical judgment;
    d. Administrative, financial, and clinical interference by intermediaries;
    e. Uninsurance, underinsurance, and other cost-sharing issues;
    f. Universal coverage, including preventive services and public health;
    g. Equity in care delivery;
    h. Protection of physician-patient shared decision-making;
    i. Market consolidation, vertical integration, and profiteering;
    j. Drug pricing and access to evidence-based therapies; and
    k. Transparency and reporting of the true cost of care;
3. Environmental Scan: To inform the roadmap, the task force will conduct a comprehensive review of existing global and domestic healthcare programs and reform proposals to evaluate their strengths and weaknesses based on how each framework centers patients, upholds clinical judgment, and promotes healthcare system and physician practice sustainability; and
4. Reporting and Engagement: The task force will:
    a. Report at least annually to the AMA House of Delegates on its findings and progress;
    b. Provide recommendations to the AMA Board of Trustees on areas requiring further policy development to support this work;
    c. Regularly convene focus groups within and outside of the AMA House of Delegates to review draft elements of the roadmap as they are being developed; and
    d. Deliver a final comprehensive legislative roadmap to reform the U.S. healthcare delivery system for consideration by the AMA House of Delegates.

602. STANDARDIZING THE APPOINTMENT PROCESS FOR AMA COUNCILS
Introduced by American Academy of Family Physicians

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association develop a phased implementation plan – including selection criteria, procedural steps, and necessary bylaw amendments – to establish a House of Delegates-elected Nominating Committee responsible for the appointment and reappointment of all Council members, subject to final approval by the Board of Trustees.

603. UPHOLDING PROFESSIONAL INTEGRITY AND ETHICAL LEADERSHIP

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ALTERNATE RESOLUTION 603 ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 603 AND RESOLUTION 604
S*ee Policy D-300.971*

RESOLVED, that our American Medical Association commit to sustaining accessible, physician-led education and discourse on the ethical challenges in medicine.

RESOLVED, that our AMA publicize opportunities for medical ethics engagement and learning across the association.

RESOLVED, that our AMA will continue to advance and fund opportunities for editorial fellowships in ethics for trainees and early-career physicians commensurate to the AMA Journal of Ethics Editorial Fellowship.

RESOLVED, that our AMA will report back on its progress and advancement for medical ethics engagement and editorial fellowships for trainees and early-career physicians at Annual 2026.

604. SUSTAINING ETHICAL LEADERHIP THROUGH CONTINUED SUPPORT OF THE AMA JOURNAL OF ETHICS

Resolution 604 was considered with Resolution 603. See Resolution 603.

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

RESOLVED, that our AMA reaffirm its commitment to sustaining accessible, physician-led ethics education and discourse.

REFERENCE COMMITTEE J

801 was not considered

802. PATIENT CHOICE OF PHYSICIAN
Introduced by Michigan

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED**
See Policies H-160.901 and H-180.952

RESOLVED, that our American Medical Association continue its support of the patient-physician relationship and the patient's choice of physician by reaffirming existing AMA policies, "Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care H-160.901" and "Physician Penalties for Out-of-Network Services H-180.952."

803 was not considered

804. MEDICARE ADVANTAGE FILING LIMIT
Introduced by New England Delegation

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED**
See Policy D-190.966

RESOLVED, that our American Medical Association and other stakeholders advocate for and support federal efforts to ensure policy uniformity regarding claim filing time limits between Medicare Advantage plans and traditional Medicare, with a uniform time of one calendar year.

805. SHARED MEDICAL APPOINTMENTS
Introduced by New England Delegation, American College of Lifestyle Medicine

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-160.882

RESOLVED, that our American Medical Association recognizes Shared Medical Appointments, and/or Group Medical Visits, as an effective model of care delivery.

RESOLVED, that our AMA advocate to hospitals and health systems that they support physicians and other clinicians who desire to host Shared Medical Appointments, and/or Group Medical Visits.

RESOLVED, that our AMA advocate for payment of in-person or telehealth Shared Medical Appointments and/or Group Medical Visits, utilizing CPT codes and AMA-CPT coding guidance.

806. INSURANCE COVERAGE FOR COLONOSCOPY PREPARATION COST
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-185.960

RESOLVED, that our American Medical Association advocates that all health insurance plans cover colonoscopy preparation costs without cost-sharing as part of colorectal cancer screenings, ensuring that all Americans have access to necessary, cost-free preventative measures for colorectal cancer.

807. PROTECTING HOSPITALS AND PATIENTS FROM INAPPROPRIATE DENIALS OF INPATIENT ADMISSIONS
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-240.959

RESOLVED, that our American Medical Association advocate that if an insurance company denies "full admission" status for a patient being hospitalized, that the insurance company must provide the ability to revert the status to observation to protect the patient and the hospital from total denial of payment.

808. NO PRIOR AUTHORIZATION FOR INEXPENSIVE MEDICATIONS
Introduced by ORGANIZED MEDICAL STAFF SECTION

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-320.968

RESOLVED, that our American Medical Association advocate that low-cost medications and procedures should not require prior authorization.

809. ENSURING PATIENT SAFETY AND PHYSICIAN OVERSIGHT IN THE INTEGRATION OF HOSPITAL INPATIENT VIRTUAL NURSING
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED**
See Policy D-360.990 and H-225.938

RESOLVED, that our American Medical Association undertake a comprehensive study of hospital inpatient virtual nursing, including an assessment of its benefits and risks for patient safety and an analysis of guidelines for credentialing, privileging, and documentation standards and any policy gaps related to oversight by the Centers for Medicare & Medicaid Services and The Joint Commission.

RESOLVED, that our AMA recognizes that organized medical staffs, as leaders in hospital medicine who have a duty to protect patient safety within their institutions, should work collaboratively to ensure physician-led, high-quality, patient-centered care in the integration of inpatient virtual nursing,

810. OPPOSING UNILATERAL DOWNCODING OF PHYSICIAN SERVICES BY INSURANCE COMPANIES
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policies D-70.940 and D-320.972

RESOLVED, that our AMA work with state medical associations, specialty societies, and regulatory authorities to challenge payer-initiated downcoding policies through regulatory, legislative, and when appropriate, legal channels.

RESOLVED, that our AMA report back on payer downcoding practices, their effects on physicians and patients, and strategies for collective advocacy at the 2026 Interim Meeting.

RESOLVED, that our AMA will develop and disseminate guidance and educational materials for physicians regarding insurer downcoding and recoding practices, including how to document, appeal, and report inappropriate payer conduct to regulators and AMA advocacy channels.

RESOLVED, That Policy D-320.972 be reaffirmed.

811. NON-MEDICAL SWITCHING
Introduced by Florida, South Carolina, Tennessee, Oklahoma

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED**
See Policy H-125.971

RESOLVED, that our American Medical Association opposes the practice of non-medical switching by pharmacy benefit managers and health insurers, except when clinically justified and approved by the prescribing physician.

RESOLVED, that our American Medical Association study and report back at I-26 on the clinical and economic impact of non-medical switching on patient outcomes, medication adherence, and overall healthcare utilization, and disseminate these findings to policymakers and the public.

812. DISCONTINUE REVIEW CHOICE DEMONSTRATION PROJECT FOR INPATIENT REHABILITATION HOSPITAL ADMISSIONS
Introduced by American Academy of Physical Medicine and Rehabilitation

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED**
See Policy H-365.974

RESOLVED, that our American Medical Association oppose CMS's expansion of the Inpatient Rehabilitation Facility Review Choice Demonstration Project and advocate that the project be immediately discontinued.

813. INCREASED REGULATION OF FOR-PROFIT HEALTHCARE INSURANCE
Introduced by New York

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: POLICIES D-160.906, D-160.907, D-160.908, AND H-160.884, H-180.947 REAFFIRMED IN LIEU OF RESOLUTION 813

RESOLVED, that our American Medical Association promote public awareness of the harms of for-profit vertical integration of health insurance systems.

RESOLVED, that our AMA advocate for a comprehensive review by the legislature of current regulations and increased regulatory oversight and increased resources for the monitoring of State Medicaid and Managed Medicare for-profit health plans, including vertical integration.

814. MANDATE FOR INSURANCE COMPANIES TO ASSIST IN THE TRANSITION OF PATIENTS TO ALTERNATIVE PARTICIPATING PHYSICIANS UPON CONTRACT TERMINATION
Introduced by New York

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED
See Policy H-185.901

RESOLVED, that our American Medical Association advocate through legislation or regulations that private and public health insurers be mandated on the event of a treating physician terminating participation with that insurer to provide assistance to affected patients in transitioning to other in-network physicians, including providing a list of alternative participating physicians who can continue to provide care to the patient.

RESOLVED, that our American Medical Association advocate through legislation or regulations that private and public health insurers be mandated to provide resources to ensure continuity of care for patients who are mid-treatment or require ongoing care with the exiting physician without penalties to the physician, including offering extended benefits or out-of-network coverage when necessary.

RESOLVED, that our American Medical Association advocate through legislation or regulations that private and public health insurers be mandated to provide an online payment policy tool that has a uniform interface that works across all insurers and physicians, ensuring consistent and streamlined access to coverage information for physicians and patients.

815. MANDATING HEALTH INSURERS TO PROVIDE A REAL-TIME ONLINE TOOL FOR COVERAGE AND PAYMENT POLICIES, INTEGRATED INTO ELECTRONIC HEALTH RECORDS (EHRS)
Introduced by New York

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-478.972

RESOLVED, that our American Medical Association shall advocate for legislation or regulations requiring all health insurers in every State to provide a real-time online tool for physicians and patients to determine coverage and payment policies for medical procedures, treatments, and services at the time of suggested procedures.

RESOLVED, that our AMA advocates that the online payment policy tool must include detailed, accurate, and up-to-date information regarding covered services, co-pays, deductibles, and payment policies for specific procedures, and that insurers honor the coverage and payment determination provided at the time of approval.

RESOLVED, that our AMA advocate that the online payment policy tool must be a uniform interface that works across all insurers and physicians, ensuring consistent and streamlined access to coverage information for physicians and patients.

816. PROHIBIT ARBITRARY TIME LIMITS ON PREAUTHORIZATIONS
Introduced by New York

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-320.967

RESOLVED, that our American Medical Association advocate for changes in State legislation and Division of Financial Services policy to prohibit health insurers in any State, including Medicaid plans, from establishing time limits on duration of preauthorization for care of less than one year.

RESOLVED, that our AMA seek similar changes in Federal legislation and policies to prohibit Medicare Advantage, Medicaid, Veterans Affairs Community Care, and Employee Retirement Income Securement Act of 1974 (ERISA) plans from establishing time limits on preauthorizations for care of less than one year.

817. PROHIBITING INSURERS FROM DENYING PAYMENT FOR PROCEDURES BASED ON SITE OF SERVICE
Introduced by New York

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-240.958

RESOLVED, that our American Medical Association advocate to prohibit insurers from denying or reducing payment for a procedure based solely on the site of service in which was performed, provided that the procedure is medically necessary and can safely be performed in that location.

818. UNIVERSAL OUT-OF-NETWORK BENEFITS
Introduced by New York

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **D-285.958, D-285.963, H-165.838, H-180.952, H-285.904, H-285.907, AND H-285.908 REAFFIRMED IN LIEU OF RESOLUTION 818**

RESOLVED, that our American Medical Association will advocate for federal and state laws that requires all private insurers to offer health insurance plans with out-of-network benefits.

819. UPDATE THE STATUS OF VIRTUAL CREDIT CARD POLICY, EFT FEES, AND LACK OF ENFORCEMENT OF ADMINISTRATIVE SIMPLIFICATION REQUIREMENTS BY CMS
Introduced by New York

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-190.965

RESOLVED, that our American Medical Association report at the Annual 2026 Meeting on the progress of, and action items for implementation of AMA Policies D-190.970, H-190.955, and D-190.968.

820. ESTABLISHING AN AMA "FIRST RESPONDER TEAM" FOR REAL-TIME PHYSICIAN ADVOCACY AGAINST ADVERSE INSURANCE COMPANY ACTIONS
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: REFERRED FOR DECISION

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

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

RESOLVED, that an AMA "first responder team for physician advocacy against adverse insurance company actions" be a pilot program for the first two years of operation that will develop ongoing protocols to prioritize future cases brought to them, catalog them, and then report back to the House of Delegates annually.

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

821. IMPROVING ACCESS TO EMERGENCY OPHTHALMOLOGIC SURGICAL CARE
Introduced by Oklahoma, American Society of Retina Specialists, American Society of Cataract and Refractive Surgery

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED
See Policy H-130.926

RESOLVED, that our American Medical Association supports policies aimed at enhancing access to emergency ophthalmic care—including vitreoretinal surgical services and traumatic open globe injuries— through initiatives such as improved operating room availability, facility reimbursement reforms, and changes to hospital privileging that exclude economic criteria to facilitate timely surgical care.

RESOLVED, that our AMA advocates to reduce payer barriers, including prior authorization and inadequate Medicaid and Medicare reimbursement, that hinder access to surgical ophthalmologic emergency care including vitreoretinal surgery and traumatic open globe injuries.

RESOLVED, that our AMA advocate for reducing geographic and socioeconomic barriers to timely ophthalmologic emergency care—including both surgical vitreoretinal services and traumatic open globe injuries—in alignment with AMA health equity policies, with emphasis on rural and underserved communities.

822. IMPROVING HOME OR COMMUNITY-BASED SERVICES WAIVER WAITING LIST MANAGEMENT
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-280.942

RESOLVED, that our American Medical Association support automatic eligibility screening for home or community-based services (HCBS) waivers for individuals who may be eligible, including older adults and people with disabilities.

823. ACCOUNTABILITY IN THE USE OF AUGMENTED INTELLIGENCE FOR PRIOR AUTHORIZATION
Introduced by American College of Rheumatology, Association for Clinical Oncology, American Academy of Dermatology, American Society of Anesthesiologists, American Gastroenterological Association, American College of Physicians, American Association for Geriatric Psychiatry, American Society for Gastrointestinal Endoscopy, American Society of Nuclear Cardiology, Society for Cardiovascular Magnetic Resonance

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-480.956

RESOLVED, that our American Medical Association will amend policy D-480.956, "Use of Augmented Intelligence for Prior Authorization," by addition and deletion to read as follows:

Our American Medical Association will work with stakeholders ~~advocates~~ to advocate for legislative and/or regulatory action for greater regulatory oversight ~~of~~ related to the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers and/or contracted third parties are using a thorough and fair process that:

1. is based on accurate and up-to-date clinical criteria derived from national medical specialty societies' evidence-based guidelines and peer-reviewed clinical literature.
2. includes reviews by ~~doctors~~ physicians and other health care professionals who are not incentivized to deny care and with expertise for the service under review.
3. ~~requires such reviews include human examination of patient records prior to a care denial~~
3. provides for transparency and accountability over the use of augmented intelligence for all medical service denials, to include a direct review of patient records by a qualified clinician.
4. requires direct review of the patient record by a qualified clinician of all medications flagged for denial by augmented intelligence platforms that were previously approved by payers.
5. provides robust appeals processes and guardrails to prevent algorithmic discrimination and ensure equitable access to care.

RESOLVED, that our AMA will report on actions taken by the 2026 Annual Meeting of the AMA House of Delegates.

824. EQUITABLE PAYMENT AND INCREASED ACCESS FOR IN-OFFICE PEDIATRIC LEAD SCREENING AND TESTING
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-60.890

RESOLVED, that our American Medical Association advocate for all public and private payers for equitable payment rates for in-office pediatric lead screening and testing to cover time, supplies, training, and administrative costs, including both point-of-care and other methods.

RESOLVED, that our AMA support federal and state policies to reduce barriers to improve access to lead screening and testing by incentivizing completion of such services in physician offices.

825. ENSURING COVERAGE FOR IN-OFFICE POINT-OF-CARE (POC) TESTING IN OUTPATIENT MEDICAL PRACTICES
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-185.900

RESOLVED, that our American Medical Association advocate for recognition, coverage, and adequate payment by all public and private payers for laboratory testing, when it is appropriately performed in physician offices and urgent/emergency care settings, to ensure timely and equitable access to diagnostic services for their patients.

826. INCREASE NATIONAL IMMUNIZATION RATES BY ADVOCATING FOR EQUITABLE VACCINE PAYMENTS
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-385.899

RESOLVED, that our American Medical Association supports the establishment of national standards for immunization payment rates that ensure physicians are paid at the full cost of vaccine procurement and administration.

827. OPPOSITION TO PRIOR AUTHORIZATION IN MEDICARE FEE-FOR-SERVICE, BURDENSOME ADMINISTRATIVE REQUIREMENTS
Introduced by Association for Clinical Oncology, American College of Rheumatology, American Society for Radiation Oncology, California Medical Association

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **FIRST RESOLVE REFERRED FOR DECISION**
SECOND AND THIRD RESOLVE ADOPTED AS FOLLOWS
See Policy D-320.966

[Editor's note: the following resolve referred for decision]
RESOLVED, that our American Medical Association opposes the use of prior authorization (PA) and pre-payment review in Medicare Fee-for-Service (FFS), including the proposed Wasteful and Inappropriate Service Reduction (WISeR) Model which would implement a technology-enabled review system (including augmented intelligence/artificial intelligence).

[Editor's note: the following two resolves adopted as follows]
RESOLVED, that our AMA will work with the Centers for Medicare & Medicaid Services to establish provisions that are in accordance with AMA principles and reform goals for prior authorization to protect patients, physicians, and non-physician providers including robust guardrails in any demonstration project implementing prior authorization in Medicare fee for service, such as the WISeR Model.

RESOLVED, that our AMA will continue to advocate for a legislative and regulatory framework that streamlines administrative processes, prioritizes patient access to timely care, and replaces burdensome PA with clinically-sound alternatives, such as the the greater use of evidence-based clinical guidelines.

828. CREATING A PUBLIC SCORECARD ON INSURER DELAYS IN CARE AND PAYMENT CAUSED BY PRIOR AUTHORIZATION
Introduced by California, Arizona, Hawaii, Idaho, Montana, New Mexico, Washington, Association for Clinical Oncology

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED**
See Policy D-320.965

RESOLVED, that our American Medical Association continue to lead the advocacy effort and assist state medical associations with the implementation of timely, non-aggregated public reporting by private and public plans that engage in prior authorization related to the services subject to prior authorization, the number of services approved, denied and overturned on appeal, and the timeframes for responding to requests for authorization and paying physician claims.

RESOLVED, that our AMA work with interested organizations in the development and publication of public and private plan scorecards related to prior authorization approvals, denials, appeals, and the timeframes for responding to requests for authorization and processing physician payments to better inform patients, physicians, and purchasers of insurance.

829. PUBLICIZE INSURER FINANCIAL GAINS FROM DELAYED CARE AND PAYMENT CAUSED BY PRIOR AUTHORIZATION
Introduced by California, Arizona, Hawaii, Idaho, Montana, New Mexico, Washington

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED**
See Policy H-320.935

RESOLVED, that our American Medical Association support efforts to investigate and publicize the financial benefit and profit to commercial insurers, and Medicare and Medicaid health plans that inappropriately use prior authorization to unnecessarily delay care for patients and payments to physicians.

830. WITHDRAWAL OF LOCAL COVERAGE DETERMINATION LIMITING THE USE OF PERIPHERAL NERVE BLOCKADE
Introduced by American Society of Regional Anesthesia and Pain Medicine, American Society of Interventional Pain Physicians, American Academy of Pain Medicine, International Pain and Spine Intervention Society, Pain and Palliative Section Caucus, American Society of Anesthesiologists, American Association of Neurological Surgeons, Congress of Neurosurgeons, American Academy of Physical Medicine and Rehabilitation, California Medical Association, Montana Medical Association, Washington, North American Spine Society

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: **ADOPTED**
See Policy D-330.886, H-120.922 and H-185.931

RESOLVED, that our American Medical Association advocate for the withdrawal of the draft Local Coverage Determinations issued by Medicare Administrative Contractors that restrict coverage of peripheral nerve blockade procedures for chronic pain.

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

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

REFERENCE COMMITTEE K

901. DISTINCTION BETWEEN HEALTHFUL AND UNHEALTHFUL "ULTRAPROCESSED" FOODS
Introduced by Medical Society of the District of Columbia

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED
See Policy H-150.914

RESOLVED, that our American Medical Association encourage public education on the difference between healthful "ultraprocessed" foods and unhealthful "ultraprocessed" foods.

RESOLVED, that our AMA amend AMA policy H-150.914, Addressing the Health Impacts of Ultraprocessed Foods, by deletion to remove the first appearance of the word "food," so as to read "Our AMA supports and promotes public awareness and education about the differences between healthful ~~foods~~ and unhealthful ultraprocessed foods (UPF) and the benefits of minimally processed and unprocessed foods."

902. ADVOCATING FOR IMPROVEMENTS IN SYSTEMS OF CARE FOR AUTISM
Introduced by New England Delegation

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-90.962

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

903. NITROUS OXIDE INHALANT MISUSE
Introduced by Tennessee

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-95.951

RESOLVED, that our American Medical Association encourage and support the regulation of the branding of nitrous oxide canisters by U.S. Food and Drug Administration.

904. SUPPORTING CERTIFICATION OF THE PUBLIC HEALTH WORKFORCE
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association support and endorse the Certified in Public Health (CPH) credential as a valuable certification for public health professionals.

RESOLVED, that our AMA encourage physicians engaged in public health practice to pursue and advocate for the CPH certification.

905. STANDARDIZING BRAIN DEATH POLICIES
Introduced by Organized Medical Staff Section, Massachusetts

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-410.944

RESOLVED, that our American Medical Association collaborate with appropriate stakeholders to identify "accepted medical standards" for determination of brain death/death by neurologic criteria (BD/DNC) as required by the Uniform Determination of Death Act.

RESOLVED, that our AMA work with interested parties to develop and disseminate model hospital policy for a single, unified method of declaration or determination of brain death/death by neurologic criteria.

906. RETHINK THE MEDICARE ANNUAL WELLNESS VISIT
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association advocate for a thoughtful reevaluation of the Medicare annual wellness visit and consider replacing it with an annual comprehensive examination that would integrate preventive care services, a thorough physical exam, and the management of acute or chronic health conditions.

907. IN-OFFICE DISPENSING OF GENERIC MEDICATIONS
Introduced by Florida, South Carolina, Tennessee, Oklahoma

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-115.987

RESOLVED, that our American Medical Association support development of educational material for physicians interested in dispensing generic medications to reduce patient costs, improve access, and decrease unnecessary prior authorization requirements.

RESOLVED, that our AMA encourage medical associations in states with restrictive dispensing laws to advocate for legislation allowing physicians to dispense generic medications to patients.

908. SUPPORT OF ACCESS TO INSULIN-DETEMIR
Introduced by Utah

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association support the designation of insulin-detemir as a drug in shortage to expedite FDA review and approval of biosimilar versions while the reference product remains available globally.

RESOLVED, that our AMA support allowing some of the funding allocated to the Special Diabetes Program to be used to incentivize domestic manufacturing of insulin, including insulin-detemir.

RESOLVED, that our AMA encourages the FDA to consider classifying insulin-detemir as an over-the-counter medication to expand access and affordability for individuals with diabetes.

RESOLVED, that our American Medical Association lobby Congress to pass legislation, or a similarly effective action, to accomplish the goals outlined in this resolution.

909. CLINICAL SIGNIFICANCE OF SLEEPINESS
Introduced by American Academy of Sleep Medicine

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-440.791

RESOLVED, that our AMA support the evaluation and management of sleepiness using validated clinical tools as a vital component of routine clinical services.

RESOLVED, that our AMA support initiatives that strengthen the clinical assessment of sleepiness and improve pathways to treatment.

910 was not considered

911. SAFEGUARDING NIH-FUNDED AND OTHER WOMEN'S HEALTH RESEARCH IN PEER-REVIEWED PUBLISHING
Introduced by Women Physicians Section, Academic Physicians Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-460.959

RESOLVED, that our American Medical Association supports the independence of scientific research and the integrity of peer-reviewed medical journals.

RESOLVED, that our AMA advocates for continued dissemination of rigorous women's health research in respected, independent journals and oppose measures that could impede access to this research.

RESOLVED, that our AMA publicly supports the freedom of the National Institutes of Health and other federally funded scientists and researchers to publish in independent, peer-reviewed journals of their choosing.

912. INCREASING ACCESS THROUGH FEDERATED HEALTHCARE DATA ARCHITECTURE
Introduced by Connecticut

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-460.958

RESOLVED, that our American Medical Association study federated and other data architecture to evaluate its utility in expanding access to large de-identified healthcare datasets across institutions with the aims of enhancing

interoperability through multi-center collaboration, preserving confidentiality by avoiding centralization of PHI, and accelerating ethical research and precision care.

913 was not considered

914 was not considered

915 was not considered

916 was not considered

917. URGING COMPREHENSIVE RESEARCH AND SAFETY TESTING OF INDUSTRY-ENGINEERED FOOD ADDITIVES (IEFAS), INCLUDING HIGH FRUCTOSE CORN SYRUP
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association supports stronger safety protocols and regulatory oversight of food additives, to protect the health and well-being of the American public.

RESOLVED, that our AMA advocate federal policies requiring comprehensive scientific research and safety testing of industry-engineered food additives, including HFCS and other similar substances, prior to their approval by federal regulators for use in the food supply.

918. REMOVE OUTDATED BARRIERS TO GENETIC TESTING
Introduced by New York

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association advocate for federal and state legislation to remove requirements for separate written consent for genetic or genomic testing, and to eliminate unnecessary restrictions on sharing test result records with the treating team of providers, while preserving essential patient protections, including safeguards against discrimination by insurance companies.

RESOLVED, that our AMA advocate for changes to laws nationwide in the states that continue to impose barriers to genetic or genomic testing in the form of written consent requirements in Massachusetts, Michigan, Nebraska, New York, South Dakota, and that our AMA report on the status of this resolution at the 2026 Annual Meeting.

919. STRENGTHENING TRUST THROUGH AMA-BASED LEADERSHIP FOR EVIDENCE-BASED VACCINES (STABLE VACCINES)
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: RESOLUTIONS 919 AND 925 REFERRED FOR DECISION

RESOLVED, that our American Medical Association will serve as a convener of key stakeholders to advance science-based vaccine recommendations.

RESOLVED, that our AMA will establish itself as a trusted, centralized source and public-facing megaphone for science-based vaccine guidance.

RESOLVED, that our AMA will contribute expertise and funding, as appropriate, to advance the mission of coordinating and promoting scientifically grounded and reliable vaccine guidance.

920. ALCOHOL AND AGING: EDUCATING PHYSICIANS AND ADVOCATING FOR SAFER WARNINGS
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED
See Policy H-30.940

RESOLVED, that our American Medical Association advocate for the inclusion of clear, evidence-based warnings concerning the health risks of alcohol use in seniors on all alcoholic beverage containers, and work with regulatory bodies to develop standards for such warning labels in alignment with AMA policy.

921. PRIORITIZING DEPRESCRIBING IN SENIORS
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association declare that deprescribing, the proactive and systematic identification and discontinuation of medications with potential risk greater than potential benefits, is a medical priority in the management of senior patients and advocate for the integration of deprescribing as a standard component of high-quality prescribing practices.

RESOLVED, that our AMA advocate for the development of educational initiatives and clinical decision support tools to facilitate safe and effective deprescribing in electronic health records.

RESOLVED, that our AMA call for research and policy efforts to address barriers for implementation of deprescribing in routine medical care.

RESOLVED, that our AMA advocate for all insurers to reimburse deprescribing activities.

RESOLVED, that our AMA shall report back on the status of deprescribing to the House of Delegates at A-26 and yearly thereafter, with appropriate metrics to address potential barriers and to guide further advocacy, until it has become implemented as a mainstream component of health care.

922. ADDRESSING HEALTH IMPACTS OF INDIAN BOARDING SCHOOLS
Introduced by Medical Student Section, Underrepresented in Medicine Advocacy Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED
See Policy H-350.932

RESOLVED, that our American Medical Association support efforts to address the historical injustices and ongoing health impacts of Indian boarding schools.

923. ENHANCING DISASTER PREPAREDNESS MECHANISMS FOR PEOPLE WITH DISABILITIES
Introduced by Medical Student Section, Oregon, Washington

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED
See Policy D-130.974

RESOLVED, that our American Medical Association, 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.

RESOLVED, that 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 in collaboration with relevant stakeholders.

924. PRESERVING ACCESS TO GAMETE DONATION AND GESTATIONAL CARRIERS AND PROTECTING PARENTAL RIGHTS
Introduced by LGBTQ+ Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED
See Policy H-420.943

RESOLVED, that our American Medical Association support policies and initiatives that protect, standardize, and improve access to gamete donation and gestational carrying as recognized options for assisted reproduction.

RESOLVED, that our AMA support efforts by appropriate parties to provide resources for intended parents, gestational carriers, gamete donors, and children born with the aid of gamete donation and/or gestational carrying.

RESOLVED, that our AMA advocates for accessibility, timeliness, and dignity in the process of establishing parentage for children born from gamete donation and/or gestational carrying.

925. EVIDENCE-BASED VACCINE AND PREVENTIVE SERVICES RECOMMENDATIONS
Introduced by Washington, Oregon, California, Colorado, Montana

Resolution 925 was considered with Resolution 919. See Resolution 919.

RESOLVED, that our American Medical Association will replace all references in our policies to the Advisory Committee on Immunization Practices (ACIP) and the U.S. Preventive Services Task Force (USPSTF) with “current evidence-based recommendations developed by authoritative medical entities”.

RESOLVED, that our AMA will study options for replacing, to the extent possible, the ACIP and USPSTF at the earliest possible time with a national entity which will develop and publish credible evidence-based recommendations for vaccines and preventive services.

926. ESTABLISHMENT OF FEDERAL AND STATE OFFICES OF MEN'S HEALTH
Introduced by American Urological Association, American Association of Clinical Urologists, Washington, California

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED
See Policy D-160.985

RESOLVED, that our American Medical Association amend Policy D-160.985, Establishment of an Office of Men's Health, to read as follows:

Establishment of ~~an~~ Federal and State Offices of Men's Health
1. Our AMA encourages the establishment of an Office of Men's Health ~~at the U.S.~~ within the federal Department of Health and Human Services to coordinate awareness, outreach, and outcomes on men's health.
2. Our AMA encourages the establishment of an Office of Men's Health within each state's Department of Health and Human Services to coordinate awareness, outreach, and outcomes on men's health.

927. BATTLEFIELD ACUPUNCTURE – AN EDUCATIONAL CALL TO ARMS
Introduced by Federal Services

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association encourage greater awareness of and/or instruction in the use of Battlefield Acupuncture as a quick, safe, and effective means to treat acute and chronic pain in patients, given its exceptional safety record, high level of reproducibility, and ability to be administered in an extremely cost-effective manner, without concerns for drug-drug interactions or dependence on narcotic analgesics.

928 was not considered

929. PROTECTING ACCESS TO EVIDENCE-BASED PSYCHOTROPIC MEDICATION FOR THE TREATMENT OF PEDIATRIC MENTAL ILLNESS
Introduced by American Academy of Child and Adolescent Psychiatry

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED
See Policy D-345.967

RESOLVED, that our American Medical Association opposes limitations on access to psychotropic medication as part of a comprehensive mental health treatment plan.

RESOLVED, that our AMA advocates that the U.S. Department of Health and Human Services and Congress use peer reviewed pediatric mental health research, and evidence based clinical guidelines developed by non-profit medical professional societies to inform pediatric mental health policy.

930. ESTABLISHING FIRE RISK STANDARDS FOR CIVILIAN AND NON-INDUSTRIAL CLOTHING
Introduced by The Medical Society of the District of Columbia

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association study the flammability of and fire-resistant treatments for consumer clothing materials and their potential public health benefits.

RESOLVED, that our AMA study the value of updated flammability risk standards that incorporate modern textile compositions and their associated fire risks.

RESOLVED, that our AMA encourage the Consumer Product Safety Commission (CPSC) and relevant regulatory bodies to update and enforce stricter fire safety labeling and testing requirements for civilian clothing and support educating the public on flammability risk on apparel labels.

931. PRESERVING EVIDENCE-BASED, EQUITABLE GROOMING STANDARDS IN THE UNIFORMED SERVICES.

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ALTERNATE RESOLUTION 931 ADOPTED
IN LIEU OF RESOLUTION 931
See Policy D-40.989

RESOLVED, that our American Medical Association advocate against Uniformed Services policy changes that restrict or eliminate evidence-based, medically necessary shaving waivers for service members, and oppose administrative or physical evaluation board separation on this basis when service members otherwise meet qualifications for continued service;

RESOLVED, that our AMA urge the Uniformed Services to implement any changes to shaving waiver policy through an evidence-based and transparent process that incorporates input from Uniformed Services dermatologists, occupational health experts, affected service members, and other interested parties with relevant expertise;

RESOLVED, that our AMA advocate for consistent and equitable shaving waiver policies across all Uniformed Services branches, including standardized criteria, clear re-evaluation intervals and portability of waivers across duty stations;

RESOLVED, that our AMA urge the Uniformed Services to authorize permanent shaving waivers for service members with severe or refractory pseudofolliculitis barbae, especially those who have already received Uniformed Services dermatologist recommendations for permanent waivers and are unresponsive to optimized medical therapy, and to extend this option consistently across all service branches;

RESOLVED, that our AMA support ongoing research on pseudofolliculitis barbae and related dermatologic conditions, including medical management, equity impacts of grooming practices, and evidence-based approaches to accommodations within the Uniformed Services.

932. SHARED DECISION-MAKING AND LOW DOSE CT LUNG CANCER SCREENING IN CLINICAL PRACTICE
Introduced by American College of Radiology, American Society of Radiation Oncology, American Academy of Family Physicians, American College of Radiation Oncology

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: **ADOPTED**
See Policy H-185.936

RESOLVED, that our American Medical Association, in conjunction with other interested national specialty societies of expertise (e.g., ACP, AAFP, ACR, etc.), create and share educational resources and training to help physicians efficiently discuss and document LDCT lung cancer screening during shared decision-making visits for high-risk populations.

933. ADDRESSING GAPS IN NATIONAL HEALTHCARE SAFETY NETWORK (NHSN) DATA
Introduced by American College of Surgeons

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy D-450.947

RESOLVED, that our American Medical Association advocate for the CDC to use its January 2024 definition of Surgical Site Infection (SSI) in the National Healthcare Safety Network (NHSN), and require documented clinical impression of an SSI.

RESOLVED, that our AMA advocate for the CDC to establish consistent NHSN data collection methods for surgical site infection (SSI) surveillance across hospitals and audit hospital NHSN data quality for SSI regardless of hospital performance status.

934 was not considered

935. ENHANCING HEALTHCARE SYSTEM PREPAREDNESS TO ADDRESS VETERAN-SPECIFIC HEALTH DISPARITIES
Introduced by American Academy of Family Physicians

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-510.986

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

RESOLVED, that our AMA actively advocate with medical education accrediting bodies to encourage medical schools, residency programs, and providers of continuing medical education to incorporate training on military service-related health conditions, occupational exposure assessment, and Veteran-specific screening protocols into curricula in order to improve preparedness of the healthcare workforce.

RESOLVED, that our AMA advocate for, and facilitate, robust collaboration with Veterans Service Organizations, medical specialty societies, and state public health authorities to develop, disseminate, and promote adoption of evidence-based clinical guidelines for Veteran-specific health conditions.

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